

The Journal of Applied Behavioral Science

<http://jab.sagepub.com>

Civility, Respect, Engagement in the Workforce (CREW): Nationwide Organization Development Intervention at Veterans Health Administration

Katerine Osatuke, Scott C. Moore, Christopher Ward, Sue R. Dyrenforth and Linda Belton

Journal of Applied Behavioral Science 2009; 45; 384
DOI: 10.1177/0021886309335067

The online version of this article can be found at:
<http://jab.sagepub.com/cgi/content/abstract/45/3/384>

Published by:



<http://www.sagepublications.com>

On behalf of:



NTL Institute

Additional services and information for *The Journal of Applied Behavioral Science* can be found at:

Email Alerts: <http://jab.sagepub.com/cgi/alerts>

Subscriptions: <http://jab.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations <http://jab.sagepub.com/cgi/content/refs/45/3/384>

Civility, Respect, Engagement in the Workforce (CREW)

Nationwide Organization Development Intervention at Veterans Health Administration

Katerine Osatuke

Scott C. Moore

Christopher Ward

Sue R. Dyrenforth

Linda Belton

Veterans Health Administration National Center for Organization Development

This article presents a description and preliminary evaluation of a nationwide initiative by the Veterans Health Administration (VHA) called Civility, Respect, and Engagement in the Workforce (CREW). The goal of CREW is to increase workplace civility as assessed by employee ratings of interpersonal climate in workgroups. Once endorsed by the VHA leadership and adopted by the leaders of particular VHA hospitals, CREW was conducted by local facility coordinators who were trained and supported by the VHA National Center for Organization Development. This article explains the conceptual and operational background of CREW and the approach used to implement the initiative, presents results from two CREW administrations with a total of 23 sites, and reports significant preintervention to postintervention changes in civility at intervention sites as compared to no significant changes at comparison sites within each administration. It discusses these findings in the conceptual (theoretical) and operational (intervention evaluation) context of interventions targeting civility.

Keywords: *civility; organization development; intervention evaluation; survey feedback*

This study presents results from a nationwide organization development initiative in the Veterans Health Administration (VHA), which focused on increasing civility in the workplace. The initiative is called Civility, Respect, and Engagement in the Workforce (CREW). We present the conceptual and operational background of CREW, explain the approach that the VHA used to implement it, share initial results, and discuss these findings in the theoretical and operational context of interventions targeting civility. In the CREW framework, and in this article, *civility* refers to courteous and considerate workplace behaviors within the workgroup (the group of people who work together and report to the same supervisor). More specific dimensions understood to express civil behavior are coworkers' personal interest and respect

toward each other; coworkers' cooperation or teamwork; fair resolution of conflicts; and valuing of differences among individuals, both by coworkers and by the supervisor.

Civility: Conceptual and Research Background

Civility generally refers to interpersonal behaviors that demonstrate respect and "love of thy neighbor" (Anderson & Pearson, 1999). It builds on interpersonally valuing and being valued by others—a concept that has long been theoretically recognized as important in the organization development and industrial–organizational psychology fields (cf. Adlerfer, 1972; Herzberg, Mausner, & Snyderman, 1959; Likert, 1961; Maslow, 1973). Whereas particular civility norms vary among cultures and work environments (Hartman, 1996), the importance of observing the shared norms is universally recognized and even considered a moral virtue (Anderson & Pearson, 1999). Recent research into organizational outcomes highlighted that civility may have not only moral but monetary value (Mohr et al., 2007; Moore, Osatuke, & Howe, 2008; Nagy, Warren, Osatuke, & Dyrenforth, 2007; Osatuke & Dyrenforth, 2006; Osatuke, Dyrenforth, & Belton, 2008).

Our contention is that civility constitutes an important part of the organizational climate perceived by employees, and as such, civility influences important organizational outcomes. Several meta-analytic studies have established the predictive strength of organizational context variables and, in particular, employee perceptions of organizational climate for many crucial individual-level job outcomes (Carr, Schmidt, Ford, & DeShon, 2003; Johns, 2006; Parker et al., 2003). Individual outcomes accumulate to shape organization-level outcomes (Kopelman, Brief, & Guzzo, 1990; Ostroff, 1992); this is the mechanism whereby psychological outcomes, such as satisfaction, become organizational, such as turnover and absenteeism. For example, one meta-analytic investigation (Harter, Schmidt, & Hayes, 2002) used the data from 42 studies to show that business–unit–level employee satisfaction relates to business outcomes including organizational performance and costs. These findings support the organizational relevance of employee workplace perceptions and call for closer attention to assessing and monitoring the status and impact of organizational climate variables. One aspect that has not been extensively examined but has strong theoretical support for its connections with outcomes is workplace civility.

In health care, assessing the status, organizational effects, and mechanisms to increase civility may be especially important. Health care employees are the main vehicle whereby patient services are delivered, and the highly demanding emotional drain of interacting with clients puts them at risk for burnout (Cordes & Dougherty, 1993), which, in addition to personal costs to health care employees, has severe negative effects on patient care and satisfaction (e.g., Garman, Corrigan, & Morris, 2002). The organizational climate of respect, on the other hand, is inversely related to burnout—an influence that has been found statistically significant beyond the

contributions of job demands and employee personality traits (Ramarajan & Barsade, 2006). Civility levels relate to important organizational outcomes in health care. For example, respect was found to affect nurses' trust in management (Laschinger & Finegan, 2005), whereas perceived disrespect influenced both intentions to quit and employees' actual turnover (Pinel & Paulin, 2005). Also, teamwork culture in hospitals (which is conceptually close to civility as we defined it) was reported to have a significant positive association with patient satisfaction for inpatient care (Meterko, Mohr, & Young, 2004).

Promoting civility at the workplace may be best conceived at the organizational rather than purely individual level. This is because (in)civility may be thought of as an interactive process occurring within a situational context (whether a workgroup or entire organization) rather than single static events between separate individuals (Pearson, Andersson, & Porath, 2005). For example, employee-perceived organizational support has been found to moderate the effects of psychological aggression (i.e., extreme instances of incivility) on employees' emotional well-being and job-related affect (Schat & Kelloway, 2003). Workgroup incivility has been found to have impact on job satisfaction and mental health over and above the impact of personal incivility (Lim, Cortina, & Magley, 2008). This supports the relevance of employee perceptions of the larger organizational culture to individual-level outcomes of uncivil behaviors directed at employees.

The organization development (OD) field is based on the premise that organizations have the potential to change how employees experience their workplace. For example, enhancing a positive social environment within an organization (effective communication, autonomy, participation, and mutual trust) is believed to increase employee satisfaction and positive attitudes (Argyris, 1964; Likert, 1961). Studies evaluating effectiveness of specific interventions targeting employee perceptions of organizational climate are, nevertheless, rare. With the important exception of Krebs's (1976) work, we are not aware of any studies that examined best practices of managing (in)civility at the workplace. This remains an important agenda for OD research in general (Hutton, 2006) and in health care settings in particular.

Focus on Civility Within VHA: Organizational Background

The National Leadership Board of the VHA recently endorsed civility as a core characteristic of an ideal workplace, prompted by several internal operations studies. First, a survey of former employees who voluntarily left the VHA (Sirota Consulting, 2001) showed that across all job functions employees terminated for similar reasons. From these employees' perspective, key areas in need of attention included a lack of respect and fairness and limited chances to express one's ideas and become involved in improving work processes. Another VHA study assessed rates of verbal abuse among its employees using the same instrument as in the U.S. Postal Service Survey, and it identified 67% of respondents exposed to verbal abuse in VHA (Hodgson

et al., 2004), compared to 37% in the Postal Service (Goldstein et al., 2000). Coworkers (supervisors, coemployees, and subordinates) perpetrated between 15% and 35% of verbal abuse incidents and were the next most frequent perpetrators after patients. These results highlight the rates of verbal abuse (that is, extreme instances of workplace incivility) and a need to address it. The VHA Stress and Aggression Workgroup (Kowalski, Harmon, York, & Kowalski, 2003; Yorks, Neuman, Kowalski, & Kowalski, 2007) examined how workplace stress and aggression affected employees' and veterans' satisfaction, service quality, and costs, and it suggested an intervention approach fostering an interpersonally respectful environment. Local action teams at 11 sites collected survey data and planned and conducted site-specific interventions based on the results. Compared to 15 control sites, follow-up assessment showed significantly greater work climate improvement postintervention. More positive perceptions of work climate were also associated with reduced aggression and stress and better employee satisfaction and business results (Equal Employment Opportunity complaints, violence claims, sick leave, overtime, patient waiting time). These findings suggest that site-tailored interventions at the VHA, with the general goal of promoting respectful environment, successfully addressed interpersonal work climate problems.

Collectively, these studies establish that the organizational culture of interpersonal interactions, specifically civility norms, have a steady relationship to individual-level outcomes in the VHA (work motivation, absenteeism, turnover) and the VHA organizational mission (clinical care and patient satisfaction). These results suggest a new direction of enhancing organizational performance that could be implemented in the current Zeitgeist of tight budgets, heightened accountability, and increased focus on performance measures. Casting civility as a crucial component of the workplace reflects a heightened focus on workplace culture development as a strategy for improving quality of the VHA's processes and services. This focus resulted in the nationwide CREW initiative within the VHA, with the primary goal to change organizational culture toward increasing workplace civility.

The CREW Intervention Model

The goal of CREW was to be accomplished by supporting work units as they identify their strengths and areas for improvement with regard to civility. The mechanism of change believed to be at work during CREW interventions is that, for the intervention period, the VHA organizations commit to giving time, attention, and support to having regular (weekly) workgroup-level conversations about civility. This understanding of what causes change reflects the client-centered roots of OD (Herzberg et al., 1959; Maslow, 1973; Rogers, 1977), where the client's motivation is considered to be the main driver of change and clients' own beliefs and perceptions (e.g., regarding what needs to be improved and what will constitute improvement) are taken as an optimal guide for direction. The practitioner's role is to help

clients clarify their current situation, needs, and motives and discover their capacity to make choices. The practitioner does this by supporting the client's focus on their own thinking and planning process; that is, the facilitator does not articulate the needs, define directions, or devise plans on behalf of the client. The practitioner's contribution to change is providing conditions for the client's own work, that is, making room (committing time, space, and resources to weekly discussions of workplace civility) and offering interpersonal support (positive attitude, sincere interest, active listening, ability to relate to the client's perceptions; cf. Rogers, 1959). To summarize, much as in classic client-centered counseling (Bozarth, 1999; Rogers, 1959), the practitioner helps organizational clients design their own intervention and supports them as they carry it through.

This approach, rather than providing any specific structure or ingredient of intervention, is viewed as a critical feature that causes increases in civility as a result of CREW interventions. Across the sites, the specifics of in-group process and follow-ups are allowed to vary greatly, and as a result, the interventions become driven by responsiveness to local needs and local culture-based civility definitions. Conceptually, this is based on the premise that, as interventions proceed, clients' needs and perceptions often change or become redefined. This conclusion, well established in the OD field (Armenakis & Zmud, 1979; Golembiewski, Billingsley, & Yeager, 1976; Millsap & Hartog, 1988), is taken into account by process-oriented OD approaches of which CREW is one. The main distinguishing feature of successful interventions in the CREW framework is their "responsive" (flexibly adjusting to the changing contexts and new needs that emerge on a moment-to-moment basis) rather than "ballistic" (fully planned and specified in advance, as prescribed by intervention theories or practice manuals) nature (Stiles, Honos-Webb, & Surko, 1998).

The importance of responsiveness over any specific intervention ingredients is supported by process-outcome research in other fields (e.g. counseling, psychotherapy). For example, correlations between outcomes and certain types or elements of interventions overwhelmingly yield null findings (Beutler, 1991; Elliott, Stiles, & Shapiro, 1993; Luborsky, Singer, & Luborsky, 1975; Stiles, Shapiro, & Elliott, 1986). A lack of a connection between outcomes and specific intervention types or ingredients has been documented in OD research as well (e.g. Porras, 1979), which we believe supports the argument for the crucial importance of responsiveness of interventions, although studies evaluating effectiveness of OD interventions on workplace climate change remain rare.

The CREW initiative thus represents a customized and flexible intervention approach, whereby each site chooses its specific definitions and areas of focus related to civility. Whereas this strategy optimizes local autonomy and adaptability of the interventions and, we believe, drives the success of the interventions, it also clearly creates additional challenges for systematizing and summarizing the results for research purposes. To make the CREW interventions comparable across sites, preintervention and postintervention assessments of workgroup civility climate relied on survey data

(the civility measure used is explained in the Method section). Beyond the research purposes of examining civility outcomes for intervention and comparison sites, the data were also used to capture and present a picture of the participating workgroups' preintervention civility levels. The survey feedback provided an objective basis to inform their subsequent discussion of what civility means for the group and which aspects of workplace climate they want to improve. This use of survey data is a typical and recommended one in the context of OD efforts (e.g., Nadler, 1977).

CREW and the Prototype Model

To translate the notion of responsiveness into how it was specifically implemented in CREW, consider another conceptual perspective provided by research on prototypes as design tools for organizational change, specifically in health care (e.g., Banathy, 1996; Coughlan, Suri, & Canales, 2007; Weick, 2001). Although the CREW approach was not designed with the prototype model in mind, the two models parallel each other closely: Descriptions of how to use prototyping to facilitate organizational change in health care are very consistent with how CREW interventions proceed. The following aspects are similar between the two models.

With respect to conceptualizing the intervention mechanism, the prototype-based approach emphasizes connections between individual behaviors and their context (workplace environment) and suggests the importance of redesigning the context to shape the behavior. The same assumption (workplace behaviors are contextually defined) is made within the CREW approach, with the same implication that attending to workplace environment is an important direction of change.

With respect to the intervention process, the prototype approach specifies that employees first generate ideas to support specific organizational goals. In CREW, this happens as well (usually at the first meeting); employees generate ideas of how to increase civility of workplace interactions, which represents the specific organizational goal of CREW. The next step, in the prototype model, involves collecting and sharing data on workplace perceptions, employee, and customer behaviors to clarify areas of strength and opportunities for improvement. This step also applies to CREW and occurs at the first meetings at the sites.

With respect to facilitative tools used within interventions, in the prototype model as well as in the CREW framework, ideas on how to support the goals of change are brainstormed and translated into concrete, easy-to-grasp, visually friendly expressions (such as sunny or stormy weather icons to express the daily interpersonal climate in the workgroup). These visual expressions serve as reminders of the group's focus and help monitor progress. In the prototype model, such tools are called prototypes—tangible expressions of ideas that are made quickly from inexpensive, accessible materials that serve to provide immediate, concrete feedback mechanisms for facilitating organizational thinking. In CREW, most of the assessment instruments in the intervention tool kit (described later in the Method section) can be thought of as prototypes.

Another common feature is flexibility of the intervention focus: In both models, the focus is explicitly allowed to shift, reflecting the changing needs of the users. In the prototype model, the foci for specific desirable changes suggested by prototypes do not stay rigid throughout the intervention but are meant to evolve, reflecting organizational learning. This is similar to the CREW concept of responsive, not ballistic interventions. Furthermore, in the prototype model, the evolving nature of prototypes creates a higher-than-traditional degree of collaborative involvement from the intervention users. Intervention tools thus become influenced and shaped by the users' experience that the consultants do not necessarily possess. As the employees collectively redesign the prototypes and reality-test their improved understandings of new behaviors represented by the prototypes, further experimentation is encouraged, failures are allowed, and feedback processes are used extensively. These same processes (growing employee engagement in designing their own interventions and consequent ongoing redesign of the foci and tools) also happen during the CREW. Throughout the CREW intervention, employees at participating sites actively redefine the tools to reflect their local culture and changing needs and foci of the intervention. Recognizing the crucial importance of incorporating user experience in organizational change processes, including specifically in health care, is consistent with extant OD thinking (e.g., Bate & Robert, 2007; Bragg & Andrews, 1973; Weick, 2001). In the CREW approach as well as in the prototype model, testing various alternatives against the requirements and constraints of the local culture helps employees learn faster what works and what does not. In this process, ideas with promise, and tools that express them, become elaborated and further disseminated in the workplace, and ideas and tools that do not work are discarded. In CREW, the results are interventions that share the same goal (increasing workplace civility) across all participating sites where particular intervention methods are custom adapted by the local users. Shared and site-specific elements of the interventions are discussed in more detail in the Method section.

CREW Within the VHA: Operational Context

The overarching framework for the CREW approach that was endorsed by the VHA National Leadership Board is as follows. Providing organizational support for consistently civil workplace behaviors (the first element) is expected to affect workplace perceptions, resulting in employees' feeling respected and empowered to act (the second element). This, in turn, is expected to influence employee actions within the organizational context evidenced by an increase employee engagement (defined as collaborative efforts toward VHA goals)—the third element. These expectations, based on the National Leadership Board's interpretation of results from internal studies, are generally consistent with the directions of previous OD thinking (e.g., Ostroff, 1992) and extant research (e.g. Laschinger & Finegan, 2005), and they represent a broad operational context for CREW.

The CREW initiative, and its evaluation in this article, focuses specifically on the first element of these expectations: civility. This study is based on the data from the first two administrations of CREW. We compared VHA employees' civility ratings before and after their workgroups participated in CREW. We contrasted these results with comparison groups that did not participate in CREW and concluded that the civility-focused CREW intervention was successful overall. Additionally, we describe our approach to devising and implementing CREW interventions, discuss strengths and limitations of this approach, and make suggestions for further research on interventions targeting workplace civility.

Method

Participating Sites

The two CREW administrations examined here (we will refer to them as *CREW-1* and *CREW-2*) included VHA facilities from all over the country of all sizes and structural complexity (e.g., small, rural hospitals and large, urban facilities in metropolitan areas). Preintervention and postintervention tests were included within each administration. Eight facilities, one workgroup each, participated in CREW-1; six of these could be matched to comparison groups and were, therefore, retained in final analyses. Thirty-eight workgroups from 20 facilities, from 1 to 5 workgroups each, participated in CREW-2. Of these, 17 workgroups were retained in final analyses because they satisfied two conditions: They had at least 10 participants in both the preintervention and postintervention surveys and also could be matched to comparison groups. Staff members in participating workgroups had moderately diverse professional backgrounds (e.g., clerks, secretaries, and administrative supervisors) but were all part of the same service (e.g., administrative personnel, clinical care providers, pharmacy). Professional background and facility characteristics were similar for comparison groups and their matched intervention groups. Demographic background of comparison groups was not systematically different from VHA overall and represented a variety of gender, age, length of organizational tenure, and racial characteristics. Demographic background of intervention groups was not assessed for operational reasons (to avoid creating a perception that individual participant identities within small CREW groups will be focused on). However, there is no reason to believe that demographic background of intervention groups systematically differed from comparison groups and VHA overall.

Intervention Procedure

Local facility coordinators conducted the CREW intervention with the support and coordination of the VHA National Center for Organization Development (NCOD). Implementation of the CREW framework at the facilities was shaped by two major

influences: (a) the NCOD practice model that summarizes NCOD usual strategies of conducting organizational consultation and intervention and (b) the local workplace culture. NCOD made the same educational kit available to each site; its elements were selected and used at the local facilitators' discretion.

NCOD practice model. The NCOD practice model is process consultation (Reddy, 1994; Reddy & Phillips, 1992; Schein, 1988, 1990, 1992, 1999, 2006), with strong influences of action science and action inquiry (Argyris, Putnam, & Smith, 1985; Argyris & Schon, 1974, 1978, 1996; Torbert, 1989, 1991a, 1991b). The client is seen as a subject matter expert. The practitioner brings in expertise about human and organizational processes and about facilitation of the client's actions. The client is a decision maker, responsible for owning, planning, and implementing change. The practitioner clarifies the client process, highlights resources and options available, supports local leaders, trains local facilitators, and uses professional expertise on interpersonal and systemic processes and client assessment data as sources of information and feedback to the client. Organization development is a data-based activity (Harvey & Brown, 1992; Nadler, 1977), and while facilitating CREW, NCOD routinely uses instrumentation to generate data that clients then use for assessing the situation, interpreting current needs, and planning actions.

NCOD practitioners provide overall resource coordination, a tool kit of educational activities, and opportunities to exchange experience among CREW facilities. They act as process consultants to the local facility coordinators, for example, answering questions about meeting facilitation or sharing experience on working methods from other sites that had similar environment or workplace issues. The practitioners who facilitate CREW are all clinical or counseling PhD or PsyD psychologists with postdoctoral OD training. They work as a team, valuing continuous learning from clients and from each other. Consistent with the action science and action inquiry, they adopt a multitheoretical approach to cases, which leads to joint conceptualizations of interventions through a consensus-building process. Like all of NCOD work, CREW is based on involving all employees in the organization (i.e., all members of participating workgroups). The interpersonal relationship is understood as the core of intervention and action planning. Consequently, the local conversation about civility is given top priority, as opposed to implementing models and directives brought from the outside.

Local influences. Local workplace culture is considered crucial to capture during CREW implementation. The literature describes incivility as unique to particular situations (e.g., Hutton, 2006). Similarly, the CREW approach conceptualizes civil behaviors as culturally specific to each organization; a rural, Midwestern hospital and a large, urban New York facility may each define civility differently. Incorporating local culture into each CREW intervention was, therefore, considered vital to success. This created variation among sites' definitions of civility, intervention foci, and strategies.

Shared aspects of CREW intervention. The NCOD intervention approach shaped shared elements in defining civility across the sites. Civility is defined as workplace behaviors. Civil behaviors are seen as impersonal, displayed on behalf of the organization, and are directed toward everyone at the workplace, not exclusively towards people with whom one has a personal relationship. Civility is understood as based on awareness of one's interpersonal impact; people monitor their own behavior during specific interactions with others and pay attention to how others receive it. More specific contents of civil workplace behaviors are defined locally and thus vary across sites.

Shared aspects of the CREW intervention process across sites are as follows. NCOD trains local CREW leaders from each site by explaining the rationale for CREW and its operational background and sharing the data in support of the organizational relevance of civility. A preintervention survey is conducted using the civility scale. Based on preintervention survey scores and/or the tools within the educational kit that they see as fitting their needs, each site chooses specific areas of foci related to civility. For example, some sites (often those with low pretest scores) devote much time to discussing their definition of civility and respect and focusing on improving basic communication between participants. Others (with higher initial scores of civility) focus on extensive sharing about their backgrounds and deepening workplace relationships. Some sites also develop actions supporting greater collaboration toward employees' shared work-related goals. CREW coordinators lead interventions at their facilities by facilitating regular on-site meetings. At the meetings, baseline data on civility are first shared and discussed within workgroups. The workgroups then decide which actions to take to improve their overall civility, thus developing their own methods for improving their work environment. Six-month follow-up assessment is conducted using the same civility scale. As additional support to the sites, NCOD offers and facilitates pilot meetings and monthly conference calls for all local coordinators.

Educational tool kit. NCOD shares with each site the same educational tool kit containing ideas and experiential activities that promote exploration of CREW components. Appendix A lists the items included in the tool kit.

Measures

Civility levels at the participating sites were measured by an 8-item civility scale (Meterko, Osatuke, Mohr, Warren, & Dyrenforth, 2007, 2008). The scale measures aspects of workplace civility through employee ratings of personal interest and respect from coworkers, cooperation or teamwork in the workgroup, fair conflict resolution, and valuing of individual differences by coworkers and supervisor. The civility scale is a group of items originating from the voluntary, anonymous VHA All Employee Surveys (AES), administered in 2004 and 2006 and

yearly thereafter. These items belong to one of the three parts of the AES: the Organizational Assessment Inventory (OAI), made of questions where respondents rate particular characteristics of their workgroup climate. The OAI was composed by the Office of Personnel Management at the Federal Human Resource Agency (Gowing & Lancaster, 1996) on the basis of two sources: their pre-existing survey (available at <https://www.opm.gov/surveys/services/OrgAssessSurvey.asp>) and the Generic Stress instrument used by the National Institute for Occupational Stress and Health (Hurrell & McLaney, 1988).

In the exploratory and confirmatory factor analyses of the OAI data in 2004 (Meterko et al., 2007, 2008), the group of items that later formed the Civility scale showed high consistency in their loadings on a single factor, interpreted to reflect the concept of civility. Item-to-scale correlations ranged from .67 to .83 for the eight items; Cronbach's alpha for the scale was .93. This group of items was used in the AES without modifications in all subsequent years. In VHA internal operation studies, an index score based on this group of items has shown statistically significant hospital-level relationships to employee absenteeism and turnover and to independent measures of patient satisfaction. These relationships, the content of the items that had face validity for VHA stakeholders, and endorsement of the civility concept by the VHA leadership contributed to a wide use of the civility scale within the VHA organizational culture, and eventually prompted its choice as a preintervention and postintervention measure for the CREW initiative.

The Civility scale items with their labels are listed in Appendix B. For each respondent, a single index of workgroup civility was computed as an average of the 8 items. A workgroup-level aggregate of the civility index was then used to measure workgroup civility. The scale provided quantitative data for comparing employee perceptions of organizational climate from preintervention to postintervention, and it allowed for comparing CREW participants' ratings to other VHA groups within the same year. Internal consistency reliability for the scale was found to be high: Cronbach's alpha values for CREW-1 and CREW-2 were .93 and .94, respectively, consistent in preassessment and postassessment surveys and also consistent with the VHA AES data.

Research Design

The study included two administrations of CREW: CREW-1 and CREW-2. CREW-1 included eight intervention workgroups, with 899 participants altogether. Two workgroups, due to their unique occupational makeup, could not be matched to any comparison groups and were excluded from the analyses. This left six intervention workgroups (participants' $n = 425$ pretest and $n = 328$ posttest altogether), matched to six comparison workgroups (participants' $n = 236$ pretest and $n = 407$ posttest). CREW-2 included 38 workgroups, with 1,295 participants altogether. Of those, 26 workgroups had 10 or more respondents on both preintervention and

postintervention surveys, and 17 of these 26 workgroups could be matched to comparison groups (the other workgroups could not be matched due to their unique occupational makeup). This left 17 intervention workgroups (participants' $n = 688$ pretest and $n = 647$ posttest), each matched to a comparison workgroup (total participants' $n = 607$ pretest and $n = 680$ posttest). Civility ratings compared from preintervention to postintervention came from the CREW surveys, for intervention workgroups, and from the matching years' AES data for comparison groups.

The Civility scale for CREW preintervention and postintervention surveys was administered at CREW-1 participating sites in September 2005 and July 2006, respectively, and at CREW-2 sites in February 2006 and March 2007, respectively. For operational reasons reflecting VHA data security and confidentiality procedures, matching individual CREW participants' ratings from preintervention to postintervention surveys was impossible: Respondents had to be identified by their workgroup ID only, not by their individual ID. Therefore, although individual ratings were available and were used in the analyses, preintervention to postintervention scores were comparable at the workgroup level only. Because the scale items clearly reference workgroup climate, the preintervention and postintervention ratings still measure the same referent for members of the same workgroup. Score changes are therefore interpreted as workgroup-level changes in civility climate.

Control sites that did not participate in CREW but had participated in the VHA AES in May of 2004, 2005, and 2006 were retrospectively matched to intervention sites within the respective years. Preintervention comparison sites' data for CREW-1 were from the 2004 AES administration and the postintervention data for the same sites came from the 2005 AES data. For CREW-2, preintervention comparison site data came from the 2005 AES administration and the postintervention comparison data came from the 2006 AES administration for the same groups. This strategy reflects nonequivalent control group design (Campbell & Stanley, 1963), a quasi-experimental design used when random assignment to groups is impossible, whereby compared groups are assembled naturally rather than experimentally. Given this design, attributing groups' differences on the posttest to group differences in intervention status (i.e., to whether they had or did not have CREW) assumes similarity in all other characteristics of intervention and comparison groups. To ensure such similarity, we matched intervention sites and comparison sites by two criteria: occupations within workgroups (e.g., nurses, human resource specialists, clerks) and organizational complexity of the hospitals. The latter included five complexity categories used in the VHA system based on (a) patient volume, (b) patient risk level, (c) number of clinical specialties and patient services, and (d) amount of teaching and research done at the hospitals. Whenever available, the match also incorporated a third criterion: geographic proximity. Similarity between intervention and comparison groups was further confirmed by comparing their pretest scores.

Data Analyses

A random effects two-by-two univariate analysis of variance (ANOVA), with an alpha level of .05, was used to examine differences in civility index scores for intervention and comparison sites as a function of survey time (preintervention or postintervention). We considered individual-level data, first from both administrations of CREW together and then separately for each CREW administration. That is, we first compared civility scores from all CREW intervention sites within both CREW administrations to civility scores from all of their respective matched comparison sites. Then we used the same approach to compare all intervention sites to all comparison sites within CREW-1 only. Finally, we compared all intervention to all comparison sites within CREW-2 only. This approach, rather than comparing single intervention to single comparison groups site by site, was chosen because many CREW sites had small numbers of participants and would, therefore, yield little statistical power to detect differences.

Results

We found significant group differences in civility levels only between intervention sites. As expected, at these sites only, ratings of workplace civility increased from preintervention to postintervention, whereas at the comparison sites, civility levels remained stable across time. In other words, the only factor associated with significant differences in civility was the interaction term (intervention by time): that is, the combination of intervention status (did or did not participate in CREW) and survey time (preintervention or postintervention). Main effects of time (comparing civility ratings across time while examining intervention and comparison sites all together) and main effects of intervention status (comparing intervention to comparison sites while considering their preintervention and postintervention ratings all together) were not significant. The nonsignificant main effect of time suggests there were no changes in civility levels at the sites that would be due only to the different survey timing (preintervention versus postintervention). That is, timing of the survey alone did not make the difference in reported civility levels; the combination of intervention and survey timing did. The nonsignificant main effect of intervention status suggests there were no differences in civility levels that would be due only to the sites' membership in the intervention group versus the comparison group. That is, civility levels at intervention sites were not overall different from those at comparison sites, unless we consider the timing of civility measurement (preintervention versus postintervention). These results speak to the main point of this evaluation: They allow us to ascertain that CREW participation is associated with significant

Table 1
ANOVA Tests of Between-Subject Effects for Civility
Scores for CREW-1, CREW-2, and Overall

	Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	η
CREW-1	Intervention status	59.92	1	59.92	5.89	0.85
	Time	3.96	1	3.96	0.39	0.28
	Status \times Time	10.17	1	10.17	11.87**	0.01
	Error	1192.45	1392	0.86		
CREW-2	Intervention status	1.81	1	1.81	0.42	0.29
	Time	14.54	1	14.54	3.34	0.77
	Status \times Time	4.35	1	4.35	4.42*	0.00
	Error	2573.00	2618	0.98		
Overall	Intervention status	13.50	1	13.50	1.06	0.51
	Time	14.83	1	14.83	1.16	0.54
	Status \times Time	12.73	1	12.73	13.35***	0.00
	Error	3828.62	4014	0.95		

Note: CREW = Civility, Respect, and Engagement in the Workforce. Intervention status consists of CREW participants and equivalent comparison groups. Time consists of preintervention and postintervention.

* $p < .05$. ** $p < .01$. *** $p < .001$.

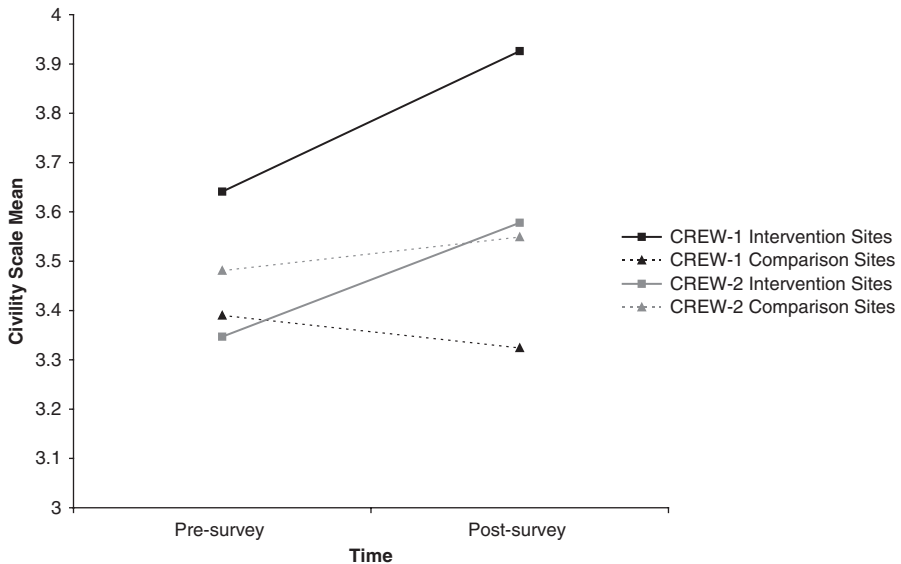
improvement in civility ratings after the intervention and that the CREW intervention is what causes these improvements. The next subsection presents the specific findings, first reporting them for the overall sample and then breaking down into CREW-1 and CREW-2 administration.

ANOVA Results

Examining all CREW data together (Table 1) showed that differences in civility index scores were not significant for main effects of the intervention status (intervention or comparison site) and for main effects of the survey time (preintervention or postintervention survey). The interaction term (intervention status by survey time) showed significant effects, $F(3, 4014) = 13.35, p < .001$. The overall intervention sites' mean increased from 3.459 ($SD = 0.99$) at preintervention to 3.695 ($SD = 0.93$) at postintervention, whereas the overall comparison sites' mean remained stable: 3.456 ($SD = 1.00$) at preintervention and 3.465 ($SD = 1.01$) at postintervention.

Examining CREW-1 data only showed the same pattern: Differences in civility index scores were not significant for main effects of the intervention status (intervention or comparison site) and survey time (preintervention or postintervention). The interaction term (intervention status by survey time) showed significant effects, $F(3, 1392) = 11.87, p < .001$. The overall intervention sites means increased from

Figure 1
Mean Changes for the Intervention and Comparison
Sites for CREW-1 and CREW-2



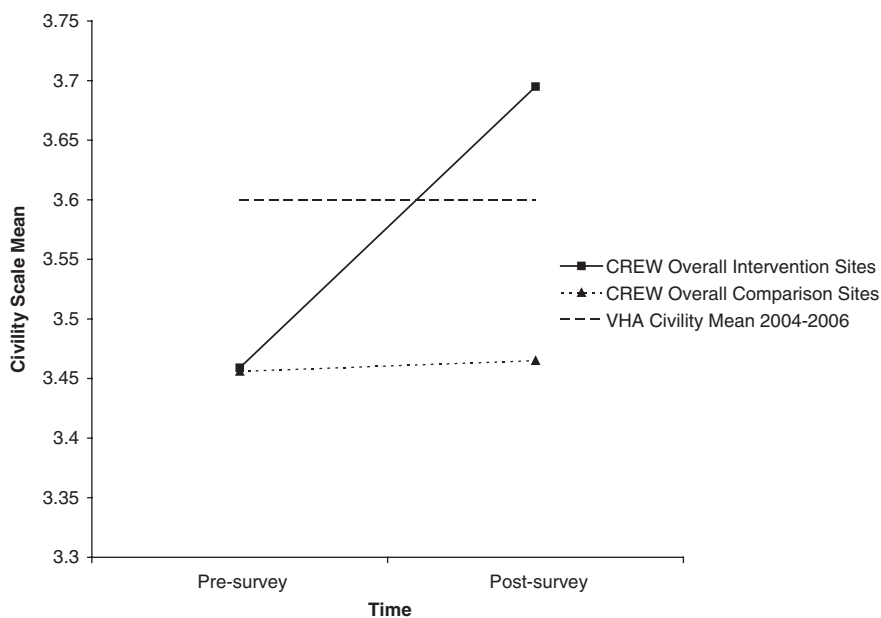
Note: CREW = Civility, Respect, and Engagement in the Workforce.

3.641 ($SD = 0.85$) at preintervention to 3.956 ($SD = 0.77$) at postintervention, whereas the overall comparison sites means remained stable: 3.390 ($SD = 1.03$) at preintervention and 3.324 ($SD = 1.04$) at postintervention.

Examining CREW-2 data only showed the same pattern again: Differences in civility index scores were not significant for main effects of the intervention status (intervention or comparison site) and survey time (preintervention or postintervention). The interaction term (intervention status by survey time) showed significant effects, $F(3, 2618) = 4.42, p = .05$. The overall intervention sites means increased from 3.347 ($SD = 1.01$) at preintervention to 3.578 ($SD = 0.98$) at postintervention, whereas the overall comparison sites means showed no significant change: 3.481 ($SD = 0.99$) at preintervention and 3.549 ($SD = 0.99$) at postintervention.

Figure 1 shows estimated marginal means for CREW-1 and CREW-2, obtained by the 2×2 ANOVAs reported above. Figure 1 illustrates significant differences between preintervention and postintervention scores for intervention sites only but not for comparisons within both CREW administrations. Figure 1 also shows how the pattern of change for the intervention and comparison sites was different for CREW-1 and CREW-2.

Figure 2
Mean Changes for the Intervention and Comparison Sites for All CREW Interventions With National VHA Civility Mean Across 3 Years



Note: CREW = Civility, Respect, and Engagement in the Workforce. VHA = Veterans Health Administration.

Figure 2 summarizes results of CREW overall and compares them to VHA national civility ratings as measured by the AES. The VHA mean for the civility scale remained constant from 2004 to 2006 at 3.60. The difference between the postintervention means and the VHA national average provides a context for evaluating the impact of CREW and its operational implications.

Discussion

The purpose of CREW was to increase employee-rated workplace civility at the participating sites. The main conclusion of this study is that this purpose was achieved, as is demonstrated by significant improvement of employee civility ratings from preintervention to postintervention surveys at sites that had the CREW intervention but not at the comparison sites. These results support our conclusion of significant

improvement in perceptions of workplace civility post-CREW and lend evidence to our claim that CREW interventions cause improvement in civility. Importantly, the intervention sites as a group did not have overall higher civility levels than the comparison sites did; improvement in civility thus cannot be attributed to inherent characteristics of these sites. Also, no changes in civility happened spontaneously over time at comparison sites; significant improvement in civility at intervention sites postintervention, thus, cannot be attributed to the passage of time alone. Together these findings suggest that higher postintervention than preintervention civility ratings at the intervention sites are due to their participation in the CREW intervention.

The anticipated by-products of CREW-targeted culture change were (a) employees' conscious awareness of the importance of civility at the workplace and (b) employees' understanding of a connection between acting civilly and effectively carrying through the VHA mission (to provide excellent health services to the nation's veterans). Post-CREW qualitative data (written comments that CREW participants and facilitators provided with their postintervention ratings) offer some evidence of an improved understanding of the business case for civility postintervention. Unprompted, respondents endorsed connections between civility of workplace interactions and success in outcomes of specific work-related tasks. Their comments suggested this heightened awareness was a result of exposure to the information included in the marketing materials for CREW and also of experiential-interpersonal learning as CREW participants.

It is noteworthy that both CREW administrations were overall highly successful in increasing employee perceptions of a civil workplace. The CREW-1 sites were those whose leaders volunteered to try a new initiative in the VHA system. Given this reason for their self-selection into the intervention, these sites were collectively above the VHA level of civility. Their overall results demonstrated that the CREW intervention was able to bring their civility ratings even higher. The question of a ceiling level (high civility baseline that remains unaffected by CREW) may have been indicated by one of CREW-1 sites where the preintervention and postintervention ratings remained essentially the same. (This site was not included in the analyses reported here because, due to its unique occupational makeup, we were unable to find a matching comparison site for it.) In one participant's comment provided with postintervention ratings, this site had "Good CREW environment to start with. Any CREW activities just supported what we already do." On the other hand, unlike CREW-1 sites, CREW-2 sites were collectively below the VHA mean on civility. Their self-selection into the intervention likely illustrated the impact of success of CREW-1 in the VHA system, which increased the visibility of the CREW initiative. That is, facilities with lower civility levels appear to have joined CREW-2 in the hopes to use CREW to remedy their known difficulties with workplace climate. This raises a question to be further explored about whether there is a floor level for CREW impact (a low civility baseline that remains unaffected by CREW).

Whereas the results of this study have addressed the question of evaluating success of the CREW initiative overall, these results also raise new questions that merit

further examination as CREW data from new administrations accumulate. Variability in postintervention civility ratings across intervention sites, particularly the best and worst postintervention ratings, appears to be of most interest for future studies. This variability is to be expected based on a number of potential factors that vary across sites: for example, support of executive leadership, supervisors, unions, skills of facilitators, and issues within the workgroups. Additional differences may be found in ways that sites make use of the resources offered to them: for example, extent and the exact nature of contact with NCOD coordinators throughout the intervention, reliance on particular elements within the tool kit rather than other elements, and so forth. Because CREW aims at making full use of rather than eliminating the sources of differences in intervention process among participating sites, addressing this variability by imposing a tighter structure onto the intervention process will not be possible. This poses a question, both for us and for others to ponder, about optimal strategies for summarizing and evaluating an intervention that is unstructured by its very definition, as it is designed and redesigned by the participants themselves throughout its entire course.

The main feature of CREW intervention is its extreme flexibility. Responsiveness to local needs and local culture-based civility definitions is thereby maximized and emphasized over any specific ingredient of intervention. This approach is typical of process consultation models (Reddy, 1994; Reddy & Phillips, 1992; Schein, 1988, 1990, 1992, 1999, 2006). It has been corroborated by process-outcome research findings in OD (Porras, 1979) and in other fields (Larson & Yao, 2005; Stiles, 1988; Stiles et al., 1998). As one illustration, alliance, a contextual factor reflecting participants' interaction, has been found to predict intervention outcomes better than any specific treatment component or technique (Blow, Sprenkle, & Davis, 2007; Castonguay & Beutler, 2005; Marziali, 1984); and the interpersonal relationship has been described as crucial in defining intervention outcomes, even in nonpsychologically oriented treatments (Larson & Yao, 2005). However, whereas the strategy of capitalizing on the variability of local needs and cultures may underlie the success of CREW, it certainly creates additional challenges for systematizing and summarizing the intervention results for research purposes. Also of note, substantial differences in site size may complicate statistical comparisons at the site level. Increasing sample size at the sites may help prevent this potential problem for studies interested in comparing CREW interventions across sites.

Limitations of This Study

This study was based on a quasi-experimental rather than true experimental design (Campbell & Stanley, 1963) in which the compared groups were assembled naturally: No random assignment of participants to groups took place. Intervention sites were matched to comparison sites on two categories: occupational composition of

the workgroup and operational complexity of the hospital (the latter incorporated 4 separately assessed criteria). We believe this matching substantially increased similarity between intervention and comparison groups; the similarity was further confirmed by absence of significant main effects for intervention status. A further limitation of the group matching is nonequivalent time periods between preintervention and postintervention surveys for the comparison groups. The CREW groups were tested at 6-month intervals, whereas the AES data are available annually. This means a 12-month interval for comparison groups that did not occur at the same time as the preintervention or postintervention surveys for the intervention groups. In spite of the chronological mismatch, we feel the comparison groups adequately illustrate the reality that civility does not spontaneously improve without intervention. We also contend the incongruent survey time frames, 6 versus 12 months, do not present a comparison issue because it is unlikely that civility ratings occur in an inverted *U* on a 12-month cycle. Nevertheless, random preintervention assignment to intervention or experimental condition, if it were possible, would provide stronger grounds for our claim that postintervention changes were due to intervention, not to preexisting differences between the intervention and comparison sites. The nonequivalent control group design used here appeared to be the best choice available, given that the study took place within the working parameters of a functioning health care system. Nevertheless, a replication of the study in pure experimental conditions would further strengthen our conclusions.

Similarly, matching individual participants' scores from pretest to posttest, if it were possible, would enable paired samples analyses and thus provide stronger statistical grounds for evaluating significance of change from pretest to posttest. Within this investigation, this option was not available given the boundaries and operational parameters of the organizational system under study. Future studies would benefit from overcoming this limitation.

Recommendations for Future Research

Variability in site characteristics and intervention processes across sites raises questions about optimal ways of capturing this variability and systematically relating it to postintervention results. It appears that an optimal strategy may involve measuring process variables (e.g., degree of involvement of participating workgroups, facilitators, and supervisors as well as their extent of using NCOD staff as consultants and resource) rather than any fixed set of site characteristics or intervention elements. This strategy may help systematize variability in CREW processes without artificially homogenizing the uniqueness of interventions and participating sites. For example, levels of supervisors' commitment to CREW may be a promising predictor to evaluate. Previous studies found management commitment to proper implementation to be essential for success of workplace interventions (Rodgers & Hunter, 1991; Rodgers, Hunter, & Rodgers, 1993), although this predictor has not

been examined specifically for civility-targeting programs. Our preliminary findings (Osatuke, Mohr, et al., 2008) suggest that a combination of workgroup supervisors' and coworkers' commitment to participating in the CREW process is an important predictor of higher postintervention ratings of workplace civility and an even more important predictor of postintervention perceptions of higher improvements in workplace civility.

Alliance between the facilitators and participants may be also important to account for in future studies. In therapy and counseling process-outcome studies, alliance rather than any specific intervention technique has been repeatedly revealed as the strongest predictor of treatment outcomes (Blow et al., 2007; Castonguay & Beutler, 2005; Marziali, 1984). Alliance, however, may also be thought of as an intermediate outcome rather than a pure causal factor: For example, one cannot decide to use "more" or "better" alliance when it is poor. Alliance is a product of other interpersonal processes and behaviors in which both participants and facilitators engage over time. These processes and behaviors may represent the causal factors that bring about both alliance and positive intervention outcomes.

Evaluating the impact of CREW from the perspective of its recipients, including their perception of the intervention itself and of the difference it made for them personally, appears a useful direction of subsequent research, qualitative or quantitative. Participant experience is an important but typically understudied aspect of organizational change (Bartunek, Rousseau, Rudolph, & DePalma, 2006). CREW intervention design makes such studies possible because it includes both qualitative data (open-ended comments from participants, facilitators, and NCOD staff) and quantitative data (preintervention and postintervention ratings of civility, comparable between participating sites and also to the entire VHA, because the civility scale is part of the annual VHA AES).

A viral spread metaphor was frequently used to describe CREW process at the sites. This analogy captures how employees' perception of civil treatment within the organization may invite more prosocial behaviors and increased collaboration, resulting in higher perceptions of a civil organizational context, thus generating more prosocial behaviors and collaboration, and so forth. Whereas preliminary facility-level data (e.g., Mohr et al., 2007; Nagy et al., 2007; Osatuke & Dyrenforth, 2006) are consistent with the postulated connection between civility and organizational outcomes, further studies of civility and its relation to workgroup-level outcomes (e.g. absenteeism, turnover) are needed and are now in progress at NCOD (e.g., Moore et al., 2008; Osatuke, Dyrenforth, et al., 2008; Osatuke, Mohr, et al., 2008). To the extent possible, future studies of civility in the field of health care should include patient variables as well, for example, patient satisfaction and clinical outcomes. The concept of an upward spiral of civility may also be usefully examined in parallel with the previously described concept, a downward spiral of workplace incivility (Pearson et al., 2005). Our work in progress suggests these constructs may be related but nonoverlapping (Mohr,

Osatuke, Moore, Hodgson, & Warren, 2008); together, they may explicate the paths whereby (in)civility affects employees and organizations.

Implications for OD Theory and Practice

The main implication for OD theory suggested by this study is the following. Successful implementation of the CREW approach illustrated by this study within VHA offers empirical support for the intervention model behind the CREW: the process-oriented, responsiveness-based approach rooted in client-centered thinking about organizational change. In terms of applications to practice, whereas CREW interventions are flexible by design, shared aspects of the intervention process across sites are sufficiently well defined and operationalized within the VHA CREW model. To reiterate, these shared aspects are defined by the NCOD practice model and include descriptions of coordinator and facilitator roles, educational tools made available to all participants, and the VHA civility scale as a preintervention-to-postintervention measure of change. A detailed account of these aspects offered in this article allows for replication of the CREW approach in health care organizations other than VHA and, more broadly, in other OD contexts.

Appendix A

Items Within the Educational Tool Kit

1. Suggestions for facilitators

- (a) Successful facilitation tips, including an overview of facilitation skills, key points to meeting planning, ideas for responding to disrespectful behavior, definitions of possible facilitator roles and expectations from workgroups, possible formats and ground rules for workgroup discussions, templates of group sessions, ideas for follow-up, and recommendations on how to encourage discussion.
 - (b) Possible questions for discussion of presurvey and any follow-up assessment, for example, “What are we doing well? What are each of you individually doing that contributes to that good score? What do we need to improve on? How could we use our strengths to improve the lower scores? How could each of you individually have a positive impact on these scores?”
 - (c) Suggestions about specific devices that workgroups could adopt to recognize CREW-promoting behaviors. These include certificates of appreciation, CREW-In-Action newsletters, buttons (“You’ve been caught doing the right thing and treating others with civility and respect”), and lists of strategies for involving staff into reinforcing others using these means.
 - (d) Experiential materials including lists and explanations of group activities, vignettes of situations for problem solving in groups, and stories and metaphors for facilitators to use in group discussions.
-

(continued)

Appendix A (continued)

2. Assessment instruments to be used at facilitators' and workgroups' discretion
 - (a) Visual tools for daily or weekly progress tracking, for example, CREW Daily Weather Report kept at a location where staff gathers. It instills awareness of the workgroup climate by expressing it through weather icons (from sunny to rainy or stormy). Each employee rates the report at the end of the day by making dots or Xs; employees can discuss these ratings the following day. Several sites reframed the tool as Pain Scale, a metaphor they saw as more relevant to health care settings.
 - (b) Open-ended assessment tools, for example, sentence-completion forms: "I consider it a great day at work when. . . I feel appreciated when. . . If I could change one thing about my job, I would. . . I know someone respects me when they. . . The kind of person that is hardest for me to deal with is. . . I could be more productive in my work if. . . If people really listened to me, they would find out. . ."
 - (c) Structured questionnaires evaluating areas of workgroup functioning, for example, an Employee Recognition Survey Form elicits lists of behaviors seen as conveying appreciation ("Please mark the top 5 ways you would like to be appreciated"). As another example, a Management Feedback Survey invites confidential comments about workgroup leaders' observable behaviors: those they were especially effective at, those they could do better, and specific confidential feedback. Yet another example is an Initial Team Effectiveness Assessment: "Please offer your candid opinion about your team by rating it and your role along the scale below" (from 0 = *never* to 10 = *always*). The scales include personal role (e.g., "I know what is expected of me at work"), team role (e.g., "Communications between and among team members are open and two-way"), and general team functions (e.g., "Team members regularly receive useful performance feedback").
 3. Conceptual tools for facilitators and groups
 - (a) Summaries of key points of several psychological models of social behavior and its determinants, for example, systems theories, Maslow's (1973) hierarchy of needs, Lewin's (1948) force field analysis, and Berne's (1996) transactional analysis of ego states—parent, child, adult.
 - (b) Recommended popular literature on promoting and maintaining positive workgroup climate, for example, Forni (2002); Covey (1990); Oakley & Krug (1994); Lundin, Paul, Christensen, and Strand (2000); and Johnson and Blanchard (2002).
 - (c) Educational materials on group dynamics, for example, on conflict resolution, with an overview of strategies and techniques; on the importance of rewarding desirable behaviors, with key points explained (defining and identifying desirable behaviors, timely recognition, award mechanisms, clearly linking recognition to the behavior); and others.
 4. CREW information such as the history of the initiative in the Veterans Health Administration and civility business case materials (e.g., graphs of clinical and business outcomes associated with high versus low civility ratings). The graphs make it visually obvious that higher civility ratings at particular Veterans Health Administration facilities are associated with lower absenteeism, fewer equal employment opportunity complaints, higher scores on clinical performance measures, lower turnover intentions of employees, and higher inpatient and outpatient ratings of overall satisfaction with clinical care.
-

Appendix B

Veterans Health Administration Civility Scale

- Q1 (Respect): People treat each other with respect in my work group.
Q2 (Cooperation): A spirit of cooperation and teamwork exists in my work group.
Q3 (Conflict Resolution): Disputes or conflicts are resolved fairly in my work group.
Q4 (Coworker Personal Interest): The people I work with take a personal interest in me.
Q5 (Coworker Reliability): The people I work with can be relied on when I need help.
Q6 (Antidiscrimination): This organization does not tolerate discrimination.
Q7 (Value Differences): Differences among individuals are respected and valued in my work group.
Q8 (Supervisor Diversity Acceptance): Managers/Supervisors/Team leaders work well with employees of different backgrounds in my work group.
-

Note: Item labels are in parentheses to distinguish from the actual item wording. Items were rated on a Likert-type scale from 1 (*strongly disagree*) to 5 (*strongly agree*), with a middle option, Neither Agree Nor Disagree. Do Not Know and Not Applicable options were available.

References

- Adlerfer, C. P. (1972). *Existence, relatedness, and growth: Human needs in organizational setting*. New York: Free Press.
- Anderson, L. M., & Pearson, C. M. (1999). Tit for tat? The spiraling effect of incivility in the workplace. *Academy of Management Review*, 24, 452-471.
- Argyris, C. (1964). *Integrating the individual and the organization*. New York: Wiley.
- Argyris, C., Putnam, R., & Smith, M. C. (1985). *Action science: Concepts, methods, and skills for research and intervention*. San Francisco: Jossey-Bass.
- Argyris, C., & Schon, D. (1974). *Theory in practice: Increasing professional effectiveness*. San Francisco: Jossey-Bass.
- Argyris, C., & Schon, D. (1978). *Organizational learning*. Reading, MA: Addison-Wesley.
- Argyris, C., & Schon, D. (1996). *Organizational learning II: Theory, method, and practice*. Reading, MA: Addison-Wesley.
- Armenakis, A. A., & Zmud, R. W. (1979). Interpreting the measurement of change in organizational research. *Personnel Psychology*, 32, 709-723.
- Banathy, B. (1996). *Designing social systems in a changing world*. New York: Plenum.
- Bartunek, J. M., Rousseau, D. M., Rudolph, J. W., & DePalma, J. A. (2006). On the receiving end: Sensemaking, emotion, and assessments of an organizational change initiated by others. *The Journal of Applied Behavioral Science*, 42, 182-206.
- Bate, S. P., & Robert, G. (2007). Towards more user-centric OD: Lessons from the field of experience-based design and a case study. *The Journal of Applied Behavioral Science*, 43, 41-66.
- Berne, E. (1996). *Games people play: The basic handbook of transactional analysis*. New York: Ballantine.
- Beutler, L. E. (1991). Have all won and must all have prizes? Revisiting Luborsky et al.'s verdict. *Journal of Consulting and Clinical Psychology*, 59, 226-232.
- Blow, A. J., Sprenkle, D. H., & Davis, S. D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital & Family Therapy*, 33, 298-317.
- Bozarth, J. D. (1999). *Person-centered therapy: A revolutionary paradigm*. Ross-On-Wye, UK: PCCS.

- Bragg, J. E., & Andrews, I. R. (1973). Participating decision making: An experimental study in a hospital. *The Journal of Applied Behavioral Science, 9*, 727-735.
- Campbell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research*. Chicago: Rand McNally.
- Carr, J. Z., Schmidt, A. M., Ford, J. L., & DeShon, R. P. (2003). Climate perceptions matter: A meta-analytic path analysis relating molar climate, cognitive and affective states, and individual level work outcomes. *Journal of Applied Psychology, 88*, 605-619.
- Castonguay, L. G., & Beutler, L. E. (Eds.). (2005). *Principles of therapeutic change that work*. New York: Oxford University Press.
- Cordes, C. L., & Dougherty, T. W. (1993). A review and integration of research on job burnout. *Academy of Management Review, 18*, 621-656.
- Coughlan, P., Suri, J. F., & Canales, K. (2007). Prototypes as (design) tools for behavioral and organizational change: A design-based approach to help organizations change work behaviors. *The Journal of Applied Behavioral Science, 43*, 122-134.
- Covey, S. R. (1990). *The 7 habits of highly effective people: Powerful lessons in personal change*. New York: Free Press.
- Elliott, R., Stiles, W. B., & Shapiro, D. A. (1993). Are some psychotherapies more equivalent than others? In T. R. Giles (Ed.), *Handbook of effective psychotherapy* (pp. 455-479). New York: Plenum.
- Forni, P. M. (2002). *Choosing civility: The twenty-five rules of considerate conduct*. New York: St. Martin's Griffin.
- Garman, A. N., Corrigan, P. W., & Morris, S. (2002). Staff burnout and patient satisfaction: Evidence of relationships at the care unit level. *Journal of Occupational Health Psychology, 7*, 235-241.
- Golembiewski, R., Billingsley, K., & Yeager, S. (1976). Measuring change and persistence in human affairs: Types of change generated by OD designs. *The Journal of Applied Behavioral Science, 12*, 133-157.
- Gowing, M. K., & Lancaster, A. R. (1996). Federal government surveys: Recent practices and future directions. In A. Kraut (Ed.), *Organizational surveys: Tools for assessment and change* (pp. 360-380). San Francisco: Jossey-Bass.
- Harter, J. K., Schmidt F. L., & Hayes T. L. (2002). Business-unit-level relationship between employee satisfaction, employee engagement and business outcomes: A meta-analysis. *Journal of Applied Psychology, 87*, 268-279.
- Hartman, E. M. (1996). *Organizational ethics and the good life*. Oxford, UK: Oxford University Press.
- Harvey, D. F., & Brown, D. R. (1992). *An experiential approach to organizational development*. Englewood Cliffs, NJ: Prentice-Hall.
- Herzberg, F., Mausner, B., & Snyderman, B. B. (1959). *The motivation to work*. New York: John Wiley.
- Hodgson, M., Reed, R., Craig, T., Belton, L., Lehman, L., & Warren, N. (2004). Violence in healthcare facilities: Lessons from VHA. *Journal of Occupational Environmental Medicine, 46*, 1158-1165.
- Hurrell, J. J., McLaney, M. A. (1988). Exposure to job stress—A new psychometric instrument. *Scandinavian Journal of Work Environment & Health, 14*(1), 27-28.
- Hutton, S. A. (2006). Workplace incivility: State of the science. *Journal of Nursing Administration, 36*, 22-28.
- Johns, G. (2006). The essential impact of context on organizational behavior. *Academy of Management Review, 31*, 627-647.
- Johnson, S., & Blanchard, K. (2002). *Who moved my cheese? An amazing way to deal with change in your work and in your life*. London: Vermilion.
- Kopelman, R. E., Brief, A. P., & Guzzo, R. A. (1990). The role of climate and culture in productivity. In B. Schneider (Ed.), *Organizational climate and culture* (pp. 282-318). San Francisco: Jossey-Bass.
- Kowalski, R., Harmon, J., York, L., & Kowalski, D. (2003). Reducing workplace stress and aggression: An action research project at the U.S. Department of Veterans Affairs. *Human Resources Planning Journal, 26*, 39-53.

- Krebs, R. L. (1976). Disrespect—A study in hospital relationships. *Hospital Health Services Administration, 21*, 67-72.
- Larson, E. B., & Yao, X. (2005). Clinical empathy as emotional labor in the patient-physician relationship. *Journal of the American Medical Association, 293*, 1100-1106.
- Laschinger, H. K. S., & Finegan, J. (2005). Using empowerment to build trust and respect in the workplace: A strategy for addressing the nursing shortage. *Nursing Economics, 23*, 6-13.
- Lewin, K. (1948). *Resolving social conflicts: Selected papers on group dynamics*. New York: Harper.
- Likert, R. L. (1961). *The human organization*. New York: McGraw-Hill.
- Lim, S., Cortina, L. M., & Magley, V. J. (2008). Personal and workgroup incivility: Impact on work and health outcomes. *Journal of Applied Psychology, 93*, 95-107.
- Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "Everyone has won and all must have prizes"? *Archives of General Psychiatry, 32*, 995-1008.
- Lundin, S. C., Paul, H., Christensen, J., Strand, P. (2000). *Fish! tales: Real-life stories to help you transform your workplace and your life*. New York: Hyperion.
- Marziali, E. (1984). Three viewpoints on the therapeutic alliance: Similarities, differences, and associations with psychotherapy outcome. *Journal of Nervous and Mental Disease, 172*, 417-423.
- Maslow, A. H. (1973). *Dominance, self-esteem, self-actualization: Germinal papers of A. H. Maslow*. New York: Brooks/Cole.
- Meterko, M., Mohr, D. C., & Young, G. J. (2004). Teamwork culture and patient satisfaction in hospitals. *Medical Care, 42*, 492-498.
- Meterko, M., Osatuke, K., Mohr, D., Warren, N., & Dyrenforth, S. (2007, August). Civility: The development and psychometric assessment of a survey measure. In M. Nagy (Moderator), *Measuring and assessing workplace civility: Do "nice" organizations finish first?* Symposium presented at the 67th annual meeting of the Academy of Management, Philadelphia.
- Meterko, M., Osatuke, K., Mohr, D., Warren, N., & Dyrenforth, S. (2008). *Civility: The development and psychometric assessment of a survey measure*. Unpublished manuscript.
- Millsap, R. E., & Hartog, S. B. (1988). Alpha, beta, and gamma change in evaluation research: A structural equation approach. *Journal of Applied Psychology, 73*, 574-584.
- Mohr, D. C., Osatuke, K., Moore, S. C., Hodgson, M., & Warren, N. (2008, April). Do more civil workplaces actually have less incivility? In D. Mohr (Moderator), *Workplace civility and incivility: Implications for healthcare*. Symposium at the annual conference of the Society for Industrial Organizational Psychology, San Francisco.
- Mohr, D. C., Warren, N., Hodgson, M., Osatuke, K., Ward, C., & Dyrenforth, S. (2007, August). Workplace civility, workplace incivility and employee sick leave rate usage. In M. Nagy (Moderator), *Measuring and assessing workplace civility: Do "nice" organizations finish first?* Symposium at the 67th annual meeting of the Academy of Management, Philadelphia.
- Moore, S. C., Osatuke, K., & Howe, S. (2008, April). Modeling turnover and absenteeism through civility and job satisfaction scores. In D. Mohr (Moderator), *Workplace civility and incivility: Implications for healthcare*. Symposium at the annual conference of the Society for Industrial Organizational Psychology, San Francisco.
- Nadler, D. A. (1977). *Feedback and organization development: Using data-based methods*. Reading, MA: Addison-Wesley.
- Nagy, M. S., Warren, N., Osatuke, K., & Dyrenforth, S. (2007, August). The association between civility and monetary organizational outcomes. In M. Nagy (Moderator), *Measuring and assessing workplace civility: Do "nice" organizations finish first?* Symposium at the 67th annual meeting of the Academy of Management, Philadelphia.
- Oakley, E., & Krug, D. (1994). *Enlightened leadership: Getting to the heart of change*. New York: Fireside.
- Osatuke, K., & Dyrenforth, S. (2006, August). *Civility in VA hospitals relates to costs and performance indicators*. Paper presented at the 114th annual convention of the American Psychological Association, New Orleans, LA.

- Osatuke, K., Dyrenforth, S., & Belton, L. (2008, May). *Organizational change towards greater civility: What helps intervention success?* Poster presented at the 14th annual national research conference of the British Association for Counseling and Psychotherapy, Cardiff, Wales.
- Osatuke, K., Mohr, D., Ward, C., Moore, S. C., Dyrenforth, S., & Belton, L. (2008, August). *Organization development intervention to increase civility in the workforce: What explains variability of outcomes across participating VA facilities.* Paper presented at the annual national conference of the Academy of Management, Anaheim, CA.
- Ostroff, C. (1992). The relationship between satisfaction, attitudes, and performance: An organizational level analysis. *Journal of Applied Psychology, 77*, 963-974.
- Parker, C. P., Baltes, B. B., Young, S. A., Huff, J. W., Altman, R. A., Lacost, H. A., et al. (2003). Relationships between psychological climate perceptions and work outcomes: A meta-analytic review. *Journal of Organizational Behavior, 24*, 389-416.
- Pearson, C., Andersson, L., & Porath, C. (2005). Workplace incivility. In P. Spector & S. Fox (Eds.), *Counterproductive workplace behavior: Investigations of actors and targets* (pp. 256-309). Washington, DC: American Psychological Association.
- Pinel, E., & Paulin, N. (2005). Stigma consciousness at work. *Basic and Applied Social Psychology, 27*, 345-352.
- Porras, J. I. (1979). The comparative impact of different OD techniques and intervention intensities. *The Journal of Applied Behavioral Science, 15*, 156-178.
- Ramarajan, L., & Barsade, S. G. (2006). *What makes the job tough? The influence of organizational respect on burnout in the human services.* Available from <http://knowledge.wharton.upenn.edu/paper.cfm?paperID=1338>
- Reddy, W. B. (1994). *Intervention skills: Process consultation for small groups and teams.* San Diego, CA: Pfeiffer.
- Reddy, W. B., & Phillips, G. (1992). Traditional assessment: The way of the dinosaur. *OD Practitioner, 24*, 1-2.
- Rodgers, R., & Hunter, J. E. (1991). Impact of management by objectives on organizational productivity. *Journal of Applied Psychology, 76*, 322-336.
- Rodgers, R., Hunter, J. E., & Rodgers, D. L. (1993). Influence of top management commitment on management program success. *Journal of Applied Psychology, 78*, 151-155.
- Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of science: Vol. 3. Formulation of the person and the social context* (pp. 184-256). New York: McGraw Hill.
- Rogers, C. R. (1977). *Carl Rogers on personal power.* New York: Delacorte.
- Schat, A. C. H., & Kelloway, E. K. (2003). Reducing the adverse consequences of workplace aggression and violence: The buffering effects of organizational support. *Journal of Occupational Health Psychology, 8*, 110-122.
- Schein, E. (1988). *Process consultation: Vol. 1. Its roots in organizational development.* Reading, MA: Addison-Wesley.
- Schein, E. (1990). Organizational culture. *American Psychologist, 45*, 109-119.
- Schein, E. (1992). *Organizational culture and leadership.* San Francisco: Jossey-Bass.
- Schein, E. (1999). *Process consultation revisited: Building the helping relationship.* Reading, MA: Addison-Wesley-Longman.
- Schein, E. (2006). Culture assessment as an OD intervention. In B. B. Jones & M. Brassel (Eds.), *The NTL handbook of organization development and change: Principles, practices, and perspectives* (pp. 456-465). San Francisco: Jossey-Bass.
- Sirota Consulting. (2001, April). *Veterans Health Administration former employee survey.* Presentation at the weekly Veterans Health Administration Network Director's conference call.
- Stiles, W. B. (1988). Psychotherapy process-outcome correlations may be misleading. *Psychotherapy, 25*, 27-35.

- Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*, 5, 439-458.
- Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). Are all psychotherapies equivalent? *American Psychologist*, 41, 165-180.
- Torbert, W. R. (1989). Leading organizational transformation. In W. Pasmore & R. Woodman (Eds.), *Research in organizational change and development* (Vol. 3, pp. 83-116). Greenwich, CT: JAI.
- Torbert, W. R. (1991a). *The power of balance: Transforming self, society, and scientific inquiry*. Newbury Park, CA: Sage.
- Torbert, W. R. (1991b). Teaching action inquiry. *Collaborative Inquiry*, 5, 2-12.
- United States Postal Service Commission on a Safe and Secure Workplace. (2000). *Report of the United States Postal Service Commission on a safe and secure workplace*. New York: National Center on Addiction and Substance Abuse, Columbia University.
- Weick, K. (2001). *Making sense of the organization*. Cambridge, MA: Blackwell.
- Yorks, L., Neuman, J. H., Kowalski, D. R., & Kowalski, R. (2007). Lessons learned from a 5-year project within the department of Veterans Affairs: Applying theories of interpersonal aggression and organizational justice to the development and maintenance of collaborative social space. *The Journal of Applied Behavioral Science*, 43, 352-372.

Katerine Osatuke, PhD, is a staff psychologist at the Veterans Health Administration National Center for Organization Development.

Scott C. Moore is a health scientist at the Veterans Health Administration National Center for Organization Development.

Christopher Ward is currently self-employed as a practitioner of psychological services with a focus on forensic practice.

Sue R. Dyrenforth is the Director of the Veterans Health Administration National Center for Organization Development.

Linda Belton is the Director of Organizational Health for the Veterans Health Administration National Center for Organization Development.