Fall 11-7-2011

Culture Change and Healthcare

Jenny Hertter
jhertter@siu.edu

CULTURE CHANGE IN HEALTHCARE

by

Jenny Hertter

B.S., Southern Illinois University, 2004

A Research Paper
Submitted in Partial Fulfillment of the Requirements for the
Master of Public Administration.

Department of Political Science
in the Graduate School
Southern Illinois University Carbondale
December 2011

RESEARCH PAPER APPROVAL

CULTURE CHANGE IN HEALTHCARE

By

Jenny Hertter

A Research Paper Submitted in Partial

Fulfillment of the Requirements

for the Degree of

Master of Public Administration

Approved by:

Dr. John Hamman, Chair

Dr. John Foster

Dr. Dhitinut Ratnapradipa

Graduate School
Southern Illinois University Carbondale
November 9, 2011

Introduction

In the environment of healthcare reform, healthcare leaders are scrambling to prepare for an uncertain future. Regardless of the long term outcome of President Obama's recent healthcare reform bill, healthcare delivery as we know it is unsustainable. In order to survive in the new era, providers must learn to collaborate, technology must improve, and delivery mechanisms should be revisited in order to put quality before all other measures, including profit. Shifting provider focus to delivering the highest possible quality care given upcoming resource constraints is the key to true change. The attitudes of all parties involved, from physicians to patients, must change together in order for successful reform to occur. This paper will examine lessons healthcare leaders can draw from public sector experience regarding culture change, specifically in response to healthcare reform legislation.

Why does America need to reform healthcare? There are several factors that contribute to the need for change; now. First of all, the number of uninsured Americans is unacceptable. Between 2008 and 2009 alone, the uninsured population increased by 3 million people (Clarke, 2010). The large number of uninsured leads to the problem of cost shifting, since someone must ultimately pay for their medical care. What tends to happen is the cost of caring for the uninsured is passed to the insured population through increased healthcare costs and increased insurance premiums. Secondly, the growth in national health care expenditures as a percentage of the GDP continues to grow at an unsustainable rate. The Congressional Budget Office (CBO) in 2009 estimated health expenditures were currently above 15% of GDP, and projected that by 2040 expenditures will be between 30% and 35% of GDP. Additionally, the baby boomer population will

soon be Medicare eligible, meaning the government will be responsible for a large portion of these astronomical costs, which is a very real concern for legislators and citizens alike. According to the Social Security and Medicare 2009 Annual Report, the Medicare program will begin operating at a deficit around 2013, and the deficit is predicted to continue to increase into the future (Clarke, 2010).

In the 2008 presidential race, the Democratic Party, led by presidential candidate Obama, made healthcare reform a top priority of their campaign. The response of Americans was mixed, but many noted that there was indeed a need for change. On March 23, 2010, President Obama signed into effect Public Law No. 111-148: Patient Protection and Affordable Care Act. Then on March 30, 2010, the president signed into effect the Health Care and Education Reconciliation Act of 2010. Players in the healthcare industry, namely providers, payers, and patients, were not taken by surprise because talk of healthcare reform had been heard across the country for years. Providers are concerned about being asked to deliver a higher level of care at reduced reimbursement rates, or doing more with less. Payers are concerned about remaining profitable while expanding coverage at a reduced rate, as well as having access to the data needed to establish base payment rates in the future. Patients are concerned about the accessibility and affordability of the care they need. Now that the reform law has passed, it is time for the players to adapt and prepare themselves for the future of healthcare in America. According to Grube and Kaufman (2010), the four core goals of healthcare reform are:

- to provide insurance to as many of the uninsured as possible
- to pay for the expanded coverage by reducing total healthcare costs by somewhere between $830 billion and $1.2 trillion over the next 10 years

- to improve value, defined as the best possible patient health outcomes per dollar spent
- and to increase provider accountability.

Worldwide, healthcare is not in crisis. While this is not a uniquely American problem, it is a bigger problem here than in other developed parts of the world. Powerful lobbyists representing both insurers and providers make it difficult for government to intervene, and history suggests that major health players have no incentive to reform the system on their own. Health care purchasers, who feel entitled to receive unlimited care with little regard for cost, demand coverage at its current level. A lazy society with fast food readily available and no desire to exercise grows unhealthier every day. Childhood obesity threatens to contribute to steadily increasing healthcare costs, as we are raising a nation of individuals predisposed to chronic conditions such as diabetes, heart disease, and stroke. Just to make matters worse, baby boomers are ready for retirement and Medicare does not have the funds to support the high demands of this traditionally unhealthy age group.

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) passed with much controversy. How can an act designed to curb skyrocketing costs and increase accessibility for all Americans come under such scrutiny? I believe it comes down to one answer: fear. Fear of changing a culture of instant gratification and unlimited supply, and fear of changing a culture where so many different players stand to lose huge profits, including pharmaceutical companies, specialists, insurance companies, and malpractice attorneys. It should be noted that many groups saw a chance to capitalize on this fear, and they turned it into a marketing tool of sorts, namely by

presenting very narrow pictures of what healthcare reform would and would not do, without presenting the entire truth.

Culture change is a difficult process in any sector, but it may be particularly difficult in the healthcare sector, where people's lives and lifestyles hang in the balance. Why, other than attitudes and predispositions against "too much government," would people be upset that they have to have health insurance coverage? Perhaps it is because the task is daunting. In order to truly reform the system, every participant in the healthcare cycle has to change.

Many organizations attempt to proactively change the culture of their employees, and few succeed. Those that succeed invest a lot of resources and time, and leadership must show continuous commitment. Now imagine, rather than changing the culture of one organization, changing the culture of an entire nation. In order to gain insight into changing culture on a large scale, we must review lessons learned on a much smaller scale, namely in the public sector.

I have just given an overview of the health system today and why there is a need for change. The focus of this paper is on healthcare leadership, as leaders have the power to influence and shape culture from within their organizations and practices. They also have the attention of both patients and payers, and therefore have external influence as well as internal influence. This paper will review the role of leadership in culture change, and apply it to the healthcare setting. We will define and discuss culture and its role in organizational attitudes and processes. Lessons will be drawn from chaos theory and the theory of structural inertia and applied to the challenges currently facing healthcare providers. This paper will also include discussion of healthcare reform specifics because

the government mandates set forth in the legislation demand a reaction from providers in the industry, and leaders are the individuals tasked with planning the strategic responses to these mandates. I argue that the most important strategy healthcare leaders can apply is intentional culture change that alters the way we think about healthcare delivery in America.

Culture Change and Healthcare

Leadership and Successful Organizational Change

Leaders are in a position to intentionally shape the culture of their organizations, which in turn can guide culture change in the patient populations they serve. Taking a closer look at leadership, we will consider two categories of leader behavior: people oriented and task oriented. People oriented leader behaviors are considerate behaviors and include a democratic style. Task oriented leader behaviors are more structural and include authoritative behaviors (Antonakis et al., 2004). Different behaviors are appropriate in different settings. Knowing when to exhibit each behavior style increases overall effectiveness. Transformational leaders tend to be more people oriented, but task oriented behaviors are also effective in certain situations, such as initiating culture changes. In my opinion, a combination of people orientation and task orientation is necessary when leading major changes, particularly culture changes.

Chaos theory, which is about instability and unpredictability, may provide important lessons for today's healthcare leaders, namely what not to do. The basis for chaos theory is that non-linear connections are the root of complex behaviors. According to chaos theory, "some things are inherently unknowable" (Smith, 2001, p. 262). Patterns, called attractors, tend to result when modeling chaos. These attractors find the

hidden order behind chaos, thereby giving disorder some sort of structure. According to Smith (2001), organizations fall into category four within chaos theory, which suggests that organizations can be stable for long periods of time, but unpredictable interruptions occasionally happen. While many agree that healthcare reform was predictable, the sweeping legislation still took healthcare leaders by surprise. Even though many recognized a need for reform, such an open policy window was unexpected.

Some leaders use Chaos theory as a reason to constantly change an organization and to continuously learn, rather than to focus on long term planning. Those following this theory also believe that it is impossible to be in full control of the change process. The underlying belief is that change just happens, and planning or designing change is not a useful approach to something that occurs naturally (Smith, 2001). In my opinion, an overreliance on the ideas presented in chaos theory does not contribute to strong leadership. It becomes an excuse for laissez-faire leadership, which is not an appropriate style for an organization facing major environmental turbulence. Laissez-faire leadership is not a recipe for success in the healthcare environment, as changes must be well planned and intentional.

Boyne and Meier (2009) support the theory of structural inertia, which recommends structural stability in response to environmental factors. Under the theory of structural inertia, the process of change is so disruptive that the reason for the change should not be a factor. They argue that internal organizational change magnifies the negative effects of environmental turbulence. "A turbulent external environment is widely believed to have damaging effects on public service performance" (Boyne and Meier, 2009, p. 799). Many of today's public and private organizations know this

firsthand because of the recent worldwide recession. A common question for organizations to consider is whether to change internally or to maintain structural stability. Is structural stability enough to overcome external stress? Would internal change be more effective for building strength? Environmental turbulence is a real threat to the survival of organizations.

Supporters of the theory of structural inertia believe organizations should conduct business as usual in the face of external turbulence in order to cope effectively. The result is that both staff and leaders understand their roles and can focus on performance rather than reform (Boyne and Meier, 2009). While internal stability may be the best option in some situations, it is naïve to state this is the best way to handle all turbulent situations. What is the stance when the source of turbulence is mandatory legislation? In such situations, internal change must occur in order to survive. Boyne and Meier (2009) admit that no empirical studies have explored whether internal change actually neutralized the effects of external turbulence. While structural stability may have a place in other sectors, the same does not hold in healthcare; in fact leaders who are hesitant to join healthcare reform efforts might want to reconsider their stance on structural stability. The best response for healthcare leaders probably lies somewhere between chaos theory and structural inertia.

The arguments presented in this paper repeatedly return to the importance of culture in healthcare today, but what is culture? "Culture refers to the deep structure of organizations, which is rooted in the values, beliefs, and assumptions held by organization members" (Antonakis et al., 2004, p. 273). One responsibility of leadership is to create, monitor, and change culture that is in line with the mission of the

organization and will help guide follower's actions and decisions. Culture grows from three possible sources: beliefs, values, and assumptions of leaders, learning experiences gained as the organization evolves, and new beliefs, values, and assumptions possessed by successors (Antonakis et al., 2004).

The culture of an organization lays the foundation for values, direction, and purpose, thereby creating a community. There are two dimensions of organizational culture: sociability and solidarity. Sociability represents relationships based on emotion, such as the sharing of values and interests. Solidarity represents relationships based on the mind, such as common tasks and mutually beneficial shared goals (Goffee and Jones, 1996). Healthcare organizations tend to have a high level of sociability and a low level of solidarity. The ideas presented in this paper come from the point of view of organizational change within a highly sociable culture, and the role of leadership as a driver of culture.

Dull (2010) describes culture as one of "the most complicated words to define in the English language" (pg 857). He goes on to remind readers that the devil is in the details, for example, the symbols and assumptions that distinctly define organizations. In healthcare, these details include physical geography, patient demographics, payer mix, service lines, and levels of provider alignment. Regardless of the individual personalities that exist in the healthcare sector, this nation is facing a need for broad culture change, and that can only be accomplished one organization at a time.

Let us look to an actual example of a successful culture change endeavor. Experiences gained in the public sector can offer insight into leading successful organizational change. It is relatively well accepted that leaders can attempt to

manipulate their organizational culture in order to improve performance. However, many disagree on just how to do so, and how to create sustainable change. We will use the story of Alexandria, Virginia as a guide for public sector culture overhauls. In 2005, Jim Hartmann became city manager. Alexandria was a risk averse, "siloed," and procedure-ridden city. Government occurred with little community involvement or understanding. Communication, customer service, and accountability were undeveloped. Hartmann recognized the need to change the culture of Alexandria from heavily operational to one capable of preparing for the future. He accomplished this by creating front line decision makers, therefore allowing time for strategic planning amongst leaders (Hartmann and Khademian, 2010).

Hartmann did so by making changes in several key areas, including structural reorganization, open communication, crisis management, and leader development. Many of his initiatives had no end, leaving room for continuous improvement. His methods allowed the members of his organization to share the same vision. Five years into the change process, Hartmann achieved many successes. He managed to change the culture to one that promotes innovation and creativity.

A survey from OnPoint Consulting stresses the importance of not only initiating organizational support, but also reinforcing that support. Leaders should use "change talk," which means guaranteeing continuing conversations on the pros and cons of the change, employee perspectives on the change, employee confidence in a successful change, and obstacles presented during the change process (Dialogue of Change, 2007). Hartmann's "road show" represents the equivalent of change talk. He kept his change efforts in front of his employees, preventing stagnation in the change process. Human

beings are creatures of habit, so ongoing change is difficult to inspire among employees. Hartmann's road show acted as a communication-building tool for interdepartmental communication (Hartmann and Khademian, 2010).

Hartmann also applied the incentive/consequence cycle. In this model, incentives of varying degrees of value are available as rewards. For every action, a consequence will follow, be it good or bad. Incentives and consequences form an ongoing cycle as individuals intentionally implement changes, then they see the consequences of those changes. Leaders have the ability to influence incentives and, to some degree, consequences (Hartmann and Khademian, 2010).

There are several practical insights that leaders can gain from Hartmann and Khademian's (2010) review. The first is to be pragmatic. Focusing on culture as a means rather than an end promotes a culture that is readily adaptable to external environmental turbulence. Another is to manage that which is manageable using incentives and consequences. The result is purposeful change management. A final practical insight we can gain is to allow for creativity in resource utilization (Hartmann and Khademian, 2010).

Dull (2010) studied the culture change efforts in Alexandria, and made several observations we can carry over to the healthcare sector. He utilizes the "eight Cs" of organizational culture to guide his review. The eight Cs are complicated, control, competence, commitments, credibility, conflict, context, and change. Note the extremes presented in the eight Cs, which are representative of the different ways leaders define and approach organizational culture and intentional culture change.

Complication results from the fact that there is no one size fits all method for managing culture. Each organization is unique and therefore must apply individual change efforts. Control comes into play as leaders recognize the potential to control employee behavior through organizational culture. While I am not certain that I agree a relationship between culture and competence exists, I do agree that culture also shapes commitments, specifically as leaders try to align their employee's commitments with those of the organization (Dull, 2010).

The credibility of leadership, or trust, is vital in order to get employees to follow. The public sector follows the line of thinking that organizational performance improves when a high degree of leadership trust exists, and I propose that the same holds for willingness to change culture. Conflict within an organization comes into play when we view culture as a grouping of sub cultures. While organizations tend to have an overall culture, subcultures still develop within each organization. Some believe that these subcultures make organizations more flexible, so competition and conflict in an ever-changing environment is not entirely bad (Dull, 2010).

Context and change are the final two Cs. Context is a consideration when examining an organization's culture. Dull provides the example of an employee who arrived at work early every day. One hundred thousand dollars later, staff discovered that his early arrival made it easier for him to steal coins from parking meters. Context can also apply to point of view, meaning the party in question sees events in one context while other parties see events in an entirely different context, for example providers, payers, and patients. Noting that one of the positive effects of culture is the stability that it can provide in the midst of external turbulence, as well as its ability to guide

organizations to share one set of values, organizations with strong, well devised cultures are more likely to survive in the face of inevitable organization changes, both internal and external (Dull, 2010).

Dull states that "advocates of public sector reform know well the frustratingly slow and unpredictable course of organizational learning, problems amplified by bureaucratic organization and by the distinctive character of public sector governance" (Dull, 2010, pg 858). The key for leaders engaging in proactive culture change is to recognize that there is no fast track. Time and sustained energy are essential to guide widespread culture change. Dull also notes that change is risky, and leaders who intentionally try to change culture will surely be held accountable for both successes and failures.

Healthcare Reform Bill

In order to better understand the driver of healthcare change, we should take a closer look at the PPACA legislation and what it entails. Providers will be pressured to improve patient outcomes and the quality of care they deliver in order to stay alive in the new healthcare environment. An unfortunate assumption on the reform agenda is that providers are financially strong enough to absorb the financial impact of reform, while simultaneously investing in Electronic Health Records (EHRs) and physician integration that will be required in order to significantly change their care delivery systems (Grube & Kaufman, 2010). The result for providers is a "fundamental redefinition of the provider-success model" (Grube & Kaufman, 2010, pg 55).

In recent years, provider reimbursement has been and remains based on volumes, a methodology that unarguably does not provide incentives to improve quality of care or to reduce the cost of providing care. However, deep payment cuts are on the horizon, expected to total $148.7 billion for hospitals alone over the next 10 years (Clarke, 2010). On top of that figure, physician payments will be reduced in the near future as well. We can also expect the addition of incentive payments for primary care physicians and general surgeons in an effort to discourage the growth of specialties. Simultaneously, Medicare will extend quality reporting incentive payments. Payment methodology is changing to a pay for performance type of system, and providers need to adapt.

Following is a summary implementation outline of PPACA, specifically focused on provider initiatives. Beginning in 2012, the payer market will apply penalties to providers with high readmission rates. This also marks the year when medical home (a key component of Accountable Care Organizations or ACOs) pilots will be tested. In 2013, reimbursement methodologies such as bundled payments enter the picture. Bundled payments mean that care provided by all parties (e.g. hospital, physician, specialist, etc.) roll into one payment for distribution between all providers involved in the patient's care. Providers need to watch this closely so they can adjust practices accordingly. Providers also need to learn to play well with payers. In 2014, Medicaid is expanding, which will result in a major financial blow to providers. Medicaid reimbursement is already very low, often below cost, and payments in Illinois specifically remain untimely. Then, in 2014, add dramatic Medicare and Medicaid reimbursement reductions. Theoretically, the cuts to Medicaid and Medicare reimbursement should be offset by increases in the insured populations. The reality is that payers are also working

on ways to reduce reimbursement, so it is difficult to measure the true impact until these changes actually unfold. At the same time, providers with high levels of hospital-acquired conditions (HACs) will face reimbursement reductions, formally linking quality to reimbursement (Clarke, 2010).

Please note that none of these ideas are new concepts, rather what makes them constitute major payment reform is that fact that Medicare and private insurers will apply these concepts across the board. The plan of the Centers for Medicare and Medicaid Services (CMS) is to implement value-based purchasing, which is payment based on a quality and cost combination. Providers will receive payment based on the delivery of desired outcomes, compared to benchmarks finalized in June 2011. Medicare will offer incentives for meeting or exceeding standards of quality. The result of increased cost transparency and outcomes data should be increased provider accountability (Grube & Kaufman, 2010). Eventually, the current fee-for-service reimbursement methodology will be replaced by an outcomes-based payment system, specific to defined episodes of care (episodes of care are discussed later in this paper).

According to the Office of Management and Budget (OMB), 18 percent of Medicare patients readmit to hospitals within 30 days for care related to their original stay. According to the OMB, preventing these readmissions could save $26 billion over a 10-year period (Grube & Kaufman, 2010). This is exactly the sort of care delivery that reform legislation intends to address, and rightfully so. The current fee-for-service payment system actually rewards readmissions because payments are volume based.

Providers need to increase care coordination with all caregivers associated with a patient in order to be successful in the new healthcare environment. Some strategies

recommended by Grube and Kaufman (2010) to help providers accomplish this goal include hospital and physician integration, the development of care and disease management programs, and the implementation of IT solutions such as EHRs. The Obama administration is looking to provider organizations such as Kaiser Permanente and the Mayo Clinic as models for the desired future state of care delivery. These groups represent health systems with strong hospital-physician relationships, sophisticated care management systems, and IT systems that have the ability to track and trend patient outcomes. Many providers remain uncertain as to whether or not the cultures found at these established organizations are replicable at all levels. Unfortunately, providers will have to try whether they are financially and organizationally strong or not.

Following, we will examine ways in which the healthcare industry may benefit from changing culture. According to a 2011 Medical Group Management Association (MGMA) survey, the median first year salary for primary care physicians (PCPs) nationwide was $165,000 in multispecialty groups in 2010. The median first year salary for specialty physicians was $258,677 (MGMA Survey, 2011). These numbers illustrate the reward system found in the United States healthcare system, a system that drives medical students into specialty fields rather than primary care. The shortage of PCPs we have today will come back to haunt us over the next few years, when preventive services are sought after more than curing services.

Another vital change for true healthcare reform in America is increased communication and collaboration. Grenny, Groah, Lavandero, and Maxfield (2010) wrote that healthcare colleagues routinely witness genuine care delivery mistakes and inappropriate shortcuts in the healthcare setting. Specifically, 88 percent of physicians

have seen colleagues demonstrate "poor medical judgment," however, less than ten percent do anything about it. This is the current standard of healthcare in America, leaving 195,000 Americans to die in hospitals each year as a direct result of provider errors (Grenny et al, 2010).

How can we counteract the culture of silence that exists today? Many healthcare leaders are investing in "safety tools," such as standard care protocols and electronic systems. There are still weaknesses in the communication and accountability issues, even with these tools in place. The key to success in this area is to create a culture of communication among the nurses and physicians who actually provide care to patients. Even if safety tools work, hospitals still need care providers who use the tools, which boils down to culture. Healthcare leaders cannot ignore this aspect of culture because the professionals who actually provide care will always have the greatest impact on care delivery, regardless of what their organizational leaders may like to believe.

Along the lines of communication, we cannot ignore the relationships between different provider types when evaluating cultures in need of change, specifically the relationship between physicians and hospitals. Providers recognize the need to band together, but past mistakes have many leaders proceeding very cautiously. How do providers learn to work together, improve quality, and lower costs, all at the same time? The key is dramatic, sweeping culture change, and the time is now.

What are physicians looking for in alignment strategies? In general, they want to give up their administrative responsibilities, increase their access to Information Technology (IT) tools, and balance work and personal life. Additionally, employment offers a buffer from the effects of external turbulence of the changing healthcare

landscape as hospitals are financially better positioned to respond to regulatory requirements. Cultures collide however, as physicians try to maintain autonomy, even under existing employment models. What are hospitals looking for in alignment strategies? They are trying to prevent physician shortages and to prepare for an uncertain reimbursement future in which providers will likely have to assume financial risk for the well-being of the population they serve. Hospitals cannot make communities healthier without a physician component.

Information technology requirements will be an important driver for provider alignment as independent physicians alone cannot afford to meet the IT requirements of federal legislation, including both PPACA and The American Recovery and Reinvestment Act of 2009 (ARRA), the legislation that sets forth most of the IT requirements for EHRs. Hospitals have a need to align as well, in order to position themselves for delivery systems of the future with physician components, namely the need for a primary care component. For example, Accountable Care Organizations (ACOs) are getting a lot of attention under PPACA legislation. ACOs provide care across a continuum, which means that all provider types must collaborate and work well together (HFMA Educational Report, 2011). Please note that ACOs might not be successful if the federal government does not create safe harbors from antitrust and anti-kickback laws. ACOs do have the potential to improve care delivery as we know it.

Revisiting culture change, a reality for providers is that there is no "one best way" to enter the reform environment; every organization needs to behave differently based on their patient and payer environment. However, one thing is certain for all providers, and that is operational changes must occur in order to increase efficiency and reduce fixed

costs. The only way we will get there is through sweeping culture change. Small organizations may need to partner with larger organizations to survive, and larger organizations should be open to these partnerships in order to meet the care needs of the patients they serve. Ultimately, providers need a strong geographical market position, a solid physician integration platform, a cost and quality management culture, and sophisticated IT infrastructures. They also need to increase the focus on daily operations to offset costs associated with reform (Grube & Kaufman, 2010).

Payers will have less pricing flexibility under the new law (Clarke, 2010). This is because the foundation on which healthcare reform legislation resides defaulted to health insurance reform more than delivery system reform. Payers will have to be tougher in their negotiations as they work with providers to find a balance of assumed financial risk. Rather than jumping into episode based reimbursement, a safer first step may be modification of the current fee-for-service type reimbursement methodologies, which can be accomplished by applying penalties or bonuses based on quality performance measures. An example of an episode based payment is payment of a flat rate for all care provided in relation to a specific health condition, such as a total knee replacement. This flat rate could include pre-operative consults with a specialist, hospital care provided during the surgical visit, durable medical equipment such as braces and wheelchairs, physical therapy, follow up physician visits, anesthesia, radiology, and any other care related directly to the patient's knee issues. There is a real potential for cost savings with this payment methodology since all payments are pre-determined. Additional care beyond the industry standard, such as hospital readmissions due to HACs, will no longer result in additional payment. The downside is that minor changes in reimbursement

methodology will likely result in minor behavior changes on the part of the provider (Ginsburg et al., 2010).

Both government and commercial payers are looking toward reimbursement mechanisms that reward quality (outcomes) over volume. Rather than behaving as competitors, physicians and hospitals need to partner in care delivery, which is a huge culture change from the way they have practiced medicine for the last 20 years. Culture is the key to successful alignment strategies. Everything from developing goals, to selecting leadership, to creating an identity, to nurturing a partnership, revolves around working within a mutually acceptable culture. Leaders should also watch for "culture clashes" as they are essentially trying to marry together oil and water. A collaborative culture is the ultimate goal; one that fosters trust between all parties involved (HFMA Educational Report, 2011).

The way we structure payments in the future will influence the operational side for payers. Because of this, payers need to take an active role in guiding the future of pay for performance reimbursement practices. Episode based payments may become the norm for high dollar and/or chronic care delivery. Depending on changes to payment structure, payers may be expected to formally define an episode of care and establish base payment rates. For example, what will constitute an episode of care for a patient with congestive heart failure or cancer (Ginsburg, Lake, Maxfield, and Pham, 2010)? Defining the episode for chronic conditions will likely prove most difficult since the patient receives treatment throughout their entire lifetime, often with the largest cost incurred at the end of life.

Hybrid approaches that include risk sharing may be the most realistic approach for payers initially, and as more providers establish EHRs, the resulting data may allow for more flexibility. The new reimbursement methodologies should initially be dynamic, as providers and payers attempt to find the balance that will allow them to survive while meeting the demands set forth in the new legislation. In order to add the most value they can to reform efforts, payers must pay for quality in order to hold providers accountable for outcomes, although actual experience in this area is limited (Ginsburg et al., 2010).

Ultimately, the responsibility for payment reform rests largely with Medicare. Private payers tend to follow Medicare's lead, and actually pay many providers at a percentage of Medicare rates. I will not focus on Medicare reform in this paper, but the reality is that Medicare is the leader in the area of pay for performance. Not only is Medicare the dominant player, it is also the only payer with sufficient historical data to create reliable benchmarks on efficiency and performance.

The most difficult task of all may very well be changing the culture of the recipients of healthcare services in America. While many patients will reap rewards such as previously unavailable access to care and better coordination of care by providers, they will also have to take on more responsibility. Patients may be asked to provide input in order to define an episode of care. To date, Medicare has been hesitant to involve the patient at this level, but patient involvement may not be preventable. Payers may also attempt to engage patients in actively selecting their primary provider based on the episode of care they qualify for (Ginsburg et al., 2010). In the future, patients could receive incentives for going to more efficient providers, such as lower cost sharing for selecting high quality providers.

Patients will likely select a medical home in the future, rather than a primary care physician (Clarke, 2010). Patient-centered medical homes (PCMHs) and ACOs are terminology that patients should become familiar with because groups such as these will be responsible for monitoring the care we receive. Provider groups need to combine resources in order to better coordinate patient care as well as offset their cost of care delivery, and they may do so through ACOs.

The overall health of Americans will gain even more attention over the next several years as healthcare leaders work to shift the way we think about healthcare. A National Prevention and Health Promotion Strategy was implemented with a much needed focus on prevention. The individuals behind this strategy recognize the need to incorporate wellness into American lives. PPACA called for this strategy in order to change the way we think about healthcare, shifting the focus away from sickness and disease toward wellness and prevention (The National Prevention Strategy, 2011). Ultimately, prevention and wellness will play a major role in reducing healthcare costs.

One major goal of the Strategy is to create healthier consumers. It recognizes the need for easily understandable education tools and accessible resources. The focus is on basic lifestyle choices that we know we should make, such as eating healthy, exercising, and avoiding bad habits (The National Prevention Strategy, 2011). Much of the responsibility for this strategy falls to the public health sector, which will play an increased role in the future of healthcare delivery.

As a result of PPACA legislation, insurance coverage will expand to cover 32 million presently uninsured Americans by 2019. Some of this coverage will come from private payers and some from the expansion of state Medicaid programs. In order to

guarantee that citizens take advantage of the increased coverage options, penalties will be imposed beginning in 2016 for those who choose not to select an insurance plan (Clarke, 2010). This means patients will not have the option to ignore reform; they must become a part of the change or suffer financial consequences. Assuming PPACA remains intact, passive management of individual health issues and coverage will no longer be an option for patients.

Healthcare leaders are all over the map when asked what the most important changes are to care delivery systems. Some believe we should eliminate waste, some look to technology, others to integration and accountability, and others still to quality and value. As a result, individual organizations are going to have different cultural goals, but that is not necessarily bad. The key is that all leaders should be drivers of positive change. Eventually healthcare players will end up much closer together culturally than they are today.

Culture and Organizational Change in the Healthcare Sector

In the face of external turbulence in the current healthcare environment, what lessons are available for the healthcare sector? Even if healthcare reform legislation is repealed entirely, which is possible, due to the questionable Constitutionality of the health insurance mandate, the government is facing a Medicare crisis. Rising healthcare costs are unsustainable at the status quo. Let us not forget the discouraging state of American health. With or without PPACA, we must change. And who will be tasked with leading this change? Today's healthcare leaders play a very important role in shaping change. Leaders will be looked to as healthcare workers, patients, and even politicians wonder where to begin with the PPACA mandates. Leaders have the difficult

task of representing stability in the face of change, while at the same time trying to intentionally manage changes that will contribute to their success over the next several years. Successful leaders will be those who understand their role as change agents, as well as understand the turbulent environment that surrounds them.

Let us shift our focus to the importance of transformational leadership in the face of external and internal change. According to Chronister (2003), a leader should inspire hope in order to improve the likelihood of successful change. Hope energizes, reduces uncertainty, builds community, and sustains when staff is most uncomfortable and challenges are greatest. Leaders can spread the seed of hope by communicating honestly about change, including the future goals of the organization and the importance of the contribution followers make during the process (Chronister, 2003).

Kouzes and Posner (2006) remind leaders that they should not take trust for granted. They list several actions that invoke trust such as having confidence in others, valuing the opinions and perspectives of others, and being honest with everyone, regardless of their rank in the organization. In order for followers to trust leadership, leadership must also trust followers (Kouzes and Posner, 2006). Relationships based on trust within an organization allow leaders to focus on spreading hope and support of the change rather than putting out fires caused by distrust. Leaders have a real opportunity to turn fear into trust by staying in front of their employees and communities. Honest, open communication about the current state of healthcare issues is a good strategy because consumers are going to hear about the issues from someone, and that someone will likely become their trusted source.

Leaders are the driving force behind organizations and communities. Every customer or client served can feel the effects of the style and behaviors passed down by top leadership. Employees should work to find a way to fit into the culture of the organization to which he or she belongs. Leaders are responsible for deciding the direction of the organization and monitoring progress to guarantee success. Poor leadership can cause the failure of an organization. The study of leadership is relevant today, especially if applied to continuous improvements and knowledge sharing. Without a solid, accurate understanding of what an organization expects from its leaders, poor leader choices may result in instability. This instability can be financial or structural, but without identification and correction, may cause the organization to fail. Most importantly in healthcare today, leaders should be aware that the culture of an organization spreads to the culture of a community. This is the contagious energy healthcare needs in order to face the next phase of care delivery in America.

Leading Change

Transformational leaders have the charisma necessary to bring about successful organizational change. Does this mean successful organizational change is dependent upon the presence of a transformational leader? I believe that organizational change is more likely to be successful under the leadership of a transformational, charismatic individual. I am not arguing that cultural change will fail in the absence of transformational leadership, but rather that the process is likely to be less disruptive to employees if high-level leadership has good communication skills. However, in the face of a crisis, as is the case in the current healthcare environment, personality is secondary. This means all healthcare leaders should take the opportunity that is before them to create

positive change. While individual healthcare leaders have their niche, they are also the most informed about problems in the healthcare system, and much more informed than average community members and healthcare consumers. Leaders can emerge in a crisis as well, so individuals should embrace their knowledge and make their enthusiasm for change contagious.

To revisit and apply the change talk topic discussed previously, a transformational leader finds the change talk process quite natural. Because of the importance of communication during the change process, it would be logical to deliver this communication charismatically, with the intention of gaining and maintaining employee support. Open communication will foster trust and allow the leader to spread a feeling of hope throughout the organization. A more reserved leader may find the "change talk" process difficult, but it is none-the-less an important factor in the change process. Perhaps more reserved leaders should appoint a charismatic change representative.

A unique ally in the healthcare sector that should be considered is the media, as employees and community members alike are already aware of the healthcare crisis. Leaders still need to reinforce and personalize the messages the media is sending because they are the experts in the field. Leaders should translate media messages and put them into terms specific to their geographic region and the demographics of those they serve. Healthcare leaders cannot rely on media alone to keep their community informed, but the fact that the issues are in the forefront of the news does serve to open the dialogue for change talk.

According to Burns, transformational leaders are associated with strong values. Rather than conform their ideals to that of the consensus, transformational leaders elevate

followers to a higher system of values. Transactional leaders, on the other hand, focus on process based values (Antonakis et al., 2004). In order to meet the needs of leadership into the future, a general change in ethics and morals will form a solid foundation of accountability. Leaders must choose to step out of the process-based habits they often follow and transform others. They must set an example for followers in order to guide them toward global thinking. This type of thinking will apply heavily as the delivery system changes to one of accountable care. Collaboration must occur for the good of the patient, and anything else will soon be unacceptable.

Healthcare leaders should also be aware that the trend toward thinking globally is evident now more than ever in the healthcare field. Changing on a national level is the first step toward the ability to think globally. According to Karen Davis, PhD, president of The Commonwealth Fund, a national philanthropist group specializing in health research and policy issues, the resources required to transform America's healthcare system include political, organizational, technological, financial, and leadership resources (Hope for Healthcare Reform, 2009). The Commonwealth Fund tends to think globally when considering healthcare reform. I find it interesting that Davis listed leadership, and she is right. Transformational, ethical leadership must lead the way in this endeavor.

Revisiting the importance of hope, Davis (Hope for Healthcare Reform, 2009) is hopeful about healthcare reform in the current environment. Her statement of hope is relevant because she was influential in leading the nation's healthcare change efforts and decisions. The Commonwealth Fund has shaped healthcare in America for almost 100 years in areas such as establishing mental health services for children, setting standards for public health departments, providing grants for minority medical education,

establishing training programs for physician assistances and nurse practitioners, and funding care delivery innovations (Hope for Healthcare Reform, 2009). The list of contributions made by this group goes on, touching all aspects of healthcare in America.

The purpose of the Commonwealth Fund is a transformational one: to "do something for the welfare of mankind" (Hope for Healthcare Reform, 2009, p. 52). The group provided leadership in the efforts to reform healthcare in America with the goal of achieving affordable health coverage for all citizens. Additionally, they understood that the best care provides coordinated, efficient, and patient-centered services. The Commonwealth Fund has a reputable name in the field, and as a result is very influential in the political environment.

Davis and the Commonwealth Fund were influential enough to play a role in convincing the Obama administration to pass legislation affecting coverage, care delivery, payments, national standards for performance, and monitoring and reporting of performance. Healthcare legislation changes are here for now, resulting in an extremely turbulent healthcare environment. This is exactly the sort of external turbulence that healthcare leaders are frantically trying to respond to. The industry is changing, while at the same time, our nation is still struggling to recover from an economic crisis.

Conclusion

Healthcare leaders can apply lessons learned from the Alexandria, Virginia example provided above. The city of Alexandria was accustomed to operating in silos, much like our healthcare environment. They were also notably weak in the areas of communication and accountability. Hartmann provided a great example of the positive results of open communication. Leaders are not doing their organizations any favors by

keeping strategic thinking to just a few key executives without opening communication and dialogue at all levels of the organization. Because most people are aware of the problems that exist in healthcare today, a lack of communication in this environment could actually be counterproductive because employees may tend to change culture from the bottom up, and these cultures may clash.

Opposition from employees is common in the face of change. Routines reduce the need for individuals within an organization to react consciously in repeated situations. They provide a level of comfort for employees. As discussed earlier, a downside of organizational routines is the risk of structural inertia, which means employees may choose well-established routines rather than exploring other options. On the opposite end of the spectrum and related to chaos theory are "change sensitive" organizations, which are more likely to interpret situations as an opportunity for change (Beck, Brüderl, and Woywode, 2008). These organizations may be too quick to look to structural change as a solution.

While this may hold true in the face of trends, healthcare leaders cannot make this mistake today. The changing face of healthcare is not a trend, and the new delivery styles and information technology advances that emerge over the next decade are very real and necessary. There is no room for leaders to sit back and wait for changes to unfold before they begin the process of updating organizational routines. An advantage of proactive change today is the fact that most other providers are in an equally bad position right now. Those who wait to react will be noticeably behind and may not have the market share or payer mix needed to catch back up to the curve.

Healthcare leaders should consider a few more lessons provided in the Alexandria example. Hartmann led his culture to one focused on continuous improvement. The American healthcare system is so complex that there will always be room for improvement. While the window is open now for leaders to make very intentional changes within a relatively accepting audience, they should realize that this is a window that will ideally remain open over the long term. The culture change that is needed in healthcare today is far too broad to simply move to the next level and stop. The change should lead to a culture that is aware of external surroundings and readily adaptable to the next round of changes.

Another lesson taken from the Alexandria example is the incentive/consequence cycle employed by Hartmann. This has value when applied in the healthcare setting because incentives and consequences mark the future of reimbursement for medical care. Applying this cycle at all level of organizations may guide the thinking of employees to be more in line with upcoming drivers of organizational strategy. The incentive/consequence cycle will ultimately be applied to the payer/patient dynamic as well, as patients may ultimately be held financially accountable for their own health improvements.

Dull's mention of credibility (one of the eight C's) should also be highlighted as a valuable lesson to apply in the healthcare sector. Leaders should focus on gaining the trust of their followers in order to intentionally guide organizational culture. Culture is ultimately put into practice by staff, and if staff does not trust those in charge, they will develop their own subcultures that may clash with the culture goals of leadership.

Leaders should not underestimate the power of these subcultures to undermine change efforts, regardless of what may truly be best for the organization and industry as a whole.

Environmental turbulence is a reality in healthcare today. Even though reform legislation may be repealed, change is still in the air due to unsustainable healthcare costs. In response to healthcare turbulence, many leaders will change their cultures to more service oriented cultures. Others are changing their relationships with multiple provider types in order to create a partnership based on collaboration. Strategic leaders can justify structural change easily if external threats are severe or if immediate responses are required (Boyne and Meier, 2009). In the United States healthcare system today, this statement holds true.

My personal recommendations are actually quite simple. Everyone has a responsibility to educate himself or herself and be accountable for their healthcare decisions, regardless of which player category they fall into. "Not knowing" is no longer an excuse, because successful reform requires the best efforts of all parties involved. There is actually an opportunity for the majority of Americans to "win" with healthcare reform, but only after trial and error, and only if all parties do their part. As a result, I see no option other than to change internal structures in order to be more responsive to an external environment in crisis. Becoming more responsive to customer needs, collaborating between all provider types, and focusing on quality care rather than volume of care will allow individual organization members to serve an already stressed population in the best possible manner. The bottom line is, the cultures of providers, payers, and patients must change because the future of healthcare in America is here. What are you going to do about it?

REFERENCES

Antonakis, John, Cianciolo, Anna T. & Sternberg, Robert J. (eds.). (2004). *The Nature of Leadership.* Thousand Oaks, CA: Sage Publications.

Beck, Nikolaus, Brüderl, Josef, and Woywode, Michael. (2008). Momentum or Deceleration? Theoretical and Methodological Reflections on the Analysis of Organizational Change. *Academy of Management Journal,* 51 (3), 413-435.

Boyne, George A. and Meier, Kenneth J. (2009). Environmental Turbulence, Organizational Stability, and Public Service Performance. *Administration & Society,* 40, 799 – 824.

Chronister, Paula. (2003). Inspiring Hope to Mobilize Change. *Leader to Leader,* 49-53.

Clarke, Richard L. (2010). Impact of Healthcare Reform: A Conversation with HFMA's Dick Clarke. *HFMA Webinar*, March 31, 2010.

The Dialogue of Change. (2007). *Leader to Leader,* 45, 61-62.

Dull, Matthew. (2010). Leadership and Organizational Culture: Sustaining Dialogue between Practitioners and Scholars. *Public Administration Review,* 70 (6), 857-864.

Ginsburg, Paul B., Lake, Timothy K., Maxfield, Myles M., and Pham, Hoanmai H. Episode Based Payments: Charting a Course for Health Care Payment Reform. (2010). *National Institute for Health Care Reform- Policy Analysis,* 1, 1-15.

Goffee, Rob and Jones, Gareth. (1996). What Holds the Modern Company Together? *Harvard Business Review,* 133-148.

Grenny, Joseph, Groah, Linda, Lavandero, Ramon, and Maxfield, David. (2010). *The Silent Treatment: Why Safety Tools and Checklists Aren't Enough to Save Lives.* Retrieved March 25, 2011, from http://www.silenttreatmentstudy.com/.

Grube, Mark E. and Kauffman, Kenneth. (2010). Positioning your Organization for Success in the New Era. *Healthcare Financial Management Association,* January, 54-62.

Hartmann, Jim and Khademian, Anne M. (2010). Culture Change Refined and Revitalized: The

Road Show and Guides for Pragmatic Action. *Public Administration Review,* 70 (6), 845-
854.

HFMA Educational Report: The New Era for Hospital-Physician Alignment. (January, 2011).
Retrieved June 17, 2011 from www.hfma.org.

Hope for Healthcare Reform. (2009). *HFM,* 49-52.

Kouzes, James and Posner, Barry. (2006). *A Leader's Legacy.* San Francisco, CA: Jossey Bass Publishers.

Maslin-Wicks, Kimberly. (2007). Forsaking Transformational Leadership: Roscoe Conkling, the *great* Senator from New York. *The Leadership Quarterly,* 18, 463-476.

MGMA Survey: Starting Salary Greatest for Specialty Care Physicians in Multispecialty Practices. (2011). Retrieved June 17, 2011 from http://www.mgma.com/print.aspx?id=1366391.

Senge, Peter. (2006). Systems Citizenship: The Leadership Mandate for this Millennium. *Leader to Leader,* 21-26.

Smith, Warren. (2001). Chaos Theory and Postmodern Organization. *Leader to Leader,* 259-279.

The National Prevention Strategy: America's Plan for Better Health and Wellness. (2011).
Retrieved June 17, 2011 from http://www.healthcare.gov/news/factsheets/prevention06162011a.html.

VITA

Graduate School
Southern Illinois University

Jenny Hertter

jhertter@frontier.com

Southern Illinois University Carbondale
Bachelor of Science, Finance, May 2004

Research Paper Title:
Culture Change in Healthcare

Major Professor: John Hamman