Culture Change in the Integration of Physicians and Hospitals

Focus Paper

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Abstract

The health care delivery system is experiencing substantial change. This change is driven by a number of key drivers, including financial and value necessities. Many health care organizations are responding to this change by pursuing integration amongst physician and hospitals. Oftentimes integration is led by hospitals and health systems, as they most often have a greater capital position to acquire, consolidate, and build physician networks. Integration does present an opportunity for improved health care delivery; however, bringing together organizations that have vastly different organizational cultures presents numerous challenges. The purpose of this paper is to explore the steps necessary to advance healthcare organization’s culture, in a positive direction. Through literature and personal experience, this paper will seek to provide a better understanding of the characteristics of a positive culture and key elements, actions, and considerations in arriving at such destination. Culture has been shown to improve organizational performance, profitability, and the likelihood of an integrated system to sustain excellence in responding to external changes in environment. Common characteristics of both positive and negative cultures are described as well as steps necessary to initiate a positive culture. Sustaining a positive culture requires periodic measurement, on-going strategies, and physician leadership.

Keywords: organizational culture, physician-hospital integration, healthcare change
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Introduction

In the twentieth century, medicine has been the heroic exception that sustained the waning tradition of independent professionalism. Physicians not only escaped from corporate and bureaucratic control in their own practices; they channeled the development of hospitals, health insurance, and other medical institutions into forms that did not intrude upon their autonomy. But the exception may now be brought into line with the governing rule (Starr, 1982, p. 420).

Paul Starr’s *The Social Transformation of American Medicine* was amazingly correct on a great number of predictions, such as the move to for-profit entities, horizontal and vertical integration, corporate restructuring and industry concentration. He was thus-far, premature about his prediction of the pending future over-supply of physicians. Particularly interesting in the current time of accelerated integration of physician and hospitals, was his concept of a “collision course” amongst physicians and hospitals. This conflict was expected to occur as physicians assume more traditional ancillary institution services such as ambulatory surgery centers, imaging, home health, and rehabilitation services, and as hospitals become more directly involved in providing ambulatory services, outpatient clinics, and entering the health insurance market (Starr, 1982, p. 426).

Certainly much has changed from when Starr wrote his Pulitzer Prize winning, visionary essay on the history and future of the U.S. healthcare delivery system. Today, only 33% of U.S. physicians are independent (Accenture, 2015), versus 77% in 1982 (Silberger, Marder & Willke, 1987). Although collisions have occurred in some local and regional markets, it appears that integration is largely driven by capital assets and sheer size and hospitals have prevailed as the dominant provider, in most markets. This enormous swing in both the organizational and the structural alignment of physicians and hospitals can be summarized in a statement from former
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Medical Group Management Association (MGMA) President Dr. William F. Jessee (2010) when he said,

Traditional models of physician-hospital interaction simply will not work in the new environment. Rather, hospitals and physicians will be called upon to find ways to ensure they function effectively and efficiently as an integrated unit. Their shared economic fate will be tied directly to their success in maximizing efficiency, patient satisfaction, and quality outcomes while minimizing cost and patient risk (Jessee, 2010, p.23-24).

An Institute of Medicine, (IOM) (2012) committee affirmed what had previously been suspected in that:

The entrenched challenges of the U.S. health care system demand a transformed approach. Left unchanged, health care will continue to underperform, cause unnecessary harm; and strain national, state, and family budgets. The actions required to reverse this trend will be notable, substantial, sometimes disruptive-and absolutely necessary (IOM, 2012, p.4).

Specifically, the IOM committee estimated that 30% of healthcare spending was wasted due primarily to fraud, unnecessary services, and administrative costs (IOM Report, 2010). The administrative burden of escalating costs can be better understood in looking at an estimate provided by Casalino et al. (2009) when they stated the average cost for interacting with health plans was $68,274 per physician. Even more telling is that a separate study found the third leading cause of death in the United States is preventable medical errors, behind only heart disease and cancer (Makary & Daniel, 2016). The ultimate conclusion of the IOM committee was that, “Incremental upgrades and changes by individual hospitals and providers will not suffice as large scale, systematic changes are necessary” (IOM, 2010). As Eoyang and Holladay (2013) stated, “Not only are the rules of the game of life changing, but the game itself is being transformed”.

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Without question, alignment of physician practices and hospitals is occurring at an accelerated velocity. A key issue of optimizing such alignment relates to the co-existence and ultimate merging of what can often be very different organizational cultures. This alignment will be necessary to achieve the desired transformational change that elevates the value of care provided to patients in a new paradigm.

**Purpose**

The purpose of this paper is to explore the steps necessary to advance an organization’s culture, in a positive direction, as healthcare delivery systems are becoming more of an integrated conglomerate of physician practices and traditional hospital services. Through literature and personal experience, this paper will seek to provide a better understanding of the characteristics of a positive culture and key elements, actions, and considerations in arriving at such destination.

**Background**

**What is Organizational Culture?**

Perhaps the most universally accepted definition of Organizational Culture comes from Edgar Henry Schein, a former MIT Sloan School of Management professor, “The set of shared, taken-for-granted implicit assumptions that a group holds and that determines how it perceives, thinks about, and reacts to its various environments” (Schein, 1992, p. 9). Further definition was provided by Charles S. Jacobs (2009), “The collective story the group tells itself… that drives the thinking that drives behavior” (Jacobs, 2009, p.193). Although Heskett (2011) provided a much simpler explanation, “The way we do things around here” (Heskett, 2011, p.17).

**Why is Organizational Culture Important?**

Culture has been studied for over 80 years by industrial psychologists, anthropologists, and members of numerous other professional disciplines whom have shown time and time again that workers are more productive and have better attitudes when they are recognized and when concern for their working conditions is expressed. Beyond just being happier and more productive, strong, positive cultures have been shown to improve profitability dramatically and
increase the long-term viability of an organization as it is more likely to adapt to environmental changes. In fact, one study found that of the three most important organizational variables that impact profitability: 1) culture, 2) strategy, and 3) execution; culture alone accounted for 70% of profit achieved (Heskett, 2010). Furthermore, it is estimated that 20% of people’s time in an organization is wasted on issues, concerns, and processes related to the corporate culture (Senn & Childress, 1999). Organizations with a strong culture can improve individual employee productivity by 12-25% each and every day (Deal & Kennedy, 1982).

Body

Culture is Constantly Moving

The negative impact of culture is exposed in John Kotter’s book *That’s Not How We Do It Here!* where he depicted colonies of meerkats, which are catlike creatures in the mongoose family that live in large clans. His child-like novel depicts the rise and fall of several meerkat families based upon the organizational cultures and ability to detect and adapt to changing external environments. The meerkat culture is analogous to some human cultures in the business world. This book clearly illustrates that cultures can and do change but it takes strong leadership and constant action to transform clans towards a positive culture (Kotter & Rathgeber, 2016).

Kotter’s story also depicts that cultures are not fixed, they must evolve. This concept is often hard to understand as many individuals may be set in their culture as it has been successful in the past and may appear to be working now. A focused effort to change and measurement of change are necessary for a positive cultural to evolve. The difficulty for an organization to change its culture is evidenced by the fact that only 1% of U.S. organizations have a life span that survives for 40 years or greater (Stubbart & Knight, 2006). Furthermore, as Heskett (2011) stated, “Cultures are formed with our without formal, organized effort” (Heskett, 2011, p.91).

Undoubtedly, healthcare is a very complex industry that has been categorized as having nonlinear causality in regards to the key driving forces. Eoyang and Holladay (2011) provided a definition, “linear causality means that one side has all the power to cause change to another.
Nonlinear causality tends to magnify situations over time until they explode” (Eoyang & Holladay, 2011, p.22). The dynamic change of the healthcare industry can be paralleled with the natural illustration of an earthquake. Numerous, independent variables (many which have changed gradually over long periods of time) are connected to the sudden, major catastrophe of an earthquake. This is very similar to how the healthcare industry experiences change. Effective renewal and adaptation of organizational culture must be reinforced by leadership and management actions or cultures will deteriorate. Organizations are not static, as described by Quinn, organizations, “continually becoming more negative or more positive” (Quinn, 2015, p.2). Furthermore, as cultures develop with or without conscious effort, they require consistent effort and focus to change positively. This is frequently evidenced in the healthcare environment in the following two examples. First, patients may receive the best possible care and most positive clinical patient experience only to be disappointed by the back-end billing process from a corporate or third party billing office requiring an individual to pay the insurance balance. Second, a physician recruit may be “wowed” with an initial visit, love a community needing a skilled-physician, only to later be disillusioned in dealing with corporate attorneys on specific details and language of contract for employment. In both cases, it is perceived as dealing with two, or more totally different organizations, with vastly different values and culture. These disconnects in organization culture are particularly relevant as physician practices and hospitals further align bringing together vastly different groups of stakeholders and employees. Healthcare organizations that wish to remain viable for the long-road of healthcare transformation must recognize, value, measure and execute actions towards a strong, positive organizational culture.

**Characteristics of Positive and Negative Cultures**

The MGMA Body of Knowledge was used as the framework for contrasting the attributes of culture in this focused paper. The Body of Knowledge is organized into six major areas of responsibility called domains. The six domains are Organizational Governance, Financial
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<table>
<thead>
<tr>
<th>Positive Culture of Excellence</th>
<th>Negative Culture of Silence &amp; Mistrust</th>
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<tbody>
<tr>
<td><strong>Organizational Governance</strong></td>
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<tr>
<td>1) Employees view executives as highly-regarded friends, and feel an individual and personal connection to leadership and have no fear in speaking truth; 2) Employees understand and are proud of their individual role in an organization’s future success; 3) Governing bodies welcome constructive confrontation, as they believe good things emerges from the bottom-up are not mandated from the top-down. Change can be driven from every level of the organization;</td>
<td>1) Employees avoid interactions with leadership as they feel they are detached from what is really going on. Blind spots exist in organization as governance and leadership does not receive candid feedback from employees; 2) Employees frequently question governing body and believe they do not know where the organization is going; 3) Organizational paralysis with uncertainty;</td>
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<tr>
<td><strong>Financial Management and Human Resources Management</strong></td>
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<td>1) Employees are intrinsically motivated and employees flourish, often exceeding expectations; 2) Overwhelming focus on shared goals versus individual goals; 3) Aware of financial challenges, well in advance of financial reporting;</td>
<td>1) Conflict, chaos, crises mode, over-staffing, under-staffing, finances and HR functions hide underlying issues of poor leadership. The results of the above are that employees withdraw as they are underutilized and exhausted; 2) Pursuit of individual recognition and extrinsic rewards often characterized by numerous layers of managers supervising other managers; 3) Environment of constant planning and re-planning. Valuable resources and time are wasted instead of directed to executing strategic and operational plans;</td>
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<td><strong>Operations Management</strong></td>
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<td>1) Self-organization and empowerment; 2) Decisive action with speed and urgency; 3) Consistent and dependable managerial control; 4) Collective learning and creative collaboration; 5) Employees think their work is important; 6) Managers are accepting of multiple perspectives as there are no hard boundaries; 7) Executives understand employees as they speak executive talk as well as the language of front-line employees;</td>
<td>1) Group think; 2) Knee jerk reactions by managers; 3) Frequent inability to meet plans and retain focus; 4) Self Interest, individual egos, bureaucracy and micro-management are positively rewarded by organization; 5) Frequent re-organization and turnover of leadership; 6) Inability to make timely decisions. Decisions are often deferred or ignored;</td>
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<td><strong>Patient-Centered Care</strong></td>
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<td>1) Cohesive teamwork; 2) Authentic relationships;</td>
<td>1) Fragmented, confusing, wasteful, poor sense of true mission, taking care of patients;</td>
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<tr>
<td><strong>Risk and Compliance Management</strong></td>
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<td>1) Organizational predictability; 2) Procedure compliance; 3) Accepting of failed experiences, as they are viewed as powerful learning experiences;</td>
<td>1) Policies overly risk adverse and burdensome; 2) Inconsistent standards; 3) Emphasis on self-preservation.</td>
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(Quinn, 2015)
Negative Culture

Dysfunctional, disintegrating, non-authentic, negative cultures have been described by a variety of terms: culture of silence, culture of explanation, culture of fear, and culture of apathy, just to name a few. What does it say about an organization’s culture when employees and physicians are reluctant to use their own care providers to receive healthcare for themselves and their families? Likewise many public and federal facilities have recently received unwanted notoriety for less than optimal quality of care, patient access, patient experience, and patient satisfaction scores. Political influences, which are often more prevalent in federal and state sponsored institutions, often confuse organizational values and beliefs and result in organizational inconsistency.

However, there is hope. All cultures can change but they must be proactively and consistently nurtured and reinforced by managerial actions and organizational leaders. This includes being truly open to receiving feedback from all stakeholders and then acting on such feedback to create a positive culture of inclusion. An organizational commitment to transparency and openness must be authentic or it will actually re-enforce and fuel a negative culture. For example, leaders of an organization may publically advocate and support “skip level meetings” where managers skip reporting through their immediate supervisor to meet with their boss’ boss. Conceptually this approach sounds like a great way to enhance connection, improve communications and increase understanding amongst various levels in the organization. However, two critical elements are necessary to preserve the integrity of skip level meetings and thus enabling them to be a positive influence on culture. First, clarity must occur so all understand the purpose of the meetings. Second, a well-outlined process must be communicated as to how information from the meetings will be used. Third, trust must exist between all parties in that they have confidence regarding the purpose of such activity and are not threatened or have alternative motivations (Robberson, 2016).
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Major precaution should be present as an organization carefully evaluates and avoids both conscious and unconscious bias regarding “culture fit” of individuals who may join an organization. Culture fit should not mean an abundance of homogeneity, nor should it mean being exclusive of different points of view (Davis & Daniels, 2016). Many organizations have failed, largely because they exclusively promote within and are blind to new perspectives and slow to adjust to environmental adaptations based upon experiences at other organizations. Defined benefit pensions and tenured employees may retain employees in an organization beyond their optimal time of productive and contributory service.

Steps to Positive Culture

The following steps can change negative cultures into positive ones as hospitals and medical practices continue to integrate:

I.) Assess the current culture of all organizations integrating

II.) Determine what is needed to strengthen culture to the desired attributes of integrated organization (see Body of Knowledge Culture of Excellence above)

III.) Facilitate authentic conversations with all key stakeholder groups and individuals, as authenticity drives cultural change

IV.) Use multiple media to communicate concise message of desired shared values, behaviors, and performance expectations
   a. Connect people to their new desired roles and expectations
   b. Provide regular formal and informal feedback on individual and organizational performance

V.) Recruit physicians and employees for right cultural “fit”
   a. Continuously orientate people to the common vision of the integrated organization
b. Selection of leaders and employees should include sense of urgency in confronting brutal truths of current competitive position and desired future positioning of the organization

VI. Actively manage all culture conflicts

a. Remove obstacles such as unnecessary organization structure, conflicting individual incentive systems, and those who refuse to change

b. Resist the temptation of declaring ultimate victory too soon

VII. Measure the engagement of employees and physicians

a. Deploy clinical integration tools

b. Measure results such as employee retention and in-network and out-of-network referrals, and relationships with stakeholders, as well as speed of innovation and integrated financial performance

c. Align compensation with performance measures

d. Link and show how new integrated culture improved organizational performance (Jessee & Rowlee, 2012)

Measuring Change in Culture

Once efforts to change a culture have been implemented, it is critical to measure periodically the impact of these changes. At least two well-validated instruments for measuring culture in healthcare organizations do exist, the AHRQ Patient Safety Culture Survey and the Minnesota Medical Group Culture Survey. Below is a summary of the two surveys where stakeholders would indicate the degree of agreement with the following statements:

i. We have a team approach to patient care

ii. We highly value decision support tools such as clinical guidelines, standardized policies, and protocol
iii. We are actively doing things to improve patient safety

iv. Staff feel like their mistakes are held against them

v. Things fall between the cracks when transferring patients from one care unit to another

vi. We have a strong shared vision of who we are and how we practice

vii. We view ourselves more as a business than as a community health resource (Kralewski et al., 2005), (AHRQ website, 2016).

**Sustaining Positive Culture towards Physician- Hospital Integration**

As described earlier, leaders can influence cultural change but in order to sustain change it must be embodied in all levels and all employees of an organization. This includes the freedom, encouragement, and organizational priority to redesign structures and routines collectively. Continuous improvement and re-design can be a very contagious and positive influencer towards organizational change. Furthermore, as Bridgewater CEO Greg Jensen says, We have a set of principles, but we do not want people to merely follow them. We want people to engage them, wrestle with them. Follow them if they make sense. But most importantly, if they do not make sense, we want people to fight like hell to get them changed, show us why they don’t make sense (Kegan & Laskow Lahey, 2016, p.115).

A commonly accepted principle is that structure drives behavior. Even subtle decisions like employee office configurations and unwritten logistic rules of an organization are important. Below are a few considerations that may help re-enforce culture development in an organization:

1) Are administrators located in close proximity to clinical leaders? This can result in number of unplanned, random collisions that are extremely productive. 2) Do senior executives always sit in the same chair or gather in front, together, but separated from the other employees at group meetings? 3) Are employees comfortable in questioning processes that fall outside their normal scope of operations? 4) Are alternative opinions discouraged as each functional area is overly
sensitive to operations and performance of their specific area of responsibility and are interested in spending more time disputing facts than they are working to improve? The existence of all of these beliefs may unintendedly cause divide and represent a closed system. Constant attention as to how people interact routinely is required to maximize culture development.

**Lessons Learned in Culture’s Role in Physician-Hospital Integration**

Vertical integration by creating financial and structural relationships between hospitals and physicians often has had only limited success in fostering the desired-level of physician-hospital alignment (Budetti, et al., 2002). In a study of over 3,000 physicians and 14 integrated hospitals, financial incentives and management-support services provided by hospitals were found to be only somewhat effective in enhancing physician-system alignment, but structural arrangements and productivity controls were not deemed not effective (Alexander, J.A., et al., 2001). Additionally, Burns (2001) found that physicians’ involvement in structural relationships such as Independent Practice Associations (IPAs) or Physician Hospital Organizations (PHOs) alone, did not enhance physicians’ commitment to an integrated delivery system (Burns et al., 2001). In fact, when strategic and policy decision making was centralization and dictated solely by hospitals, physicians actually showed less support for the hospital. Interestingly enough, directly linking physician compensation to measures of individual productivity had a strong negative effect on physicians’ attitudes toward hospitals (Burns et al., 2001).

Hospitals also often fail to deal effectively with the natural independent-mindedness of professionals such as physicians. This is largely because of the newness of many integration efforts and that there is little sense of a culture that could sustain these relationships. Furthermore, physicians did not exhibit the degree of trust, faith, and confidence in hospitals necessary to have sustainable, well-functioning relationships. Leadership problems are often widespread, with physicians lacking confidence in administrators, even administrators who were themselves physicians (Gillies et al., 2001).
So what is the solution? The type of payment and revenue to both the physician group and individual physician does seem to improve, some aspects of physician-system alignment. As the proportion of revenue coming to a medical group from managed care arrangements increases, physicians were more likely to have positive attitudes, increased loyalty toward the hospital, and a greater degree of alignment. Also, the greater the operational support provided by the hospital to physicians’ practices the more enhanced is the physician-system alignment (Alexander, J.A., et al., 2001).

The Physician Leadership Imperative

Historically, the role of a physician could be described as “to provide direct medical care one patient at a time” (Abrams & Morris, 2016, p.1). This statement is still true, but it only represents a portion of the role of today’s physicians where they are expected to lead complex clinical programs, integrated service lines, master information technology and data mining applications, and care for populations, as well as individuals. The ideal description of a present-day physician leader is someone who is “part strategist, part steward, part catalyst, and part operator” (Abrams & Morris, 2016, p.1). Physician leaders must also think strategically, be able to communicate those strategies, understand and know how to lead people and teams. “Emotional intelligence, developing and sustaining a teaming culture, and using collaborative decision-making with patients and their families – these are some of the characteristics that can translate to leadership success” (Abrams & Morris, 2016, p.1).

Medical school curriculums are rapidly changing in response to the new prerequisites. Team-based and interdisciplinary care and coordination are becoming a common component in medical school and other healthcare providers’ training curricula. Other new competencies are mega and micro data retrieval, instead of the mastery of memorization, and delivering a high-quality patient experience. The summary statement of the new curriculum is that physicians must adhere to a career of life-long learning and continuously learn new ways to learn as healthcare is transformed.
As the health care reimbursement continues to move from fee-for-service to a new era that is more collaborative and outcome-based, physicians will need new skills, bolder decision-making and the next-level business strategies. The next phase of health care delivery requires “physician leaders who are innovative, interdisciplinary thinkers with the skills to envision and shape the future” (Abrams & Morris, 2016, p.1).

As health care delivery shifts from volume-based to value-based business models, success will be realized through offering services with the best possible quality, outcomes and access, at the lowest possible cost. Alignment between hospitals and physicians will be essential in changing the care delivery model, increasing patient and physician satisfaction and delivering the value equation—quality, outcomes, cost and access. Since physicians are responsible for driving the clinical care of patients, physician incentives must be value-based and financially aligned with hospitals. Physician-hospital alignment will reduce duplication of health care resources deployed in communities and decrease the overall costs to payers, employers and patients.

**Strategies to Guide Physician-Hospital Integration Efforts**

In 2012, Kaufman Hall & Associates (2012) outlined key elements to guide future models of hospital-physician integration:

1. Understand the current factors impacting physicians; design options and strategic offerings to address the needs of physicians.

2. Understand the hospital’s distinctive competence, specific capabilities and infrastructure available to the communities served.

3. Provide the appropriate resources, financial, time, and others to execute a well-defined physician-integration plan and corresponding performance targets.

4. Foster strong physician participation in leadership, governance, and operations.
5. Optimize use technology to connect with physicians, patients, and payors.

6. Assess organizational readiness for value-based care transformation, including a formal clinical integration program.

7. Use a discipline and consider culture when evaluating practice acquisition, mergers and physician employment.

8. Broadly communicate the necessary level of financial commitment to employ and support a strong physician network.


10. Structure effective, fair, market-based, and sustainable compensation programs for employed physicians.

11. Actively manage and engage employed physicians to achieve goals.

12. Use a structured process to evaluate, develop, implement, and measure success of new business ventures (Kaufman, Hall, & Associate, 2012).
Conclusion

“Knowing is not enough; we must apply. Willing is not enough; we must do” (Goethe, n.d.). Frequently, leaders design and implement change because it is their “job” to do so. They feel pressure from boards, peers, and colleagues to do something and do something now. Often times this rush for action does not penetrate the cultural membrane of an organization as leaders do not have the awareness or commitment to drive and instill the necessary change. Sustained change is derived from a willingness to own vulnerabilities, confess failures, and acknowledge that many experiences do not have happy endings (Block, 1997).

The Mayo Clinic provides a remarkable example of a positive organization where they continuously re-align corporate culture as demanded and as shaped by customers. The Mayo culture is largely founded upon the premise that there is no product or service good enough to overcome a bad customer experience (Everett, 2016). According to former Mayo Clinic CEO, Dr. Glenn S. Forbes,

What makes Mayo Clinic distinct is that we have said ‘The needs of the patient come first’ from the beginning. Over generations, we have driven the needs of the patient into our thinking about how policies were developed. We’ve driven it into our thinking about how we structure ourselves and our governance and how we allocate resources. We’ve driven it into our thinking when we recruit people and form staffs. We’ve driven it so broadly and deeply into our management and operations that it becomes part of a culture. Thus, when we bring an issue forward, I’s not a thin layer of, oh yes, that was the marketing mantra that somebody thought of last week. No, this is driven much more deeply into the fabric of the organization. That’s what makes us different (Berry & Seltman, 2008, p.20).

The traditional hospital model of management and cultural value is that of hierarchical control, problem-solving, and efficiency. This is often in great contrast to the cultural values of physician-governed entities that are much more relationship based and concerned with key
stakeholders such as referring physicians, patients, business partners and communities served. Positive “culture can foster organization stability and facilitate changes in strategy, (Heskett, 2011, p. 22). As summarized by Kuhlmann and Philip (2009), ”with the right culture, the problems of commitment, alignment, and motivation go away and hierarchy becomes irrelevant” (Kuhlmann & Philip, 2011, p.125).

The right corporate culture drives profitability and provides a sustainable, unique competitive advantage. Organizational culture is built from the bottom-up and but shaped from the top-down (Everett, 2016). A strong culture facilitates survival and adaptability in times of great adversity. This is exemplified through Southwest Airlines that actually gained market share in the post 9-11 downturn in the airline industry. Southwest Airlines’ culture is extremely strong and is based upon the following values:

- A warrior’s spirit
- A servant’s heart
- A fun loving attitude (Makovsky, 2013).

Southwest’s “Warrior Spirit” can further be described as, “Work hard, desire to be the best, be courageous, display a sense of urgency, persevere, and innovate” (Southwest Airlines company web site, 2016). The organizational culture of integrated physician practices and hospitals can positively evolve with strong leadership, a carefully articulated plan, periodic measurement and the warrior spirit to advance the culture towards a truly unified and integrated organization.

The health care delivery system is experiencing transformation at an accelerating pace. Many variables are driving this change some which are known and some of which are yet to be defined. Physicians will continue to be a core element of health care services. The alignment of physicians, hospitals, and other components of the health care delivery system requires integration towards more efficient, more effective, patient-centered systems of care.
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Restructuring and re-organization of what have been historically very different organizational cultures presents many challenges. Sustainable organizations will be those that pro-actively define and execute strategies to advance a new, unified culture that values, measures, and continuously improves organizational performance, patient outcomes, and the overall patient experience.
References


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