ORGANIZATIONAL MANAGEMENT OF NEW KNOWLEDGE:

A CASE STUDY OF A STATE BUREAUCRACY

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ABSTRACT

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This case study of the medical division of a state welfare department examines the organizational management of new knowledge and the concept of a learning organization. Knowledge is broadly defined to include not only new information, but also the set of events triggered by the entry of that information into the organization, while new is defined by the inclusion of that which is perceived by organizational members to be outside their routine performance.

Current descriptive models of organizational change by which new knowledge is introduced are examined. These include two prime models: the "crisis" and "guerilla" models, both of which, while partially effective, tend to be widely disruptive of the organization and create lasting frustrations and antagonisms. The resultant changes tend to wither away, thus necessitating a reactivation of either of the models. New models developed in response to this situation are examined and a basic underlying thrust towards the concept of organizational learning is uncovered.

The author here defines organizational learning to be the development of patterns of response to new knowledge in a manner which is not perceived as wasteful of energy, time or other resources, but which has both significant and lasting effects. This definition is elaborated in the study to include six possible levels of learning. These levels also serve as criteria by which putative learning organizations can be evaluated. The levels include:

1) learning new tasks and an associated development of new policies

2) learning to routinize those tasks and policies over time

3) learning general principles which can be used to improve task performance or which are transferred to other task areas

4) developing general patterns of action or "programs" of behavior which permit the generation of new tasks or principles

5) developing overall approaches for the learning of those principles and patterns

6) learning (or changing) the organization's paradigm.

The studied organization, a 40-member central office division of a large welfare bureaucracy, administered a program of medical care for the poor. That division was examined via a detailed exploration of fifteen situations of new knowledge and was evaluated using the above criteria. Within the space of two years the organization developed such that it successfully met these criteria for a learning organization.

Neither the crisis or guerilla models nor the more normative models were found to be useful in accounting for this success. Rather, a model based on both teaching and management and on the evocation of an organizational paradigm were found to be the main sources of the division's effectiveness. Competent management of routine activity was found to have created a basic credibility with the division's environment such that the division was given breathing room to explore new task areas. These new areas were entered with a sense of organizational confidence created by the same management style and the organization's strong paradigm - a "responsible buyer" (of health care services for the poor). Explicit principles and tacit patterns of action were then developed through the use of a teaching style which prospered because of a unique agency head and competent staff members.

These sources of effectiveness were found to be different from the conventional change models in a) their basic pragmatism, b) an emphasis on ends at the expense of means, c) an explicit focus on the organizational paradigm, d) a tolerance of a diversity of styles, and e) a balance between an emphasis on the teaching of new principles and an emphasis on responsibility and accountability aspects associated with routine performance. Nonetheless, the division's learning model was found to have certain costs associated with it, principally an avoidance of internal advocacy of dissenting positions.

The division's model was also examined from the point of view of its durability and possible transfer to other organizational situations. The division's success in creating a learning organization combined with the problematic conclusions regarding its durability and transferability lead the author to conclude that the achievement of the fifth and sixth criteria (including transformation of the organizational style or even its paradigm) as necessary conditions of organizational learning is an excessively stringent criterion. A more flexible and less rigorous definition of a learning organization is thus posited, one in which organizations need achieve the six successive levels of learning only in accordance with general environmental demands.

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Chapter I

Introduction

1. Introduction

This study is concerned with the manner in which organizations manage, mismanage or fail to manage new knoweldge either generated from within or injected from the organization's environment. The rationale for choosing such a topic is the current helplessness felt by both academicians and practitioners in finding solutions to the problem of making organizations, particularly government bureaucracies, responsive to new knowledge in a manner which will have significant and lasting effects.

In the study, I have chosen to approach these themes in a deliberately broad manner. Thus, in "new knowledge" I would include all that which is perceived by the organization members as new - that is, outside their routine behavior patterns. This new knowledge might range from a complete new technology (e.g., a caseload versus a functional technology for social workers) to a specific new procedure for job performance; from new attitudes about employees' jobs to new strategies for goal attainment or even new goals and organization's definition of their mission (their paradigm). "Responsive" indicates that the organization had in fact developed a pattern for responding to those sorts of new knowledge in a manner which is not perceived as wasteful of energy, money, time or other resources. Significant areas of responsiveness might include broad transformation of the organization's mission or paradigm, but could also include, for example, development of new approaches to learning or even adoption of important working principles. Lasting effects (i.e., some degree of durability) would require that there be some consequences of those patterns beyond the initial success in responding to new knowledge.

Thus the prime question asked in this study is: can organizations, in situations where their environment expects or mandates a response, develop effective methods of managing new knowledge. And, if so, can they do so without excessive disruption of the performance of their routine activities;and can such a learning style be maintained over appropriate periods of time.

Current descriptive organizational theory suggests that organizational responses to new knowledge occur in one of two ways. The first, as described by Crozier and Downs, for example, suggests that typical management of new knowledge derives out of a crisis situation in order to implement an idea or program publicly deemed to be"in good currency" and is accomplished by a massive and sudden injection of resources into the organization.

Downs, in his earthy and descriptive work, suggests as "laws" that all organizations (and individuals in them) tend to become more conservative as they become older, unless they experience periods of very rapid growth or internal turnover. He also suggests that no one can ever fully control a large organization and that even this partial control becomes weaker and internal coordination poorer as the organization gets larger, even leading - in some cases - to direct counteractions by some organization officials. Such officials tend to distort information upward, are biased in favor of programs they personally favor, and act upon orders only to the degree that it will further their own interests. Downs elaborates considerably, but the vision he presents can only be seen as pessimistic to advocates of organizational change, no matter how realistic it may sound to those millions who have toiled in government bureaucracies.

Crozier has also developed an interesting theory of how these "vicious circles of bureaucracy" develop. He describes how bureaucrats tend to "escape from the reality" (of uncertainty) to preserve their own autonomy. The only tools the organization has to counteract this escape - development of rules, centralization of decisions, and strata isolation - tend to form a vicious circle, since their failure leads to pressure to extend them rather than abandon them. Ability to change them recedes upward and even top management becomes impotent except in situations of crisis or when tacit assumption is made by a majority of the organization's members that "the rules" will be suspended while the organization adjusts.

These and other authors describe how a massive and sudden injection of resources into the organization is required to change these situations. Yet this approach to change is seen to be disruptive of routine activities and wasteful of both energy and resources, since most organizations fight to remain the same - they are "dynamically conservative" (Schon).

A second approach to change less commonly observed but well described by Schon, Rogers, Burns, Stoffer and even Merton and others is based upon activity by organizational "guerillas" and "insurgents" (who may also be called "deviants", "zealots", or "misfits"). They are usually mid-level persons in the organization but occasionally bureau heads. They aggressively fight for change and support for their ideas, all the while disrupting the organization and, after burning themselves out, leave the agency. The organization then continues, often structurally unchanged and often backsliding into its former pattern of rigidity. While the disruption has not been as great as in the first approach, the reform or change is often short-lived and a legacy of

antagonism towards future guerillas or,more importantly,change itself, has usually been created.

Normative responses to these two descriptive theories of organizational change have been many. The "technologists" and management scientists (J.D. Thompson, J.R. Galbraith, Beers, etc.) have suggested the importance of developing formal structures based on the specific technologies needed, and of utilizing planning, project management, PBBS and other sophisticated tools for the smooth integration of both new and routine information. Thompson and Galbraith, for example, have suggested (in two separate works) that all organizations deal with new information in what might be viewed as a tendency towards certainty or a re-establishment of stability. They first establish rules, then a hierarchy (Thompson calls this pooled interdependence and links it to a specific kind of technology, as he does with his other types of interdependence), then establish a planning system (to manage Thompson's"sequential interdependence"). The two authors go further to show how some organizations may passively deal with new information by "buffering" or creating slack and by changing or isolating the core technology so the need for interaction is lessened. Or they may actively deal with new knowledge by changing the "vertical system", that is adding assistants, computers or early warning systems and even spies who can assure the adequate flow of knowledge up and down the structure and who can take corrective action to forecast, level or ration resources. They may also actively deal with new information by improving lateral relations (to deal with Thompson's"reciprocal interdependence")with committees, liaison staff or project managers.

The human relations and organizational development school (Likert, McGregor, Bennis, Argyris, etc.) has stressed the importance of personal growth and competence in organizational management of, or adaptation to change. This school advocates flat organizational hierarchies, decentralied control, few rules, combined with open, trusting, and honest organizational members who develop a shared understanding of organizational purposes. They participate in group problem solving and decision-making and rely heavily on coordination and liaison activities to both probe the environment and to follow up on task completion. More sophisticated members of this school (e.g. Argyris, Schon and Vickers) have begun to draw from other fields and have advanced notions of "learning organizations" in which the organization, through a variety of as yet mainly unexplored means, but including the human resources techniques and the principles of individual learning, will learn to change itself without the disruptive effects inherent in the "guerilla and insurgent" theories.

The environmentalists (Lawrence and Lorsch (1967), Wilson, Vickers, etc.) have suggested the importance of developing sound relationships between the organization and its environment. For example, Lawrence and Lorsch have shown that the performance of businesses in responding to the uncertainty of their environments is strongly related to the various manners in which they differentiate their task structures and to their success in integrating these tasks through a variety of structural and personnel devices. Others concentrating on government have stressed that bureaucracies must knowingly derive power from their environment and exercise it in response to that environment.

More recent work by a variety of authors (Perrow, 1967, Lawrence and Lorsch, 1969, etc.) have stressed a contingency approach in which structures, technologies and organizational development styles for organizational change vary depending both on the complexity and certainty of the environment and specific mixes of internal factors such as organizational history and personnel.

Central to all these alternative normative theories, however, is the implication that organizations designed in such ways can become "learning organizations". That is, not only can they accomplish their tasks effectively, but they can improve their task performance over time, develop specific patterns and approaches for improving this performance and, more importantly, even change the nature of their tasks in response to externally or internally generated information or knowledge. Such organizations would act without the disruptive and inefficient effects said to be inherent (Downs, Bennis) in the crisis or guerilla models.

As one author asks- "Is it possible for organizations to be continually adapting to both environmental changes and changes among their individual contributors? By what processes can this be accomplished?" (Lawrence). Another (Schon) states that "we must become able to not only transform our institutions in response to changing siutations and requirements; we must invent and develop institutions which are learning systems, that is to say, systems capable of bringing about their own continuing transformation." This normative call for a "learning organization" is a powerful one and is why I have chosen that framework of analysis as a basic departure point. It is also why I have chosen to call the raw material of such an organization new knowledge, since

it seems only approrpiate that a learning organization be one which processes or manages knowledge. The broad definition of new knowledge suggested on page 6 thus includes not only the initial awareness, contributed from outside or from within, that new elements could be added to the organization's repertoire of behaviors but also the succeeding patterns and methods of responding to that initial event. A learning organization would thus be one which effectively manages (according to my earlier suggestion) not only that initial awareness but the succeeding behaviors it triggers. Since my definition of new knowledge is a broad one, one which might but might not include a new paradigm, then the importance of a change of organizational paradigm implied in "continuing transformation" is one which should remain open to investigation.

Not only should we be open on such particular points but the whole learning organization framework of analysis, while useful as a departure point, must be further tested in practice and its basic concepts more thoroughly examined. Actual experience with such "learning organizations" has generally been limited, usually to organizations very specifically designed with learning in mind, such as some research and development bodies. And upon closer examination of other putative learning organizations, one of the two conventional models (the crisis or guerilla pattern) is more often found to be at work (e.g., Burns and Stalker, Nelkin). Nonetheless, idealists argue that such learning organizations must be designed and extensively, if not universally, implanted; otherwise, our complex organization-based society will perish via "dry rot" (Gardner).

Others also assert the need for such organizations but stress that they may only be necessary at certain times in an organization's life cycle or in certain environmental situations. That is, when an organization's environment is continuously stable and where routine tasks are called for (e.g., a Department of Motor Vehicles), the organization may not need to be a learning organization; there are no, and would likely not be, any societal requirements for it to acquire new tasks or to significantly change the way it performed its existing tasks. Other organizations, particularly research and planning organizations, may need to be learning organizations throughout their lives. Another large group of organizations - probably including most government bureaucracies offering direct services to the public - need only have the capacity to learn when the environment requires it to change the mix of its routine/non-routine tasks. In general, however, these questions about the necessary scope of learning organizations fuse with the earlier questions about what learning organizations might, or should look like and how they might be designed and managed.

2. Focusing the Study

This study is a case study of one particular bureacracy, one chosen as a medium size, stable and entrenched government agency not obviously subject to either the crisis or guerilla patterns of change described on page 7 . The reason for selecting a specific organization is that I believe the vocabulary for discussing organizational learning is so rudimentary that a more exploratory approach is called for in which practical and conceptual frameworks different from these two predominant models can be developed.

Specifically I will try to develop a method of understanding the relationship between different kinds of new knowledge and the organization's management of its various systems of behavior. The analysis begins (Chapter II) by examining the organization's task structures, its personnel/career systems, its technological system and its political system (a very useful classification suggested by both Price and Burns and Stalker), but concludes by focusing on how the agency managed these systems with tools which cut across each of them. While I have many personal notions about such management and have been influenced by a wide range of authors, it is not my purpose here to test in an experimental fashion any one particular hypothesis about the manner in which organizations manage new knowledge but rather to understand how one organization does so, and, from that, to generate definitions of what learning might be in that case, evaluate whether and how that organization achieved it, and describe any limits of that learning, or of the manner in which it was achieved.

The organization chosen was the medical division of a state welfare department. While a part of a larger organization, the division was seen, by its members, by the welfare department's members, and by the otuside environment as being a distinct and separate organization. The division was responsible for administering the federally supported Medicaid program which financed health service delivery for welfare clients. The division (and the program) was begun in 1968 and grafted onto a 1500 member welfare bureaucracy acknowledged to be one of the most unmanageable and resistant to change in the state by both the legislature and cabinet level officials. By 1973 the division had a staff of 22 persons and

adminstered a program which purchased over $300 million worth of medical care. It relied on other divisions of the department to carry out many of its functions (particularly on the local level) and was constrained by many other state and federal agencies in its policy development. In 1973, after the assistant commissionership of the division (its head position and a political appointment) had been vacant for eight months, a new head was appointed. Over two years he doubled the staff, created new programs, increased the agency's monitoring capacity and watched the service budget double. The division's external credibility with members of its environment improved considerably and the new head stated that "we're building a learning organization here", one that presumably would manage new knowledge effectively and perhaps even efficiently.

I have asserted that the vocabulary for discussing organizational learning is so rudimentary that survey type analysis, quantitative analysis or comparative analysis are inappropriate for the research question I have posed. What is needed in such areas of uncertainty is, as Rhenman states, the development of a "language for describing unique cases" (as, for example, Freud and Keynes so compellingly developed) rather than comprehensive generalizations in a shifting world "beyond the stable state" (Schon). Therefore my initial responsibility here is to be rich in the telling of this story about one (putative) learning organization, thus permitting the reader to determine how that language and the concepts developed may be useful in his own situation.

But this initial responsibility of <u>vocabulary</u> development is not the only task suggested by the study. The simple effects of demonstrating that a possible <u>alternative</u> to the crisis and guerilla models, or to more

normative theories exists, are also significant. Similarly, a consideration of the possible limits of that model, not only inherent limits but also limits which might only become apparent over time or through application to other situations, will be helpful to the reader.

3. Initial Conceptual Development

After observing the organization for several months, it became clear that the many calls for learning organizations (pg. 11), were overly general and that more specific criteria which would define a learning organization must be sketched out. Bateson's work on the levels of learning seemed useful not only in its use of levels, but also because of the suggested systemtaic relationship between levels. I thus attempted to define several rough, successive levels of learning by which the organization could be evaluated. Those levels included:

1) learning to perform the organization's routine tasks
2) learning new tasks and an associated development of new policies
3) learning to routinize those tasks and policies over time
4) learning general principles which could be used either to improve task performance or which could be transferred to other new task areas
5) developing general patterns or "programs" of behavior for approaching new task areas
6) developing overall methods for the learning of those principles and patterns, and finally
7) learning (or changing) the organization's paradigm.

The attainment of each of these levels by the organization would thus indicate the degree to which that organization had become a learning organization. Reaching only, say, the initial levels, would indicate simply that the organization was learning to a lesser degree. The criteria for evaluating a putative learning organization are thus encompassed in the working definition. The significance of this working definition of a learning organization lies in the use of levels. Thus earlier, more global definitions of a learning organization (as, for example, that it must be able to change its paradigm) are replaced here by a definition which is somewhat more flexible. I will later suggest that the degree to which any organization need meet these criteria is determined basically by environmental forces.

These are the main criteria which will be utilized throughout chapters III through V in describing and evaluating the types of learning which take place within a specific organization. Not all these levels will have the same importance in the development of the study. For example, the first level of learning (learning to perform the organization's routine tasks) is adequately covered by other management literature and will not be stressed here. Thus, the level of learning new tasks and policies will constitute the first level for dealing with new knowledge in this study. Also, the importance of an overall approach to learning (levels 6 and possibly 7) and details of the development of such an approach were not clearly understood at the commencement of the study. Nor was the significance of the criterion of the changeability of the organization's paradigm.

These upper level criteria and their significance in the definition of a learning organization are thus more fully assessed at the conclusion of the study. The discussion in Chapters VI and VII of their utility in describing this one situation, and more importantly, their application to other organizations, must also be assessed by the reader of the study. But I believe that these upper level criteria are reasonable ones to be applied to organizations managing new knoweldge even though they may be met only infrequently.

It would, of course, have been relatively simple to construct a much more elaborate and theoretical conceptual schema here before commencing the study. But my definition of levels of learning and their attendant criteria for evaluation have been influenced by:

1) the belief that learning is a process and that evaluations of putative learning organizations must be geared to uncovering processes (e.g., the teaching and management approaches) rather than to an adherence to more rigid criteria;
2) the need for clear and simple concepts which can be recognized by, and whose embodied realities are accessible to, members of the organization and its environment; and
3) the somewhat normative views of the researcher.

The working definition of learning will thus be tested in the main chapters of the text - does it adequately define learning, what are the consequences of those levels of learning and how useful is the definition and the language accompanying it for uncovering processes of learning which are understandable by, and accessible to, both practicing managers and researchers.

4. Methodology

While the organization chosen was not as stable and entrenched as I had originally envisaged and became more politically visible over the course of two years, it was based within two conservative and unmanageable systems (welfare and health care delivery). I had also not desired to study a "strong leader" agency, but the high competency of the agency staff convinced me that other features than those stressed by the management folklore about strong leaders would be present. And finally, I had no real practical choice as the chosen organization was the only one whihc would permit my methodology, that of participant observer, to function. For a year and a half, I was employed as a full-time member of the organization, responsible for a particular medical program.

This employment period meant that an arbitrary cutoff date had to be imposed even though in some of the cases, it became evident that an assessment of the division's learning (or not) would probably change over time. Thus the time period covered in the text is limited to that between the summer of 1973 and March of 1975.

During that time I examined some fifteen cases of new knowledge management within the division. A "case" was defined as the set of actions and decisions triggered by the initial knowledge that a new response was called for. These cases were triggered by new knowledge ranging from how to punish violators of the agency's regulations, to how to develop new medical policies,to how to deal with other state agencies and bureaucrats around specific programs. All these cases were new to the agency although not all were new in any societal sense. That is, many of the situations had previously been confronted by other health agencies or other states. But each case called for a response

not previously called for and was thus deemed by the researcher and confirmed by staff members to be outside the organization's routine activity. These 15 cases, along with an equal number of new situations not examined here in detail, probably accounted for approximately 20% of the agency's time, the rest being consumed in routine functions. (See Chapter II.)

The selection of appropriate cases to examine was the first methodological problem faced. A random selection was first made but this proved unfruitful since they turned out to be of such a widely varied nature that no consistency could be determined in their development, despite the fact that staff members and I felt there were significant recurrent patterns. A search for patterns was signficant since the conceptual framework detailed above included both the generation and use of principles in varied but not too varied situations (level 3) and the development of relatively consistent programs of behavior (level 4). Thus the originally randomly selected seven cases were enlarged to 15 in three quite definite streams of activity - involving five cases of new medical services development, five cases of provider-monitoring activity and five cases of the division's internal administration. The three streams of activity were thus selected in order to provide three sets of cases of a similar nature for which tests for the achievement of levels 3 and 4 could be applied. Within each stream, the cases were selected randomly except for their arrangement in a time sequence. A time sequence was necessary since any criteria which would be developed to determine if levels 3 and 4 had been achieved would necessarily include the transfer of principles over time and the development in time of a pattern for approaching new areas.

This method of choosing cases presented the inherent possibility that I was choosing cases in order to confirm developing hypotheses. However, the study results indicated that my original (after the development of the first seven cases) observations about the content and style of the organization's learning were not so much confirmed or denied, but rather more fully differentiated and that a wider variety of explanatory factors needed to be added. For example, that the study organization willfully ignored certain new areas was early on confirmed, but only later explained by examining it's chief administrator's particular view on cost effectiveness and only later elaborated by the observation that areas the agency head truly felt committed to, the organization would not ignore. Finally, after two years from the initial date of employment, a full body of 15 cases was available to which the rough criteria of learning could be applied.

During that period I had wide access to the agency and kept a daily diary of events. I was also able to observe many meetings in which I was not legitimately involved through my professional responsibilities. Also, most documents and records concerned were available to me. But the most important method of data collection was in personal interviews with staff members. Over 100 interviews (of an hour or more in length) were conducted to determine the facts of each particular case of new knowledge, how that new knowledge had entered the agency's consciousness, what members' perceptions about it were and how the responses to it were generated. In addition, over 25 persons outside the division were interviewed.

This reliance on interviews as the main method of data collection necessitated that the data be confirmed as much as possible by several means. The 25 persons outside the division were used to confirm much

of the data, as was considerable use of records and documents and my personal observations. With both division members and the outsiders, a consistent case history was built up by successive interviewing and re-interviewing until no new or conflicting relevant data appeared to be forthcoming. Each case required from a minimum of four to a maximum of twelve interviews, in addition, of course, to considerable reliance on my own observations and records and documents. While the need to acquire consistent interview data which would indicate the division's acquisition (or not) of the first four levels of learning was great, less rigorous data for determining how (levels 6 and 7 on page 16) the division may have met these levels was accepted, since at the outset of the study I had fewer preconceived nations about such levels and was willing to accept a wide pool of ideas from anyone who had insight into the organization.

The basic method of data collection presented several real problems. There was the obvious problem of being swamped by the data I had accumulated ("knowing too much") and of not "seeing" other data since I was a member of the organization. I attempted to minimize these by regular testing of the plausability of my conclusions with my academic colleagues and, to a limited extent, with the division's members and the 25 outside respondents. Complete feedback from the participants (i.e., showing them drafts of material) was not possible since some of the material was either confidential or potentially disruptive and injurious to the working relations of the agency. It was necessary to overcome this by somewhat generalized feedback, usually oral and usually non-specific and non-accusatory with staff members. In addition,

when the generation of the learning framework on page 16 was solidified after the first seven cases, specific data was gathered in order to determine if criteria for reaching those learning levels had been met; thus much irrelevant data could be eliminated. A second problem was that data gathering by taping was not possible since I regretfully assessed that this would hinder most staff members' ability to respond openly. For both these reasons the identity of the agency has been concealed and the names of all participants disguised. Finally, in order to gain much needed perspective, it was necessary to take a leave from the division as the final conclusions were generated.

Despite all these problems, the participant observer method, particularly in this organization, led to some very rich data, certainly usually unobtainable by other means. The whole organization operated out of one single block of offices and was easily observable by any one person who could gain access to it. The staff members developed a considerable relationship of trust with the researcher and were very candid and open about their behavior. Similarly, the agency head, while also trusting the researcher, believed that people know their own "theories of action" and thus was quite open in talking about his own and other's theories. This made the study considerably richer since he was a key figure. Finally the high educational level of most members made them relatively articulate and sophisticated in those subjects of interest to the researcher.

The participant-observer method clearly presents limits. However, one of the main perspectives I wished to adopt is that of a member of the organization - in particular, one who had some responsibility for managing new knowledge. Such a <u>manager</u> always 1) has restricted views

of reality and 2) has available only a few levers for changing the organization. With respect to the former, it follows that any extension of individual awareness of how new knowledge is managed is worthy of effort. What I sought to do was to extend those boundaries for myself and for prospective readers. This is simply a different kind of objectivity from that experienced by a researcher operating from outside the agency(although bias could be corrected through use of fairly specific and objective tests for some of the levels of learning - see below). Thus I believe that after a year and a half I had constructed as complete an understanding of the organization as anyone in it, including even the agency head. With respect to the latter (2), I stressed those variables which can be managed, i.e., accessible levers, not necessarily those casual variables explaining the division's success (or lack of it). In order to understand how any particular manager perceives what are accessible levers and what are not, an insider's view was necessary. Thus, in using the participant-observer method I was attempting to be useful not only for perspective readers, but also for practicing managers, including the staff of the agency - although I was not called upon, nor did I act in a consulting role.

The data collected by these imperfect methods just described was utilized as evidence of the division's achievement of each of the several levels of learning. The assessment of that evidence was made through the use of a set of criteria developed early in the study to determine if each of the levels of learning had (or had not) been achieved. Thus, for the first level of learning which I shall examine (considering level 2 of page 16 as my first"working"level), one

would ask whether the events surrounding a case of new knowledge indicated that a new policy had actually been developed and that process concurred in by members of the organization and its environment. For the second level one would ask whether this development had been in some way imbedded in the organization's formal processes, i.e. had new staff been assigned to continously deal with the problem, was the outcome of the event codified in the organization's manuals or directives and were principles developed which could be, and were, used in roughly similar situations. At the third level one would also ask if principles of sufficient generality had been developed and used in situations of great divergency from the original events. At the fourth level one would examine whether there was a consistent pattern of behavior used to develop these principles and for deciding how and when they should be applied to similar or more divergent situations. Finally, one could also ask how widespread and shared any of the above levels of learning were within the organization - for example, did all the relevant members of the organization explicitly "hold" and believe those programs and principles?

The complete assessment of whether the study organization met the criteria of learning and how it did so will be made in succeeding chapters. It should be clear, however, that this relatively specific focus and method, both designed to be manageable with the researcher's scarce resources, meant that some possible themes had to be discarded while others took on a more prominent light as the study progressed. Thus, I was interested not in the totality of such a putative learning organization but more specifically in how information and perceptions

perceived as new by the organization itself, were managed. Similarly, I was more interested in the relatively explicit and conscious management of new knowledge, that is, those elements which are subject to some control by the organization. I thus did not focus extensively on that societal or cultural learning which is less subject to the will and perceptions of individual managers - for example, the educational skills of the pool of potential staff members, the political process in which federal priorities were set, or the technology for assessing the effectiveness of health policies. Such parameters of social and cultural learning are discussed in detail by others (Rogers, Merton, Ogburn).

Nor did I focus on the manner in which routine or standardized information is processed, even though the distinction between routine activity and new knowledge activity is not a sharp one and many interesting behavioral patterns at the edges of these overlapping definitions may have been ignored. I have had to limit the study to exclude not only routine information, but also an examination of the relationship between routine activity and new knowledge, although I feel this is an interesting relationship particularly since many of the techniques of, and approaches to, new knowledge development which were observed also appear to be quite applicable to routine activity management.

Nor did I stress the importance of the environment in directing the organization's attention to new knowledge, but rather I focused on the responses to the uncertainty created by those knowledge inputs, by the organization's members, a concept stressed by Perrow, Schon, Rodgers and others. An additional theme of interest, which could only be partially focused on, was the effect of any organizational learning

I observed on the organization's members. Indeed the larger theme of the concordance of personal learning and organizational learning also needed to be addressed but was unfortuantely not stressed in this study.

The cases described in the text also presented considerable material which might be evaluated from a perspective other than that of learning. Regrettably, a focus on such themes as policy-making, state bureaucracy and health care administration had to be neglected. However, the interested reader will have no trouble finding raw nuggets of these themes. He need only "polish" them and examine them from his own perspective to assess their worth.

5. A Preview of the Study's Conclusions

An attempt was made to assess the success of the medical division in creating a learning organization. There is evidence that its success was significant, not only using the researcher's criteria but also using the division's own criteria and those contributed by relevant members of its environment.

The division succeeded not only in processing particular cases of new knowledge but also in routinizing this success over time and over a series of similar cases. It also learned a set of principles for use in a wide variety of situations and it appeared to have learned how to develop these principles through the generation of a generally tacit program of action which guided its behavior when confronted by new knowledge.

An attempt was made to assess how it was this significant success in learning was achieved. The evidence suggests that netiher the crisis or guerilla models of change adequately describes or accounts for that success. That evidence also suggests the importance not of

the rational/ scientific, human relations, or political models or styles discussed previously but rather of a model much ignored in the social science literature and inadequately discussed in the business literature although it has some similarity with the environmental/contingency models.

That model is the model of management and leadership with some significant new developments added by the division. The division's approach or style consisted of three important factors. The first was an emphasis on what the agency head called "good management". This management style was principally important in developing both internal confidence among agency staff and external credibility with the division's environment. The result of the application of this management style to routine activity was then utilized to give the division "breathing room" and resources to adequately tackle new knoweldge. The second factor was the strong emphasis by the agency's head on a teaching style. The success of that style accounted for the manner in which the division's set of principles and a program for developing them was learned. Finally, the continual evocation of a simple but powerful organizational paradigm - the "responsible buyer" (of health services for the poor) - not only reinforced the division's credibility, but provided a touchstone against which the large number of health care delivery principles could be tested.

The success of the organization appeared to have been made without the disruption of routine activities inherent in the crisis and guerilla models described on page 7. Some disruption occurred but it appeared not to have affected employee performance or morale. A basic pragmatic focus on high pay-off strategies contrasted with the focus on "solutions" to complex problems inherent in the crisis model. That pragmatism also

focused on strategies which could be implemented in contrast to the antagonistic sense of "correctness" found in the guerilla models. These observations combined with the unique style of the division just discussed, permit an assertion that a third identifiable and successful model of organizational change, one called "learning" can be described.

Several observations about the sources of effectiveness of the organization are significant in that they differ from both the crisis and guerilla models and much conventional bureaucratic practice. For example, the role of the teaching element is significant since it is so rarely discussed or observed as a part of bureaucratic change. In addition, the usual stress on the development of explicit patterns of action (means) at the expense of a usually tacit organizational paradigm (ends) was here reversed. That explicit stress on the paradigm here successfully contained much of the uncertainty and consequent "wavering" tendencies found in many organizations and provided a built-in test for learning by the division's members. There also was the reversal of the usual style/content balance in that considerable freedom of style was permitted as long as the organization's "content" - its paradigm and its principles developed through teaching - were observed. Finally, there was the equal prominence and delicate relationship between routine performance, accountability and learning which avoided the perils of many so-called learning organizations which place learning and change at the top of their lists of priorities and downplay accountability, often unnecessarily shortening their effective political life. That success had, however, some costs associated with it and several of these are also identified.

While the organization had clearly learned a successful style, one might ask whether more stringent criteria, such as the capacity of the organization to maintain this style over time or even its ability to transfer it to a wider set of circumstances, should be applied -that is, did it possess the qualities of durability and universality sought by some authors (Argyris, Schon, Gardner, etc.). While the speculations I will make concerning its continued success are based on observed characteristics of the organization, the conclusions are essentially problematic. That is, the passage of time will create internal political rivalries (the absence of which is currently notable) as resources get differentially distributed; increased size will lessen the potency of the "teaching" model as staff become more isolated from the leader; and the certain departure of the agency head will destroy the cohesive qualities and sense of confidence of the organization. Similarly, the very conditions which permitted the organization to succeed (small size, expansion, primative technology, professional staff, a policy orientation, and general environmental support) constitute, in combination with the positive aspects of the model developed by the organization itself, such a unique package of circumstances that the general transferrability of the model to a wide range of other situations should be appraoched with caution.

The obvious success of the organization combined with its speculated difficulty in meeting such stringent criteria for learning, suggest that completely "self-renewing" organizations are extraordinarily difficult to create. It also suggests that the search for such pure and universal

models by some idealists is a vain search, since the environment does not require that all organizations in all circumstances be perpetual learning organizations. If organizations are viewed not as individuals (in that they do not seek learning for its own sake) but rather as tools in the service of goals - whether generated by the environment, by organizational members or by a combination of the two, then the normative search for models of organizational change might thus be more profitably directed towards:

1) more politically-oriented studies of how organizational goals are generated and disseminated by usually small clusters of individuals inside the organization or from a specific sector of its envornment; or
2) mid-level case study explorations of organizations (such as this study) which examine actual learning alternatives to the "crisis" or "guerilla" models, but still alternatives within a goal achievement framework.

Chapter II

The Medical Division

1. History of Medicaid

The Medicaid program was begun in 1967 by the federal government. It provided for financial sharing of the costs to the various states of assuring that welfare recipients received adequate medical care. It, along with its counterpart, Medicare for the elderly, was conceived of as an insurance program, that is, government would not provide services directly, but rather pay the private sector for services rendered.

The federal government's role was two-fold. Firstly it defined a minimum package of services which all states had to include in their program and also an optional set of services to be provided at the states' discretion. For both these groups of services, the federal government would provide financial participation ranging from approximately 50% in the richer states to 80% in the poorer ones. In order to receive this federal financial participation (ffp), the state had to abide by usually complex sets of regulations defining precisely what services were eligible and how they should be delivered.

The states, for their part, would further define the "amount, duration, and scope" of the mandatory and optional services, determine the eligibility of clients, (usually those single parents and aged or disabled persons below a certain income and thus eligible for welfare cash assistance payments) and pay licensed medical providers for the delivery of services. Many states had previously had very minimal programs of medical assistance for welfare recipients but nowhere near the broad scope of the new Medicaid program.

More importantly, the federal regulations required that the recipients have complete freedom of access to the whole private medical sector. The medical profession at first fought the new program, but it soon became clear that the freedom of access provision, combined with the surety of payment by government, was creating a huge new demand for medical services. Some likened it to giving a (medical) credit card to the poor. This new demand was met by an increase in supply, but one which lagged behind the demand. Consequently, prices rose and many providers were able to either begin to break even for the first time or to make very large incomes.

The size of the welfare rolls was also greatly increasing at this time,creating commensurate problems in the state welfare agencies. Most of the state agencies were totally unprepared for both these developments, the increase in clientele and the addition of a new medical program. State governments for the most part had never been viewed as particularly responsive to problems of this nature due to such well documented forces as poorly qualified staff, divided organizational responsibility and provincial outlooks. Thus the federal government prodded the states to reach minimal levels of performance in such vital Medicaid areas as assuring that providers enrolled in the program, that recipients received their "credit card" and that providers were paid, generally at their usual and customary fees.

This necessary focus on such basic management processes assured that the high goals of the program were not immediately met and that many unforseen consequences were ignored. In addition to the surge in demand and prices already mentioned, many providers set up what

came to be known as "Medicaid mills"- clinics which processed welfare clients at considerable speed and with some doubt as to the quality of services. Monitoring by the states of such practices was generally lax and much unfavorable publicity resulted. Many providers also declined to participate in the program because of the considerable paperwork involved in filing a bill with the state or in waiting for an often delayed or disallowed payment. Others simply declined to serve welfare clients since they presented cultural problems many providers were not accustomed to dealing with. And for some recipients, the credit card meant little because there were few or inadequate places to utilize it, that is, the program often did not assure access to care although in many states transportation services were paid for.

Despite these problems, the overall assessment of the program was relatively favorable. Many recipients who had not previously received care were now receiving it although at vastly inflated costs to the governments involved and with no real assurance that its quality was high. For others, access to care was uneven and equality in delivery was not assured since the medical profession was and continued to be organized to deliver care to middle class patients and not the poor, the elderly and minority groups. Many observers felt that the "expose" of the inadequacies of the health care delivery (and financing) system brought about by both Medicaid and Medicare was one of the contributing factors to the increased discussion about a national health insurance system.

2. The State's Response

The state welfare agencies were caught in the middle of this complex mix of new programs, federal pressure, strong medical lobbies, increasingly vocal welfare recipients, inefficient state agencies and ill-informed state legislature. The state chosen for study, while able to confront some of these forces in a more responsive way than some other states, had its own unique problems to deal with. It had paid for, like some of the other states prior to 1967, a limited program of medical services for welfare recipients. In 1969, the state legislature enacted a bill which provided for all the federally mandated services of the program and virtually all of the optional ones (e.g . adult dentistry, podiatry, physical therapy, etc.). This package was one of the most comprehensive of all the states and, combined with the relatively generous cash payments already granted to recipients, was the reason to assert that the state could be proud of its efforts for the poor.

The state welfare department, the Department of Public Welfare (DPW) was, however, not up to the complex task of administering either the cash grants or medical assistance program. In the late '60's, the state had "taken over" the administration of welfare from the previously independent cities and towns. Each town had had its own benefit levels, had contributed varying amounts from local resources, and had administered the program according to its own views. The state DPW attempted over the next several years to standardize policy and payment levels and to institute controls over these previously independent local offices. In most cases the whole local staff was simply transferred

to the state payroll and the same facilities utilized. In addition to the obviously immense problem of standardization and control imposed by this shift, the new Medicaid program was thrust upon them.

Virtually all of the 1500 employees of the department had grown up in it, or were trained in the "welfare" aspects of the department. Most were social workers and had little experience with medical care. The new program received little attention from the old bureaucracy who remained focused on their essential tasks of assuring cash grants to recipients and arranging for, or providing, social services. However, a central office Medical Division was created whose mandate it was to create policy for the Medicaid program and to assure that it was administered properly by the local offices. (For a chart of the DPW see Figure 1). As is clear from the chart, the division had no direct control over the local or regional offices and had to rely on the good graces of the other divisions to ensure that its policies were carried out.

3. The Medical Division

By 1973, the Medicaid program was costing nearly 300 million dollars or close to 20% of the state budget. The cash grants and social services programs provided for another 20% of the budget, yet these latter two divisions received the lion's share of the department's personnel budget. The twenty members of the medical division viewed themselves as terribly understaffed and only "coping" with the routine tasks they had to perform. These tasks included interpretation of federal guidelines and further refinement (or change

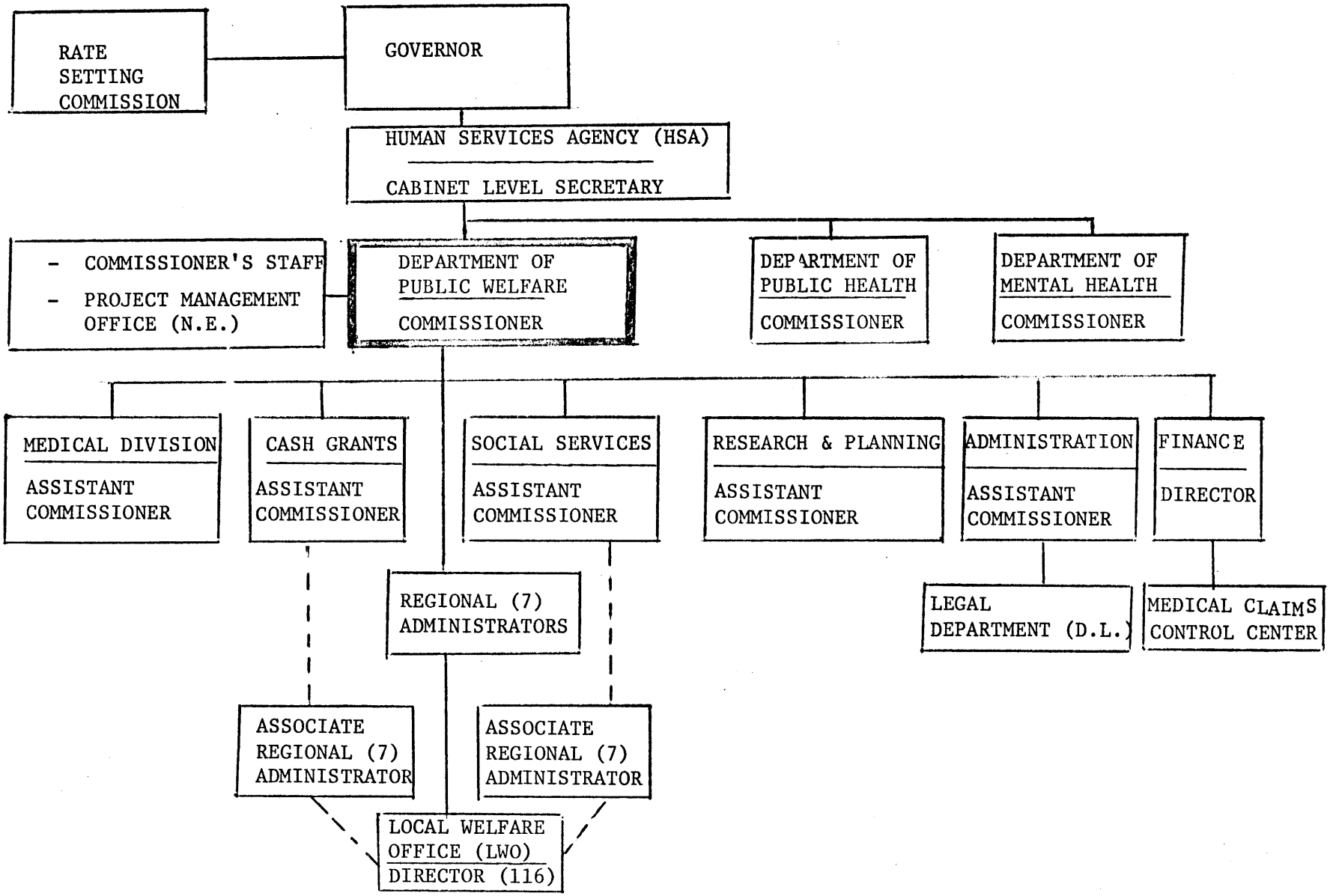


Figure 1. The State Welfare Department

where there was leeway) as to what and how medical services should be provided, monitoring of the quality and extent of services provided, developing and encouraging innovations in the overall health care delivery system and problem solving at the local level. As will be described in later case material, the central office was only able to deal with these problems in the most rudimentary manner and according to both inside and outside observers, spent most of their time "fighting fires".

The division's management up to 1973 had been varied. The chief operating officer of the small division was an assistant commissioner, an appointed position serving at the "pleasure of the governor". The first occupant of the position after 1968 had apparently antagonized the medical profession and soon exited. Two later assistant commissioners failed to acquire the necessary administrative support for the program they felt they needed and they too left, discouraged after terms of less than two years.

Several explanations were offered for this situation. Firstly, the welfare commissioners all came from the social service or welfare fields and were seen as simply not giving high priority to the medical program. Secondly, the legislature, while voting relatively liberal medical benefits for recipients in the enabling act, declined to give adequate staff support since they could gain political points by claiming they were cutting down the size of the "wasteful" welfare bureaucracy. This was particularly important in a state where a large part of the bureaucracy was viewed, perhaps not paradoxically,

as both patronage ridden and also inefficient. Finally there is some evidence that the then poor management of the medical program, e.g. its failure to produce adequate budget requests, angered the legislature such that they refused to vote monies to correct the situation. Finally the legislature's displeasure with a brash young human services secretary (see Figure 1) led it to deny many of the secretary's and commissioner's requests.

In the fall of 1972, the assistant commissioner of the division had resigned and a search was instituted for a replacement. The secretary knew that"a manager would be needed" since the changed national climate clearly called for that. By then some of the problems created by the Medicaid program had begun to be discussed on a national level by various health experts and this coincided with the Nixon administration's social and fiscal conservatism. The result was an omnibus health bill passed in 1972 with several amendments to the Medicaid law. It provided for some new service benefits but generally stressed increased management and control activities states would have to take in order to halt some of the abuses then being exposed. As the secretary expressed it, "we wanted a person who had good management sense, good policy sense, could recruit talent, had fiscal and financial sense, and some political skills. Now where could you get a guy like that for $24,000?" But he decided not to settle for "half the guy" and so the position lay vacant for eight months.

Finally an adequate replacement was found. He seemed to possess most of the needed talents and, not insignificantly, would accept the

appointment at that low salary level since he had sources of independent income. He arrived in April of 1973 with an existing staff of about 20 persons including clerical and secretarial personnel. Over the course of the next two years the division budget and staff were to double, new programs were to be instituted, monitoring activity increased and a newly acquired credibility gained. The story of how these were accomplished will be detailed in Chapters III, IV and V. Here I shall more fully describe the division's routine tasks, the expectations held out for it by outsiders and by the new head, and the initial transformation of the agency.

4. Organizational Tasks

I have chosen to discuss the division's routine tasks first since these will help to "situate" the division for the reader. This is not to imply that the division had no sense of goals or mission or was not influenced by environmental forces, but the former did not become clear until well into the new appointee's stewardship while the latter have already been briefly described and will be explored in more depth in Section 6.

Several interviews with staff members confirmed that the division's tasks were four-fold. The first was developing and administering medical policy. That is, within the limits of federal regulations, the division had to decide what kinds of services would be paid for, under what circumstances they could be delivered, and had to recommend a suitable rate to the Rate Setting Commission (RSC), a separate state agency appointed to set rates (and avoid collusion with providers).

For example, in the durable goods area, the division would determine that certain types of wheelchairs were appropriate while others were not, that they only be delivered to clients upon prior approval by the division of a request by a physician, that they be purchased at approved vendors and that a price of X dollars (to be approved by the RSC) was appropriate. Similar types of decisions were made for nursing homes, hospitals, clinics, dentists, individual physicians and all other licensed providers such as nurses, home health aides, rehabilitation specialists and mental health providers. Each of these policy decisions were formalized in a written policy manual which was the basic working document of the division's field offices and those providers with large Medicaid clienteles. The complete set of policy instructions constituted over 200 pages of the department's policy manual and were continually being revised.

The administration of these policies primarily involved insuring that the new policies were inserted in the department's manual and understood by field personnel and providers. Recall that this latter function was not directly under the division's control and the day-to-day contact with clients and providers was through these local welfare offices (lwo's). For example, a client would be told (or already knew) by his social worker that he was eligible for say, rehabilitation treatments after a stroke. The recipient would go to a rehab clinic, present his Medicaid card and be treated. The clinic would send a bill to the local office, who would make the necessary approvals (sending it to central or regional offices if it was a complex case), and then forward it to the finance unit of the department (see Figure I) for payment.

The second major task of the division was to monitor the program to uncover provider and client abuse and to generate overall management information. For example, through examination of "exceptional" bills (see task 4), through field inspections or through perusal of the financial reporting from the finance unit, it could determine both on an individual basis and on a system basis whether, say, clients were being placed in an inappropriate level of nursing home care, or whether there appeared to be an excessive usage of a new form of dental treatment given what the division knew about local patterns of usage.

The third major task was to promote new medical resources (or the restructuring of resources) in areas inadequately or improperly served. This task was not as explicit as the others despite the language in the enabling act specifying that the division, "in cooperation with the Department of Public Health", "stimulate", "plan for" and "assist" in the development of new medical resources and the delivery of services. Given the small staff of the division, the achievement of this task was limited to what small amounts of technical assistance it could provide through staff consultation, or to pointing out to the medical community that certain geographical areas were undeserved or that certain situations were detrimental not only for Medicaid clients but for the health-consuming public at large. For example, the very existence of the Medicaid program as a source of financing might encourage providers to offer new services (e.g. nursing homes, rehab agencies) or the advocacy of the use of generic drugs (as opposed to brand name drugs) for welfare clients might help

to point out patterns in the pharmaceutical industry viewed by many as far too costly.

Finally, some of the division's tasks revolved around handling exceptions and "foul-ups" generated by policy implementation, billing irregularities, or cases of emergency medical or financial need. The first category consisted of services which required a prior approval by the central office. These services and others which were of sufficiently unique nature that no price could be set in advance were sent to the central office for review by a staff of medical consultants. These "PA" and "IC" (individual consideration) items, while constituting a small proportion of the budget, generated a considerable amount of paperwork. Billing irregularities would also often be the focus of central office action as providers phoned to find out why their bill had been disallowed or their payment slow in reaching them. Local offices of course handled much of this activity but much also filtered directly to the central office. Finally, in situations where a client needed a particularly unique service or some "red tape" had to be cut to gain his access to services, the central office would often become involved. For example, finding a suitable nursing home for a "problem" patient who had been refused at several homes or arranging for an out-of-state provider to give very specialized treatment to a client, e.g. heart treatment at the famous Houston clinics.

I shall not make an attempt here to assess how well these tasks were accomplished or their range of accomplishment. The staff

complement almost assured that only the most pressing or urgent areas within these tasks were covered. During the latter part of 1973, an extremely rough estimate of the percentage of staff time and energy devoted to the few major tasks would be as follows:

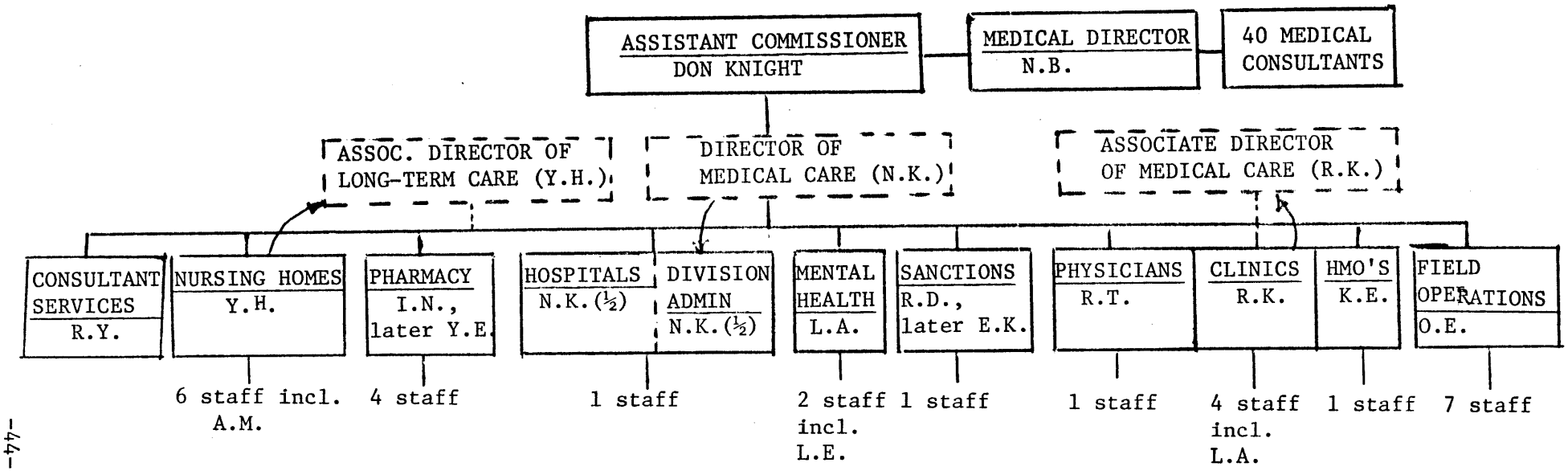
a. developing and administering policy - 45%

b. monitoring - 15%

c. developing new resources and programs - 20%

d. handling exceptions - 20%

For the most part, each of these task areas was carried out by a unit within the division responsible for a specific medical program area, i.e. clinics, nursing homes, hospitals, etc. That is, the division was organized principally on a program, not functional, basis. This organization was completed by the new assistant commissioner shortly after he arrived. The manner in which each program unit carried out these tasks varied somewhat from unit to unit depending on the nature of the program and the staff assigned to it. Figure 2 indicates the major program areas in late 1973, and the staff assigned to them. The development of this particular form of the organization will be described separately in section 8 since its early stages had considerable influence on the later success in managing new, non-routine knowledge. To conclude this section the relative proportions of the 400 million budget for that year are listed below.



NOTES:
1. All the heads of program areas shown functioned as "assistant directors".
2. The director of medical care, N.K., over the course of 1973 and 1974, assumed the functions of an assistant director.
3. Y.H. and R.K., by late 1974, had begun to function as "associate directors".

FIGURE 2. THE MEDICAL DIVISION IN LATE 1973

Provider type	Percentage of Budget (approximate)
Hospitals	22%
Chronic Hospitals	14%
Nursing Homes	40%
Clinics	3%
Mental Health	(Inc. in Hospitals & Physicians)
Physicians	7%
Dentistry	5%
Pharmacy and durable goods	6%
Licensed practicioners	2%

5. Routine Activity

Each of the program areas carried out a wide variety of routine subtasks. I use routine here in the sense that (1) there was near unanimity from the staff on the need for action, (2) the required action was known by the staff, and "expected" or anticipated by providers or other agencies and (3) in virtually all cases, the subtasks had been carried out, however superficially or sporadically, by staff members for several years previously. Over the course of two years, the number of routine subtasks increased considerably as new knowledge was integrated into the division and became routine, and existing routines were subdivided or enlarged with the addition of new staff.

In the long term care unit (nursing homes and chronic hospitals) regular certification and inspection of all homes in the state was carried out under a contracting arrangement with the Department of Public Health. Agreements were signed and reviewed with each of the homes as required by federal law. Additionally, medical review teams (DPH teams under contract) were established to periodically check on care provided by the patients own doctors. The unit also developed its own "little list" of poor providers and with the limited staff available,

closely watched, cajoled and, in a few cases, closed down inadequate homes. It, like the other units, handled a wide range of "local" problems such as transfers of patients from one facility to another or unclogging providers bills in the payment system. The unit had little control over the supply or cost of nursing home beds (these being regulated by DPH and RSC respectively) but did continually testify at major hearings to determine new construction or rate changes.

The hospital unit consisted of one person half-time plus about half the time of the nursing home director. The hospital director was principally involved in assisting the Rate Setting Commission in determining new hospital rates and in routinely notifying local offices of these changes. Occasionally, the mix of services paid for in the hospitals per diem changed and those had also to be reflected in the policy manual. The only significant hospital monitoring activity was a contracted-out program which reviewed each patient's length of stay. The nursing home director managed this contract. The hospital director, in his remaining half-time, concerned himself with the division's internal administration (space, manuals, supplies, etc.). Equally important, he assured that all the division's documents were procedurally correct and had been formally approved by other divisions of DPW or other state agencies since many other state agencies administered laws defining how medical care could be delivered and the "state plan", actually a contract with the federal government, specified what could or could not be legally reimbursed by HEW.

In the ambulatory care area, routine activity consisted of periodically reviewing the entire fee schedule for physicians and assuring that the schedule was adequately communicated to the local office, physicians and the department's computer-operated payment systems. Monitoring activity was unsystematic and inspection of facilities sporadic, but had slowly begun to develop into a more routine activity (see Chapters III and IV). The dental and pharmaceutical units had very well elaborated policy positions and here their activity was concentrated on monitoring, that is, reviewing individual bills and granting prior approvals or permitting deviation from the fee schedules. The development of new resources was most apparent in the ambulatory areas (again see several examples in Chapter III). A wide variety of providers (chiropracters, psychologists, physical therapists, abortion clinics, health maintenance organizations, ambulance companies, podiatrists, etc.) continually approached the division to be certified as eligible providers, or if already certified, to seek a new rate.

The mental health unit was a newly-created unit but by early 1974 had already settled into a routine of setting conditions of participation (which had the force of informal regulations) for the many varieties of mental health clinics, encouraging them in their attempts to restructure the mental health field and in attempting to handle their billing problems.

Two or three other units cut across each of the above "program" units. The sanction unit, receiving tips from a wide variety of sources (billing patterns, other providers, audits, etc.) sent out warning

letters to providers to change the pattern of resource utilization (although rarely in strict "quality of care" areas - see Chapter IV). Field relations were coordinated by a central office staff member who worked to assure that the division's seven regional representatives and the local welfare offices were aware of, and responsive to, policy changes. Finally, one central office staffer organized a group of forty part-time medical consultants who reviewed bills, approved claims, and acted as general advisors to the division. As will be described below, other possible cross-program functions, such as research and planning, budgeting, or lobbying were either not carried out due to the small numbers of staff or were executed by individual program personnel or the assistant commissioner.

This summary of the division's routine activity is of course in no way complete. It makes no attempt to discuss how well the division carried out these tasks or the levels of consistency, energy, or integrity it brought to the tasks. It is intended only to give a flavor of the more common daily activities of the division by late 1973 before the new assistant commissioner had an opportunity to completely make his mark on the agency. He had, by that time however, managed to organize the division into the basic program areas described above and to add a few new staff. From April to late 1973 the division adjusted to his new organization, carried out its routine tasks, and reviewed the need for changes. It is impossible to understate the sheer bulk of this routine activity. The division was universally viewed as being very understaffed and, it is clear, could have spent

nearly all its time performing these routine tasks or responding to crises created by new federal regulations or severe provider or client pressures.

But by late 1973 it had begun to develop a distinctive approach not only to these routine tasks, but also in dealing with situations of new knowledge-which is the subject of Chapters III through V. It should be pointed out that the dividing line between routine tasks and new knowledge is not a sharp one. New tasks often become routine, certain staff dealt "routinely" with new program areas and tasks, and new staff created new roles. But in general, what has been described here was the type of activity which the division carried out before Knight's arrival and during his early days. It is also activity which would have had to be carried out in some form no matter who occupied the staff and appointed positions. Indeed, all the above activity continued well on into 1975, during the full period of the study.

6. Environmental Forces

This then was the organization in late 1973. It faced certain general environmental pressures and carried out certain routine tasks. A new head had been appointed and, with that appointment, certain more specific expectations were created. Let us now examine in more detail what these pressures and expectations were and what the new appointee brought to this situation.

The federal climate has already been briefly described. A new law had been passed requiring increased monitoring and encouraging improved management of the state's program. This law produced a

voluminous amount of regulations requiring not only improved management but in some cases newly organized services, e.g., child screening programs or family planning services. Federal regional officials (who oversaw several states' efforts) realized that the division was understaffed and thus only selectively applied pressure on it to live up to the regulations. But other priority areas were strongly emphasized by Washington (e.g. nursing home safety inspection) and the regional office had no choice but to pass along the pressure. The division could only respond to the most urgent of these pressures. Indeed the division was out of compliance with many federal regulations and, while regional officials ignored many of these, they also saw that the lack of a clear management focus and the concurrent focus on solving local problems or responding to crises was prohibiting the development of an overall program philosophy, divisional credibility and an integrated, efficient policy - one which would "bring some light to the delivery system", assure respect from medical providers and stem the flow of dollars to those providers who were, legally or otherwise, "milking the system". As one official put it, "This is a highly-politized environment, with vast amounts of money flowing through it...you've never had a real philosophy or strategy to deal with this."

The state legislature viewed the situation, according to one state official, as "a giant moneyhole". They had voted in one of the most comprehensive benefit packages in the country several years earlier and now were amazed to discover how expensive that program had become, although rising prices in general and in the health field in particular and rising welfare caseloads had also contributed to the increasing

budgets. The legislature as a whole did not appear to be concerned with the quality of care delivered or the more innovative aspects of restructuring proposed. But several of the provider groups had particularly strong lobbies and their major wishes (i.e. Medicaid rates) were usually acceeded to by the Governor or the legislature. One of the providers' clearly less unreasonable requests was for a centralized bill paying operating to reduce the backlog of claims due. This was voted in in 1971 and by 1975 had calmed many of the providers' concerns.

Non-payment of bills due to the state treasury running out of cash each year also involved the legislature. The division and the DPW were never able to accurately predict the total year's spending since caseloads and medical utilization were quite variable and since many rate changes occurred during a fiscal year. The department's estimate was usually low (or cut by the legislature to spite a governor and human services secretary of the opposite party) and at the end of the fiscal year all funds usually stopped while a time-consuming deficiency appropriation was made. Providers were always eventually paid, but the legislature resented the administration not being able to submit "accurate" budget requests. In the patronage-ridden state, legislatures viewed more management staff for the division as "throwing good money after bad" and generally washed their hands of the program despite the fact that it represented nearly 20% of the state budget. As the HSA secretary remarked - most of the legislature was "totally ignorant of Medicaid". Others saw it as a "fiscal sore spot" or a "pain in the ass". The efforts of the HSA secretary and

the DPW commissioner to convince the legislature of the need for more support were, however, not perceived as being adequate. As the HSA secretary remarked, "we tried to convince them but I guess we didn't try hard enough".

HSA, however, had additional priorities. Many of the state's health services for indigent groups (particularly in mental health, for example) were supported completely by state money. If the patients could be "squeezed" into Medicaid categories or if the services could be considered Medicaid services then the costs would be partially reimbursible with federal money. Many of the division staff felt HSA concentrated too much on this strategy to the detriment of revising program policies or changing the overall delivery system. The HSA undersecretary said, "Medicaid doesn't have 'programs' in the traditional sense". Here, he meant that since the division did not deliver services or did not generally affect the delivery of services, but only financed existing services, it did not have real programs (except in a few areas, e.g. nursing homes).

Thus the secretary was viewed as seeing the division as a "quick, sharp insurance program". He saw that many of the controls needed in the insurance industry were needed here also but first had to "get DPW straightened out" before he could tackle Medicaid. This involved the computerized bill payment system and the computer recipient files on which a Medicaid management system would have to be based. He felt that "using Medicaid to influence the system was a long way to go", but that it could be done. But his first priority was to improve management (in DPW and Medicaid), the second to improve Medicaid services and the third to influence the health system.

The provider community generally recognized the importance of the program in financing their system (e.g., the hospitals no longer had bad debts or charity cases) and the relative generosity of the benefit package - indeed, the benefits were more generous than most private insurance schemes, covering a wider range of services and having fewer or no upper limits on utilization. But they viewed the program as unwieldly and unresponsive. Paper work was extensive, bills were paid late and, for many providers, the clientele was difficult to deal with, often from minority groups and with a large proportion of "psycho-social" illnesses. The fees were seen as low but not unreasonable and the profession, long steeped in a climate of lack of public accountability (bordering on a reactionary arrogance according to some) simply wished the division would "keep its nose out of our business." They viewed the program as just another insurance carrier like Blue Cross, only less efficient. Indeed many suggestions were made to the legislature to turn over all or part of the program to a private carrier as had been done in some other states. The other carriers also viewed the program is inefficient and made overtures to take it over but to no avail.

The public at large had little comprehension of the program. Welfare recipients were unorganized and when they did begin to organize in the late 60's and early 70's, did so around the welfare, i.e. cash assistance side, of the DPW's program, not the medical side. The commissioner reflected this pressure as he too concentrated on reforming the other divisions of the department. While sympathetic to the medical program, he was a social worker by training

and the division seemed to suffer from lack of attention as he continued to gain national prominence as a welfare administrator.

The above summary has reflected the various environmental pressures on the division by 1973. Each of these pressures were real and had to be responded to in some way. It should be clear that the most generalized picture of the division was that it was not focused, out of control, unresponsive and, while clearly responding to some of the real needs of clients, not living up to its potential nor seriously affecting the health care system other than to pump over $300 million inflationary dollars into it.

7. A New Appointee

The newly appointed assistant commissioner, Don Knight, of course brought his own set of priorities to the division. He was well aware that he would be entering a highly charged political arena, but he chose to focus or define his role somewhat apolitically. His prior background had been in the management of a large, heavily market-influenced company in the sporting goods industry and he saw himself primarily as a manger. He had helped his prior company expand enormously over 20 years and then, in middle age, made an abrupt career shift. A physician friend and he founded a neighborhood health center in one of the city's ghetto areas and built it up into a well managed and responsive provider of care. The center took advantage of both federal and local grants and Medicaid financing and built a reputation in the city and the state.

Knight, during these four years, learned about the delivery of health care and became well known in the health community. His attitude that "health care delivery is not the same as the practice of medicine" obviously did not sit well with all the medical community who would have liked to see "one of their own" in the assistant commissioner's position, but given the strict requirements laid out by the secretary for the position (see Page 38) he was an admirable, and perhaps the only choice.

Knight combined these two prior experiences, management and health care, into his formulation of what the division needed. He said he felt he "had to get this house in order, give the agency a direction and then develop a commitment to some goals and strategies". He felt he had first to concentrate on the implementation of the new omnibus federal law, and then he could worry about the actual delivery system. He saw that the staff "was not intelligently generating priorities" and so began to organize the division on a "purchase of service" basis (see Figure 2).

After he had "got the house in order", then he felt he could begin to worry about "what we are really buying, accountability, quality, and improving information flow". This role of "buying medical care" was one which was not clearly formulated at the beginning of Knight's tenure, but his role as a purchaser in industry had influenced this basic posture. When asked what the division goals should be, he replied "we have a responsibility to buy quality care and to be sure that we do that in the most effective way". That meant that

the "care should be good, useful, actually be delivered, be at a fair price and someone should be responsible for delivering it." At other times he said that these goals were "not routine or platonic goals - they're very reasonable." He felt that the problem was "not to spend more money on care but to control it". He wanted to provide a "viable standard of living for the elderly (mainly in nursing homes) and held kids grow up healthy".

These goals were of course, reasonable. The prevailing health delivery literature stressed quality care, cost effective pricing, and improved access for all patients. Those concerned with welfare clients often added a fourth goal, equality of treatment and a "voice" for the patient. Knight translated these goals easily. Quality care could not be defined absolutely but could be defined relatively. He felt that welfare clients should receive the same quality care as middle class patients (thus combining both the quality and equality issues although he did elaborate on what quality might mean - need, fair price, etc.). This was to be achieved (at one end of the scale) by refusing to purchase care from poor providers or poor categories of providers. Cost effective goals would be achieved by stressing ambulatory care since it had the highest potential financial payoff (particularly with children) and since it also would help to keep recipients out of institutions. Access was a desirable goal but less attention needed to be paid to it since in general the state had a very well elaborated network of providers, although many refused to deal with welfare recipients. Both the access question and the equality of treatment could be approached, he felt, by gaining the respect and confidence of providers.

These goals of Knight's were invoked relatively early in his tenure. The staff had, of course, no difficulty in understanding these goals nor did the division's most immediate environment of the HSA secretariat, federal officials and the major providers. What was interesting however was the manner in which "the house was put in order", attention focussed on these goals and new areas tackled quite differently than they had been before.

8. The First Few Months

During the summer and fall of 1973, Knight began to "put his house in order" and "develop commitment to goals". Many of the strategies used during this period were conscious ones, others were conscious but strongly dependent on permissive conditions within the organization and its environment, while others simply evolved out of a complex interaction of many forces. The use of these strategies did not of course stop after the fall of 1973; they continued in a stabilized pattern. This pattern permitted the division to carry out its routine tasks in a more efficient, responsive and credible way. This general success then,permitted (a point I shall elaborate on in Chapters III through V) the division to turn part of its attention to the management of newer, less routine areas.

J.L. Price (1968) has suggested that four main systems of an organization are generally amenable to analysis and usually to management. These are the "production"or economic system (usually reflected in the formal structure), the personnel/career/sanction system, the political

or decision making structure, and the technological system. Burns and Stalker (1966) have suggested a similar system without stressing the importance of the technology system as separately important, linking it with the production system (the two may or may not be coincident). I shall use Price's four classifications to describe the initial development of the division since the manner in which Knight dealt with each of these systems were determinants of the division's later success in both routine and new tasks.

a. The production system

Firstly, the "production" system. Prior to Knight's arrival, the small core group of six or seven staffers dealt with routine tasks on a fairly unstructured basis. Two staffers did specialize in nursing homes and pharmacies but the remainder "covered the waterfront", dealing with a wide variety of problems in all of the service areas as they arose. An example of the titles used is indicative - "research economist", director of "program services", "director of medical care", "director of the innovation unit" - they were non-specific and probably well suited to the climate in which the division found or had placed itself. The staff saw themselves as each sharing in all the major decisions and being knowledgeable about "the whole system". Recall also that the division had previously been without a full time head for eight months and while this structure may be seen as a response to the uncertainty of such a situation, it was also perceived by outsiders as being un-focussed and difficult to extract consistent answers from.

Knight reorganized the division on a purchase of service basis as shown in Figure 2 and initially described on page 45 . Each unit was to be responsible for a particular medical service while only a few (field relations and sanctions) cut across all these program areas. More importantly, the division of the tasks into a wide number of programs was accomplished by having each program person report directly to Knight. The acting head of the division had a title and salary level greater than the remaining staff but he soon became, in effect, not the director of medical care, but simply one of a number of assistant directors who all reported to Knight. Similarly, some staff who had civil service ranks and titles below that of assistant director (which paid about $14-15,000) were given acting assistant director titles. Even with this large span of control, some of the staff who remained at the level below assistant director continued, if not reporting to Knight, to at least share the reporting task with "their" assistant director. Much later, in 1974, two of the assistant directors were "promoted" to an associate directorship (although this title did not exist in the civil service lexicon). They did not come between Knight and <u>all</u> the remaining assistant directors, but instead took charge of only one assistant director. The other assistant directors continued to report to Knight.

What this meant of course, was that Knight was able to keep a close watch on all activities and to develop an approach to the division's tasks which each of the staff and he could share. This initial wide span of control is not uncommon when a new manager is appointed;

what is unusual here is the length of time it endured and the effect it was to have in developing a shared approach both to routine tasks (discussed below) and new knowledge (Chapters III, IV, V).

Equally important was the development of an informal structure. At each of the regular staff meetings during that time (also during informal meetings), each of the staff were encouraged to step outside their program role and criticize other staff's programs or raise issues which cut across several programs. For example, questions of political implications, or of ultimate effect on the daily lives of clients, or of general "system" consequences were continually being raised by specific individuals even though no one was specifically charged with those roles. This informal organization (which I shall label the "informal matrix" since it had many of the attributes of a matrix organization) was effective not only in raising issues and sharing perspectives but also in assuring that their resolution was satisfactory to Knight, who, when irreconcilable differences arise, could be assured that he could resolve the differences. When the meetings were informal, and when Knight was not present, this matrix style helped to raise issues and differences, but many of the staff felt that their resolution was not as rapid.

This informal matrix did not endure as long as the formal system. By early 1974, Knight stopped the increasingly large staff meetings saying that he felt people now knew what they had to do and should no longer be sharing responsibility with so many others. A few cynics suggested that Knight had become unable to "control" the increasing level of argument

at the staff meetings. In any case, only a few (not the cynics) regretted the passing of the large meetings. Some degree of the informal matrix did endure however, in casual or scheduled meetings among the staff.

b. The Personnel System

The personnel/career/sanction system was also utilized effectively by Knight during this period. The staff basically consisted of three groups of people in the fall of 1973. First were several long time members of the division - career employees who had grown up in the social work and medical service professions. All were over forty, but most nonetheless had advanced degrees, usually in social work. A second group consisted of six newcomers to the division who had been part of a separate,federally funded, innovation unit. They were young, generally untrained in medical areas but had each had a year or two of experience in some health care administration position. Several of this group also had advanced degrees. A third group consisted of several newcomers to the division for whom Knight was able to acquire positions. Three of these were young generalists with advanced degrees and a few years experience (although only had a health care degree) while the others were young persons he had found "languishing" in secretarial positions in the central office or in social work positions in the division's field structure.

Each of these groups had a particular response to the new manager and to the new structure. The long term staff who, while " thinking anecdotally and not in a policy sense" (Knight) did not appear shaken up by the changes. Some expressed private fears and hesitancies about

their competence, but each dug into their new tasks with relish. As one put it, "we've been frustrated for so long, now Don will be able to take the groundwork we've laid down and really do something". Knight was now giving a focus and some tools for the older staff. For example, one of the long-term staff turned with great delight to "cleaning up" wayward nursing homes, something he had felt the division had never had the "clout" to do (see Chapter IV). Knight generally permitted the long-term staff to carry on in their old roles although they were circumscribed somewhat by limiting them to one, not several, program areas. He also used them as "bridges" to the rest of the welfare department bureaucracy.

The other two groups fused into one as Knight disbanded the innovation unit and assigned specific tasks to each of the members. But this assignment was not made rapidly. Many were permitted to "float around" and "find something interesting you'd like to do, then come and talk to me about it." Others (at least six of the twelve or fifteen in this group) were permitted to play the "fly on the wall game" as Knight described it. Here they would occupy a desk in Knight's office for a few weeks with no specific tasks, all the while watching the full range of telephone calls, meetings and outside visitors. Usually, by the end of a few weeks the "fly" would have been given a few specific short term tasks since he was the most obvious person available and was "free". For example the researcher was given the task of coordinating the new omnibus federal legislation. This general "freedom to select

a task" was a conscious strategy of Knight's. He knew that the civil service salaries were low and that not only could he not recruit very experienced persons, but that even those he could recruit (or had available to him) could not be "forced" to take assignments they did not like. Indeed he felt "you have to get peoples' egos involved in their jobs".

The division as it was constituted offered very little room for advancement as the assistant director level was the last step on the career ladder in the division - the next position being a political appointment - Knight's. Even within the total health field, the future of the Medicaid program did not appear bright as at that time it seemed likely that it would soon be obliterated by a national health insurance program. Thus the formal organizational sanction system seemed to play a minor part in the restructuring of the division. Where Knight did have to confront it, he did so boldly or simply ignored it. For example, he assigned "acting" titles to many staff, brought in professional staff at clerical salaries with the promise of eventual boosts, bent the hiring regulations specified by the civil service commission for job qualifications and even used volunteers to whom he assigned full task responsibility.

This free floating selection of tasks and the overlapping task responsibility described earlier indicates a flexible development which could only have been partly due to Knight's actions. The personal qualities of the staff should also be considered. These appeared to be four principal reasons for this high level of role flexibility,

with several members of the staff combining two or more reasons. Firstly, some staff had been explicitly trained as generalists in law, management or planning. Secondly, others (particularly the long-term staff) had had lengthy experience running all aspects of the program when the staff had been much smaller and they thus felt at ease with each of the many pieces of the division's program even though they no longer held as great responsibility. Still others had a considerable degree of personal self-confidence backed up by a well thought out philosophy of health care delivery which enabled them to slide into many areas with ease. Still others had a great curiosity and desire to learn about the medical system and took considerable pleasure in understanding it and being able to manipulate it.

It should be apparent that there is a considerable possibility that a "dependency" situation had been created due to the combination of the structure developed by Knight, the young and generally inexperienced staff, and the turbulent outside environment. Indeed one comment by an observer was that Knight had "bought off" the staff and assured their philosophical allegiance by offering them (a) responsible positions involving (b) new (to them) fields of endeavor. While I shall later (Chapter III) discuss this issue more fully, here I will only briefly describe the linkage between each of the assistant directors and Knight and forego any consideration of whether a dependency was created or what its long term effect might be.

Each of the long term staff appeared extremely solicitious of the new head of the agency during its early stages and sought to prove their eagerness and competence to him. Of the younger staff, two were unabashedly linked to Knight, one through past associations and commitments in the neighborhood health center movement and another through his desire to "please" Knight and prove his evolving managerial competence. Three new assistant directors indicated to the researcher that they felt insecure about the definition of their tasks and, when confronted with an overwhelmingly large potential area of action, said they looked closely to Knight for priority setting. One other assistant director felt that many of his "managerial outlooks" were counter to Knight's (e.g., around the need for planning) and yet he clearly realized "who pulls the strings", so he was forced (by his own choice apparently) to check with Knight to define their area of agreement. Finally, two other staff managed to operate quite independently. Both possessed their own sense of personal outrage at the inefficiencies in their program areas. Both were also further separated from Knight by, in one case, the complex professional nature of his program area (pharmacy) and the other by his retained loyalties to the Human Services Agency from whence he had been "parachuted".

The allegiance to Knight, whether it be called dependency or "buying off", did create some interesting sidelights. For example, there appeared to be,at least during the early stages of Knight's tenure, very little of what might broadly be called "human relations" problems. While there was the obvious and frequent communication between staff,

it was nearly always task centered ("what is the right policy") rather than interpersonally centered ("how we do relate together around job issues"). Several of the staff commented on this situation but felt that any such problems were discussed with Knight on a one-to-one basis and not between staff. Given a task structure which appeared well suited to the environment(a mismatch of which seems to be a frequent cause of human relations problems), there may not have been an obvious focus for such behavior. The researcher also observed that many of the staff were somewhat shy personalities who had difficulty dealing with open conflict involving philosophy or style. Conflict did center around substantive issues of policy however, but even then it was infrequent. These are sweeping statements and probably unprovable, but of the few staff members who were eased out by Knight or who left the division on their own, most were observed to have relatively "conflicting"styles, thus lending some credence to the notion of the difficulty of the division in tolerating conflict.

c. The Technological System

The technology that the division had available to it in those days was (and remained) a primative one. Basically it consisted of three parts - the practice of medicine, the delivery of care and the practice of government. While the practice of medicine was viewed as relatively sophisticated, the delivery of care was not. And, of course, the practice of government is the overall subject of this

research. Knight very early on realized that to attempt to both learn and intervene in the practice of medicine would be bound to bring reprisals on his organization from the medical profession. Rather he stressed the delivery of health care as the relevant technology of the division. This was strategically important since it avoided direct clashes with the professions and because this technology could be rapidly and easily learned by non-medical personnel. In fact, he stressed that professionals should not manage each of the division's program areas (only the pharmacy unit was headed by a professional).

The political climate, while ripening every day for a direct approach to the control of medical practice, still required that the technology the division utilized be one of delivery, not practice. In addition Knight felt that most practitioners in the state were competent and well intentioned providers and there was less need compared, say, to other states, to up the general level of practice. He could thus utilize the delivery and governmental technologies.

Using these available technologies, the division began to harness them in the service of its goals. Recall that its general goals were seen as assuring that quality care was given, at economic but reasonable rates, in an equitable and accessible manner. The division began to approach the first by weeding out (sanctioning or suspending) obviously poor quality providers or categories of providers; the second by promoting reasonable rates for most providers and offering attractive rates for those services deemed to have high medical financial or social pay-offs, i.e., neighborhood health centers, pediatric care,

deinstitutionalization etc; the third by a quite rigorous process of assuming the client's or patient's interest about all others where possible and the fourth by paying bills more rapidly and by developing competence such that more providers would feel compelled to serve Medicaid clients.

In summary, then, the division did not, in its first months feel particularly constrained by the available technology. Indeed, it chose one that matched both the external political climate and the particular organizational style being created.

d. The political system

Price's final classification, recall, was the political system. To the degree that decisions are made in accordance with the formal production structure or hierarchy, then the political system overlaps the production system. This, of course, is not always the case in bureaucracies as decisions may be made quite independently by members who identify with vested interests or who maintain independent control of resources. Such independence may cut down on the organization's ability to be responsive to new knowledge.

Two factors in the division generally prevented the development of any of these potentially disruptive political activities over the control of resources. Firstly, the annual budget was an open ended one and the staff could not directly control the amount of money flowing through it (e.g. monies could not be "shifted" from, say, hospitals to nursing homes except over a long period of time and with the aid of complex political and administrative strategies). The other potential

disposible resource was the personnel budget. This, Knight, operating within strong Civil Service constraints, directly controlled himself, assigning staff assistance to only a very few division members. Recall that each program unit basically consisted of only one or two persons each of whom reported directly to Knight. Thus potential political activity could be kept at a minimum especially since each of the staff was new to the division and well able to find their own buffered niche in an expanding organization.

As might be expected, the only potentially scarce resource the staff could compete for within the division was leadership. Although such competition was not evident in the early stages of Knight's tenure there was some indication that throughout 1974, there developed some competition for the attention, time, or confidence of Knight. Several members expressed these feelings but these will be described more fully in Chapter VI.

9. Certainty

During this time the researcher observed that a climate of considerable certainty was being generated among the staff. Upon further observation and some responsive interviews however, it became clear that this certainty was not, at that stage, centered around what was "correct" policy in the health field, e.g. how should the division pay for non-emergency ambulance rides, should a nursing home be allowed one, two, or six months to correct its deficiencies. Rather this certainty was at another level of "how to do one's job."

This climate of certainty is important for two reasons. Firstly, it united the division so that it might later focus more clearly on the choice of substantive goals - a much more complex area given the turbulent outside environment and disagreement about how best to deliver care. Secondly, it permitted routine activity to be carried out with a degree of confidence such that not only the staff but also the division's providers recognized that the division's basic functions were being well carried out. This then permitted the division the psychological "space" to tackle new areas with some degree of confidence and success.

This initial climate of certainty seemed to be created by three factors evident in late 1973. There was first of all the informal task structure described earlier. It helped to create certainty by assuring that the staff covered all the ground and that they were not "missing" anything. This structure occasionally even helped determine what was "right policy", but its major function was the raising of a wide range of issues. A second factor was the role flexibility developed through the specific personalities of the staff, the newness of persons to roles and the conscious switching of staff by Knight until they found "the right slot". At first glance this second factor might be expected to create uncertainty since new people (no matter how broad their outlook or training) in new positions is an inherently unstable situation. But viewed more in a complex fashion, the importance of this role flexibility seemed to be to create natural interdependencies (and thus certainty) between staff members, their styles, and job demands,

as each unconsciously sought out areas of mutual certainty. The strategy of letting staff "float" but then "grounding" themselves appeared to be a valuable one in the circumstances.

A third factor, the constant leadership by Knight and his conscious attempts to teach a style of management to his staff during this early period was also helpful to creating this climate of certainty. He continually stressed "ways to go about your jobs" in his evoking management maxims such as "do things within the Department the easiest way... try to create the fewest waves", "think in investment terms - where we can get the most return for our limited dollars and time," "take your time thinking out a problem - we want to be 'right' but once we know, move rapidly". "Be sure to cultivate 'reliable' sources of information". "Get things in writing - the paper trail is very long". These features will be explored more fully in later chapters - here I only wish to illustrate how Knight's strong emphasis on management helped to create an aura of initial certainty about job performance within the division.

Nonetheless, by the end of several months of Knight's tenure, some "testing" of the certainty began to be observed, testing at least to the degree to which certainty had been directly instilled by Knight's actions (as opposed to the informal task structure and the role flexibility). Knight began a very slow "weaning" of staff. He still kept a large and visible hand in all discussions during this time, but felt that "I give people a lot of rope". He began to extend that rope considerably but many staff commented that it was, while long,

nonetheless taut, and could be withdrawn easily. For those who began to act more independently, he maintained an open door and encouraged staff to come to him with problems even though his response was "well, you know the answer to that don't you?" Freedom to carry out tasks in individual ways was increased. With other staff he not only kept a close watch on task implementation but still maintained a casual but close check on hours, attendance, commitment to work, etc. In general though, the staff and Knight began to feel much more certain about their approach to policy questions despite the turbulent environment.

This certainty was all the more surprising given the generally low level of general or even specific feedback from the division's environment. During this period (and even later), feedback from the environment came mainly from providers of service despite the rhetoric which said that the division's environment was composed of both providers and recipients ("our clients"). Since the providers mainly complained about excessive paperwork and late payment of bills there was very little basis upon which to judge the ultimate effect of the division's actions. Staff members complained of having only surrogate measures of effectiveness, i.e. total dollars spent, not even dollars per person per treatment category in many cases. Even if the later figures were available, the relationship between it and the health of welfare recipients was tenuous.

The response to this situation seems to have been that mentioned earlier - the adherence to a comparative standard of care equal to that a middle class family would receive. That provided much more

certainty since most of the staff "knew" what middle class care was, being middle class by origin or status (education or income). Another factor, also a relative one, permitted the division to carry on with the assurance that "we must be doing something right". This was the fact that the program in the state was one of the most liberal in the country in terms of benefits offered and fee schedules permitted. Another early response to the feedback problem was the enlargement of the definition of quality care to encompass first efficiency of delivery, then adequate distribution across the state and districts, and finally, consumer representation. Overriding these factors, however, was a strong sense of moral rightness - it was often simply assumed that there were "right" ways to deliver care and that if the division could chose such a way and manage to get it implemented then this was considered a very positive action. All these factors then, both those consciously manipulated by Knight and those that emerged out of a lack of feedback, created an air of certainty which enabled the staff and Knight to "get their house in order" and to respond to and develop new initiatives.

10. The Launching Pad

By the turn of 1973, the division had begun to change. The informal task structure had become much less informal, there was much less talking among staff about shared problems and there were more clear lines of authority. That appeared to be at Knight's instigation as he had begun to state that he didn't want "people stepping into other people's jobs". If there were any problems about who should

take responsibility or how it should be divided, he asked that they come to see hom. He then generally assigned the task to one specific person or took it upon himself. The staff still talked informally but rarely generated action from such conferences and began to refer questions from outside to the appropriate staff rather than attempting to answer them themselves. The groups thus took on less collective responsibility. Individuals appeared to be making decisions more independently although this must be understood in the light of the shared philosophies being created and the similar personalities of the staff.

While this increased differentiation appeared fairly obvious to most, the concurrent absence of any formal integrating devices was especially apparent. Knight appeared to have an aversion to such coordination or liaison devices although some did develop out of necessity (e.g. sanction activity) Knight felt that "good people will do the necessary liaison work" and that "managers need decision power" whereas when committee or liaison staff take on a strong role they "are afraid to delegate responsibility". The division's integrating devices thus remained informal and at this stage were most clearly evident in the shared approach to management developed through Knight's teaching, and a competent and willing group of "students".

Over the next several months the division's activity was to turn from the more routine activity to the development of an organizational paradigm or mission - the "responsible buyer" of medical care and to the development of a set of principles to make this paradigm

come alive and take form. The way in which these were developed was through the same teaching and management approached used in putting the routine actions in order - but the focus was different. Many new services, philosophies and techniques were attempted. These new services, philosophies and techniques I have called new knowledge since they represented a new situation to which the division would respond. In some cases, the new situation or knowledge was stimulated by some force outside the agency; in other cases it was generated by the division, in either case the division made a decision about how to manage that new knowledge and (usually) then set out to implement that decision. Some 15 representative situations of such or new knowledge wll be the subject of the next three chapters, each chapter grouping five cases in a particular "stream" of activity.

Chapter III

The New Medical Services Stream

One of the self-defined tasks of the Medical Division was to promote the development of new medical services and design policies for their delivery to Medicaid clients. Along with development of policy for existing services, the monitoring of these programs and the handling of exceptions to the division's rules and regulations, these were considered the main tasks of the central office. In some cases, the agency actually grew to believe that their purchasing power could be a major factor in changing the way health care was delivered within the larger "private" health care system. The assessment of that thrust is made in Chapters VI and VII and here I shall discuss only those new services developed for Medicaid clientele.

Over the course of two years, many factors were evident which led the division to devote resources to new services development. Often there would be a strong push from the federal bureaucracy which controlled 50% of its funding. Other state agencies occasionally wanted to involve the division in joint program development since they saw Medicaid as a source of revenue. Some programs were selected for potential leverage in a particular area ("we can have a big effect here"), while others were the pet projects of some of the staff members. Still others were programs which involved very obvious cost savings and quality improvements which usually could be achieved at minimal expenditure of effort. And finally some were selected in order to set an example of credible management which could then be utilized in the service of other goals.

The descriptions which follow highlight only five of the dozen or more new services the division developed over the course of two years.

Other significant new services which were developed included the coverage of renal disease, a family planning program, a revised transportation policy, a home health care program, the development of a system for the improved permanent and temporary placement of nursing home patients, a psychiatric day care program, the enlargement of psychology services, and the addition of certain mentally retarded patients in intermediate care facilities to the division's clientele. Yet the five discussed here adequately serve to indicate the particular "program for action" developed by the division, the teaching of health care principles, the important roles of credibility achieved through management and the development of a conscious paradigm as key elements in the division's learning model through which new knowledge was managed.

The cases are arranged in a rough chronological order although there is considerable overlap. The ordering is based therefore, on the period of time during which the agency made its major concentrated effort in the policy development for that service.

1. EPSDT

EPSDT, standing for Early and Periodic Screening, Diagnosis and Treatment, was a federally mandated program begun in late 1972. It fell among those several services which a state had to offer if it was to participate in the Medicaid program at all.

Many states had had difficulty in assuring that welfare children were being adequately cared for and so a new delivery mode was specified by the federal mandate - mass screening of large groups of children in order to detect well-known diseases. The use of public clinics was encouraged and considerable outreach was mandated. It was a program directed at those

states with few providers of care and with otherwise low benefit packages or fee schedules. No new federal money was offered beyond the normal 50% (although financial penalties for non-compliance were included) nad staff assistance was not specifically provided.

The questions addressed by the new program were ones which the Medicaid apparatus, both federal and state, had to address each time a new service was proposed. Firstly a determination of the need for the service had to be made, a target population had to be singled out and a mode of delivery and potential provider types suggested. Then a reasonable cost for the service had to be determined and negotiations with providers entered into. Finally an effort to propagate the new services'availability had to be made. In each of these issue areas in the EPSDT program the state was at one time or other to be at variance with the federal authorities although the political pressure eminating from Washington waivered considerably over time. Eventually, this pressure was reduced as the federal agencies admitted the confusing and complex problems involved in the program. This story first describes how this external environment confronted a key member within the agency who responded passively to these varying inputs. This passivity in following federal directives was strongly determined by this staffer's personal style since he had little personal commitment to, or "feel" for the medical components of the program. Initially the story describes the weak external and internal management by this key person, who continually mirrored the strong but inconsistent focus of his environment.

A newcomer to the organization then became convinced of the nonviability of the program based on his past experience and the ministrations of a friend. His need for public commitment on the program and

his lack of fear (through a healthy naivite) of the federal apparatus stabilized the grounds for action and confronted the waivering federal inputs. Finally, as an alternative solution was developed, the state began to develop allies while continuing to use the federal rhetoric. Its strategy was straightforward but sophisticated, and this sophistication, coupled with an aggressive stance, eventually "absorbed" the waivering focuses from the environment. Slowly the division's strategy began to dominate, until its environment began to demand proof that this conceptual strategy was actually having an impact and was being routinized.

The federal agency, the Social and Rehabilitation Service (SRS), directed the program through its regional offices which had been notified by Washington that EPSDT was a priority program. Pressure was to be applied to each of the states. There was some feeling (later confirmed by the regional office) that it was applying pressure only because it had received directives from Washington. It was not determining policy. The SRS regional office maintained a tight watch on the division since it (the division) had had a poor follow-up record on other mandatory programs of this nature due to its excessively small central office staff and the difficulty of controlling its 100 local offices.

The program was initially assigned within the medical division in 1972 to the Innovation Unit; a group of five persons including three with advanced degrees in economics, management, and sociology and two research assistants. At that time these were the only staff available to respond to a new initiative although the unit's original mandate had not been to deal with this sort of "required" program. The director of the Innovation Unit,

(R.D.), began to explore what other states were doing as he was personally concerned that the program be implemented and that he not be caught in a poor follow-up position by HEW. He was not deeply involved in the program's content per se but said he felt a professional challenge to make something the federal agency required work well. He was concerned that unless he could show SRS that Medicaid providers were not only screening children but were also following up by assuring adequate diagnostic, referral, and treatment facilities, that SRS would hold him responsible. In addition, his mentor and supervisor at the time was the DPW commissioner, who would be forced to take political "heat" if the program was not accomplished.

SRS officials waxed hot and cold over the program however, appearing uncertain about how to encourage or monitor it since, as one DPW staffer said, few health professionals were involved in its design. This uncertainty was much later admitted by SRS in private discussions. Not only was there a question of the political "will" behind the program, but there was uncertainty about whether the screening should be done en masse or by private physicians, about how much emphasis would be placed on referrals and treatment, and about how adequate outreach was to be achieved. The regional office of SRS at the time, however, made a "deal", stipulating that if the state would promise to act in good faith on trying to implement the program as perceived by Washington and would accept technical assistance, the immediate pressure would be relaxed. Finally one person was sent from SRS to oversee the state's efforts and provide this assistance. The person "stuck to the coat-tails" of R.D. while they jointly attempted to develop a plan. At first she was seen as a hindrance

and R.D. felt he was being "shadowed". They even shared an office. It took him some time to feel comfortable with the situation and to recognize and accept the assistance offered.

But finally she began to offer what was seen by R.D. as valuable assistance and began to report back favorably to SRS. She had had experience with other states and was able to provide R.D. with cost data, contacts with others in the state government and to help design a reporting form to be used by providers of service. She was finally convinced by R.D. that the effort would be more difficult than anticipated due to what he described as the "complex mix of actors, resources and goals" and the need to superimpose the programs on an existing structure (i.e., the state could not set up its own delivery system).

The Innovation Unit staff were assigned to three separate areas, operations, resources and evaluation, with an overall project leader reporting to R.D. who continued to maintain all contacts with the outer environment. R.D. felt that he was the only one who had the "overall picture" and that he should be the "valve" for all contacts. He did however take staff with him to meetings and informed them via formal memos of the state of the world "outside". He spent considerable time on other responsibilities and looked to the project leader to manage the project since he was felt to have "a good program sense". The project leader had good credentials, was older than R.D. and had previously been in sole charge of the program. However, he was eventually seen by R.D. as not being a capable administrator and this, in addition to the loose definition and understanding of the program, led to a shared feeling by the staff that they were "floating and accomplishing little". This led R.D. finally to deal directly with the staff and to attempt to rectify the confusion.

His attempt was viewed by the staff as being inadequate even though he felt he was dealing with the confusion felt by them. None of them came directly to him to admit their confusion however. R.D. felt that perhaps he wasn't projecting enough but felt the "problem" was under control or at least minor compared to other problems facing his staff and the whole medical division. The division was without an assistant commissioner during this time and was physically dispersed in two separate locations. The staff eventually grew more confused since the federal guidelines kept changing, the grant supporting the Innovation Unit was due to run out and they felt they had been hired to do other types of work.

Despite this, R.D., under continuing heavy pressure, managed to put together a"package" which included a fee schedule, a separate billing form with model provider contracts. He had come to view the program as one which must be statistically segregated in order for SRS and the regional office to be able to monitor their progress. The only way this was possible was to isolate all the EPSDT activity via these separate fee schedules and billing forms. EPSDT was, by necessity then, a separate program, with separate procedures, fees and billing forms.

R.D. retained little personal interest in the philosophy of EPSDT. While he at times thought of approaching Washington concerning the confusing nature of the program, he continued to relate only to the regional office, explaining that he had made a commitment to them to follow their lead, and did not feel he could go "over their head" to Washington. So he buckled under and did the job over the next several months.

During the spring of 1973, R.D. addressed a meeting of the local chapter of the American Academy of Pediatrics which grouped virtually all of the state's pediatricians (but did not include general practitioners, who also cared for a large proportion of Medicaid children). One of the chapters leading members, S.Y., listening to the address, felt that R.D. did not have a good sense of the program and furthermore did not have the medical knowledge to realize that the federal agency was also confused. S.Y. "got upset", felt that "things didn't smell right" even though he "had no analysis of the situation and no alternative plan." He only knew that medically, a massive screening program without follow up, referral and treatment was useless. He had tried a screening program in his neighborhood health center with disastrous results. However his colleagues decided to support the program since "it had good intentions" and most had not had experience with Medicaid and wanted to show their willingness to participate. They agreed to "play along" according to R.D.

The subcommittee of the professional society had no further meetings of substance on the issue so the pediatrician, S.Y., returned to his health center and talked it over with his director, Don Knight, who would in a few months time become the new assistant commissioner. They both decided that there was no clear understanding of EPSDT but made no further moves to change its direction. S.Y. felt that Knight "didn't really get a grasp" of the situation until he was appointed to his new post.

A few months later, Knight was appointed to the division. His roots in the neighborhood health center movement gave him strong concern with providing ongoing regular pediatric care. He immediately looked at the

EPSDT program and "saw it was a non-program", that is, that it was really only a component of ongoing regular pediatric care. Shortly after his appointment, S.Y. "dragged" him to another meeting of the local chapter of the academy. Knight was well known and had the respect of the chapter. In talking with some of the key members of the group he declared that "we must integrate EPSDT with the regular Medicaid program." S.Y. felt that Knight had said this without any real sense of how to do this ("almost without any plan"), but would commit himself to it. This public commitment and statement of philosophy, then, coincided closely with his realization that it was a "non-program".

We see here for the first time several features which are to reappear in succeeding cases. Knight relied heavily on both his prior experience and on the advice of a trusted colleague. And he assumed a strong conceptual position (and a role for the division) without excessively dwelling on all of the effects of this decision, for example, how others would view it, or how difficult it might, or might not be to implement that position. Knight - "I <u>assumed</u> the problem, rather than spend a lot of time <u>identifying</u> it. We wanted to get something done and then evaluate it." Nonetheless, he knew that some of the SRS officials would be upset, but that would mean little since there were few detailed regulations to evaluate the division's performance at that time and no financial penalties were envisioned then. We also see the first glimpses of the importance placed on the principle of comprehensive care - that to segregate the screening aspects of the program would be against good medical practice.

At first Knight decided to take a low profile within the division and suggested to R.D. that he begin to rely on his friend from the health center,

S.Y., whom he had retained as the division's consultant. In addition, he assigned some of the EPSDT staff to quite unrelated areas, fired the project leader, and generally devoted limited attention to the situation for the first few months. He was in effect acting on his own declaration that it was a non-program. In addition, he felt that some of the staff who were doing research might better be utilized in policy management positions. But S.Y. was seen by R.D. as not understanding the "program" requirements of the federal agency and in an inappropriate position to act as a managerial advisor since he, R.D., was the "manager". S.Y. continued to gain confidence in the "non-program" idea and to advance it to R.D.

Slowly, however, S.Y. began to realize that R.D. lacked drive, energy and interest in the area of pediatric care. He felt that R.D. could not explain EPSDT well to groups and was only transmitting what the federal agency wanted - he was "doing a job". But R.D. still maintained that EPSDT must be conceived of as a "program" at least for federal reporting purposes. That is, there had to be some way of reporting how many children were processed, whether through the EPSDT "program" concept (as viewed by SRS) or through the regular system of pediatric care which the division paid for.

One of the two remaining staff members (N.L.) who had previously been little involved with the project had already begun to rebel against the concept of a mass screening program. She felt that she had always had her own doctor when young and "why shouldn't welfare clients ahve the same" - there seemed to be no need for mass screening. She began to be struck by Knight's and S.Y.'s commitment. The remaining staff person admitted his low productivity in the area and was immediately given a new assignment by Knight.

Contact with the outside began to increase. Previously, a task force (mainly other bureaucrats from outside the division) had consulted sporadically with R.D. for overall policy advice, but he never met with this group as a whole and indeed tried to keep them at arm's length since he felt that "they would only confuse things". He wanted to keep them "in reserve" for later "promotional" type activities. This whole effort at touching base with the environment was seen by Knight as inadequate since the task force (including R.D.) had had little direct experience in actually delivering services. In addition Knight found such committees to be generally ineffective devices.

The professional society began to alter its conception of the program. S.Y., who now headed an EPSDT committee within the Academy, began to adopt a more active posture as he worked with Academy members to develop an acceptable protocol for reimbursable pediatric visits. He felt that since EPSDT was really only a part of ongoing quality care, the major task was simply to get "the private sector" to accept Medicaid clients (and provide statistical data on patients seen). Most had done so with reluctance in the past since fees were seen as low. Now, however, Knight decided the division would permit a liberal $15.00 fee. This had always been permitted, but a lengthy report had been required for each visit.

Knight and S.Y. proposed that the pediatricians could use the $15.00 fee regularly if they signed an agreement to (a) follow a protocol of activity, and (b) provide adequate statistics each month (as opposed to individual reports). This positive proposal caught on. It seemed to reaffirm the pediatricians' commitment and more importantly, translated it into reality. The principle begun to be developed here would be used

in many later similar situations. That is, for those services the division wished to encourage, it should offer a very "sweet" fee. In addition, a large group of pediatricians in one region of the state had a backlog of bills cleared up by Knight and this added credibility assured the cooperation of that group. Here again this attempt to understand providers' problems (in order to assure their cooperation) was a principle which Knight and the staff were later to utilize.

The federal agency, SRS, appointed S.Y. as its own consultant for the region (involving several states). He tried to downplay the fact of this potential conflict of interest, but it never surfaced since SRS rarely consulted him. However, the fact of his appointment indicated some concurrence with the division's "non-program" idea. It is likely that they asked the Academy of Pediatrics to recommend a professional advisor and the chapter, seeing that it was their own S.Y. who was the most involved, recommended him. At the same time, S.Y. (in his chapter role) was also asked to chair a national meeting of the Academy on EPSDT.

There he got "a bird's eye view of the disaster" occurring in the other states and began to propose the same solution as he was advancing locally. The other chapters seemed to grab eagerly onto the idea. He was even asked to write a national plan and a manual for the Academy. He began this with the assistance of Knight as a co-author. This growing (national) professional credibility and acceptance then served as a background for Knight's contacts with the federal agency and he began to realize that other agencies (SRS in this case) could be "swung around" if the division had the backing of the professional bodies. Knight interacted frequently with the regional office of SRS and slowly began to convince them of the

medical value of their idea, while simultaneously stressing that the rigid federal reporting requirements would only drain energy from the true task. Much later, during a trip to Washington, the regional director of SRS and Knight even concurred in presenting a united view to the Washington office of SRS.

Thus, while it appeared that the regional branch was being slowly won over to the non-program idea, Knight did not manage at this stage to obtain assurance in writing that they agreed with his concept. In fact, R.D. believed the term "non-program" was never voiced in SRS's presence. In essence, then, Knight was adopting the SRS rhetoric, a considerable change from his initial goal of doing nothing about the "program" and of assigning as few people as possible to it. He had come to learn that at least initially one must talk the monitor's language. He was still unconvinced however of the need to "go through the motions for the feds" and began to suggest the new strategy to R.D.

R.D. then began to adapt his strategy to the new one which involved outreach to get children into the aegis of regular providers who would sign contracts, follow a protocol, and agree to supply statistics. He felt that he had had this in his own mind as a strategy all along but had devoted effort to trying to comply with SRS's guidelines which had emphasized screening and separate clinics as the mode of delivery and the provider types preferred. Now he had only to "retool" his thinking to the old strategy, i.e., to adopt an offensive strategy as opposed to a defensive one.

R.D. had, however, not won the confidence of Knight and the latter continued to diffuse the responsibility for EPSDT relying on others such as S.Y., one of R.D.'s staff (N.L.), and another new director in the division, R.K. Knight said that he began to realize that while medical skills were not needed, his staff must at least have some interest in health delivery. R.D. seemed to lack the necessary commitment and did not respond to Knight's teaching style. Knight felt much happier now that R.D.'s involvement was lessened and he began to work closely with N.L. stressing with her not only the importance of having a philosophy to guide themselves but one that assured comprehensive pediatric care and not the fragmented program proposed by the SRS.

R.K., a former associate of Knight, was also asked to help R.D. with the program. R.K., like his boss, had valuable pediatric experience and was able to oversee the project for a few months. He too, however, had originally conceived of EPSDT as a separate program and had recommended the setting up of a distinct billing system for it. But Knight convinced him that in terms of philosophy, statistics, and billing, EPSDT was a non-program and that emphasis on separating it out could only lead to excessive concentration on the format, not the content of the program. Thus, "non-program" came to take on a new meaning -- that is, EPSDT, while having substantial medical content, should not be segregated as an administrative program, like,for example, nursing homes or dentistry.

R.K. helped to contact providers and neighborhood health centers using the sweetener of the higher fee for solo practitioners (which had always been in existence but unknown to most of the providers) and the threat of withdrawal of support from the neighborhood health centers.

He also participated in the contacts with Washington and the professional society. But he did not wish to stay involved for long and began to pull away.

At that point, it was decided by Knight that too much time had been spent in identifying the problem. Rather, he would "assume the problem", take a risk, "do something" and then evaluate it. He concluded the project did not need a manager at all and made the sole remaining staff member (N.L.) fully responsible although she still reported to R.D. on other matters. A disagreement developed between R.D. and Knight over assigning a staff person to "manage" a program. But Knight prevailed and, a few months later when R.D. assumed new tasks, N.L. began to work more closely with Knight who had then begun to beef up his own involvement by writing the national EPSDT manual (for the Academy). Most of her efforts were devoted to persuading providers to sign contracts and to complete the now minimal reporting forms.

Knight's interest picked up with his writing of the manual, which was designed to explain EPSDT to a national audience of pediatricians. One of the by-products of this manual was that the state's EPSDT philosophy began to be nationally "legitimized" by the American Society of Pediatrics. Knight felt this legitimacy could be used as a tool in future defensive actions with SRS which might be necessary to head off any question of non-compliance with federal regulations. But the regional office appeared convinced of the division's approach and no financial penalties were envisaged although they and Knight had to continue to keep convincing Washington of the validity of the state's strategy. Thus, over the next few months, at least two "audits"

of the program's effectiveness were conducted by federal officials from Washington. Each time Knight managed to convince them that the philosophy of his approach was correct and that the pressure should be lessened so that they could "get on with the job".

However in late 1974, a citizen's group made plans to file a suit against the division for non-implementation of the program. The advocacy group, after meeting with Knight and the staff, accepted the philosophical direction of the division but commented that not enough clients knew of the program. The regional office of SRS felt pressure from Washington to produce hard evidence of success and began to try to pressure Knight to show more evidence of progress. But the advocacy group's problem could only be solved by improved performance by the field staff at the local level,over which the division had no direct control (see field case in Chapter V). Similarly, an improved effort at enlisting more EPSDT providers, a central office function, would necessitate considerably greater staff than were available. Knight did not appear disturbed by either of these challenges since he felt his philosophy was correct and indeed welcomed the challenge since it might force the state's new administration to provide more staff in the face of federal penalties.

When some additional staff did become available through a federal job training program, he assigned several of them to the division's regional offices to begin to provide the necessary outreach. However other staff members, and the department's lawyer, D.L., and N.L. remained worried and often asked themselves "have we really done anything". I call this the "nagging ego problem", one which is seen to appear often

among the staff (not Knight) as they assessed their activity after a burst of enthusiasm and energy. In the short run such a syndrome did not appear to present a problem but in the long run was potentially destructive in that staff might feel their constraints were so severe that certain minimal aspects of job satisfaction (i.e., positive feedback from the environment) were not being met. Yet they continued to work in the direction laid down by Knight, trying to minimally satisfy the "bureaucratic" federal requirements with the few staff available.

The generating force behind all this activity, the concept of a non-program is difficult to trace to its source. Knight had had extensive experience in a high quality pediatric system and little experience in dealing with federal regulations concerning the kind of care offered. He was thus ready to brand the program as a sham, one unacceptable to the state, and one that he, as a responsible official, could not in good faith support. Furthermore, he sensed that R.D. lacked a "gut" program sense and would cater to "what the feds thought was right" and not develop a strong offensive. If R.D. had felt strongly about the program content, Knight's realization might have been delayed considerably. But Knight was able to ease R.D. out of the EPSDT responsibility and in effect, take it over himself. N.L. and R.K. shared his approach and only needed to be convinced that SRS could be confronted on an issue of policy. Knight's strategy of convincing SRS consisted of gaining credibility with allies (the professional society) based it on the integrity and soundness of his approach while continuing to use the federal rhetoric. As his strength grew and he was able to convince the regional office, he became more bold.

It is clear that the learning not only of this strategy but of the possibility that it could be effective was the most important contribution this case made to the organization's overall mission.

The mission or paradigm, as described in Chapter II, was to act as a "responsible buyer". While this paradigm was not called upon this early in the division's new life, some of its features were evident in that they clearly guided the development of some of the division's working principles. For example, buying quality products translated into not purchasing a separate system of treatment for welfare children and responsibility translated into holding specific providers accountable both to the department (via provider agreements) and for the referral of children to needed specialists.

The manner in which the division developed its strategy is interesting in that much of what we see here will also be seen in later cases. I shall introduce the term "program for action" here to briefly describe, in a generic sense, the behavior rules which Knight (and the division) used to generate their final decisions. Since the use of the term "program" within the division had a more specific meaning, i.e. anything carried out by one of the staff, e.g. a "nursing home program", or "a sanction program", there may be confusion with the term "program for action" here. I will generally specify the use of the term or, alternatively, refer to the "pattern of action" or "program for learning".

Firstly there was the early attempt to deal with the complexity of the new program by linking it to another program - in this case, ongoing pediatric care. There was the strong role assumption by the division that it was responsible and should take a stand on the issue.

A specific goal was formulated early on - in this case "do nothing". Then there was the direct assignment of responsibility, in the case taking it away from a large unwieldy group and vesting it primarily in Knight himself. There was the clear attempt to "bend" the regulations of SRS to suit the division's outlook and then a strong reliance on past experience and close friends (i.e. S.Y.) to formulate that outlook, coupled with a widening move to convince or "touch base with" the provider community. Also evidenced was the entrepreneurial spirit in which a "problem", i.e. having to respond to the federal mandate, was turned into an opportunity to develop, for the first time, a protocol of good pediatric care.

In addition to the "program for action" developed, several specific principles about how to deliver medical care or how to mobilize others to assure that it was delivered were developed during the case. These principles were the first entries into an expanding pool of principles which the division would draw on in later cases.

I have already mentioned the emphasis on "comprehensive" care as an important pediatric principle, the use of high fees to encourage providers, that working with children had a high pay-off, and that providers' philosophies should be listened to. Knight also began to stress the importance of having a philosophy, i.e. knowing what you want - not only for himself but also in his staff (see the lack of it in R.D.). Other minor principles were also generated in the case which were to have greater significance in later cases. For example, the feeling that welfare clients should not be discriminated against (as would occur in a mass screening program), that local offices

could not be relied on to provide outreach, or that one must be very careful with reporting systems since they could be easily manipulated and could lead to misunderstanding. These principles, however, were not initially widely shared since only Knight, R.K. and N.L. worked on the program. Knight was later to invoke these principles (and others) when dealing with program staff in other cases.

Knight's approach here in developing these principles was not as clearly a teaching style as in later cases. Here Knight clearly viewed the program as his program and he was, to a considerable degree, teaching himself about how to implement the set of working principles described above. It is not clear whether much learning of these principles or strategies occurred through the staff. R.D. remained unconvinced that it was an appropriate strategy to directly confront the federal apparatus. His prior experience had taught him this and he still felt the division was open to possible financial penalties for non-complaince. He did admit to learning that tighter control should be kept on his own staff, since he felt he had not provided adequate "direction". The EPSDT staff itself had been summarily decimated by Knight and learned little about operating strategy with SRS since they had had little contact with them.

N.L., however, continued to work on EPSDT and gained considerable confidence and knowledge of pediatric care delivery with Knight's backing. She also benefitted from his teaching style as he carefully laid out the facts of each situation and explained his decisions to her, let her observe him in meetings, and was generally non-critical of her when she made "mistakes", since he was equally concerned with the process of her learning. He also showed an ability to anticipate N.L.'s talents, that is, she was viewed as being very interpersonally adroit and could help "win

over" various SRS officials and HEW auditors with her skills. These and other aspects of Knight's teaching style will be more fully described later in this and other chapters. Here the reader is alerted only to the success of that style with N.L. and its failure with R.D.

We also begin to see some of the features of Knight's management style. There was his reluctance to rely on a committee structure (as R.D. had), or on research or "innovation" units, his keeping a close check on staff in whom he had not developed confidence, his belief in the importance of non-medical staff managing programs and his willingness to let those staff "find their own slots" while following a direction worked out between them and himself.

Both these management and teaching approaches were directed at the fulfillment of the division's paradigm - the responsible buyer. In summary then, this case has described how a concept originally conceived of as a program came to be viewed as a "non-program" since it did not fit within that evolving paradigm. It is a story of how Knight "learned" and how he convinced (taught) others inside and outside the agency. Equally important, it is a story of how the agency was forced to demonstrate that not only had its concept been learned but that its practical effects were being felt.

2. Free-Standing Mental Health Centers

This case concerns the establishment of a purchasing policy by the division for free standing mental health clinics. These clinics had existed in the state since the mid-sixties and by 1973 some 50 of them were providing services. They had received considerable federal grant funding but their primary source of income was from the Department of

Mental Health (DMH) which paid the clinic's staff salaries. Local contributions (up to 25%) covered some overhead and other expenses. The clinics, many of which were small and staffed by part-time professionals, provided "free" services to their clients, including Medicaid recipients.

In 1969, a group from a state mental health association and the DMH approached the Welfare Department to propose that the division include the free-standing clinics (FSMHC's) in their reimbursement plan. At that time the extra cost to the DPW was estimated at $2,000,000 per year and was rejected by DPW budget officials as being too costly. With the advent of a new commissioner in 1970, the group tried again and the commissioner convened a task force of his research director, the director of medical care (who reported to the Assistant Commissioner of the Medical Division) and other DPW, DMH and DPH staff. The issue lagged for over two years with three principle roadblocks being cited; the question of whether the clinics needed to be licensed by DPH; what criteria DPH would use as certifying agents for DPW (a second role for DPH) and the overall lack of leadership within the task force.

Finally the emergence of the new umbrella human services agency (HSA) managed to resolve the licensing question, and DPW began to write conditions of participation for the clinics to be used as DPH criteria. These conditions were generally viewed as being "obsolete" since they were intended mainly for child retardation bureaus but were accepted by the task force as being plausible in the short run. The question of leadership was not resolved until mid-1973 when Knight was appointed.

Two young DPW staff members had been working part time on the conditions of participation but both had left the department (one before Knight's arrival, one shortly after) and this had slowed down the process according to the director of one of the clinics and a key member of the task force, Y.E. Upon Knight's appointment, he was informed of the task force's meetings and the length of time it had taken to produce such little agreement and began to attend the meetings with a new staff member, L.A. He was somewhat cynical about the whole mental health area, feeling that in most cases it was a "rip off" or an "exercise in mutual gratification" between the professional and client.

But the HSA was stressing that as much federal money as possible be attracted into the state and the opportunity to convert the clinic's 100% state funding to 50% state funding (at least for the Medicaid portion of the clinics) was appealing. Knight also felt wary of the clinics free standing nature (not connected to other medical care) but felt that, "the clinics were there, we had to deal with them". He responded openly to HSA's push but adopted his own immediate specific goal that he would not worry too much about program content but rather concentrate on the financial aspects of the problem. The clinics, for their part, saw possible Medicaid involvement as a source of additional dollars.

Knight was disturbed by the amount of time the task force process was taking and suggested that one of the clinics be selected as an experiment through which an acceptable dollar rate per visit could be determined. He had familiarity with one clinic and suggested it be chosen. The clinic members of the task force at first perceived him

as "abrupt" and even "uninformed" on mental health. For example, they convinced him ("shouted him down" according to one task force member) to add a more representative clinic to the experiment. While he was later to shy away from large task forces such as this since he felt them to be ineffective, he felt he was saddled with this group and could only prod it along, not disband it.

While these costs were being developed, the task force turned to another issue, the double payment issue. That is, state Medicaid money would be paying for the services of DMH doctors already salaried by the state. Considerable debate was conducted on this issue with Knight and HSA taking a hard line, i.e., the clinics would only be allowed to keep 12 1/2% of the rate (still to be determined) as an incentive to pay for the costs of billing for Medicaid patients. Otherwise there would be no incentive to bill Medicaid since each dollar coming in would be, in effect, "subtracted" from the DMH salaries and returned to the state treasury.

The issue appeared to be settled satisfactorily after many hours of negotiation so the clinics agreed to the formula and the Undersecretary at HSA said that as long as the DMH and DPW were in accord then he too "would go along". But the calculations for these billing costs and the rate determination revealed that the clinics had no real idea of their cost per visit and similarly had no idea whether the 12 1/2% rebate would be good or bad. ("It looked good so we went along." - Y.E.). Knight began to be upset at putting money into such poorly managed clinics but felt that it was the only way possible that he could influence the delivery of services. The clinics did not initially perceive him as having a desire to change their service patterns, but their poor management,

combined with Knight's own basic mistrust of the mental health profession, led him to add a restructuring of service patterns to his agenda.

Knight, while as usual having a specific goal (increase federal dollars) was not as quick to assert the division's perogatives as he was later to become. It was only when he saw one of his principles (good management) being abused and another possibly violated (poor clinic treatment of Medicaid clients) that he began to be more assertive. He moved rapidly on the question and with authority, and while this often annoyed the clinic members of the task force, it gained him considerable credibility since "we couldn't believe we were getting anywhere - it had taken seven years of talking".

Here we see a beginning of the iteration of the principles which were to be used in other cases both within and outside the mental health area. For example, the principle that Medicaid clients should not be "discriminated against" through excessive provision of care by residents or nurses was stressed in the EPSDT, 442 and HMO cases. Similarly the principle that the division should devote its energy to well managed providers surfaced later in the HMO and Day Care cases. And finally the feeling by Knight that the staff must talk to providers, be open and try to understand their problems was stressed in the EPSDT, HMO and Day Care cases.

The remaining issue to be settled before services could be provided was the actual rate to be paid and what were to be considered as allowable costs (i.e. services) within that rate. One way to have approached this would have been to begin work on revising the conditions of participation (which had the force of regulations). But each of the parties seemed

to feel that the rate question was more important and, since it was to be a rate developed from scratch, any agreements on cost components could then be later developed into conditions of participation. The director of mental health, L.A., knew however that the old ones previously prepared would have to be revised at some time so as to make the understandings reached more binding.

The clinics wished to include the cost of many types of mental health professionals in addition to the psychiatrist, for example, social workers or even occupational therapists. In addition they felt that group therapy was an important service to be reimbursed. It was here that Knight's initial biases against the mental health field focused on the clinics. As one of his staff was later to remark, "Knight had a medical model of mental health - that you have 3 to 4 patients going at one time, that there are no "no-shows", and that you are treating a "disease", whereas the mental health profession worked in terms of 1 hour blocks of time, frequent "no-shows" and an attack on circumstances surrounding the"pathology". Despite Knight's background in a neighborhood health center, his view of mental health services was based on "the private practice model" according to his consultant in the area.

But Knight persisted and the compromise reached was that professionals such as psychologists and social workers with masters degrees could provide service but that they would have to be billed in the clinic's name and then under the direct supervision of the director of the clinic who must be a physician. He had begun to see how social workers and other "mid-level professionals" could be useful in certain settings (like his former health center) but he feared that in unstructured situations

like the DMH clinics, the services could easily "get pushed from a reasonable level of professionalism to simply outreach." The rate also covered the services of residents and interns with which Knight disagreed since he felt it was "second class care". The rate actually agreed upon was a high one, $30/visit, allowing all these para-professional and trainee services to be hired but designed so that the clinics could be prodded to tighten up their medical accountability (the internal control was to be that all services must be under the direct supervision of the physician) and their financial management.

By this time Knight had a full-time staff person, L.A., working on mental health (where no one had been previously) and she was able to negotiate the rate through the Rate Setting Commission (RSC). She had a social work background and no specific mental health background, but learned quickly during the negotiations with the clinics as she and Knight developed a shared understanding of the key principles involved. Knight began to place more responsibility in her hands ("she thinks very logically") and this negotiation of the rate was her first solo effort in the area. The high rate was questioned by the Rate Setting Commission but L.A. relied on the support of the chairman of RSC, with whom the division had good relations, to push the rate through. The clinics again requested that occupational therapists and rehabilitation workers be included in the comprehensive rate determination but, upon the division's advice, the RSC denied this. They did however set a separate rate for para-professional visits against the division's wishes but the division simply refused to purchase this particular service even though a rate had been set. But these aides were only at a bachelors level and Knight felt strongly about such "dilution" of quality.

Knight's initially strong position on the mental health area was thus negotiated to a successful initial compromise. He felt he had stressed the role of accountable, well trained providers and then began to rely on his staff to carry out the program - ("He doesn't like to get his hands that dirty" - L.A.). But here the staff was to influence him and the program in a significant manner. L.A. had just had a young man (L.E.) added to her staff who had had some experience in community development work and in a state public health hospital. When the problem was now specifically in their hands, they began to explore with detail how the accountability could be secured (i.e. monitored) and how they might get Knight to accept some of their "newer" views of mental health such as the role of non-physicians. While they did not ignore the guidelines established by the task force in any way, they continually discussed with Knight these and other topics such as "problem-oriented records", which had been suggested by the division's two consultants, his brother-in-law and a psychiatrist (D.M.) at Knight's former health center. Knight had great faith in the two consultants and began to leave the medical decisions to D.M., while the staff, sensing this strong personal relationship, worked through him to get their views across to Knight.

This relationship was apparent even to the clinics and to one official in DMH who said they were clearly aware that the consultant was by then the key person in the division. He shared the goals of Knight however and their relationship was mutually reinforcing. Knight was intrigued by the idea of problem oriented records in which, for each case, the clinics would submit a plan outlining what the patient's problem was

in functional terms, not psychiatric terms. That is, what could the patient not do that was causing his maladjustment in society. The record would also include a plan for treatment and progress notes as to how well the patient was meeting the goal. They discussed the idea of requiring these from each of the clinics along with considerable debate about the role of non-psychiatrists in mental health.

Both L.A. and her staff member, L.E., and D.M. felt that they had managed, over the course of the succeeding year to change Knight's view on the possible treatment forms offered by non-MDs. The clinics, of course, felt encouraged by the change and entered into discussions about the problem-oriented records with a more open attitude. Knight saw these records as a way to further increase medical accountability. He agreed with the HSA undersecretary, L.N., who, in expressing his hesitancy about the effect of problem-oriented records, said that "you don't improve management by imposing conditions", but felt that he had no other lever to do so other than the division's buying power.

Evidently both the clinics and DMH felt the effect of that lever since they agreed to the problem-oriented record system. Both the key member of the task force (Y.E.), and a DMH official said they did feel Medicaid power was significant and that they had "clout", and they respected Knight's attempt to understand the philosophies of the clinics. While this may appear strange at first glance, the clinics, long in a state of poor and "under management" were responsive to the first person making demands of them. They were a very decentralized physician-dominated organization and their responsiveness can only be explained by sheer "shock". They simply were not used to the idea of accountability but

when this vacuum was filled by Medicaid, they did respond. Knight also used this principle of "stepping into a vacuum" to advantage in the EPSDT case and in HMO and Day Care where other staff successfully filled similar vacuums.

Meanwhile, L.E. began the certification process. Each of the 50 clinics had to submit documents describing their operation and be inspected by the department. This inspection was informal as the department had arranged with DPH to conduct formal certification visits. During this process L.E. built up relations with each of the clinics and prepared them for the advent of the problem-oriented records. His style was deemed "difficult" to work with by Y.E., who also felt that "he does not know who to go to to to get things done" but the relationship was still one of general acceptability. L.E. felt that DMH personnel were "impossible to work with" but continued to work with the clinical (medical) directors of each clinic, bypassing the executive directors. This apparently weakened the community input into the discussion since the board of the clinics reported to the executive director and not the medical director.

Given L.E.'s difficulty with DMH staff and his view of the importance of community development, this is at first glance inexplicable. But initially L.E.'s learning was internal - that is he was enjoying strong support from Knight and also felt he had benefitted by his relationship with D.M. who made him realize that his former community development work was quite parallel to and indeed was "community mental health". He also felt that he had learned from Knight that his former "ideologically pure" view of publicly run centers was a red herring in that the public/

private question was really one of "do the clinic staff have the right values, the commitment and the managerial and medical ability." More importantly, he felt that "we can get something for our resources." Thus the division was a buyer, one with clout. L.E.'s aggressive and heavy handed approach to the clinics may have been an over-reaction to this newly declared power and probably accounted for his "difficulty" in working with the clinics.

After the certification process was completed, attention shifted to the problem-oriented records. Knight felt that these would be a great step forward and urged their progress. L.E. and D.M. worked with several of the clinics and developed an understanding of the requirements. They also instituted a regulation that all visits after 10 per year must have the prior approval of the division in addition to submission of the regular treatment plans. Knight felt that what the division was doing was "getting itself into a position where we can set criteria for what services the clinics provide." The clinics for their part did not completely understand the position they were being maneuvered into and felt it would be easy to "fake the record", i.e., provide what DPW wanted to hear.

L.A. feared this also, but other staff officials at DMH and Y.E. and D.M. agreed that the simple fact of preparing such a record would change the attitude and performance of the clinicians. The act of making one's tasks explicit would be a great step forward in the mental health area, long characterized by a closed-system, dependency relationship between patient and clinician. The rejection rate of records submitted for D.M. to review was low. The only problem appeared to be that DMH

clinicians were also operating with their own parallel record system and that the existence of the two was confusing.

The experiment with the rate formula however was soon to create another problem. After a period of several months it became clear that not all the clinics were actively billing for Medicaid clients. Some of them were suburban clinics who were relatively well managed but who had few welfare clients. Others, it turned out, felt that the administrative work required to complete the complex billing requirements was not worth the $3.25/visit the clinics were allowed to keep before rebating the fee to the state treasury. This new billing requirement had also come on the heels of additional federal record-keeping requirements on the clinics which had been "a fiasco" and had left them "battered".

Despite the fact that all had agreed initially that the fee was adequate, this seemed to confirm Knight's convictions - that the clinics were poorly managed and had little idea of what it cost them to do anything. But the clinics could not prove they were losing money at this fee, they just "felt it". A staff member from the state budget agency (Administration and Finance) toured the facilities and discovered to his amazement how small (and consequently undermanaged) many of the facilities were. He returned to argue with the secretary and under-secretary that the rebate should be 50% not 87 1/2%. Knight actively opposed this, and the association of clinics, later admitting that they should have tried to convince Knight himself, lobbied directly with the cabinet secretary. But they "put their eggs in the wrong basket" according to Y.E. and the decision was made not to change the formula.

The A&F staffer then became a member of an advocacy group working with the clinics and continued to push Knight for a better deal on the rebate. But Knight felt that DMH should have forced the clinics to bill Medicaid for the state to get the federal financial participation (which was a greater net gain to the state than any "loss" the clinics might suffer by billing Medicaid). Knight also felt there was no reason why most of them could not handle the paperwork for less than the 12 1/2% and saw this as a chance to force better management on them. DMH agreed but their control over the centers was so loose that they did not appear to envisage any action in the short-run, although the DMH commissioner had a budget-review team inspecting all the centers as part of an overall program.

Discussion with the clinics continued on other grounds such as the possibility of not billing for trainee professionals and the possibility of having more part-time employees. But Knight took a hard line on these questions, particularly since he felt that trainees were a second class form of service. This was in line with his overall principle that if it is impossible to evaluate care absolutely, one can at least be certain that it is as good as what middle-class people get, i.e. the fully trained professionals. L.E. also revised the conditions of participation somewhat to conform to the agreements worked out (although a major revision would be necessary soon - said both he and L.A. - to reflect the actual practice demanded of the clinics) and worked the guidelines through the DPW bureaucracy so that they appeared in all the field offices' policy manuals. D.M. felt that still more work needed to be done with the clinics on such matters as peer review, but felt that

that could be slowly "folded into" the requirements. Attention was then turned to mental health services in comprehensive neighborhood health centers (NHC's).

Here the team moved ahead much more rapidly. R.T., the NHC director, began to participate and he stated that "the process was easy. We used the guidelines and the rates developed in the free standing clinics." The NHC's appeared to be slightly better managed and the idea of comprehensive care appealed to Knight much more, particularly since he received, in a moment of candor from Y.E., the admission that the free standing clinics often did discriminate against Medicaid clients. But L.E. and D.M. felt that their continuing conversations with Knight had educated him to accept the role of non-psychiatrists in mental health. Indeed the discussion with the NHC's, for example, centered not on whether psychologists would be permitted to bill for services, but what their qualifications need be to do so. Finally, after the conditions of participation for NHC's were inserted in the policy manual, L.E. moved on to develop similar conditions for hospital out-patient departments and family service agencies. He was buoyed by Knight's statements that "after sanctions, getting mental health (and its abuses) straightened out is our next priority."

Given that Knight deliberately chose to place resources in the mental health area without any strong pressure from outside, it is apparent that this decision was based on his overall philosophy. He perceived the mental health area to be one where services were of extremely varied quality and the opportunity to get "ripped off" was high. Not only could he improve quality but there was a chance to exercise the responsibility

he wanted to achieve - the mental health field was decentralized, lacking in direction and poorly managed, thus Medicaid "might have some real clout here". It was clear that the clinics and DMH recognized the clout.

The success of the new program can, of course, not be completely evaluated. A new service was provided and with relatively little delay. The providers gained a respect for the program and seemed willing to work with the division on further refinements and to accept their lead in focusing on tightening up their procedures given a lack of leadership from DMH. The Medicaid staff easily transferred their learning to new areas of mental health and the division's perceived role as a responsible buyer was enhanced. The mental health field is one relatively insulated from other areas of medicine and effects in other cases in the division cannot be easily assessed although many of the principles developed in this case were used in other situations.

These principles have already been described in the case - for example, the principle of working in areas where federal financial participation could be increased or where a vacuum of responsibility existed. Similarly the principle of exerting effort only with well managed providers, unless such efforts might reasonably effect service patterns was developed here and applied elsewhere. And the principle of assuring medical accountability (in this case a psychiatrist) was stressed.

The teaching by Knight so evident in other areas appeared to be more mutual here. The staff learned most of these principles and about their increased buyer power while Knight himself broadened his view of the possibilities of the mental health field. Knight, as usual, carefully explained why he felt the clinics were poorly managed and why he wished

to stress medical accountability,yet was open to the teaching of his staff and consultant. He let the two staff members develop the program in their own styles (which were quite different from each other) and the three of them very clearly recognized that they had established a set of principles which could be used in other settings (i.e. they knew what they had learned).

All the features of the "program for action" described in the first case were evident here and a few more features were added. The division was first of all comparatively open to its environment in accepting that there was a problem to be dealt with. It assumed a moderately strong role position and adopted a fairly specific goal which could initially be focused on,i.e. develop an adequate reimbursement rate. As usual, Knight tried to conserve resources by first assuming that mental health services were analogous to regular medical services (i.e. the medical model later downgraded by his consultant and L.E.). The usual reliance on close friends for advice and the common teaching base with the larger provider element was also clearly in evidence here.

We also see here a feature not shown in the EPSDT case. That is, after the initial goal was established, a relatively slow but persistent search for a satisfactory (as opposed to "perfect") solution was instigated. Indeed the satisfactory solution was viewed as one which could be used elsewhere,thus turning a problem into an opportunity. This complex of behaviors became a quite common feature of the division's program and was clearly one of its strengths. That is, despite the very strong sense of mission and the assertion of the rightness of the division's perogatives and its principles, the combining of these into a <u>workable</u>

solution was usually carried out with considerable prudence and lack of arrogance - all of which helped to assure credibility with providers.

Knight's conscious management approach was most evident here in his insistence on sound management from the clinics and also in his feeling that the clinics must understand the division's position - that it was aiming for a program of high integrity. Knight's usual desire to have clear lines of authority was not so evident here as the team of D.M., L.A. and L.E. shared the responsibility with little supervision from Knight at all. It seems that this may be explained by the high degree of trust and confidence he placed in each of these three. But as usual, he did stress the important role that non-professionals should play in managing health care and the value of experimentation. Thus, not only did the clinics and DMH recognize the "clout" the division possessed, but they clearly respected the manner in which the division exercised it, both in the division's implicit program for action (e.g. using well qualified consultants), and in the way Knight consciously managed that program in the service of a goal-acting as a responsible buyer.

3. The 442 Program

This case involved the development of a new service by a group of outside state agencies who felt that Medicaid might make a financial impact on, or have program inputs to, their new service. Their estimate of the size of these inputs varied widely as did their interest in involving the division. The Medicaid staff made tentative forays into the program - trying to link it to an existing service, then dropping involvement when advised to by the assistant commissioner. He, keeping his overall strategy to himself, later swept in to defend his agency's perogatives and to

"assemble" a trusted group of allies to develop policy. Throughout this time,however, he continued to try to instill a sense of purpose in his staff, one of whom devoted little attention to and one of whom became quite involved in, the actual details of the program. Eventually a harmonious agreement as to the division's role in the program was reached while the other agencies continued to implement it and further refinements were made by one of the division's staff.

The "442 program" was a law (Chapter 442) passed in mid-1972 by the state legislature. It was intended to mandate that local school districts assure that the full range of regular educational programs be available for all children with physical, medical, emotional and developmental problems. The needs of all school-age children were to be determined through a "core evaluation" by a multi-specialty team who would also develop an educational program based as much as possible within the school system. The implementation of the law was to be primarily designed by the Office of Special Education (OSE) within the Executive Office of Education (EOE) although the Office of Children (OOC), a Governor's coordinating body, was assigned to coordinate interagency activity shortly after the 442 bill was passed. The OOC had not concerned itself with Medicaid and stated that if it had thought about Medicaid's role, it assumed it would be just like another bill payor, like Blue Cross. Thus no role was initially mandated for the Medicaid program or for any other third party payor.

Knowledge of the program first penetrated the Medical Division in late spring of 1973. N.L., who had been working on EPSDT, heard the program mentioned in a meeting with the Office of Children. She called the Special Education Office but was informed that no regulations had

been developed and that they could not yet define the program and were also not certain if Medicaid would have a role in it. She suggested that if some patients being "treated" were Medicaid recipients (as was likely, probably more than 15% of the total), then she would need to at least know the numbers of Medicaid clients involved so that they might be included in EPSDT statistics. At this point the OSE did indicate that they were worried about program duplication with Medicaid and double billing (one source of state funds paying another). The discussion ended there, however, with some later indication that OSE took a rather parochial view of the program and was not very interested in involving other agencies. N.L. then simply prepared a summary of the legislation which was transmitted by her senior (R.D.) to Knight who had just recently been appointed.

According to N.L., Knight read the material and "decided that Medicaid had no input", although he did not give his reasons for this decision to her. Knight himself could only vaguely recall having been presented with N.L.'s summary and felt that Medicaid would indeed have a role but that it would have been premature to jump into it at that time or to designate a person to work on it. In fact, Knight said he was quite interested in the 442 concept, but did not move immediately since he knew that eventually those in charge of the program would have to come to Medicaid, asking for its money. He did not discuss it with his staff since he "felt he knew more about pediatric care" than any of them and there was thus no need at that time to enlarge the scope of a problem which was not yet an issue. The question was again brought to Knight's attention in the early fall by one of the division's regional offices,

but he waited until early December to further precipitate some action. There is nothing to suggest that he concerned himself with the problem during this time.

This first series of events illustrates several features common to many of the cases in the stream. The division (N.L.) was quite open about initially learning about the program (another staff member also later went through the same process) but after this initial phase, a clear role definition was made - that the division should not get involved just yet since it was premature. Normally in such situations, Knight would actively try to influence program direction but here the initial complex mix of other agencies likely pointed him away from early involvement. He was generally loath to become involved in large committees such as the inter-agency task force here. In addition, since his recent arrival, he had concentrated on what he perceived to be more serious problems and issues. Another member of the staff indicated that he was probably relieved at that time to hear that other agencies were taking the lead. Knight also exhibited a feature evident in the EPSDT case, the clear definition of internal responsibility. Initially, he assigned it to himself and much later to his mental health director.

The mental health director, L.A., had been contacted in August by a representative of the Office of Children who knew her personally and who had been working on writing regulations for the program. While he had previously seen no role for Medicaid he now asked if the division should be involved and invited L.A. to attend a few meetings concerning the drafting of the regulations. She went "as an individual", but said she was soon viewed as "representing Medicaid".

Finally, she suggested to the OOC that they contact Knight directly since she had been frustrated by "not seeing Don" on the problem. She had not been able to convince Knight that their involvement in the program was becoming an issue. Knight had been individually seeing a lot of the persons involved in the program development, but she felt that he did not really understand it. T.L. from the Office of Children contacted Knight to arrange a meeting and simultaneously the Executive Officer of Education contacted her to ask what would Medicaid's involvement be. The EOE had become concerned about Medicaid involvement since they had had a ruling from the governor's office that the schools, i.e., the Education Division, must pay for all treatment necessary for a child's education (which could include medical treatment), and that all possible sources of third party payment be solicited to lower costs. This proposal was later dropped, but the idea of billing Medicaid for the core evaluations remained. She suggested a combined meeting of the OOC and the EOE with Medicaid although Knight later recalled that he called the meeting together.

In any event the meeting was held, significantly without the Office of Special Education - the office that would likely have to implement the program. At the meeting Knight "told them that sooner or later you'll have to come to us for money". L.A. felt that Knight had given a "This is the Medicaid program and aren't we marvelous" type of presentation at the meeting without really realizing the impact of 442 and the potential involvement of the division. The OCC representative (T.L.) resented the fact that Knight was also suggesting that the EPSDT program be used as a substitute for, and "valve" for, referrals to the school system. T.L.

felt the two were being confused and resisted Medicaid's attempt to dictate program content. L.A. also later sensed that Knight did not want to become involved in any large committee meetings to discuss the development of the service.

Knight's right hand man, R.K., had also attended this meeting and felt that the others did not understand the program or did not see that they were headed towards a separate system of care based in the schools, a separation which would only be bad, in his view. Within that context however, he stressed that the neighborhood health centers be used to conduct evaluations, thus paralleling Knight's attempt to "squeeze" the 442 program into another format. But he remained quiet since Knight had voiced the opinion that Medicaid should not get involved and that it was beyond his (R.K.'s) and the division's control anyway.

Thus three key principles were highlighted here which were stressed throughout this case and used occasionally in other situations. Firstly, there was the attempt to link one program to another or to meld one into another; there was the belief that as much as possible, the existing school medical system should be avoided for it provided only sporadic, low level care (Knight wanted the best available for Medicaid clients) and finally that if the potential new service being examined was not too big, then the division should wait for the other actors to approach Medicaid. While the reasons for such principles were explained to L.A., they were advanced as being more or less self-evident.

At this time the program was seen by the other agencies as being centered on a "core evaluation" whose major inputs were to be psychological, social and educational. The medical component was still seen as being a minor component although the OOC and the EOE were anxious to get other agencies such as Medicaid to commit as much resources as possible for the evaluations. The local school districts were in favor of the program but feared that any state reimbursement for a program they would have to provide would come only after the completion of the fiscal year thus presenting them with cash flow problems. Similarly they wished to keep overall costs down and, backed by the Department of Education, did not clearly see the medical component as important. (Knight -- "the education people wanted to keep the M.D.'s out of the program.")

At this point, OSE staff began to feel they might not be able to use Medicaid money for the program and began to discuss the possibility with Knight. He had indicated that a "layer cake" approach should be used; i.e., that third party insurance should be used for the program with private insurance, Medicaid and then local school district money being used in that order of priority. He saw no problem in using Medicaid money and the only problem was how to identify the Medicaid population at risk without violating confidentiality regulations.

L.A. and N.L. began to work with personnel from the Human Services Agency (HSA) during which time the question of whether the 50% federal share of Medicaid money could be committed to a program which had a very loosely defined medical component and which so overlapped the other educational and psychological components. HSA had a strategy of using Medicaid dollars whenever possible (even to the point of keeping

children in institutions if the federal share was greater, complained the Education Dept. official). Thus, a lawyer from HSA assigned to the Office of Children began to deal directly with the question of federal participation in the use of Medicaid dollars for 442. Knight and the HSA secretary had meanwhile decided on a strategy of simply submitting the 442 bills through the federal apparatus and seeing what happened.

But the HSA lawyer began to act as though Medicaid money was completely committed and would also be accepted by the federal government. Knight had heard of this attempt to commit "our money", was angered and, after clearing the matter with the Secretary, requested a meeting with the federal regional office to clarify the use of Medicaid dollars. Clearance was received with the proviso that Medicaid money not be used for services provided in the school or not selected freely by the recipient. Knight thus achieved his goal of keeping the program out of the school physician's hands. The federal regional office informally concurred since it trusted Knight and his handling of the program and felt that 442 concept would likely be included in a national health insurance program which then appeared imminent.

The regulations appeared in January and, much to the consternation of L.A., the division had not been involved in their drafting despite the continuing talk about a possible use of Medicaid dollars. The other agencies had not seen fit to deeply involve Medicaid either. The Office of Children staff member, in particular, saw the division as a "quick, sharp, insurance program", a view he said he inherited from working with the HSA secretary. In addition he saw the division being filled up with

"social service" types and he didn't want to be responsible for "unravelling" any turmoil the Division might create.

L.A. felt that Knight had not wanted to get involved in the drafting of the regulations since, in general, "he thinks that regulations don't have much effect", although he says he jumped in "head over heels" only to later pull back and leave the task to L.A. Knight often used this approach of involving himself early on to set the direction for the agency but in this case, it seemed that L.A. perceived this as only establishing "turf". He ignored the rule making process, feeling that regulations could usually be bent to serve the agency's purposes. And then he assigned full responsibility to his staff who, while not losing their confidence, did feel that more of Knight's involvement was needed. Knight, however, was in general willing to "let the staff make mistakes as long as we get where we want to go" and he had a strong faith in L.A.'s capacity. It was not until later when his enthusiasm was rekindled that his accessibility to L.A. on the issue increased and she began to trust his judgement about the importance of the whole program.

About mid-February a call from a member of the capital city's school committee had triggered off the idea in Knight's mind of using one of the neighborhood health centers as a place where the concept of a "core evaluation" could be tested. He began to develop enthusiasm for the content of the 442 program, stating that a child's malfunctions at school could be due to a variety of reasons, including medical ones, and that their "solution" might equally validly be part medical. He concentrated on the evaluation part of the program, a concentration which appeared to bother L.A. since she felt he was ignorning later diagnostic

and treatment components. The OOC also was ignoring these aspects although they later stated that they had not stressed medical treatment since the schools could never afford to get into such heavy-cost programs.

Knight's use of one health center (the one he had founded in his earlier career) indicated a kind of "tunnel vision" to N.L. and to L.A., who felt that the center was atypical. Similarly, the OCC staff did not believe that many Medicaid recipients lacked a family physician for the core team thus necessitating a health center to perform that role. It was justified by Knight as being an experiment with a well-managed group he could trust (thus keeping it out of incompetent school doctor's hands). He felt he needed to "institutionalize" the most complex part first, after which he would concentrate on the treatment aspects. But again, these plans were not conveyed to N.L. or L.A. Nor was any explicit priority ever assigned to the program, although L.A. felt that Knight felt it was a good idea "because it was for kids and had a high pay-off."

During this time, Knight had contact with a member (E.B.) of the Department of Education who was later to move into the position of the head of OSE and to initiate a more aggressive OSE role. E.B. stated that Medicaid never seemed to have a clear philosophical direction but that since they shared his humane concerns, he assumed their strategies would agree. Knight concurred on this although they never really discussed any detailed strategy. Medicaid provided "crisis relief" for E.B. in a time when he was under great pressure to implement the program, and he felt that Medicaid "must have made it a high priority" since the division was always "creatively involved" in their meetings.

But no one in the division had ever really calculated how large a piece of the total picture they would be nor had anyone in the other agencies. Around July, a series of "back of an envelope" calculations were agreed upon by the various agencies which suggested that the division had about 13% of all eligible children state-wide, 20% in urban centers and 50% in the capital city. However, a realization that Medicaid money might be used to pay for the special needs of institutionalized children in the 442 program was always an unspoken factor. The amount of Medicaid money potentially involved here was much larger than the "ambulatory money" but the two components always seemed to be separated in discussions. However the realization that the division would have financial "clout" in this adjacent area likely influenced the agencies' sense of priorities, that is, of granting Medicaid a large voice.

A few months later, following a period of little activity within the division (L.A. continued to meet "with other agencies, which took up too much of my time"), an impromptu lunch was held during which several Medicaid staff and Knight discussed the program. R.K. discussed the need to involve the whole family in the core evaluation and the need to have a team doing the evaluation. It was agreed that Medicaid could pay for three-quarters of the team members involved in such core evaluations. Yet two problems remained. L.A. and R.K. continued to feel the link between evaluation and later treatment by the schools was being ignored. L.A. felt this since she saw little medical component in the treatment plan. Knight seized on the idea of establishing the linkages but did not appear to follow it up at that meeting although later a friend of Knight's did begin to develop a form for school districts to

use to assure adequate medical follow-up. R.K. also seized upon this potential problem. Neither realized at that time that a liaison for each school district had been appointed to assure follow up. L.A. also felt that the definition of what was a core evaluation was thrust aside. When she tried to ask Knight for consultant resources to define a core evaluation, he said, in essence "come to me and I'll tell you". (L.A.)

Thus Knight was seen as initially ignoring or giving a once-over to some of the elements of the problem (their share of the "market", the regulations, the treatment aspects) which he later returned to upon urging by the staff. This increased involvement coupled with the health center experiment led him to frequently proclaim to the staff that he "hadn't realized what a big thing 442 was" and how pleased he was that the division was now making "real progress" on the issue.

R.K., however, continued to have doubts about the program since he had assumed that all children in the school system, not only referred ones, were to be evaluated and thus felt that the program had serious faults (i.e., lack of coordination and a stress on testing, not evaluation and treatment). He was about to write a letter to the HSA secretary when L.A. alerted him to the incorrectness of the first assumption. He was annoyed since no one had told him that only referred persons would be evaluated despite the fact that he had participated in several meetings on the program. Despite his unfamiliarity with the program, he appeared to have learned from the EPSDT program and a second pediatric program ("TAP") that mass screening was inefficient and adequate follow-up must be assured and thus "pushed his ideas for the program although he was not a major participant. But his involvement here led him to contact

the staff he had been involved with on the "TAP" program to stress that the guidelines developed for the 442 core evaluation were the kind of guidelines needed for TAP. The TAP personnel eventually began to use 442 guidelines for their evaluation of children destined for group care residential programs.

The experiment at Knight's old health center produced cost data for the core evaluation which indicated a rate of over $300. Thus Knight, through using this trusted ally, was able to develop a rate which he felt was fair. Other providers who were, in the development of other new services, usually brought into the process quite early, were kept on the outside for some time. L.A. was then able to negotiate through the RSC this favorable rate which would encourage providers to offer the complete evaluation. She then signed a contract with the center and continued to develop contracts with other health centers for the core evaluations. The professional associations were then contacted and informed of the need to develop further teams of evaluators.

L.A.'s insistence that the treatment aspects were equally important eventually bore fruit as Knight and she began to discuss with the Education Department just how the costs of such treatment could be shared. Medicaid regional staff were also assigned to coordinate the division's 442 activity in their areas. The actual progress, however, of the total Education-administered 442 program remained somewhat slow and chaotic as the hundreds of local school districts sorted out the deluge of new responsibilities and money in the fall of 1974. Nonetheless the division had succeeded in responding to the new initiative by outsiders. It had developed a policy and had begun to apply it, being restrained only by the fact that they did not administer the total program.

The overall pattern of action displayed by the division in this case is similar to that of the other new services' development cases in this stream save for the longer period of waiting before any initial action was taken and the relative guardedness with which Knight explored the new knowledge with his staff. The hesitation can probably be best explained by the newness of Knight to the division and the lack of any outside pressure on him to develop a 442 program. L.A. did assert, however, that "it was our fault too, not only Don's hesitancy and lack of knowledge. N.L. and I could have bitten the bullet sooner".

These features (hesitancy and guardedness) somewhat dulled the rich exposition and discovery of general operating principles through Knight's teaching. The idea of linking 442 to another program (EPSDT) proved to be an impractical vehicle. The principle of letting the other agencies come to Medicaid if their program was small was reversed when the other agencies began to "commit" Medicaid's resources. Only one other principle was developed here, that of giving as little responsibility as possible to school medical programs. Nonetheless some principles developed in earlier cases were invoked here, for example, that a "sweet" fee be used to encourage providers, that federal financial participation should be increased, or that programs for children had a high pay off. As usual though, Knight did place considerable confidence in his staff, both anticipating their qualities and generally being non-critical of the way L.A. carried out her tasks. He even backed down eventually and acceeded to L.A.'s insistence that treatment aspects of the program be considered. But these qualities, along with his willingness to experiment were the only visible aspects of his generally well elaborated teaching strategy.

The internal management of the case seemed to bear little on its outcome although several of the usual features of Knight's management approach were in evidence, e.g. the clear delegation of authority, the unwillingness to get involved with large "task forces" and his eventual open door policy with L.A. (and with all the other staff). Knight had not had the chance to convince many of the 442 actors outside the division that he was running a sound program since most of them were other bureaucrats and not providers. Thus he had to stake his claim for program integrity fairly directly and harshly with the HSA secretary. Later, however, some of the education officials, including the key person responsible, developed an appreciation of both Knight's and L.A.'s philosophies and L.A.'s thoroughness and management competence in following through. Thus, more than anything, the role that L.A. played enabled the division to produce a "product" accepted by all - a workable operating policy.

The carrier of the responsible buyer paradigm in this case was also primarily L.A. Knight did address himself to the responsibility aspect of that paradigm by staking out the division's turf, but it was L.A. who then "recovered" that turf to make certain it was not being "trespassed" upon. And it was she who stressed the purchase of quality services more than Knight and even enlarged the definition of quality. These events took place shortly after the free standing mental health clinic case and it must be surmised that she learned considerably from that exercise. Indeed a separate story tracing L.A.'s development would be informative since she alone of all the staff members had to develop several new services over the course of two years. But if the concept of

organizational learning is to be examined thoroughly, the performance of the division in other new service areas must be considered.

4. The HMO Program

Health maintenance organizations (HMO's) were a radical idea for the delivery of health care which had nonetheless been put into practice in a few isolated situations since the 30's. The idea received considerably increased attention in the medical community at the beginning of the 70's and an additional giant boost from the federal government in 1974. Despite the support of the more liberal sectors of the medical community, it received staunch opposition from others.

This case involves an early political decision by Knight's predecessor that the HMO idea be tried on a limited basis. Upon Knight's arrival he threatened to cancel the one HMO project the department had entered into, but hesitated since the HSA undersecretary was very much in favor of the idea. He delayed the renewal of the contract while attempting to acquire more resources from the department and HSA to manage the program. Finally, he found someone on his staff to whom he could delegate responsibility for developing the HMO program - which he did, "cleaning it up" to the satisfaction of both Knight and the HSA official.

The latter also wished to use Medicaid money as a key lever in initiating several additional HMO's. This strategy was finally found wanting since Medicaid's money was not sufficiently concentrated as it was in other areas such as the nursing home industry where over 80% of the industry was Medicaid supported. However, in attempting this strategy, the staff member grew quite knowledgeable in the field and became influential in offering both strategic and technical advice to both developing

HMO's and other state officials. Knight was pleased with his performance and, though the program was small in dollar terms, he cited the division's "HMO program" to HSA and the public as examples of program innovation.

Thus Knight and his staff did eventually develop a strategy to deal with the HMO area to their satisfaction - although the strategy was not as aggressive as two or three other states' nor were the boundaries established by the strategy as far reaching as the HSA undersecretary would have desired. But Knight felt that he had done the right thing - indeed all that the division could do. The program then had some "integrity" and yet did not impinge on other program areas where Knight wished to concentrate. Only the assignment of considerable staff time for such a small area might be questioned.

A contract had been signed in 1971 between the Department and the one HMO then existing in the state. The HMO had pushed the idea since it believed it could deliver quality care at a low cost to a low income group. It hoped to do this through the use of a prepaid mechanism in which the buyer (DPW) paid a monthly charge for all costs - irregardless of actual services delivered. The HMO would operate on a fixed budget, thus providing an incentive to keep costs within that limit - something regular physicians and hospitals did not face since they knew that third party carriers, not the client, would pay all costs. It was the strict application of financial accountability to medicine. As for the quality aspect, it was hoped that the HMO, through both its closed panel and its group practice features could assure better care. The financial incentive would also force the HMO to stress preventative care, i.e., they would be paid for keeping people well, not sick.

This particular HMO, backed and staffed by the liberal elements of a medical school, also wished to demonstrate its commitment to medicine for the poor. Thus Medicaid clients in the HMO would be indistinguishable from middle class clients. They also agreed to set up an outreach station in a ghetto area near their main facility to assure welfare clients' access, one of the division's main concerns in addition to quality and cost. The division, ravaged by the increasing costs of the Medicaid program, and also desirous of promoting innovative care, first signed a contract with the HMO in 1971. The commissioner of the department while willing to experiment, also stated that strong pressures had been brought on the department to sign the contract. Enrollment in the HMO was to be voluntary and within two years some 2,800 persons had enrolled in the one ghetto area near the HMO facility.

Out of the very small medical staff of under 15, some two people were assigned (part time) to work on managing the contract. The whole HMO concept was a 180 degree turnabout from the conventional fee for service sector thus necessitating adaptations to the division's billing system and reporting requirements and also involving the division directly in the marketing of the HMO to welfare clients. However, both the two staff members had a somewhat analytical, even academic, style and were keenly interested in attempting to prove whether the HMO idea did deliver better care at less cost to welfare clients. Thus little attention was paid to the management of the loose ends of the contract, nor was a routine system for bill processing or reporting built up. The idea proceeded backed by the faith of the two staff members and the willingness of the HMO (since the department was initially one of its larger client groups -

some 15-20%). The two staff members' operating goal was to at least assure that as many clients as wished could enroll and that the HMO was paid in some coherent fashion.

The idea of HMO's spread slowly through the rest of the country and by 1973 there were over 100 in existence with one large California operation having several branches and over 2 million members. The moderate success in California had led the Reagan government to adopt a vigorous policy of enrolling Medicaid clients in HMO's. Many sprang up just for this purpose; but by late 1973, allegations of misuse of funds, pressurized marketing techniques and non-delivery of services had racked the California program. The state bureaucracy was just beginning to sort out the chaos it had plunged itself into and other Medicaid agencies were naturally leery of getting too deeply involved in HMO's.

Thus, Knight arrived to a background of continuing ideological support for the idea, but with little hard evidence of its success. The one largest experiment (California) had probably failed, although much had been learned. The division's contract with the HMO was up for renewal in the summer of 1973 shortly after his arrival. The program was then being handled by the assistant director for ambulatory care, R.D., with whom Knight was to have so much difficulty in the EPSDT and sanction cases. That recent change in personnel had not helped the management of the HMO program, since R.D. took considerable time in familiarizing himself with it. He said that he "did a few academic things, a few one-time surveys of the HMO's activities and began to think how they might control the program."

Knight arrived four months later and familiarized himself with the contract negotiations. He believed that the fee-for-service sector, for all its faults (incentives to overtreat) at least did not contain the HMO capitation incentive to undertreat. He was also disturbed by the fact that the HMO might be getting paid for persons it did not treat even though they were enrolled (although in this sense the HMO, while basically a delivery mechanism, had insurance aspects, i.e., the provider assumed a risk and was paid for that risk). But none of these fears could be confirmed or denied since adequate data on actual use within the HMO was lacking and since enrollees were free to use other parts of the city's medical system. This first attempt by Knight to "situate" the new service by comparing it to other services was easily made since HMO's were a complete reversal of the fee for service sector. And the principle of avoiding incentives to undertreat was carried from Knight's earlier experience that providers must be paid an adequate, but not more than adequate,fee.

Knight at first wished to cancel the contract, but then, after making this initial strong assumption of the division's perogatives, sensed pressure from HSA (and the commissioner of DPH) and decided on a few specific "holding" strategies. He would "tighten up" the contract such that a greater burden would be put on the HMO to see people even though no monitoring capacity was available and he would take the first step to set up a system to restrict enrollees to the HMO so evaluative data would be more meaningful.

A city agency's initiative involving a proposed HMO based on a second teaching hospital and neighborhood centers (NHC's) was also

one of the items Knight was forced to confront. He was as cool to this idea as he was to the one operational HMO. In addition, he felt that if these less efficiently run NHC's could participate in the HMO movement, why not do it with well-run centers, such as his former center. He gave little support to this proposal which gave some credence to the thought expressed by R.D. that Knight felt HMO's were a form of competition to the NHC's or that those poorly-run NHC's were simply trying to save themselves by latching onto this new gimmick. Later it was to develop that Knight's resistance to the idea was mainly on the grounds of prepayment, but it also seems clear that he doubted the extravagant claims being made for the operational PMO since he felt that he had built up one of the best ambulatory care settings in the city. However, the proposed HMO (HMO-2) died a slow natural death through lack of initiative from its own sponsor and the division did not have to contend with it.

Attention turned back to the operational HMO. Knight, upon reviewing the slight cost data available, inferred that while the HMO might have been at least beneficial for the department (i.e., the capitations paid roughly equalled the services provided), that did not mean that the HMO was run efficiently. Indeed it had a high per visit cost compared to some of the NHC's (although not all) but also offered the most comprehensive benefits of any of them. He did not push these economic comparisons since he knew the NHC's (his old grounds) would also not stand up to close scrutiny. He also began to feel, through talking with the HMO staff, that they were indeed competent and concerned managers and stressed this with his staff. Thus the second of his principles was demonstrated here,

that as much as possible the agency should try to work with well-managed providers. As we were to see so many other cases, the HMO staff's goals were similar to his and he trusted their competence. Thus he and R.D. concentrated on improving the contract's provisions rather than cancelling it.

R.D., at Knight's urging, began to set in motion the necessary control measures. But the Project Management Office (PMO), which was charged with the computer operation of the Department, was under extreme pressure, and without the necessary large pushes from Knight or R.D., they simply carried on with more urgent tasks. R.D. was not skilled in pushing for, or demanding, changes from PMO, nor had Knight found the "correct" relationship with PMO, which, during the preceeding year in the absence of an assistant commissioner, had been "running the division". In addition, R.D. had had his staff decimated by Knight (see EPSDT case) and was not relating well to him.

The two were under heavy pressure from the Human Services Agency. The undersecretary, L.N., had a young staff member who very much favored the HMO idea and who proposed that as many as possible be set up in the state. L.N. and the DPH commissioner also favored the idea. A team of consultants had prepared tentative HMO policy guidelines and reporting requirements for the undersecretary and, through the staffer's urging, were proposing that an "HMO generator unit" be established with continued staffing from the consultants. Knight, the undersecretary and DPH eventually reached a compromise goal -- they would try to develop four to six HMO's within the year. The state could offer no seed money, only

technical assistance through a device like the generator unit which would be financed at between $100-300,000. The next theme of discussion was therefore how to finance this unit and where to locate it. Since the HSA agency (and Knight) had hopes that the medical division could be used as an instrument to restructure the health system, they felt there was some logic in putting the unit in Medicaid; but others felt the HSA or DPH were appropriate places. The whole issue lagged when the young HSA staff member left his position in October.

In December, R.D. and the then assistant director for provider relations and sanctions, R.T., switched positions since Knight had concluded that R.D. was not overly interested in health care per se. R.T. was now to take over the negotiating with the HMO. By this time the old contract had been temporarily extended for three months. But Knight was not rushed since he knew the HMO wanted to work out an arrangement and he would not be upset if the contract had to be cancelled -- although the ghetto area served had few ambulatory clinics, it was surrounded by hospitals and their out-patient clinics.

At the end of the month, a new staff member (K.E.) had finished up a previous task and asked for new responsibilities. He had spent the previous few months working out of Knight's office (the "fly on the wall") and had earned his trust and displayed competence in his earlier task. Knight's style was to let people try problems which appealed to them, so K.E. suggested five areas (in order of priority) he would like to tackle. Since the contract negotiations were dragging on and since R.T. would have his hands full learning the other aspects of his new job, Knight suggested the two work together on K.E.'s third choice -- HMO's.

The two (R.T. and K.E.) first of all began to develop an enrollment procedure which would assure that both the HMO and DPW knew who was on the rolls and who not, from which they could determine precisely how large the client group was. No adequate system had been developed; indeed it was discovered much later that people who had left Medicaid were still being billed for by the HMO. At Knight's prodding, PMO began to work on producing a restriction on the clients' Medicaid card limiting them to services at that HMO- thus giving the cost containment goal of the HMO some teeth. The two staff began to familiarize themselves with elements of the HMO through the "entry route" of these administrative tasks.

A month or two later, the HMO began to feel the pinch of operating at the previous year's contract prices, and tried to reopen the negotiations. By this time K.E. had also dealt with another HMO (see below) and had gained confidence in the area. He took the principles written down by Knight and the HMO vice-president during an earlier negotiating session and reopened the negotiations himself. K.E. also felt that he had, while working out of Knight's office, absorbed some other key principles such as the non-discrimination against welfare clients, the possible misuse of services and most importantly, the importance of having an overall approach to a problem.

The HMO felt it should be judged at the (low) standard of other providers -- but Knight and particularly K.E., countered that no, they professed high goals for themselves, therefore they should be held to them. The negotiations centered around issues such as reimbursement of funds if services were not delivered, the proportion of nurse visits to

physician visits, the continued working of the enrollment system, etc. Other additions to the contract such as grievance procedures, subcontracts and data reporting were readily agreed to by both sides.

During this period while K.E. was negotiating the contract, he sought and attained help from several sources in addition to Knight who encouraged him to discuss the negotiations with him. The HMO itself was willing to help "educate" him, but more importantly, a proposed HMO (HMO-3) was then knocking on the division's door to sign a contract. Their newness and inexperience enabled K.E. to test out his ideas and wring concessions from HMO-3. He was then able to use these ideas with the operational HMO (HMO-1). Similarly, several conversations with a representative of Blue Cross who had also been negotiating with HMO-3 enabled him to build up a repetoire of strategies. He also occasionally turned to the chairman of the Rate Setting Commission for political advice on how to deal with HMO-1, since the chairman had previously been the governor's health advisor and knew the HMO-1 managers. While Knight usually turned to a group of trusted friends in discussing any new service, here no such group existed and K.E. was left to develop one.

The overall HSA group which had been discussing the state's role was slowly evolving into a "task force". Knight began attending its meetings less frequently when he saw that the level of activity was going to be low, i.e., that the HMO generator unit could probably not be financed and that it was unlikely the medical division would be "bagged" into signing contracts with HMO's it did not want to deal with (this had been one of his largest worries). And there appeared to be no outside forces which would lead to a flood of HMO's for quite some time --

the federal HMO bill with attached grant money had just been passed but its effects would not be felt for at least a year or two. Having gained control of the HMO-3 negotiations through K.E.'s activity, Knight could now rest assured that no severe additional problems would present themselves.

In the meantime K.E. had prepared a critique of the HMO generator concept and other materials as proposed by the HSA consultants. Both Knight and the undersecretary accepted this critique. Thus almost by default the key HMO role in the state began to fall to Medicaid as the "HMO generator." Knight and K.E. prepared an elaborate scheme justifying this role even though K.E. felt that its logical location was in HSA. But he, too, did not wish to be "bagged". He also felt that in addition there was inadequate competence (and staff) in the other agencies (DPH, RSC, and HSA) at the time, so felt comfortable assuming that role. The HSA tacitly accepted the proposal and Knight felt convinced that assuming authority in a vacuum situation was a sound operating principle (which was also stressed in the sanction stream and here in the free standing clinics and day care cases).

K.E. took the material (guidelines and reporting requirements) prepared by the consultants and began to adopt them to DPW usage, and also tested them with a committee of providers he formed for the purpose. Blue Cross and Blue Shield were also contacted, but their interest in quality of care (and thus an elaborate set of guidelines and non-financial reporting requirements) was not high. So he worked with the committee and HMO-1 on the guidelines and reporting requirements. The committee felt that Medicaid might not be able to impose such strict requirements. K.E.

realized his "clout" was not high in all HMO territories and was even decreasing with HMO-1 (as Medicaid's proportional enrollment decreased), but he still felt that some HMO's would be anxious to satisfy Medicaid's needs as they commenced operations. The HSA still thought Medicaid's financial power was strong and permitted it to play the "generator" role.

Finally in April a contract was signed with HMO-1 some six months after the other had expired. The only significant concession the division made was in the reimbursement formula, but the conditions under which it might apply were somewhat problematic, therefore, the concession was a "philosophical" one only. Included in the new capitation rate was a person paid by the HMO but who would report to DPW. She would act as an overall monitor of the HMO's activity, and also help to straighten out the billing and enrollment problems. The person hired had extensive experience in the computer and social service fields and was ideal for the job. The salary offered was low, but her need for a career shift and the appealing atmosphere of the division convinced her. Thus Knight was able to bring on staff without changing his overall budget.

She took over the control aspects of the program and began to work with the PMO and the local welfare offices while K.E. turned his attention to the guidelines and reporting requirements and to an HMO enabling bill which was being developed for legislative action. The chairman of the RSC had been working with an HSA lawyer and the proposer of the bill (the Legislative Minority Leader) in trying to develop a bill acceptable both to the Legislature and the administration. K.E. and Knight began

to participate in these discussions held at the task force, but the discussion process soon slowed down as the RSC chairman was not anxious at that stage to involve too many others, including K.E. since he felt that in order to get the bill through the Legislature that session, political skills, not technical ones, were needed. He had had experience dealing with the Legislative Minority Leader, and Knight and K.E. could only have participated at the margin. They acceeded to his posture since they were not "unhappy" with the bill as it was proposed.

The HSA undersecretary (L.N.) felt that the HMO-1 contract had been rushed into. Upon further questioning he said that he felt only that he had not been kept enough informed of Medicaid's actions. Knight and K.E. did try, however, to keep him informed, particularly since Knight did not want him to think the division was acting in a "buccaneer" fashion. But L.N. had only a small staff and was extremely busy, therefore could not keep totally abreast of the division's action. L.N.'s assistant, who served as the link between him and K.E., asked to be kept informed on the guideline development, negotiations with HMO-3 and negotiations with a new HMO (-4) which had appeared on the scene. K.E., while informing HSA, made a practice of doing so only for major policy issues, since he felt that HSA moved slowly and was often not completely knowledgeable on the issues.

HMO-3 activity had slowed down due to its own internal problems. The several negotiating sessions and site visits K.E. had made were thus "put on ice" after July, although he kept prodding them for progress reports. HMO-4 went through a similar process and it became more clear that Medicaid's purchasing power was not always as strong as it wished. In these latter

two cases, federal grant money and Blue cross sponsorship were really the key determinants of success. But some situations in which Medicaid could test its perceived role as a strong purchaser or buyer did arise nevertheless.

An out-of-state businessman appeared one day with a proposal to link the city's neighborhood health centers into an HMO network with his firm managing the whole situation. He sought the blessing of the division via a signed contract which he would use to then "enlist" the NHC's participation. Knight was very skeptical since he doubted the ability of the group to inject good medical and financial management into the NHC's. But K.E. suggested they first enlist the NHC's, then come to talk to the division. His strategy was adopted. The profiteering HMO's in California had scared everyone and caution, particularly with for-profit HMO's, was uppermost in their minds.

Similarly, the NHC's themselves wanted to form a "network" HMO, but Knight told K.E. not to spend much time with them since the payoff was low -- i.e., the NHC's needed first of all to improve their own management before they could run an HMO network. K.E. felt that the HMO device might be used for just such a purposes, but Knight disagreed strongly such that K.E. took his advice and did not actively pursue talks with the centers.

Finally, a large in-city hospital had proposed am HMO (HMO-2). K.E. had several negotiating sessions with the hospital but Knight finally "axed" the proposal by suggesting that the hospital was very poorly run. K.E. had also felt that concerted agreement among the hospital's administrators was needed to develop an HMO and this agreement did not exist.

Although the proposal was eloquent on paper, neither Knight nor L.N. at HSA felt upset at aborting an opportunity to develop such an in-city HMO which would have at least 30-40% Medicaid enrollment.

By then Knight had begun to whittle down his own resistance to the HMO principle by suggesting that what was really needed was a system which would pay fee-for-service for ambulatory care (which was inexpensive and which he wished to encourage) and capitation for hospital care (expensive and often unnecessary). But no providers seemed about to take this half-way approach, particularly since the recently-passed federal act would not permit providers to receive grant money under such an arrangement. K.E., for his part, felt that since the prepaid concept was indeed that, a concept, one involving limiting service to a single provider, preventative care, the heavy use of paraprofessionals, etc., it was difficult for middle-class clients to adjust to and even more so -- perhaps to the point of inappropriateness -- for welfare clients. Thus both of them believed themselves justified in adopting a cautious stance towards any new HMO's although both agreed that the principles of comprehensive care with stress on the ambulatory side were sound principles to follow. They would however wait for the right situation before actively pursuing one and "do what was necessary" (Knight) with those other HMO's who presented themselves.

Meanwhile the HMO-1 monitor who had been hired carried out some of the administrative changes that Knight and K.E. thought were required. Where necessary, department policy was even bent to enable the chaos uncovered to be dispensed with. For example, a bill

over six months old was paid, contrary to DPW policy, since it appeared the department had lost it. Also, for those persons who had terminated welfare but who were still being billed for, the division decided, after much examination to pay these old bills. K.E. felt that the DPW had never developed a system of routinely handling such terminations and it was thus its responsibility, not the HMO's to absorb these bills. K.E. also experimented with turning many of the disenrollment functions over to the local welfare offices, but found to his amazement that the local offices could not be relied upon. Knight had long before realized this and upon his urging, K.E. transferred them back to the Central Office (but to the central computer, not to K.E. himself). He was able to get the changes through the PMO through the tact and persistence of his assistant and since he was a friend of the PMO staff.

Both K.E. and PMO sensed that perhaps excessive energy was being devoted to such a small program, but Knight did not appear worried. Other small programs also had large staff assignments whereas hospitals, comprising 1/3 of the division's budget had only two staff members. Knight seemed to feel that he had to "live with" the HMO-1 contract and also show some performance for L.N. at the HSA - that Medicaid was making a commitment to HMO's and was acting responsibly. It was also clear to him that experimental or new programs always required inordinate amounts of initial resources.

The HMO-1 monitor finally managed over the course of a year to install some of the needed management controls so that by late December the HMO-1 contract was "in good shape" (Knight). The

experience gained in this endeavor would be useful if other HMO's developed. But over the summer none had Instead, several groups proposed HMO's and sought the new federal grant money for planning activities. K.E. and others at the HSA sought access to the federal proposal review process and thus opened up a channel of information for them. These prospective HMO's at the time were not concerned about the state role. But they knew that a state enabling act was in process and they were curious about its development.

The HSA task force had evolved into a formal committee; its main task during the summer and fall was to redraft the enabling bill without the haste of the previous efforts. Knight encouraged K.E.'s participation since he wished to protect the division's own interests but also to ensure a healthy but cautious climate for HMO's. K.E. actively helped in the drafting and other members of the task force slowly became educated to the issues, many of which K.E. had experienced in managing the HMO-1 contract. At this point, K.E.'s pre-eminent position began to slip away as his knowledge diffused among the other state agencies who were gaining experience. Providers still occasionally came to K.E. first because they had "heard he was one of the most knowledgeable people in the state government on HMO's." K.E.'s last major step as the state's "HMO generator" was to convene a meeting in September of all interested HMO groups (some 25) in the state -- to explain Medicaid policy, its guidelines and reporting requirements. Knight saw this as the final attempt the division would make. They had a policy and a package of regulations. Now it was up to providers to make overtures and initiate operations.

K.E.'s activities thus slowed down somewhat, although HMO-4 took several weeks of his time in just familiarizing them with Medicaid's policy regulations. Most new HMO's were simply not aware of the time required for development. HMO-4 also needed to await a signing of a contract with Blue Cross before they could become operational. So K.E. redirected his efforts to HMO-1. HMO-1 had a federal grant which would study the very issues Knight had earlier concerned himself with -- a comparison of fee-for-service sector utilization and costs with HMO utilization and costs for both Medicaid and middle class users. K.E. cooperated in the retrieval of data for this study and also in a national HEW study designed to interview HMO members concerning their satisfaction. Knight felt that these two studies would finally answer the questions he was asking and so backed them both. The latter study involved quite intense community resistance to the interviewing program. Knight, normally quite attuned to community responses, nonetheless backed K.E. in his explanations to community groups of the need for the studies since both felt the division was acting in the most responsible manner in promoting the use of such evaluative data.

K.E. also renegotiated a second HMO-1 contract, this time with considerable ease since the basic issues were well understood. He even turned that contract into a "model contract" usable for other situations. The second HMO-1 contract was the culmination of contract negotiations with the four other proposed HMO's during which both Knight and K.E. had groped their way to an understanding of what they wanted. K.E. had also attended a national meeting of state

agencies concerned with developing HMO-Medicaid contracts. He returned with the conclusion that while his program was not perfect, it was better than most of the others. Indeed each seemed to have had all the same problems.

Thus by this time K.E. felt he had the program in good enough shape that he could move into additional non-HMO tasks. He requested such tasks but Knight did not seem particularly anxious to have him transfer his abilities or even add new roles. He was told that he could "help X or Y in their work if you want", but without any real emphasis. K.E. was to take a leave from the division for a few months but this did not apparently affect Knight's decision. K.E. had taken a problem off Knight's back and he apparently did not wish to see it reappear. He "had invested a lot in K.E.". So K.E. continued his work on the two evaluative studies, on the task force and in trying to promote the HMO idea.

He had by this time begun to use a consultant for help in reviewing proposals and developing further policies. Knight had suggested the use of the consultant since that was one of the few items in his staff budget he could manipulate freely. A very highly qualified person (a professional friend of Knight's) became available. Knight had always left K.E. alone since he had developed an appreciation for his competence, but with the addition of the consultant he did so even more. Their interaction now consisted chiefly of K.E. informing him of his actions or of Knight sending K.E. cryptic notes when he discovered reports in the press unfavorable to HMO's. K.E. did try to keep policy issues open with Knight since he stated that he loved to talk things

out and couldn't work in a vacuum. But Knight did not participate seriously and even permitted K.E. to write memos to the Commissioner (which was not unusual) but did not request to see advance drafts (which was unusual).

Knight's schizophrenic approach to the HMO program was further evidenced by a small study K.E. had conducted comparing the costs of the fee-for-service sector in the area served by HMO-1 and HMO-1 costs (capitations). It showed the HMO to be some 15% less costly. While it did not detail exactly what was being purchased for those dollars, it appeared that the amount of services represented was probably as great or greater in the HMO than in the fee-for-service sector. Community groups, L.N., and the HMO had been clamoring for such data for some time but Knight felt it would be misinterpreted and advised K.E. not to release it. He did not, since, while he approved of the concept of HMO's and felt this reflected favorably on them, he knew that the division might be publicly forced into a posture of developing a very large HMO program when it felt the conditions were not right. L.N. at HSA was informed of the results of the study but did not propose this idea (which Knight might have feared) since the reality was that still only one HMO existed in the state.

But a limited opportunity did arise. An aggressive ambulatory group practice wanted to head off HMO competition in its market area. They wished to avoid the federal bureaucracy and thus approached the division first, seeking "sponsorship". Knight was delighted since this was "exactly the type of provider we're looking for". Looking for, in the sense that both he and K.E. had evolved the strategy that they would seek: (1) an ambulatory based operation; (2) one that

was well managed; (3) one that had a competent outreach component and (4) one that had a large Medicaid population. This group satisfied all four criteria. The practice was headed by a very aggressive businessman-physician who had had extensive contact with the department through his family planning clinic. He offered high quality care. Upon hearing of the combination of these qualities, Knight urged K.E. to enter into negotiations. K.E. confirmed the presence of the four agreeable factors with the consultant's help and negotiations began.

Knight met the proposer of this new HMO (HMO-5) on related business and he confirmed his good impression. "If he can make big money doing good medicine, then we should support him -- most of them have to do it by delivering poor or average medicine" K.E. was "scared" of the aggressivity of the provider but entered into discussions with relish since it was a chance to actually do something after the several aborted attempts elsewhere and after a year of "continually uncovering problems with HMO-1." He had begun to feel the management of the HMO-1 contract was reaching diminishing returns especially since he felt he could be useful in other tasks. But with this new opportunity he turned back to the HMO area with Knight's encouragement.

Viewing the success of the HMO program it is clear that while the product of this activity was not as substantial as originally hoped, much had been learned. The division learned both through the "cleaning up" of the HMO-1 contract and through the negotiations with the proposed HMO's which would be helpful when those or other HMO's became operational. It learned to determine what it wanted and eventually

found it - the HMO-5 situation. It learned to specify its policy and eventually applied it in several situations.

At a more general level, the bank of principles which the division used was both drawn upon and new "deposits" made. Thus the principles of not fostering incentives to undertreat, the stressing of comprehensive care and the search for a well managed provider had all been asserted earlier in the stream and reapplied here. Similarly, the importance of holding providers to professed goals and of taking the lead from other state agencies if a vacuum of authority had been created were to be stressed in later new services cases.

The development of this set of principles which Knight and K.E. shared was accomplished by Knight's openess and availability in discussing issues but also by his cautious development of policies which he felt could pass L.N.'s scrutiny. Similarly K.E.'s initial distress at being plunged into a new and complex area led him to seek considerable outside advice and this, along with the testing ground offered by the developing HMO, provided the division with a relatively smooth yet productive opportunity to progressively use the principles it had developed during the case. All these features were of course part of what Knight referred to as his teaching style.

Diffusion of this learning to the rest of the division was uncertain -- the HMO program cut across all the other program areas and more learning occurred in the reverse direction as K.E. used the resources of the other program areas to build up its expertise. Direct transfer of knowledge (not the principles) was only evidenced in a few situations - in the use of restricted Medicaid cards (as in the HMO-1 contract) for drug abusers, the use of the idea of capitation for a home care project

by another program director or the use of HMOs' criteria for cutting hospital usage as one of the bases for doing so in the division's hospital program.

The repertoire of responses or strategies (the program for action) the division used in developing the set of working principles was similar to that shown in other cases. There was the initially strong role assumption which later evolved into a less strident but equally strongly felt responsibility, the clear assignment of staff responsibilities, the slow initial investigation of the problem despite the deadline hanging over it (which Knight simply ignored), and the wide combing of the environment for information. We also saw Knight's initial reliance on his past experience with NHC's as a touchstone by which to judge HMOs and the wide use of contacts in the community by both Knight and his staff for advice in the building of a program. We did not see however the usual cursory examination of the new knowledge since Knight was being pushed by both those above and below him to devote energy to the program's problems. Nor was the initial advice of a few trusted friends so eagerly sought since the area was so new. The division had to build up a group of friends. Nor did we see the nagging ego problem since there was overall agreement that the standards for evaluation of HMO's were relatively primitive but also because the division's success could be measured conveniently - number of contracts signed and persons enrolled.

Not only were principles developed using both the program for action and Knight's teaching style, but a relatively strong management approach to the problem was also introduced since both HMO staff had management experience and perspectives. Both were concerned with

making the division's goals understood,with clarifying lines of responsibility, with clearing up the flow of paper and with establishing a monitoring system which would report on utilization and cost effectiveness. In turn this prompted HMO-1 to devote a probably disproportionate amount of its time to the DPW contract.

This credibility in management that the division managed to establish was primarily developed via the strong link between Knight and K.E. Knight, as usual, had insisted on an early direct monitoring of the program by himself, then a gradual delegation of responsibility to K.E. With K.E. he stressed the importance of "integrity", the accountability of the HMO, and later the strategy of experimenting with well managed providers. K.E.'s resulting performance enabled the division to prevent a credible face to the HMO community and to work towards its goal of acting as a responsible buyer. The opportunity to work toward such a paradigm resulted from a somewhat excessive assignment of resources to the HMO concept since the division was being pressed to do so by the cabinet office and since Knight assigned capable staff to the area who had the time and energy to fully explore the HMO idea.

What characterized this case most clearly was this strong but wavering attempt to assert the division's purchasing power, not only as a responsible and acceptable buyer but also as a lever to change the overall medical system. This latter role, after much testing, was discovered to be only applicable in certain instances, but the division did manage to exert some leverage by being of considerable technical assistance to other offices in state government and to a lesser degree in some of the new HMO's. In the meantime the division

was able to determine the validity of the HMO idea through negotiating with both existing and several proposed (and thus weaker) HMO's. Both Knight and his staff developed and refined their ideas considerably and made more precise what it was they wanted (or did not want) in the HMO program and then moved on to other equally complex new service areas.

5. Day Care for the Elderly

This case involves the development of a program for those elderly persons on Medicaid who required some nursing attention during the day time, but who had a non-institutional setting to return to at night.

The case is set in two larger contexts. One is the payment by Medicaid, since 1968, of nursing home care. This move greatly stimulated the growth of the private nursing home industry and permitted many lower and indeed middle income families to "rid" themselves of the financial obligations of caring for aged parents. By 1974 some 80% of the nursing home beds in the state were occupied by Medicaid patients, although many of these came from family environments which were not considered "welfare homes". Concurrent with this Medicaid expansion during the late 60's and early 70's was a realization that institutions of all kinds had failed to fulfill their promise of restoration into the community, or even provide a humane, but terminal "way station". A resultant cry of "deinstitutionalization" was taken up by liberal professionals and by 1974, it was even considered a non-controversial political plant for many of the state's politicians. Not coincidentally, deinstitutionalization was also seen as financially appealing since it promised to lower costs in addition to advancing social concerns.

In 1973, federal guidelines for the possible provision of 50% federal reimbursement (to the state) for experimental day care for the elderly programs were issued in draft form. Apparently this was in response to mild pressure from the Division of Long Term Care within HEW who saw the idea as a possible alternative to institutionalization and a way of containing the escalating costs of individualized home health care. The guidelines were permissive, in that states were not obligated to "pick up" this benefit. This was customary procedure as the Medicaid programs in the various states varied widely depending on which combination of these "optional" types of benefits were offered. Final guidelines concerning the new program were not promolgated until nearly a year later in June 1974.

This case is somewhat different from others in this stream in that there appeared to be no strong input from the assistant commissioner. This situation was not one in which the environmental forces confronting the division were particularly strong nor was it an area about which Knight felt strongly or had high priorities. Rather, it involved mild exterior forces (permissive federal guidelines and provider interest) set in the context of an idea in good currency -- that of deinstitutionalization. In the larger context, this new alternative (day care) had been sought and proposed because of the failure and mismanagement of the old "solutions".

The division nonetheless responded in the manner which it had begun to develop over the preceeding year to handle new kinds of providers -- that of narrowing the grounds for involvement by writing a set of its own informal guidelines. It added a further limitation upon the urging

of an adjacent department -- that only a limited number of proposals would be accepted under the conditions the division would develop. Yet even before it began to develop these conditions it had rejected overtures to begin work on the project, citing first the inability of the division to receive federal reimbursement, then the unavailability of both staff and a suitable "technology". Slowly, one staff member became available, then the technology, then another staff member, and finally the direction of federal initiatives became clearer.

Throughout this long "sorting out" period responsibility was diffused -- no one person was ready to grab hold of the project until the several above forces had coalesced. While it is inviting to spotlight the transfer of technology from an adjacent area -- home health care -- this was in reality only one of the many pieces of the puzzle which had to fall into place before a division policy could be produced. During this sorting out period, a more finely-tuned development of the output was seen than had occurred in the other cases. There was greater disagreement on the substance of the problem than was usual and a more detailed examination of proposed federal regulations and provider proposals than was usual.

This different process seemed to have evoked a more solid confidence in the produce than was usual. In other cases in the new services stream and in others not described here,the division's process was normally more hurried and unfocused with a kind of bravado confidence being placed in the process and in the moral rightness of the goal, combined with a nagging ill-feeling that the product might or might not have had any real effect on the system. A detailed look at this process follows.

The associate director for long term care in the division, Y.H., had had the idea for day care for the elderly in the back of his mind for some time previous to the federal initiative, but had not acted on the idea, having been preoccupied with many other priorities ("on a scale of 10 to 1, it's 2 or 3"). During the fall of 1973 a private nursing home approached the Department of Public Health (responsible for licensing all nursing homes) with a proposal to offer day care and inquired whether a new type of license would be required or whether they could operate under their existing license since they were simply "adding" a service. They had previously approached the division's associate director for ambulatory care (R.K.) in October but he, being new in the position, had no time to deal with their proposal nor had he yet developed a long term plan for "home health care", an adjacent area, and thus did not see how their proposal could be considered by the division. In addition the federal guidelines were not finalized at that time to even permit reimbursement for day care. The private group retreated, not realizing what a large potential market the Medicaid population (80% of the nursing home population) might eventually form. Thus while the division was as generally responsive to the idea of developing the service as in other cases, it (both R.K. and Y.H.) made a rigid determination that they would not assume that burden or role at the time. R.K., the most programatically concerned of the two, also linked it in his mind with a program, home health care, with which he was familiar.

By January of 1974 the group had reapproached the Department of Public Health on the licensing question. DPH's initial position had

been that a new license would be required as it would have to regulate a possible dilution of care in the adjacent residential unit operated by the group. DPH and Medicaid had worked closely on other types of programs, particularly those where the clientele of a facility or class of facilities was largely Medicaid supported. In addition, a contract had been signed by the two specifying the DPH would act as quality inspectors for the Medicaid program for nursing homes and that they would develop, with Medicaid's advice, "conditions of participation", or standards for such homes. But it was not clear if day care fell under this agreement nor did the two associate directors in Medicaid think a separate license was required since the program was clearly at an experimental stage and since it involved no capital outlay of any kind, merely a change in service patterns. Medicaid thus felt a state regulatory posture by DPH was not needed at that time.

Y.H. decided to assert the division's perogatives and continued to negotiate over "turf" with DPH while the actual program work on the issue was slowly begun by one of his staff. Y.H., who had initially seized upon the issue himself, stated that he had received no pressure from outside to work on the idea, only encouragement from the HSA and a mild note from Knight saying that there had been interest from the governor's office in the proposal by the private nursing home. Indeed, Knight even thought that R.K. (not Y.H.) had assigned the problem to one of <u>his</u> staff. This without Knight's presence, no specific goal was formulated, but the seemingly necessary slow incubation period did begin. Responsibility for the project was still divided between R.K. and Y.H., and now Y.H.'s staff member.

Three other groups had also made proposals to the division by this time but the initial one was seen as the most complete and competent. Some of the other nursing homes had also indicated mild displeasure with the idea since they feared it might cut away part of their "market". Y.H., however, assessed these factors and concluded that since the concept was clearly part of his long range plan and could be attacked at "no perceived loss to himself", he would continue to back it. He felt that R.K. was the only one who had the technical expertise and so awaited his availability while permitting his staff to receive and read proposals and to discuss them with DPH. This principle of "going slow until you know what you're doing and then plunge ahead forcefully" had been expressed by Knight in many other areas. It must be assumed that its value had rubbed off on Y.H. and R.K. since both acted quite independently of Knight - R.K.,because of an overall shared philosophy and Y.H. because of his command of his program area and his alliance with HSA.

However, both R.K. and Y.H. felt that "DPH didn't know what it was doing" and that they should proceed on their own since "DPH spoke a different language" and was overly concerned with procedure, i.e., setting up a task force to deal with the problem despite the fact that they (DPH) said that they had no time to adequately deal with the issue. They would try to assert their authority given the obvious (to them) difficulties with DPH. Thus Y.H.'s staff continued to review and compare proposals on a part-time basis.

There appeared also to be considerable internal confusion within DPH over questions as to whether DPH had the authority to license a new category of service, whether the standards would need to be publicly heard before adoption and who within DPH should have responsibility for the project. These questions combined with the lack of a clear priority for the project by the DPH commissioner led it to waste considerable time on "the form, not the content of the issue" (a DPH staffer), while DPW moved ahead. The DPH staffer said that "hardly anyone here realized that we should have an alive program - we're not 'bean counters' anymore". She saw DPW picking up authority not only in day care but also in other areas since DPH had failed to take the initiative.

Concurrently, R.K. had begun to "put together his home care package", a series of programs in which VNA type nurses and other types of professionals would care for Medicaid clients at home during the day time. This had evolved into a fairly well elaborated program employing a variety of professionals in a variety of situations. He had talked with Knight at some length about the principles involved in home care and they had visited a day care center for the non-elderly to check out some of their perceptions. R.K. also felt that the experience he had gained in his own development of the home health program was directly transferrable; that is, in the day care situation, ambulatory, day-time care would be offered but at a central facility and not in the home where many patients would need a high level of care not economically provided on a one to one basis. They decided on two principles - that the program should not develop into a "recreational" program (thus the reluctance to look at proposals which were "drop in centers") and that the

clientele must have the same needs as regular nursing home patients, the only difference being that they had a place to go at night.

Several months then passed during which R.K. and Y.H. concentrated on other areas. Their involvement was centered around keeping informed of the various proposals and attempting to settle the "turf" battle with DPH. The appearance of final federal guidelines in June, and the "tidying-up" of R.K.'s home-health program brought the issue to the forefront again. Also, at that same time in June, a member of the nursing home staff, A.M., became more fully available and Y.H. felt he could assign her to his area. In fact she had become "available" much earlier but these other circumstances had prevented her from devoting much time to the area.

In January, she had become irritated at carrying out a number of minor tasks for Y.H. and went to him to ask for a clearer-cut assignment. She was offered day care or another slightly more technical area in the nursing home program. She chose the former and began to learn about day care by reading the four proposals submitted by the different provider groups during a formal presentation. Her first reaction to the proposals was one of "naivete", she "liked them all" but soon realized after talking with R.K. that they "couldn't pay for 'drop in centers'" which was how loosely structured some of the proposals were. Some were from "real bad operators" and it soon became clear to her that one proposal stood out since it was the most specific and indeed was operationally defined. She felt, however, that neither Y.H. nor Knight did anything as a result of this presentation and this slightly discouraged her.

At this time DPH began to try to reassert their authority under the DPW/DPH agreement. They were used to a fairly rigorous attending to standards and a rigid protocol of inspection. This regulatory stance, while useful for bringing the many poor nursing homes up to standard was "not suited to innovative areas" as Y.H. expressed it.

While this continued battle over turf simmered, A.M. began to outline a set of guidelines for Medicaid participation, in addition to developing a set of standards which DPH could use for licensure. She stated that she "couldn't deal with the DPH people possibly because of the agency's lack of commitment". Thus Y.H. encouraged her to write the guidelines herself with the input of R.K. who was still not yet really available to devote time to the program. She was given no particular deadline, only told to "get something on paper" so it could be reacted to. At first she wrote a mild form of conditions of participation working under the assumption that the division should have a general set of conditions which DPH could accept as reasonable. One of the conditions was to be that the day care centers meet DPH standards which she also began to draft. R.K. and Y.H. thought the guidelines should be more specific as the division was a buyer of services and it should be more aggressive, stating just what they wanted to purchase, i.e., that conditions should include detailed DPW not DPH standards. Knight said that he had been aware of this battle over authority with DPH but that he was not about to be bound by their joint agreement if DPH was unwilling to cooperate in writing conditions of participation which would assure the division's continued perogatives. A.M. said that this was her first realization that "we could monitor the program since the guidelines would be our's."

R.K. and his consultant and Y.H. continued to work on the draft conditions. The two argued occasionally over such items as whether a full-time nurse should be present at the day care centers. A.M. began to feel that she was really the only one who knew about the details of the overall concept as R.K. and Y.H. were busy and did not always seem responsive to her concerns. But she remained quiet for a while, using Y.H. as a defense when confronted by R.K. whose sense of urgency and whose style often annoyed her, and relied more on the consultant on whom she could bounce off her ideas. R.K. prepared an all-but-final version after visiting the one major proposed site on his vacation. A.M. had prepared earlier drafts but R.K. thought these were too mechanical. This earlier version had "concentrated too much on the federal regulations" and talked too much about who should be responsible for care and now how the care should be delivered. This was a continuing friction point between her and R.K. although she later admitted she had concentrated "too much on staffing" and that R.K.'s draft was an improvement although she felt it could be better still.

The division, through this struggle with DPH and the absence of a strong hand from Knight, examined the problem in much more detail than was usual, particularly in relying on the providers and not only on a few "trusted" friends. But the consultant, a close friend of R.K.'s, also played a key role. The slow iterative process eventually resulted in a satisfactory version of the guidelines being submitted to DPH for comment. DPH for its part remained angry about Medicaid's involvement but Y.H. had agreed with them that the division would only get involved in ten or twelve demonstration projects and that DPH could first comment

on their evaluation as a quid pro quo for not insisting on heavy initial DPH involvement (licensing, etc.). At that point, formal license requirements could then be drawn up by DPH based on the experience of the negotiated contracts with Medicaid.

In the mid-fall the whole possibility of the program suddenly appeared to be problematic as the federal government had, in an information bulletin (not having the force of regulation), suggested that day care could only be provided by hospital out-patient departments and from separate clinics. R.K. felt it to be dangerous to encourage increasing control over the system by hospitals and so continued to support the proposals by nursing homes. The regional federal representatives felt at first the state program was thus not possible. But Y.H. suggested that nothing stated that nursing homes must give 24 hour care and they could just "fold it into" the nursing home billing, i.e., the day care provider would be listed as a "nursing home". This also avoided the separate clinic "route" which they feared since Washington was presumed to be trying to do away with the whole day care for the elderly concept. The state's program could be forever hidden in the nursing home program. R.K. was helped by the fact that one of the officials from Washington was a personal friend, although several other states had also been granted permission to define the program in such a way to "protect" it from later cuts.

The situation then stood at the end of 1974 with some 13 proposals having been reviewed by the division with 8 to 10 to be selected, although Y.H. felt that "we'll select less if there aren't enough good ones". A memo of understanding with DPH was agreed to in which DPH would act as inspecting agents for the demonstration projects

using the guidelines developed by DPW. A.M. had also negotiated an appropriate rate through the Rate Setting Commission. The first contracts with facilities were being signed and, according to A.M., the providers were in agreement with the guidelines and rates although the ones who had the most interest and investment in it were disturbed by the length of time the process had taken.

The story then is one which developed differently than the other cases. Its slow coalescing of forces followed by a detailed, sometimes conflicting development of a product in which greater confidence could be placed (and a resultant absence of the "nagging ego" problem) nonetheless led to questions in some of the participants' minds about the actual process. The pattern of the division's responses nonetheless illustrated that many of the features of this pattern had been learned from earlier cases and could be executed without Knight. For example, there was the attempt to link the program to an already existing one, the strong assertion of the division's perogatives in competition with DPH, the bending of the federal regulations to suit their purposes, the reliance on consultants, and the slow experimental search for a satisfactory solution.

A.M.'s learning during this case was significant. She felt that this was the first major project she had worked on from its inception and that she had gained considerable knowledge about day care. Her management learning was of two kinds, one a negative one learned from watching R.K. and which primarily dealt with how not to approach providers. R.K.'s style also was felt by DPH to offend providers but Knight felt that R.K. had probably simply been forceful in stating what

the division required. Her learning from Y.H. was more positive (e.g. that authority could be seized from DPH or at another level) or "how to put things on hold" but she felt that it was unlikely its effects could be felt until she got out from under his wing and moved to another job. She however, felt that a good set of guidelines had been written and that they had responded well to the challenges, although she felt she might have asked for more help. She regretted that a lot of questions also "didn't get resolved in the division of labor between the three Medicaid staff". Writing of "constant memos" also worried her, yet she stated that "one must put things on paper" to "cover oneself", to establish agreements to generate responses.

Her contact with Knight was minimal but she commented that his teaching style was perhaps not always influential with all personality types (including her own). It is possible that Knight realized his style was not effective with all the staff and thus delegated contact with such persons to others although here A.M. logically reported to Y.H. Certainly his overall delegation to Y.H. in the whole nursing home area would seem to indicate this since there were also others in that part of the staff (in addition to A.M.) with whom the teaching style was not totally successful.

Y.H. felt that he had not accomplished much for the program, having left the task to A.M. and the consultant. He felt that the questions which had been involved were as much "professional" as managerial and, since he was not "inspired" by the professional minutae of the issue nor had the time to deal with them, he often "punted" the problem over to others -- his staff, R.K. or DPH. He felt he could only advance

things procedurally with DPH or in "cooling off" A.M. (since he sided with R.K. on the substance of the guidelines; that is, he also thought they should be quite detailed). He felt that such projects should, in the future, be "project managed" since no one really cared enough to push the idea through.

Yet the group working together not only managed to generate several working principles (as described previously), they also, without Knight's strong input, used many developed in other cases, for example, the importance of talking to providers and understanding their problems, but of nonetheless investing only in well-managed ones. While only a very few of the teaching and management approaches favored by Knight are evident here, the few that were utilized (such as the assumption of authority, the use of experiments or the stress on goals) seemed to indicate that staff members had absorbed these from Knight in earlier cases and were now testing them on other cases. That this process of testing was more confusing and lengthy does not however negate the relative success of the project, whose goal was to establish an (experimental) day care program.

Not only was the goal achieved but it was achieved in concert with the division's mission - to act as a responsible buyer - and without violating any of the body of principles which the division had begun to build up. The fact that the explicit style of accomplishing this (i.e. the teaching and management style of Knight) was not as closely adhered to raises questions about the general utility of that style which will be addressed in Chapter VI.

6. Overview

Each of the cases described above can be tentatively described as a success in that (1) a decision was made concerning the possible new services, (2) policies for assuring the delivery of these services were put into place and (3) the policies were then routinely followed or further developed.

The EPSDT case evidenced, in a situation of substantial environmental pressure, a creative response which enabled the division to develop the service in its own manner. Indications are, that while the basic policy was in place, considerable attention would be directed to "proving" its effectiveness. Since the very nature of this case was based on the designation of the service as a "non-program", it is clear that it had not been routinized in the normal sense. This, coupled with Knight's absorption of the "non-program" into his personal arena, suggests that the division's EPSDT concept might not likely outlast Knight's tenure-unless, of course, he was able to turn around the direction of the national program from his local base, a possibility which cannot be assessed here.

The free-standing mental health clinic case demonstrated that the divisinn was able to develop an approach to such clinics that it believed viable and that was shared by the provider community. The process of certification of the 50 clinics and the review of problem-oriented records was carried out with continued energy while the adjustment of the policies to assure better access to clients and a still more responsive level of treatment got underway.

The success of the 442 program is more difficult to assess. A policy was developed and placed in the agency's manual and a favorable payment rate certified. Since the carrying out of the program was basically in the hands of state and local education officials, the initially chaotic situation being created by the implementation of the latter's program made it impossible to determine how well or actively local centers were carrying out the desired core evaluations on Medicaid children.

The evaluation of the HMO program is a mixed one. The division managed to bring its existing HMO activity under control while the mechanics for continued control were embedded in a formal contract and a set of routine computer checks and evaluations. The division was not instrumental in developing any new HMO's but a spin-off benefit, that of the development of a HMO capacity within other state agencies was achieved. It is unclear how this capacity would be utilized.

Finally, the day care for the elderly program can be viewed as a success. A new idea was responded to, proposals were evaluated, guidelines were developed and several demonstration contracts entered into. By the nature of the case, its routinization was not required nor can it be used as a criterion of success.

Each of the cases, while appearing to be somewhat disparate, were directed at the fulfillment of a particular task or responsibility. This task,as described on page 70, was to make new medical services eligible for Medicaid reimbursement. While the state program was one of the most comprehensive in the nation, both Knight and the staff still saw the development of new services (or the major re-structuring of old ones) as one of their tasks.

Each time a potential new service was presented to the division, a set of subtasks or "questions" were generated by Knight and his staff, the resolution of which led to the development of a final policy for the new service. Through an examination of the way in which these subtasks were performed from case to case it is possible to assess the amount of learning occurring within the stream of cases and also to test whether that learning was utilized in other new service cases not described here or in other streams. The content of that learning, i.e. principles of medical care delivery and of its administration, will be shown in the response to these questions while the key role of teaching and management in the development of these principles will be described later in this chapter. Here I wish only to demonstrate that, through the accomplishment of the subtasks, some significant learning did take place, both within and across the streams.

The subtasks or questions generated in each case follow. A determination of the need for the service was made, a target population was singled out and a mode of delivery and potential provider types suggested. Then a reasonable cost for the service had to be determined and negotiations with both providers and other government agencies entered into to discuss not only the cost but also the validity of the first determination as to need, target population, etc. Finally an effort to "propagate" the new services' availability, whether through local welfare offices or directly through providers, was made.

The responses to the task of determining the need for a particular service indicated that the division became increasingly conscious of its role in developing new services. In the EPSDT and FSMHC cases,

Knight's first response was to take on as little extra responsibility as necessary but in the last three cases, the attitude and level of energy towards new services changed significantly. General principles began to be developed through the assessment of need. Thus the need for comprehensive care was stressed first in the EPSDT case, slighted over in the FSMHC case but then reasserted in the 442 and HMO cases. Similarly, a principle of the need to avoid "maintenance" care was developed in the FSMHC case and later reasserted in the Day Care program. And the "need" to increase federal financial participation for the state was first developed in both the FMSHC and 442 cases and later stressed in other mental health areas and in the family planning program (not described here).

The selection of a target population was based on the consistent belief of Knight that programs for children were of the greatest priority (thus his personal interest in EPSDT and 442 and, to a lesser extent, in HMO's) while other target populations were "selected" because of the obvious human benefits involved, e.g. day care or family planning. The division's willingness to respond to a wider variety of populations was limited by the restricted nature of Medicaid clientele and the already broad scope of benefits.

The tasks of determining how the service was to be provided and by whom were closely related. The division responded to these tasks by developing a set of principles which were used throughout the stream. Thus an increasing stress was placed on well managed, high level, and accountable providers although these criteria could be relaxed if a particular provider was the only one available (see the mental health clinics). Thus well managed providers were sought out in the later

cases - 442, HMO and Day Care. High level (meaning physician) providers were stressed so as to avoid discriminatory usage of nurses or interns and residents in the FSMHC,442 and HMO cases. And where this high level involvement was not possible, the principle of medical accountability was stressed both in the FSMHC and 442 cases and later in such areas as the regulation of nursing home pharmaceuticals (see Chapter IV). Similarly the question raised in the HMO case as to the advisability of gynecologists providing primary care was later used in re-examining the whole family planning program.

The mode of delivery question asked by the division evolved from Knight's insistence that a philosophy is of the first importance - one must know what one wants to do. While the importance of a "philosophy" was of course addressed in the questioning concerning the need for the service, it became stressed more often in the decisions about who was to be the provider and how the service should be delivered. The environment of the division demanded consistent policy thus placing the focus of a clear approach in the response to these questions since it was here that providers were most involved and concerned, i.e., would they and their delivery mode be eligible for reimbursement?

One of the principles which was developed here was that programs should be linked up with one another if possible or, at a minimum, comparative "analogies" should be used. This was evident in all the cases, for example, linking HMO's to neighborhood health centers or day care to the home health technology. The desire not to provide incentives to undertreat patients surfaced in the HMO case and was continually discussed in setting rates for a wide variety of new services. The

question of clients' privacy which arose in the 442 case when possible clients needed to be identified also surfaced in the HMO case and in the family planning program. Similarly the realization that loose, decentralized provider organizations are difficult to police was simultaneously developed from a survey of the HMO literature and from the hospital sanction case (see Chapter IV).

The question of what cost to allow ror each new service was one which could technically not be answered by the division since that power lay with the Rate Setting Commission (RSC). However the division's recommendations to the RSC were generally adopted. From the very beginning of the EPSDT case (the removal of restrictions on the $15 fee), Knight pushed for fees which would permit the provider to deliver an adequate service but not one which would make him turn away Medicaid clients or give "shoddy" service.

The necessary negotiations with providers about rates, provider types, client population and with other state or federal agencies about hewing to the appropriate regulatory line developed several explicit principles. First of all, Knight stressed, and his staff acknowledged, that "providers should be listened to". A simple principle but one which in previous administrations had been ignored because of lack of either time or inclination. Thus in all the cases in this stream, the provider groups' problems and needs were analyzed and incorporated into a final policy. And usually, a more general policy was developed with the division specifically initiating this type of dialogue.

When the situation which the division stepped into (or was pulled into - the FSMHC and HMO cases) was discovered to be one of confused

or absent authority; Knight stressed that the division should have no fear of assuming that authority itself. The final two cases - HMO and day care - showed that staff performing independently of Knight could also exercise this authority. Knight also stressed that the federal "partner", SRS, could be turned around if professional allies could be developed - as in the EPSDT case, although no such similar situation arose again. Finally, Knight's admonition that "if we're not sure of the right things to do, go slowly but then, when you are, plunge ahead" was followed in the 442 case and in the later working out of the HMO and day care cases.

What is significant about the resolution of the basic question the division asked each time a new service was developed is not so much the nature of the principles described above but the fact that they were developed and often carried from one case to another or from this stream to another stream (see Chapters IV and V). This development and ransfer of principles is a higher level of performance than simply learning to produce a policy (to "succeed") in a task area and to routinize that policy. Thus, while the achievement of the latter two levels of performance are criteria by which the learning of the division can be assessed (and in this stream, that assessment is a favorable one), the development and transfer of principles appears to be a third level of learning which the division reached and against which its performance in other streams could also be assessed. One of the functions of this third level lies in its role in improving performance at the first two levels. That is,one way of improving the development and routinization of specific policy is to have a bank of

general principles which can be used not only for reasons of conceptual "economy" but also for more positive or comparative learning purposes.

Despite the success of each of the individual cases and the development of a set of principles which were sometimes utilized in succeeding cases, an overall assessment as to the amount of learning is difficult to make, even though all the principles described were explicit ones, often stated in "maxim" form and usually observable in the final written policy. The principles accumulated over time in Knight's mind and were taught to staff members. But as each of the cases described here was handled by different program directors, the degree to which the principles were shared and then held by the organization is questionable. They may well have been shared only by Knight and individual staff on a one to one basis. This personal learning, (see the case of the mental health director, L.A.) while clearly necessary for any organizational learning, may not be sufficient. Thus, while each of the principles was embedded in a formal policy or program and continued to be used in other new service departments, there is no assurance that the principles would outlive either Knight's insistence on them or the staff's tenure in the agency. (See Chapter VII).

Nor is it clear whether the staff working without Knight would actively develop new services. The organizational capacity described here is one of dealing with a service area selected by Knight. A weak leader or a shift in Knight's priorities to, say, sanctions or monitoring would likely mean a lessened development of new services. Thus the use of a test for learning such as an observable and increased "momentum" (as in the sanction stream, Chapter IV) may not be applicable

here. The momentum seen here, while clearly a part of the organization's then-current "memory", may or may not outlive those members of the organization.

The development and transfer of these principles (as well as the division's success at the first two levels) may be viewed as the content of learning. But the division not only learned this "content" but also developed a pattern for developing these principles. This is the "how" of the division's learning. In stark contrast to the explicit principles, this pattern of development, which I have called a "program for action", was almost entirely tacit. This program consisted of modes of behavior quite similar to the "programs" later observed in the sanction and internal administration streams (such as ignoring or bending of regulations, or selectively trusting a few close allies), which were never spoken of but which were part of a relatively consistent and observable pattern of behavior-though the pattern varied somewhat with the goals, personnel and environmental inputs. Thus while all of the behaviors in the "program" could be observed, they were rarely talked about by staff members and never posited by Knight as principles. Indeed virtually all of the staff had to ponder considerably over the nature of this "program" when asked by the researcher. It is not completely clear why such a program was not explicit but I believe that at least two factors lessened the need for an explicit program of behavior. Firstly the fact that such a concentration was placed on the content of the principles probably lessened the very possibility that the manner of their generation would be explicitly focused on. Secondly, the strong early socialization of staff members likely lessened the need for an explicit program

that is, it could be learned by watching and doing and did not need to be explicitly advanced.

I would suggest that such a program of action helps to explain the success of the division in each of the cases and, along with the overall approach of the division (described in later pages), is a necessary component of the type of learning shown by the division. Here the "what" of the division's learning (the principles) began to be linked with the"how" of learning more fully explained by the division's teaching and management approaches and its overall paradigm. That is, the pattern of action about to be more fully described is <u>both</u> the what <u>and</u> the how of learning. As the "what" of learning it corresponds to a fourth level of learning. That is, the very achievement or development of such a program constitutes a level of learning more general than the development of principles since the program's <u>output</u> was a set of principles which were then used to improve the division's learning at the lower levels of policy development and routinization.

The "program's" features are first evident in the considerable initial use of analogy (e.g. 442 is "pediatric care") or the attempt to link one service to another (e.g. viewing HMO's as a variant of neighborhood health centers). After this "analogy" was made, we see the strong assumption of the division's perogatives in each of the cases, often with a strong "moral" posture outlining the division's "right" to be involved in the area - see the assertion of "turf" in the 442 or FSMHC cases or the "moral" authority inherent in the EPSDT case. Sometimes this assertion of authority was negative, i.e. "that is not

our responsibility, so don't get involved for the moment." This was evident in the first stages of EPSDT and 442 and in several other cases not described here. In contrast to other streams however, (e.g. the sanctions stream) the advancement of specific goals early on in the case was not made, probably due to the relative inexperience of the division with the medical aspects of the service. Generally a well defined responsibility for the new service area was made, with Knight either taking it upon himself (usually at the onset) or delegating it to one and only one of his staff. This was further heightened by Knight's admonition to staff that areas of potential new service should be brought to his attention first of all and he would decide their priority. This assumption and delegation of authority was one of only two components of the "program" which were made explicit.

An incubation period where the division did relatively little after its assumption (or rejection) of authority was observed in each of the cases although this period was considerably longer in the 442 and Day Care areas since they were completely new services quite unconnected with anything then being offered by the division. In addition these services were not being strongly pressed upon it by members of the division's environment such as providers or other state agencies. This incubation period was usually followed by a light, once-over treatment given to the details of the case. This was most evident in those areas where Knight had either a well worked out philosophy (EPSDT) or where he "knew" he could work out a strategy easily (442). Not only did each new service first incubate and was then often glanced over lightly, but any existing rules or regulations pertaining to were often ignored

or "bent" in the division's favor. This was the situation in the EPSDT, 442 and HMO cases.

Given this somewhat rarified approach, the need to somehow "ground" the new service if such a once-over approach did not seem practical led the staff (and usually Knight) to touch base with either the provider group likely to be involved or a small group of select and trusted friends. And in areas where no such friends existed (HMO and Day Care), the staff involved developed on their own a group of trusted allies. Not only did Knight and the staff increasingly ground the policy development via this consultation, but the role of experimentation also increased during the stream -- from no real experimentation in the early stages of the EPSDT case to Day Care where these services as a whole would not become a part of the division's policy manual until the results of the 10 or 12 demonstration projects were assessed. The intervening cases showed an increasing willingness to experiment either with a group of trusted friends (442) or with a well managed provider (FSMHC and HMO's).

The activity surrounding each of the new service developments, while often viewed initially as a "problem", was usually turned around and viewed as an opportunity. This change of stance was also evident in the sanction stream and is directly attributable to Knight's particular attitude. For example, the EPSDT case led to the development of a protocol which defined quality pediatric care and which could be used throughout the division. A similar definition was made for mental health and the initial problem of a chaoticly managed HMO program was turned around to advance the division's credibility. Knight's attitude

as expressed to the researcher was that, "I don't think in terms of 'being wrong', rather I think in terms of the direction we want to go, and I don't worry about the mistakes we make along the way. Thus the criteria of "success" of the case which were discussed earlier did not specify that the new service be extensively developed, only that a new policy towards that service be developed and implemented - it could be a restrictive or cautious policy as in the HMO area.

In fact, each stage of activity in the cases was viewed by Knight not only as an opportunity for him to teach himself and the staff but also as an opportunity to bolster or "lever up" that activity for other purposes. It was not clear whether this entrepreneurial, opportunity-seeking stance had permeated the staff. As with the other elements of the program for action, it too was tacit. Given that the division was faced with a wide range of "problems" both new and old to solve, it may be that one rule for selection of problems was that those that could be "packaged" to help solve other problems were unconsciously favored since they permitted the division to survive a deluge of problems.

The final aspect of the program (more a consequence of the program rather than a constituent element) is what I have labelled the "nagging ego" problem - the staff questioning whether they had really accomplished anything. It is apparent that this feeling was the strongest when Knight was the most heavily involved, i.e. in the EPSDT and the 442 cases. In the FSMHC and HMO cases the staff had greater control over the direction of the program and could take satisfaction from that, even though hard "output" measures of success were difficult to come by.

In the last case (Day Care,which had lacked output measures) the staff had almost complete control of the general direction setting and there the nagging ego was not nearly as evident. Doubts raised by staff over this lack of "essentiality" (as discussed by Argyris) concerned the process, not the product. As Knight himself put it however "This is a dilemma, what should I do, stop offering strong leadership?" It was not in his nature. Thus one of the strengths of the division (Knight's leadership) might also be seen as representing a problem in that staff might only be able to tolerate both little involvement in policy setting and lack of output measures for a very short period of time before either some sort of internal pathology developed (e.g. resistance to change) or they sought greener pastures, i.e. a more fulfilling job where they could either see results or develop policy themselves.

In later chapters I will discuss how this learned program of behavior can be more fully understood as a program for dealing with environmental uncertainty. That is, the program permitted the division to select areas it wished to pay attention to (e.g. was it within its legal or "moral" authority) and then provided it with a way of progressively narrowing the uncertainty within that area (e.g. using analogy or entrepreneurial "packaging"). Here, however, my emphasis on the initial outlining of four levels of learning (including the program for action) should be kept in mind by the reader since they will be utilized in Chapters IV and V as criteria by which the division's performance can be assessed. But other factors at a higher level of generality also help to explain how the relative success of the division was achieved and how some of the learning described above was generated.

These factors which, for lack of an immediately rich name, I will label the overall approach of the division are three in number and are, importantly, all factors which were accessible to and amenable to conscious manipulation by the division. This approach was the "glue" which held together the behaviors described above and which guided not only this approach to new activities but also the division's dealing with routine activities. The approach consisted of the teaching of general principles to a young, competent and inexperienced staff, the enhancement of the organization's credibility through management and the conscious development of an organizational paradigm - the "responsible buyer".

The nature and content of the principles developed were discussed earlier. The function of these principles was to aid in the translation of the organization's paradigm into a more firm reality and to make it possible for the division to bound sometimes seemingly complex or extensive problems. For example, "responsibility" was translated into such principles as investing only in well managed providers (FSMHC, HMO, Day Care), stepping in where a "responsibility vacuum" existed (FSMHC, HMO) or stressing medical accountability (EPSDT, FSMHC, HMO). The "buyer" function, although more evident in the sanction stream, was translated into principles such as the use of the fee structure to help achieve a "quality" product (all the cases), the "negative" principle that if lower quality services are the only ones available, the very existence of the division's purchasing power could be used to help change their service patterns (FSMHC) or that the services, before being purchased, should be tested out, and once purchased, should be regularly assessed for quality (442, FSMHC, HMO).

The role of teaching in the development of principles in the stream was clearly evident (see below) although the fact that each of the staff members primarily involved in the five cases were ones whom Knight trusted slightly more than most of the staff suggests that he was aware that even his teaching needed fertile ground. As in the other streams, each of the involved staff was young, energetic, competent, relatively unskilled in health care delivery and viewed themselves as generalists. They had each participated in the early and strong socialization process during which the "informal matrix" organization (Chapter II) was in effect and had sat through the staff meetings in late 1973 when many of the general principles described here were discussed for the first time.

But Knight's direct teaching style was also particularly evident in this stream although not all of the elements of the style were utilized here. Thus we see the manner in which he pulled people into a problem area the moment he first heard about it (all the cases except 442), the continual explanation of why decisions were made and the admission that his mind could be (and was) changed (see his change of attitude in the FSMHC and HMO cases). Similarly, his anticipation and appreciation of the staff's styles led him to tolerate quite considerable varieties within one area (e.g. FSMHC) or the working out of a group style (Day Care) or the making of "mistakes" (HMO). I suspect that this tolerance for diversity of style contributed greatly to the ease of development of shared principles and the relative absence of philosophical conflict. In many bureaucracies, the reverse is true. Knight also evidenced a strong tolerance for, and encouragement of,

experimentation in each of the five cases. Finally, his evocation of his past experience was perceived by all the staff as being valuable in their learning of many of the principles.

The second important element of the division's overall approach was the use of "management", particularly in the development of organizational credibility. The content of this management may be similar or different from what is generally considered to be "management" but I am not primarily concerned here with definitions but rather with description of what actually occurred. Knight called his process "management" and members of the division's environment outside the DPW called the product "good management" and I shall thus continue to use this term.

The role of management in developing credibility was an iterative one involving both a process of management and its product. Thus the use of sound management techniques (process) in routine activity led to a product which was perceived by the division's environment as "credible". Knight commented on this product (credibility) by stating that he saw it consisting of having a policy, making it available and known, ensuring its consistency and coherence, and trying to live up to it. This credibility then gave the division some "breathing" room in which to develop and choose principles in areas of new knowledge. And then, the manner in which these new principles were chosen, explained and made into routines using basically the same management process further enhanced the division's credibility. Thus the cycle could begin again.

Knight's management of the new policy development process was the same as his management of routine activity; that is, he showed the use of the same techniques in both situations. Thus, while competent internal management of routine activity was important, here I shall consider only how this routine management fed the "cycle" of new knowledge development. The division's routine activity was not insignificant in all the new services cases however. For example no progress could have been made on the HMO-1 contract until the division arranged to pay its HMO bills more rapidly (similarly with EPSDT).

While the fact that the division was doing something (anything) in EPSDT and with FSMHC's gained it some credibility, in the 442, HMO and Day Care cases the division's credibility had to be first earned in the working out of the new cases since these providers were unacquainted with Medicaid. Only then could it get what it wanted programatically. Here Knight's litany of: having a policy for the new knowledge, making it available, and ensuring its consistency and coherence helped in assuring credibility. Thus much of the external credibility of the division was based on the product of Knight's management activity.

Providers interviewed placed great stress on this "product" not to the exclusion of the content of policies (e.g. the mental health clinics disagreed with some of the policies) or of the details of the management process, but (I suggest), simply because it offered a pragmatic means of relating to the division. In a turbulent medical environment where there was often little agreement on principles and

yet the actors were "forced" to work together, some basis for understanding had to be found. That basis was clear.. it was the credibility as described by members of the division's environment. "People now get back to you, they're responsive. You get an answer and it's a clear one. Your policies aren't fixed, you'll change them if you have to but you do listen to expert advice. There's a pride of authorship in the division - you're focusing on what the problems are".

The manner in which the product (credibility) was developed internally was through Knight's management of new policy development. Of first importance in this stream was his generally clear delegation or assumption of authority evident in all but the Day Care case and his avoidance of large or permanent committees or task forces. Secondly we saw the open door policy for each of his staff and his general accessibility to discuss principles with them (see all but the 442 case). Thirdly, his reliance on "naive", non-professional staff to ask fresh questions led each of the cases to be developed in a somewhat non-traditional manner (all but EPSDT). Fourthly, his continual stress on the "integrity" of the division (read my "credibility") to the staff was a major component of his management style. Fifthly, there was his willingness to experiment with new policies or reward providers perceived as inventive entrepreneurs. And finally, the division's cultivation of reliable consultants and advisors helped in the acquisition of credibility. The breathing space generated by this credibility was then used to develop the needed principles which could be called upon to formalize a policy.

The importance of the conscious paradigm - a "responsible buyer" - was clear throughout the five cases. It was most evident in the day care and free standing clinic cases where the final "tune" as to the providers' direction was called by the division and where some in-roads into reshaping the overall system were made. Thus the division saw itself as acting responsibly by moving into a needed service, but doing so experimentally and with an eye to not permitting an excessive rate. As a buyer, it could specify exactly what the nature of the day care service would be through its contract guidelines. Similarly with the mental health clinics - "responsibility" was cited as one of the reasons for adopting the new service (thus increasing federal dollars for the state); but this involvement also permitted it to purchase only the quality service it sought. And the stress on problem-oriented records began to touch off changes in the larger mental health system. In the 442 case, considerably less success as a responsible buyer was achieved although Knight certainly tried to act out the role. He stated that he "had done all he could" - he had responded to the demands placed upon him by other agencies and he had developed a policy which would assure a relatively high-quality product in a new field. In the HMO and EPSDT cases, the clear assertion that the division would not be forced to (a) purchase ("buy") under conditions unfavorable to it or (b) waste energy on a program it deemed unworthy ("irresponsible") was evident. Here the division staff and Knight utilized the paradigm in a somewhat defensive posture unlike the day care and mental health areas but its role in guiding their action was the same and their actions in beginning to live out the paradigm were equally successful.

Thus the approach of the division to its new knowledge consisted of the teaching of principles, a management philosophy and techniques, and the development and invocation of a conscious paradigm. At one level these may be seen as the "how" of organizational learning - how the division was able to deal with new knowledge and transfer some of the principles to other situations. But if this approach is to be described as a necessary (or at least accessible) lever for such first order success, then the acquisition of this approach might also be seen as learning. This new services stream indicated that some progress has been made in routinizing this approach. Examination of the other streams and a search for situations where the division's actors acquired or utilized this approach independent of Knight must also be made.

In the succeeding two chapters, the reader should keep this concept in mind since it will become apparent that while the overall approach was successfully developed and applied in at least two other areas, it continued to be strongly based in Don Knight, and, as I shall discuss in Chapters VI and VII, was successful not only because of its inherent power, but also because of a very favorable constellation of other circumstances.

CHAPTER IV

THE SANCTION STREAM

1. Development of the Formal Sanction Power

The first case in this stream involves the development of a new power by the division. The power to sanction providers had existed since 1969 but had been haltingly and infrequently applied until 1973. Then Knight took initiative and clarified this issue slowly but consistently by working through the department's formal channels. The power fitted into his overall philosophy and he then had only to wait for an opportunity to utilize it.

Prior to November 1973, abuses of the medical assistance program had been handled in an informal manner. Up until the takeover of the program by the state (and the concurrent injection of federal money) in 1967, the program had been managed by a small group of less than ten central office staff. The prevailing attitude was (as expressed by one of the long term staffers) that since the allowable fees were low and there was difficulty in getting providers to agree to participate in the program, the staff did not want to do anything drastic to hinder client access to care. Sanctioning providers or even taking a strong hand would have blocked such access by limiting the number of participating physicians. At the time, this was probably a correct assessment of the limited power of the division.

In 1967, when the Medicaid program began to take its present shape, the same ten people continued to staff the division. Much of the medical profession had resented the advent of Medicaid and Medicare (although they later discovered these to be a vast, "willing" source of funds), and the climate was still seen as not being appropriate for any kind of sanction activity. For over a year, the program

operated under the temporary authority of a governor's executive order. It was not until early 1969 that enabling legislation was passed formally setting up the division and authorizing it to receive federal funds, to pay for certain services and to possess additional powers. Among these powers was the power to establish administrative sanctions (including suspensions for up to three years) against providers for violation of the rules and regulations of the program. These rules and regulations were not to include "medical criteria" but elsewhere the act granted authority to establish rules for the "efficient operation" of the program, to certify qualified providers, and to develop programs of utilization review. That these latter three powers could not be exercised without setting "medical criteria" or that the line between them and medical criteria was fuzzy was ignored in the compromise attempt to pass a bill which would assure that the department would have the necessary powers to act efficiently and in clients' interestsbut which would, in theory, avoid a clash with the medical profession.

From that point in 1969, sanction activity took a particular form. The small staff of the division would occasionally notice gross elements of abuse and would call providers in to discuss a change in practice. If the abuse was confirmed as a serious one or involved financial "shenanigans", it was then nearly always turned over to the finance director of the department. He was a strong willed, competent and energetic veteran of the department who hated to see money paid out which violated statutes or the department's regulations. For example, if a provider was found to be billing for an ineligible service

or utilizing services codes which maximized his revenue, he would be called by the division or the finance director and told he would have to make financial restitution for such billings. Such restitutions were usually negotiated settlements with the finance director being very proud of the fact that he "never lost a case", in court or outside. Indeed his reputation was a strong tight-fisted controller who nearly always did "win". More significantly here, however, is that few problems were brought to the division's attention since the means for detecting abuse were so weak and sporadically exercised (see Chapter V). Those few cases that were brought to the division's attention were seen as "financial" cases and were handled by the financial chief, who sought only retribution and not suspension from the program.

The legislature stepped into this void and created a Bureau of Welfare Audits (BWA) whose responsibility it was to be the watch-dog agency for the Medicaid program and to support the financial director. Their activities however, stressed outright criminal activities such as fraud (they became known as the "Fraud Squad") which they referred to the Attorney General's office and the recovery of monies in the vein carved out by the department's finance director. But sanction action exercised by the division alone or for poor programmatic performance was still at a low ebb.

The assistant commissioner prior to Knight had seen that the situation was not totally satisfactory, but gave its reform a low priority. He appeared to be more interested in programmatic issues, i.e., developing new services or assuring overall system effectiveness

through high payoff programs rather than in the level of medical quality of providers.

In February of 1972, however, a turning point occurred as the division made its first attempt at using the sanction power. Two dentists were suspended by the division for violation of its rules. In this case the violation was severe - billing for services not rendered (which in a court would constitute fraud.) The case was also being investigated by the BWA. The national legal climate at the time however, had as a focus the protection of individual's rights and thus the department's legal counsel determined that, while the department had the authority to suspend providers, no adequate administrative processes such as hearings, rules for examination of evidence, or appeals, etc. had been established. The acting head of the division (N.K.) declined to reinstate the dentists as he felt the suspension was warranted and the legal division of the department was forced to send out the necessary reinstatement letter. N.K. felt vindicated when the two dentists were later convicted in court on these grounds by the Attorney General's office and lost their license to practice. At the conclusion of these events, the commissioner assigned the legal division the task of developing procedures such that the department would not be denied such an opportunity again.

When Knight arrived nearly a year later in April of 1973, he was briefed by N.K. on the total operation of the division during which they discussed the case of the two dentists. Knight was disappointed when he realized that the department lacked the power to suspend providers. He stated then that his basic approach was to act as a

buyer of services, i.e., the division purchased services for a defined clientele and it must be free to not purchase from those it deemed unqualified. In his previous role as a vice-president for purchasing in private industry he had controlled many millions of dollars. Similarly, in the development of his neighborhood health center, he had hired or arranged for the services of providers who would meet the needs of that community. He had not been forced to take all comers. Thus his basic philosophy was foreign to the idea of having to purchase from all providers who met only minimal, legal standards. Knight thus requested the commissioner to speed up the legal division's actions in developing the required administrative procedures as he knew he could not exercise his philosophy without the necessary regulations in place.

There was no indication what had taken the legal division such time to develop regulations although there was some confusion about whose exact responsibility it was, the legal division's or the department's general counsel. In addition, it was, despite the commissioner's assignment, simply not given a priority status by the legal staff. As a staff member of the medical division remarked, "no one would have pushed it but us." Nor was there any pressure from outside the DPW to exercise the sanction power. But now the medical division had taken a stand and work began to speed up on the development of procedures upon the commissioner's second request for action.

The department's lawyers then prepared draft regulations and consulted with lawyers from the Department of Public Health and the Human Services Agency. The DPH lawyers had felt that the whole area

of sanctions was a regulatory one and therefore should have been assigned to it while the DPW and its divisions concentrated on "program" and financial concerns. The focus of discussion was not however that that DPW did not have the authority (despite the "medical criteria" clause of the enabling act -- which was not mentioned) but rather on the fact that an amalgamation of the two agencies into a new "super agency" was planned. DPH saw itself as the lead actor in the new agency and did not wish to be bound by something drawn up in haste before the amalgamation.

The HSA lawyer was generally supportive of the medical division's overall direction but did not take a strong position in the discussions. An additional lawyer from the Administration and Finance Department (A&F) had formerly been with DPH and generally sided with the DPH lawyer. These five lawyers from four different agencies slowly began to work out an agreement as to what the regulations should contain. Knight, who participated in the discussions, indicated that there was really no substantial disagreement among the five although he felt that a committee of 5 bureaux was chaotic. In later cases, he was not to let such important issues be settled by committees much less one overburdened with outsiders. After the question of "turf" was resolved in DPW's favor, the only change suggested by the committee was that a fuller description than originally envisaged of a charge of "violation of regulations" would have to be cited to the provider about to be sanctioned. Similarly, several examples of sanctionable acts were included in the proposed regulations. Knight

also insisted that the regulations permit him to render an initial decision after a first sanction hearing whereas the drafting lawyers had previously suggested that a separate appeals officer be provided for (as in cases involving recipient claims against department rulings.)

During this discussion period, a major nursing home containing many Medicaid patients was inspected by DPH. Dispicable conditions such that its continued DPH licensure was questionable were identified. DPH and the division decided to act in concert on the case. All the Medicaid patients were removed from the home in one day's "swoop" and the home's license suspended. The case received significant publicity. Knight felt buoyed by his action and by the publicity. It was not, however, a direct application of the DPW sanction power since state licensure had long been a condition of participation in the Medicaid program.

Nonetheless, Knight took pride in publicizing the actions of the division. He saw this, as a staffer related, as being part of his image building process to show providers that "we weren't fooling around." Knight began to push the legal task force to finish the development of the sanction regulations. But he did not "go public" with this activity. Instead, he kept the process relatively quiet. He deliberately did not consult with providers and stated that he had not investigated what other states were doing nor did he care. He felt this was a purely administrative step being taken which he had the right to take "alone" and that providers could later sue the division if they felt the sanction regulations were inadequate. It

was, he stated, a "calculated risk". Moreover the publicizing of his actions could easily have been misconstrued by a paranoid medical profession especially since the division had only begun to build up credibility in such other areas as policy design, fee schedules and payment of bills.

During this time the assistant director for vendor relations (R.T.) had been assigned to liaison with the department's bill-processing center to iron out billing problems raised by specific providers. These generally involved late or incorrect payments. But in this delving into the payment process he began to notice many irregularities in the billing processes. In addition, now that the center had one specific person in central office to relate to, they started to feed suspected "problem" bills to him. R.T. began to keep a small file of these providers but took no action. Knight saw this file as preparing the ground for later implementation of the sanction procedures being developed. His strategy would then be to "knock off" the obvious poor and abusive providers in each program area and in each region ("like the IRS" said Knight) and hope that the word would spread throughout the provider community.

Finally, one day late in November, the proposed regulations were published in the Saturday morning papers for comment. No significant comments (and none from the major provider associations)were received. The regulations became effective a few weeks later after insertion in the agency policy manual. In early January, Knight sent a letter to the

vice president of the medical society (with whom he had been on good terms) summing up some of the progress being made in the division and stating in a mild fashion that the division was now going to start taking action against providers breaking regulations. No formal response was received but the vice president continued to support Knight in a general fashion. R.T. began to send out warning letters to providers. If the abuse was not corrected a stronger letter would be sent along with a copy of the division's sanction regulations. This activity was relatively low key however, and no significant steps to sanction providers had been taken by late January.

At this point then a temporary lull set in. Knight began to further develop his "purchase" philosophy in discussion with his staff and with a young lawyer from the legal division assigned to work with the medical division. The lawyer felt that Medicaid's third party status was not a pure "purchasing" situation and that the burden of proof was upon the division to show that the provider had "erred", and that a "gross" violation of the regulations must be shown. Knight felt differently -- that the burden of proof lay with the provider and that the degree of sanction should fit the degree of violation - it need not be a gross violation. Similarly the question of the "intent" of the provider was to arise. But the working out of these and other principles had to await a first sanctionable case. One developed almost immediately in early February involving possible pharmaceutical abuse in nursing homes -- a situation which was perceived by all as a chance to test the new sanction procedures.

This case can be summarized as follows: A division having little formal power to sanction providers and, fearful of developing new powers, let its responsibilities be exercised by adjacent bureaux (the financial office, the Bureau of Welfare Audits, DPH, etc.). A new head of the division arrived on the scene but is perceived to have other priorities. The issue lags. A staff member nonetheless attempted to suspend two providers but the order is reversed by the legal division. This test case forced the division back to the drawing board to develop and refine its sanction procedures. But the issue still languished as the top position in the medical division lay vacant for 8 months and the staff became increasingly pressured with other problems.

A second and more dynamic division head is appointed. He carried a new philosophy from his previous experience and is appalled by what the acting head tells him. He adopts a strong position that the division must exercise its sanction "purchase" rights and pushes for the immediate development of adequate regulations. He is buoyed by publicity given to the closing of a poor provider by an adjacent agency and further steps up the legal research until satisfactory procedures are developed although the division's legal ability to sanction on pure quality of care grounds is overlooked in the push to get something operational. Concurrent with this set of actions, he begins to develop a principle or strategy (like the IRS) of setting an example by knocking off the worst providers but keeps the strategy close to the vest of the agency. Indeed most of the activity in the case is conducted by Knight himself and neither his teaching nor his internal management styles are yet strongly in evidence other than his

reluctance to use committees and his stress on the integrity of the division.

A staff member assigned to iron out kinds in the payment process begins to develop awareness of possible abuses and starts to keep a "little list" of providers. When the sanction procedures formally take effect, the division head notifies the provider associations in a low key way and begins to send out "corrective" letters to minor abusers. A short lull sets in and shortly thereafter a situation of major abuse arises which is perceived as an opportunity to test the new sanction procedures.

2. Pharmaceutical Abuse I

The case the division had been watching for arrived in January. It involved a large pharmacy whose business was composed principally of Medicaid patients in nursing homes. The pharmacist's dispensing patterns had been under observation for some years. The stimulus for action in this instance had been a several year old complaint lodged with the Bureau of Welfare Audits (BWA) by one of the department's regional offices. The original complaint had not been investigated and indeed even forgotten but the feeling remained within the division that this provider had been guilty of "consistent over-charging" and possibly other abuses. Finally in 1973 a complete audit of several recent months of activity by the pharmacy was reordered by BWA and in June, its current bills were retained by the division. Over the summer these bills began to mount up unpaid in the office of the

pharmacy director (I.N.). Finally in January, the BWA, while having a pharmacist on its staff in addition to several accountants, approached the Medical Division for assistance in interpretation of DPW's regulations.

The pharmacist had been participating in the program for several years, during which time the division had slowly begun to tighten its regulations to prohibit or discourage such practices as prescription splitting, over-pricing of drugs and other questionable practices. According to I.N., this pharmacist had managed to stay just a jump ahead of the increasingly tough regulations -- "as we became more sophisticated, he became more sophisticated." By 1973, he had evolved a large volume system in which prepackaged amounts of drugs were automatically provided to nursing homes at regular intervals for patients' use. This system was based on the fact that most nursing home patients had a regular and continuing need for their drugs. The basic prescription system also differed somewhat from regular prescribing practice. Each nursing home had a single order sheet on which all the patients' physicians wrote their orders (prescriptions) after which the nursing home used this form to order from a single pharmacy and, upon receipt of the drugs, to administer them to the patients.

Initially the BWA had, using a strict and literal interpretation of these regulations for nursing home pharmaceuticals, declared that 95% of the pharmacists' bills were invalid in some way. The basic abuse uncovered by the audit was that the pharmacy extended the length of the prescription written on the order sheet, or if no termination

date was specified, continued to deliver the medication. Similarly, the amount of medication delivered in any one prescription was often different from that specified by the prescription, or if no amount was specified,the pharmacist would assume an amount. For example, at one extreme, a prescription might read simply "X units per day" and the pharmacy would continue to deliver this medication indefinitely and in batch sizes determined by its own staff. On this evidence the BWA wished to take the pharmacy to court to recover as much of this money as possible. The BWA's sole function was auditing and producing evidence of abuse or fraud and it apparently needed this case as justification of their role.

A meeting was called with I.N., R.D., the sanction director, the department lawyer (D.L.), Knight, the department's finance chief (Y.E.) and the BWA to determine how to respond to both these situations. At this point it was not yet clear that this would be the first test sanction case although a hasty sanction letter had been sent out by R.D. suspending the pharmacy for 3 years, subject to a hearing with the Assistant Commissioner. Knight had apparently been very anxious to test the new regulations and felt that the onus should be on the provider to prove that the charge was inappropriate.

Upon being presented with the initial evidence of 95% of the bills being invalid, each of the actors staked out his own area by determining what he felt the issues to be. The BWA (and the Attorney General's office) focused on whether a criminal charge should be laid or not; the

finance chief focused on whether or not a civil case should be instituted in order to assure the return of all monies due the Department, the pharmacy director (and the finance chief somewhat) focused on the question of whether the pharmacy should be suspended from the program, while the assistant commissioner focused on the question of whether (and what kind of) financial restitution should be made. As each of the actors concentrated on specific views of what the charges should be, it became clear that there was no "basic sense of who should be running the process", (i.e. laying the charge). The fact that the sanction process had been instigated did not make it clear that the division was the prime actor although Knight began to assume a key role.

All the participants further agreed quite early in the investigation that no outright fraud was involved since the drugs had actually been delivered and furthermore that the drugs were needed - that is, in most cases they were life maintaining drugs required on a long-term basis by the patients. Thus the general focus changed from an initial one of potential fraud to one of abuse, gross or minor and the issue then became how to deal with this abuse.

As mentioned above each of the actors had a strong initial goal. The pharmacy director wanted only to suspend the pharmacist for a period of time in order to show other providers that the division's sanction powers now were real. He had been angry over the "lack of teeth" in the state program since previous cases of abuse or fraud had been ignored or settled for small amounts by the BWA and the Attorney

General's office. He did not realize until later that such a sanction would likely put the pharmacy into bankruptcy. This complication was based on the fact that the nursing homes depended on a steady and regular supply from one provider. If the pharmacy was suspended, for say, even as little as two months, it would have either had to provide drugs at no cost to the nursing homes or terminate its relationship with the homes - who would, in the meantime, turn to another supplier and not return to business with the pharmacist. Either way, he would lose large amounts of money and be forced into bankruptcy, although as I.N. mentioned, a businessman with his skills would likely soon reappear in another guise.

The finance director's position was that all monies advanced not in accordance with the division's policy manual should be reimbursed, and that, if necessary, a civil court action should be instituted. This was his primary concern, although he too felt a sanction (suspension) was necessary. Knight, with his business background, wanted financial restitution but was also worried about (1) unduly putting a man out of business through a large financial claim and (2) the division's right to do that, even though "lesser" action, i.e., a sanction proceeding, would have the same effect. As mentioned earlier, the BWA primarily wanted a "case", one which would involve the largest amount of recovered money possible. The division's lawyer (D.L.), the director of vendor relations (R.T.) and R.D. were more or less silent observers in the process, taking no strong position of their own. R.D. "tried to understand the process since I never really understood the

details" while R.T. tried to understand the details, but took a quiet position. Each of the three however, saw the issues converge to one of how much to recover from the pharmacy but still allow him to stay in business.

Another "minor" issue was whether the regulations were indeed implicit and available. The pharmacy said they were neither, while I.N. maintained they had been made available 2 years previously and had been verbally described by BWA agents in the pharmacy. Knight maintained that he did not really care if the regulations were explicit or not, since providing drugs without a clear physician "mandate" was clearly a case of bad pharmaceutical ethics and "certainly against the (overall) state licensing regulations." Thus, in addition to the issue of whether any action would put the pharmacy out of business or not, the issue of the pharmacy's intent arose; i.e., did he intend to abuse the regulations and professional codes and did he have full awareness of the implications of his actions. For Knight this issue was key since he felt the severity of any action by the state should be based on the intent of the provider.

While a formal procedure had been established for investigations of possible sanction procedures, they were not strictly followed. The pharmacist would often meet individually with each of the state personnel involved. Communication was poor among these officials, particularly to and from the attorney general's office. At one point a "settlement" was reached between the attorney general's office and the pharmacist but without the knowledge of the medical division.

This typified the relations with the attorney general's office and further weakened the desire of Knight and the finance chief to engage in any court case (civil or criminal) since the state would be represented by the attorney general's office - which they increasingly viewed as ineffective. The A.G.'s office also felt the case was "weak". The pharmacist also wanted to avoid a court case since it would likely be lengthy and involve heavy expenses. He also appeared to be somewhat scared of the finance director who claimed never to have lost a case he brought to court.

Finally "everyone realized that the pharmacy's intent was not criminal" although Knight felt it had been "bad pharmacy" and the pharmacist had been "a fool" in disregarding administrative and professional procedures. In the explanation of why he had carried out the practices he had, the druggist eventually "hung himself" (I.N.). That is, he eagerly and proudly explained his computerized system of automatically dispensing medication in lots of various sizes - which would maximize his revenue. After an explanation of his procedure, it became clear to I.N. that dispensing patterns had been based on adhering to a "system" rather than to the particular needs of the patients or the possible danger of a specific drug. That is, the pharmacy would dispense according to the following type of formula, regardless of the above two considerations:

1 pill per day -- in batches of 30 = 30 day supply

2 pills per day -- in batches of 30 = 15 day supply

4 pills per day -- in batches of 60 = 15 day supply

7 pills per day -- in batches of 90 = 13 day supply

The pharmacy had actually written down this procedure for the nursing home managers to follow in their ordering. Upon its exposure to the group in the medical division, I.N. "sat back and sighed", knowing that a case had been made upon which restitution could be calculated. A compromise was then worked out such that all bills would be allowed for the cost of drugs provided, but only one dispensing fee per patient per month (for each drug) would be allowed - not the often two or three times per month "required" by the druggist's system. This amounted, in a three month sample, to about 12% of all claims. This 12% figure was then applied to all the past claims made (since 1967) and a total amount of restitution calculated (in the hundreds of thousands of dollars). The suspension was withdrawn since Knight felt it likely that this would create a bankruptcy situation in which the division stood to regain only very small amounts as only one "creditor" among many. And the issue of a restitution based on what had been a "standard practice" not specifically disallowed by regulation was not raised again by any of the parties.

Knight felt that it had been "a hell of a case to start off with" (the new sanction procedures) but that it had "gone reasonably well". News of the case went out rapidly to the pharmacist community but it

was not evident what effect the actions had had and indeed it was only after a second similar case that the division began to question the effect on the provider community. Knight, however, felt that the groundwork had been laid and directed R.D. to begin building up his new program area. The concern of R.D. and the lawyer over the process of sanctions was not to surface until much later in the year. The rest of the division was kept appraised of the actions and Knight took pride in the sanction although the press and the medical community was not formally notified.

During the next several months R.D. carried out over 20 sanction cases plus equally large numbers of warnings to minor abusers. A lawyer was hired to augment the sanction staff but he later left after being found by Knight to be "too contentious" and "too used to loose situations" (R.D.). R.D. developed his procedures and investigative methods slowly, all the while "learning how to deal with providers, the media and providers' lawyers." No major cases arose during these few months although two suspensions directed by R.D. were appealed to the commissioner over Knight's head and reversed by him. The commissioner felt these two cases had been judicial matters not administrative, although Knight felt "we have to be like the government with the Mafia - get them on what we've got" even if it's minor or technical. Another attempt to suspend a druggist (to make up for the first case - according to the finance chief) was overthrown by a court.

Knight was not entirely happy with the work of R.D. He felt R.D. did not really sense what the substance of Knight's direction was and more importantly did not come to him to discuss the bounds of their "understanding". Thus Knight adopted a low profile and waited for another "big" case which could be processed and used to spread the word through the provider community. R.D. continued working on the smaller abusers but without the total confidence of Knight. R.D. said that he had learned from the case that if he had been a provider, he'd stall as long as possible and get as many people involved as possible since bureaucracies had a tendency not to record agreements reached or to simply forget them. It made him decide to be much more systematized in his handling of future cases. He also felt a sanction should have been imposed and continued this hard line throughout several other cases in Knight's dismay since Knight felt that each case should be considered on the basis of provider intent and "what do we want to get out of it." The looseness of the process in the pharmacy case led R.D. to concentrate on process in these succeeding cases and eventually this process/goal dichotomy was to be one of the factors leading to R.D.'s leaving the division

Several of the staff felt a bad precedent had been set in the case but bowed to the wishes of the majority, principally the finance director and Knight. I.N. still maintained that a sanction was necessary and felt compelled to tell the pharmacy that he had been "overruled" by the assistant commissioner. Nevertheless, he said that if he had been, say, in the commissioner's position, and forced to choose between

the views of his assistant commissioner and the pharmacy director he might not have chosen a sanction. That is, he would do the "best thing for the program" which could either be to set an example based on principle or to recover hard dollars and impress the legislature who might then support the Department on other issues.

Despite the uncertainty and groping nature of the process, several key principles were developed here such as the emphasis on provider intent, the feeling that a provider should not be forced out of business if no direct patient harm had been done, that providers' bills should be held during a sanction process and that, by expelling a provider, the division might lose possible leverage in forcing him to reform. These principles were developed very much within the group meetings and Knight's teaching style was not much in evidence. It was clear that Knight himself was learning how to develop the sanction process and he would have to wait until later cases to teach both I.N. and R.D. Here he simply declared these principles as being generally applicable.

Only a few of the elements of the program for action which were evident in the new services stream were evident here. There was no initially strong assumption of the division's perogatives nor was there a well defined goal. No attempt was made to evoke past experiences or to involve either close professional friends or providers. Nor was responsibility for the process assigned to any one specific person.

We do see however the willingness to confront a problem so evident in the other cases and the guidance of a search for a solution by what was thought to be right, even ignoring or bending the regula-

tions (see page 205 and note that other possible culprits such as the nurses or physicians were not charged). And despite this continual belief in what was right, the solution generated through a long process of internal negotiation was not held out as a "perfect" one, but a "satisfactory" one.

Knight's overall goal of appearing to act as a responsible buyer was achieved, that is, he had refused to purchase from a poor provider and had acted responsibly both in dealing fairly with the provider and in keeping him in the program so that he might be "reformed". The case can be considered a limited success in that a situation was confronted and action taken to the relative agreement of all parties. This success and the evolving principles learned were not yet so strong that Knight felt he could publicize the case widely. But within the next few months a possibility to "go public" on a sanction case squarely confronted the division.

3. Hospital Sanctions

In mid-May, a situation arose concerning a large propreitary hospital which was allegedly offering poor quality care. Up to then no provider in the state had been sanctioned on grounds of low quality of care and only once before in the country had a successful sanction action been taken against a whole hospital.

A utilization review (U.R.) program had been recently installed in all hospitals of the state by the division. It concerned itself only with monitoring the patient lengths of stay in the hospital. For

a specific diagnosis, a length of stay was assigned by a coordinator and any stay over this had to be approved by a physician advisor assigned to the hospital. This monitoring program was administered by an adjunct of the state Medical Society (the Hospital Monitoring Agency or HMA) under contract to the division. Performance of the program coordinator in the hospital and the physician advisor were subject to review by the division, however. The program had only recently been developed, primarily at the instigation of the Human Services Agency and while no evaluation had then been conducted it was expected to cut hospital-days by up to 10% solely by monitoring the length of stay. It generally ignored other factors such as the necessity of admission or the quality of care during that stay.

In January the program coordinator (a nurse) in a proprietary hospital had begun to sense that the physician advisor was being somewhat liberal in the authorization of excess hospital days (over the 50th percentile or norm for that diagnosis) and that persons were being admitted unnecessarily (although this latter area was not within her job mandate). She felt that both these problems were complicated by the fact that the hospital was owned by physicians and that the physician advisor was a member of the staff, although not an owner. She requested that the program's central office conduct an audit.

In mid-February, such an on-site audit was conducted by the central office of HMA. At the termination of the audit, an exit interview was held (and taped). The HMA discovered excessive lengths of

and unnecessary admissions. They informally warned the hospital that these conditions should be corrected and recommended a change of physician advisor. HMA stated that they would not make the warning a formal one. The hospital was later to claim that because they had not been formally warned and even because they did not receive a transcript of the exit interview that the "problem" was not serious. The HMA director could not understand this liberal interpretation, nor indeed is it understandable from a reading of the transcript.

Nevertheless, during the next few months, two new physician advisors were placed in the slot and both resigned rather quickly. Knight described the reasons as "an obvious snake-pit in which no one wanted to get involved." Apparently the conflict between the proprietary nature of the hospital and the demands of the strict monitoring role were difficult for the physician advisor to resolve - that is, there was strong pressure from his peers. At one point the hospital was without an advisor for close to two months.

The division had received word of the informal audit from HMA, and the confusion surrounding the volatility of the physician advisor problem led Knight to conclude that all was not well at the hospital and that its own audit should be conducted. As it was apparent that the situation might involve more than the length of stay problems, Knight felt strongly that he "wasn't about to let HMA take over the program (Medicaid)" and so requested in early May that the division's medical director (N.B.) conduct an on-site audit in conjunction with MHA. N.B. was accompanied by the vice-president of the medical society

and the division's regional advisor. N.B. was a well respected academician and practicioner from the state capital while the regional advisor was more representative of the practicing surgeons in the area of the hospital. The medical society representative (acting here in this joint audit as a representative of HMA) had developed a relationship of respect and trust with Knight through previous encounters and Knight felt he could rely on him to produce an independent judgement of the situation.

The second audit team examined the records of 31 cases which had been submitted by the HMA coordinator as possibly involving excessive lengths of stay or unnecessary admissions. It was not a random audit, but did account for about 5-10% of all hospital admissions and 25-30% of all Medicaid utilization for the preceding month. The audit uncovered, according to the team, cases of unnecessary admissions, inadequate records, poor work-ups prior to surgery, unnecessary treatment, excessive lengths of stay and in one instance a situation verging on malpractice. N.B. made verbal notes which were recorded and transcribed. The hospital made little attempt to refute the charges at that time. N.B. informed Knight that "here was a clear case of poor treatment" and later admitted that he felt that perhaps some of the information in the records had even been added "post-stay" as a justification for the treatment rendered.

N.B. was a man of forceful personality who was often given to quick rapid judgments and who was used to being accepted at face value. Knight explicitly trusted N.B.'s judgement but in addition made his own

thorough examination of the audit transcript. He says that at this point he became convinced that much more than excessive lengths of stay were involved and that the case against the hospital for poor treatment was "iron-clad." We begin to see some of the elements of the division's "program for action" here. The division was willing to accept information from wherever it could get it, it made a clear assertion of its perogatives and decided fairly rapidly that it would take action against the hospital.

Most hospitals have their own utilization review (U.R.) committee to monitor treatment in the hospital. These U.R. committees examine admissions, necessity of treatment, length of stay and overall quality of care. The intensity of these activities varies from hospital to hospital but all accredited hospitals must have some semblance of a U.R. committee. It was later to develop that the hospital, upon the installation of the HMA length of stay monitoring, "dropped" its other U.R. activities involving Medicaid patients, assuming that the HMA program was also responsible for them. It is not clear whether this was a misinterpretation of the program by the hospital or not. Certainly the formal documents setting up the program could not have created such an impression, but exchanges during the installation of the program might have. Some other hospitals in the state were also under that impression. But they, while assuming that HMA was conducting a total U.R. activity, nonetheless continued their own U.R. activities in addition to the HMA program.

At this point, the HMA director and Knight's senior in Human Services still felt the problem was a HMA affair and that it should be handled (i.e. corrective action suggested) by HMA. Knight however, was against the contracting out of responsibilities to others wherever possible and was anxious to assert his firm belief that the division was a purchaser of services and could therefore choose "not to purchase" from obviously poor quality providers. He wanted to make certain that in this situation it was the medical division and not some other agency which assumed responsibility for the quality of care and in this "obvious" case of poor care, his responsibility meant exercising the division's suspension powers.

Knight then discussed with his assistant director for sanctions, R.D. and the department's lawyer (D.L.) the advisability of a sanction. Both these two stated that they accepted at face value the medical director's assertion that this had been a case of poor treatment. They thought however that the maximum three years suspension should be reserved for more severe cases, and recommended a two year suspension from the program. Knight then asked R.D. to send out a sanction letter to this effect immediately. The latter scrambled to get together such a letter with the "insufficient data" (R.D.) available. He felt he had not had enough time to adequately prepare this formal and quasi-legal document in concert with the complete team that had conducted the audit. He could not understand Knight's haste, but Knight later explained that "lives were at stake" here and that the informal HMA warning some months previously had been ignored. Both these conditions

probably account for the participants' immediate focus on the maximum sanction rather than the further warnings. Thus, a hasty sanction letter was prepared and sent out. Or so the sanction director thought.

Knight had run into the HMA director at lunch and had informed him that he was sending out the sanction letter. The HMA director said he was being too hasty and they should wait until the hospital had a chance to formally reply to HMA against the charges made in the joint Medicaid-HMA audit. Knight agreed and returned to the office to inquire if the letter had gone out. He was assured it had but no letter was ever received by the hospital and no copies of it could be found. To this day it remains a mystery. Thus Knight's hasty action was temporarily aborted.

The hospital, meanwhile, replied to the MHA state committee formally admitting that, while some of the lengths of stay may have been questionable, all admissions had been necessary and denying all allegations of poor care such as poor workups and inadequate records by stressing that all the patients (save one) satisfactorily recovered. At this point, the division then prepared its (second) sanction letter, in a similarly rushed fashion. R.D. tried to draft a "strong" letter but had difficulty getting the audit team and himself together for such a drafting. A "weak and poorly prepared letter" (Knight) did go out, calling for a two year suspension from the program and citing excessive lengths of stay, poor quality care and violation of state and federal regulations concerning record-keeping. D.L. had become involved when asked by Knight to assure that the division was moving in a procedurally correct manner in this "iron-clad" case

and later dropped the record-keeping charge when he determined that no such regulation actually existed.

At this point then, the first strong action had been taken. In this turbulent climate, the division had chosen to be active. It had detected a case of what it considered poor quality care and, more importantly, had rapidly and irrevocably decided to formally move against the provider. Knight had kept his commissioner informed at key points as to what these actions were, i.e., that an audit was being made and that a sanction was envisaged. While there was a need to keep the commissioner somewhat free of the details of the new case since he might later act as a judge in an appeal, the political ramifications of the case were strong and Knight felt he should be informed. At this point, however, an event occurred which in hindsight was fortunate for the division.

The sanction letter was mailed on a Wednesday and Knight called a press conference for that Friday to announce the sanction. He requested that R.D. notify the hospital by telephone to be sure they knew what was happening before the conference (or in case they had not received the letter). He assured Knight that he had done so. On Friday Knight discussed his press presentation with the department's lawyer who was shocked by this action of "going public" so early. He requested that the commissioner be notified (he was out of town) and a long distance call was made to him. The commissioner showed displeasure at such publicity but as it was too late to stop it, an agreement was made to discuss only the procedural aspects of the case with the press, i.e., that a sanction was being declared, that the hospital

could meet with the assistant commissioner to present evidence why it should not be upheld, etc. Knight felt that he could no longer contain the press since word of the audit had leaked out and this might soon appear anyway in the papers. The hospital, however, apparently had not received the sanction letter nor the telephone call and was furious at being informed "via the press" and at having no chance to prepare a rebuttal.

Knight admitted later that he had perhaps moved too rapidly with the press. But the deed had been done and the occupancy of the hospital dropped to 25% in the succeeding weeks as the effects of the publicity were felt. The hospital immediately was caught in a cash flow problem and called upon their lawyers to request a meeting with Knight as soon as possible and in addition hired a medical consultant to prepare a case by case rebuttal of the division's charges.

Shortly thereafter, a hearing was held at the division's offices. The hospital was represented by their consultant and by a firm of prestigious lawyers, in particular a young lawyer who quickly won the respect of all the parties involved. The rebuttal presented by the hospital was threefold: they had dropped their normal UR activities (including review of the necessity for admission) for Medicaid patients since they had assumed HMA was now carrying it out; HMA had never informed them of the significant problems involved with the excessive lengths of stay being granted by the physician advisor (who was approved by HMA); and that quality of care was impossible to define except by actual "outcomes" and all the patients <u>had</u> recovered. The physician

consultant elaborated on this latter argument on a case by case basis citing a variety of medical interpretations which would justify the treatment rendered. He also advanced other arguments such as: the patient was well known (thus obviating the need for complete records); or "social complications" were involved (i.e., the life style of the patient necessitated long lengths of stay). He also stated that the hospital was indeed working on a program of developing standards other than "outcomes" -- but that no one in the country had developed such standards yet -- therefore they should not be singled out for such failure.

During this initial hearing meeting and a subsequent one, these intense medical arguments (and others) were advanced by the hospital and rebutted by the division. Knight did not act passively as a "hearings officer" as R.D. felt he should have, but rather engaged the hospital lawyer and medical consultant in discussion. D.L. was also relatively quiet during the proceedings. However a newcomer to the discussion (E.K.), who had been involved in Knight's "fly-on-the-wall" program (working out of a desk in Knight's office), actively participated by sending notes to Knight and advising him on strategy - which Knight felt to be helpful.

All this time the focus had been on the hospital's responsibilities and actions and not on the individual physicians. The hospital made a brief and early attempt to suggest that it was only a few specific physicians who had been involved. Knight rejected this argument by saying that a hospital is not simply "an office building renting space

to all comers." More importantly however was the strategic element here. Knight felt he could not take on both the hospital and physician "lobbies" at one time and so concentrated on the weakest element, the hospital. Later however the hospital was to again offer up three doctors as a sacrificial lamb in order to reduce their sanction somewhat.

The three major arguments of the hospital were slowly cut away during these two sessions. If the hospital had dropped its normal UR activities when the HMA program began then this meant either of two things according to Knight: (1) the physicians lowered their standards deliberately - which was an irresponsible professional action or (2) they had never had more than the formality of a UR system before the HMA program -- which would have also been contrary to generally accepted standards. As for the excessive lengths of stay, the hospital did admit them, but claimed the responsibility must be shared with the HMA program.

Most interesting was the argument about "quality of care." The hospital felt that since all the patients had recovered, and since the only accepted standards at the time were outcomes, they should not be sanctioned. Knight and the medical director began to search for a "handle", some practical effect of the poor diagnoses, poor workups, and unnecessary treatment on which they could hang their argument. During this first hearing and many intermediate strategy sessions, they slowly evolved the concept of risk. That is, the very fact of submitting a person to lab tests, x-rays and surgery was to put them at an unnecessary

risk. Even presence in a hospital was a risk. Here Knight and his team felt elated since they had managed to define, in a limited way, what quality care meant; they had differentiated between poor treatment, i.e., the technical side of performing isolated acts improperly, and poor care, i.e., a poor choice of acts to perform. The hospital's consultant managed to rebut each of the 31 cases but he was seen by Knight and others as simply a screen thrown up by the hospital to "cover" their poor pattern of care, despite the fact that he and the hospital's lawyer were seen as competent and sophisticated men more able than their clients.

At the conclusion of the second hearing, a standoff was reached. The hospital had felt it had made its case well (although the consultant later admitted in private that he felt the division's case was also good). It had suggested that individual doctors were to blame and that it would discipline them in order to escape a heavy sanction action. But in no way did it feel it should receive a two year sanction for the poor quality care. Their lawyer was willing to go to court and felt he had a 60/40 chance of winning. The division's lawyer estimated the odds at 50/50 and felt these were too poor to risk going to court. Knight concurred with his lawyer primarily because the state would be represented by the attorney general's office - in whom he lacked confidence.

Knight told the hospital he would make a decision within ten days. At this point two factors led the parties into a negotiating posture. The hospital's occupancy (and reputation) was declining rapidly and

the time and exposure in a court case would have been even more threatening. And Knight not only wanted to keep it out of court but also out of the commissioner's hands -- the hospital's last administrative remedy should they contest Knight's ruling. The commissioner (who would judge the case) had reversed Knight's decision once previously and diminished a second sanction. Knight thus began to negotiate directly with the hospital's lawyer, even excluding the department's lawyer, to the latter's anger at this break of legal "ethics" (i.e., lawyers should not talk to another's clients alone.) Knight however was not one to follow protocol or bow rigidly to regulations or conventional practice if he felt he was moving in the proper direction.

Knight had decided during the hearings that while the hospital was at fault for not policing its physicians, its other activities as a hospital were not to be faulted. He had visited the hospital and found it to be clean, providing good nursing care, good food, etc. He thus proposed the two year suspension be changed to six months suspension and 18 months probation with additional action to be taken against individual physicians. This was to be the final sanction. During the negotiations with their lawyer, it became clear that this would lead to a court case or to an appeal to the commissioner. Knight thus offered the hospital a choice to "plea-bargain."

They finally reached an agreement that the hospital would be suspended for two retroactive months (representing some $40,000 in return of billings), and be on probation for 22 months with their activities overseen by a "Blue Ribbon Committee" which would assure

that a complete UR system be set up for all patients. The hospital was also to provide the department with the complete records of the three physicians most involved so that they might be subject to individual sanction if necessary. And finally, the settlement was to include a signed public agreement to the above in which the hospital would admit the charges of over utilization and low quality care. This latter admission was very delicately worded such that it was not completely evident that the hospital felt it had erred or was admitting guilt. But the public effect was more important than the precise wording.

There was differing feeling in the division about Knight's actions. The staff member responsible for the HMA liaison felt that a six month sanction would probably have put the hospital out of business but that since it was a hospital in an already adequately served area no harm would come to the community or to the Medicaid clients and should have been upheld. Knight said his "heart went cold" when the hospital discussed the financial losses they might suffer from going of business. D.L. felt that Knight had been out to "get the hospital". But Knight said later that he had no particular image about proprietary hospitals; they could be good or bad, he felt.

Externally, Knight's superiors had been notified of his actions at key points but had told him to continue to chart his own road. The secretary made an independent check on the proceedings and was generally satisfied. The only real criticism the undersecretary of HSA and the commissioner had to make was of the use of initial publicity and a feeling that Knight had backed off somewhat too early on the hospital.

In addition, two politicians from the hospital's area began to inquire but Knight phoned them and suggested that before they get involved they be sure to get the division's side of the story. This seemed to lessen their interest in the case and overt political action did not seem to have much effect on the case. There was very little feedback from the medical community as a whole although the hospital community was well aware of the action and applauded its direction. However opinion was divided between those who felt the actions taken were only a slap on the wrist and those who felt the division had stood up admirably to the problem. In addition, the justification for the sanction was bolstered by the hospital's own UR committee findings some months later that over 40% of the appendectomies and hysterectomies performed in the hospital had been unnecessary.

During this whole case, no one actually questioned the division's legal authority to (a) sanction hospitals and (b) do so on quality of care (as opposed to simply over-utilization) issues. There had only been one precedent for the former and the latter was not really clarified by the division until after the case was settled. Knight had "sensed" these problems at the time of the case but felt that this "was not a grey area" (concerning quality) and so decided to "take a calculated risk". After the case he immediately assigned E.K. (the newly immersed staffer) to fully investigate this problem so as to be prepared for a program of audits of individual physicians. Such a program now seemed possible to Knight given a heightened public awareness and an increased confidence on the part of the division. This

case then shows a considerable growth, certainly a temporary peak, in the division's actions. It had further developed a sense of how to formally conduct sanction cases and it had done so in an increasingly confident manner.

Not only was the case deemed a success, but a considerable spectrum of learning occurred. The department's lawyer stated that he had learned to not always take Knight or the medical director at face value again. That is, he would try to be much more sure of both the content of the case and the division's authority to act on it in future cases. The sanction director said he learned a similar lesson and also that "haste makes waste." Both these two staff members were close personal friends and felt that the case had been somewhat mishandled by Knight. Yet both were really saying only that these sanction cases should be somewhat more formal and better prepared. Knight showed by his actions that he certainly agreed with the latter position. As for the formality of the proceedings, Knight tried to be fair, but it was his sense of goals that carried him through and not any sense of legal formalism. Nonetheless this need for preparedness can be seen as learning by the two staffers and one that the new recruit who had aided Knight was also to learn in later cases.

Knight on the other hand felt he had handled the case as well as he could and that he would have had to go to the press eventually to protect the public if the hearning had remained private or had reached the commissioner's level and been upheld there. The effect on the hospital might have been the same, only negotiations would have been even

closer to the threatened court action. More importantly Knight also felt he had learned how to conduct sanctions (e.g., make the suspension provisional until a private hearing); that regionalized policing by the medical profession was suspect since the "buddy" system was so strong (this was the major lesson learned according to the medical director), that quality of care was different from good quality treatment, and that the division now both needed to go ahead with on-site audits of physicians' offices and had the technology to do so. D.L. and R.D. also shared these perceptions although they remained worried about the strength of evidence needed in any major sanction case.

That these principles learned by the staff and Knight were not developed using Knight's usual teaching capacities can best be explained by the newness and complexity of the case for Knight and his inability at that time to have worked out what he called "philosophical understandings" with R.D. and D.L. R.D. was never to develop these understandings and D.L., while remaining quiet during most of the proceedings, always presented an independent view due to his professional role and the fact that he did not report to Knight. The new staff member (E.K.) was, however, to learn considerably from this case as will be shown in this chapter.

Many features of the division's usual "program" for bounding a case and for generating principles without Knight's teaching were evident in the case. Clearly evident was the openness to information coming from outside the division, the initial strong conception of the division's perogatives and the development of immediate goals. There

was however no incubation period for the case nor did Knight diffuse the problem by working with trusted outsiders or even a large group of staff as he typically did when developing new medical programs. Knight and his medical director did continue to "bend" the existing regulations to their advantage in an attempt to develop a new (to them) technology - the definition of quality care. As was usual, an initial problem had been transformed into an opportunity.

Knight did not have to rely in this case on any previous management credibility the division had built up. Instead his actions stood on their own - the very fact of taking action (and his dealings with the press) had strengthened his stand. But internal competence useful for future credibility was built up as the team struggled to develop an acceptable definition of quality of care. This was self-education, not the socratic teaching Knight often engaged in. It is even probable that the two staff who felt so concerned about the formal aspects of the case were pleased with the acquisition of this new, yet still fragile, "technology."

Finally there seems no doubt that the division's role as an accountable buyer was enhanced. The retroactive nature of the suspension somewhat lessened the blow to the hospital but its effect could be judged by the fact that it tried valiently over the next few months to wriggle out of the agreement. But the overall effect on the provider community was judged to be significant. And more importantly an internal momentum had been developed which would last at least several months after which the audaciousness of the division's sanction activity would demonstrate

the need for more careful planning of the technological base, a more thorough involvement of provider groups and a more carefully elaborated "political" strategy.

But before this was to occur, the division became involved in one further case where it had a chance to flex its muscles openly.

4. Pharmaceutical Abuse - Case II

The case involves the sanctioning of a large pharmacist who provided drugs to over twenty nursing homes in the state. The bulk of his business (60%) was in supplying Medicaid patients and this portion alone amounted to over $30,000 worth of billings per month. The pharmacy was one of the two or three largest Medicaid providers and had been easily identified as such by both the division's bill processing system and by a newer computerized system (for pharmacies and dentists only) under contract to a private firm.

The Bureau of Welfare Audits had been routinely auditing the largest pharmacists over the past several months. In addition, they were pleased at the success of the first pharmaceutical sanction case which they had helped to develop. Thus this second largest pharmacy was also subjected to an audit. The BWA, upon completing their audit, forwarded information to the division which suggested that the pharmacist had been violating several regulations of the division and such violations represented some $159,000 in billings over the past four and one half years.

The letter was received by the new director of vendor relations, the bright young man (E.K.) buoyed by his just completed success in sanctioning the proprietary hospital. He did not confer with the new pharmacy director (who had recently replaced the former director involved in the first pharmaceutical sanction case). E.K. said that he accepted the "charges" as presented by the BWA. He did however, discuss a draft of a letter to the provider with Knight. That letter, which was routinely prepared and "routinely sent out", told the provider that he might be in violation of the division's regulations and that he might be required to make restitution. The violations cited were similar to the first pharmacy case--that the pharmacist had refilled prescriptions more than five times and for a period greater than six months and that he had delivered drugs in amounts of less than a thirty day supply and done all the above in violation of the general DPW and DPH regulations that all prescriptions must be authorized by a physician in specific quantities.

Knight had realized during the hospital case that a period of informal discussion should be held before the official sanction hearing. Thus this letter was to request the provider to provide further information on the charges which were sanctionable "on their face." It also allowed, of course, for a process of negotiation and avoided the division being caught by surprise by a new argument as had occurred in the hospital case (i.e. the laying of blame on the HMA). The provider was thus notified to attend a meeting to discuss the proposed sanction.

Knight's only comment at the time was that it was indeed appropriate not to send a formal sanction letter. He felt that the previous drug sanction case had indicated that since no criminal acts were likely involved and patients were not harmed, the recovery of monies was the most appropriate concern and this could probably best be accomplished without a suspension from the program. He thus permitted the warning letter to go out although the whole case seemed to involve little of his or the staff's energies at the time.

As the letter went out, the new pharmacy director (Y.E.) and the department's lawyer (D.L.) were informed of the proposed meeting. This was the first these two had heard of the proposed sanction and their only inkling of the nature of the case came just before the meeting when Knight mentioned to Y.E. that "we're going to either sanction (suspend) him or get some money back." Knight seemed to feel that after the first drug case, this one would be easy. They knew what they wanted, had the authority and E.K. had swung into his new role as the division's "policeman" with amazing ease and was acting with considerable confidence.

At the meeting, the BWA presented its case to the provider, stating that he owned $159,000. According to D.L. the BWA knew such a figure would have difficulty being upheld in court but that it could be used as an initial bargaining tool. D.L. was upset at this strong, almost cavalier approach but said nothing. He also noted that the majority of the charges involved "prescription splitting" - the

dispensing of less than the standard practice amount of thirty days supply although no batch amount had been specified. This worried him since, of the four cited violations this was the only one not discussed in the regulations. Thus what had been a minor issue brushed aside in the first drug case, surfaced more prominantly here, i.e. charges based not on detailed regulations, but only on violations of "standard practice."

Y.E., the new pharmacy director, listened to the pharmacist's response and he too felt uneasy since no outright fraud was involved. Although he knew "it was counter to the health needs of the patients", he understood the reasons for such violations as he had been a practicing pharmacist for many years . Nursing home physicians rarely visited patients to renew prescriptions, this task being left to the nurse and the pharmacist to determine the duration and supplied amounts of drugs. In Y.E.'s words, the pharmacy "interpreted the regulations to suit his business needs." When in doubt (in nearly all the cases, since no amount had been prescribed - only a notation such as "drug x,y units per day"), he delivered small amounts each time, claiming a $1.85 dispensing fee for each delivery. In effect this prescription splitting was not "splitting" since the validity of the original prescription was in doubt due to the incompleteness of the physician's notations.

But the hestiations of Y.E. and D.L. were over-ridden by Knight who pushed ahead on the initial charges as presented by E.K. and the BWA. He stated that although this third charge was not in the regulations (which worried Y.E. also), it was a clear example of not

following good and acceptable practice and that he was willing to take a calculated risk in this situation that they could "win" the sanction case. As for Y.E.'s understanding of the reasons for the pharmacist's actions, Knight had little sympathy. He felt the intent was clear. In fact, this exchange highlighted one of Knight's beliefs that non-professionals should hold management jobs in the division since otherwise they might overly identify with their colleague professionals. Y.E. was a pharmacist (and was new on the job) and had not totally convinced Knight that he could work in the division's interest.

The provider, for his part, was open and cooperative in the meeting. He came unaccompanied by a lawyer (which was unusual) and had previously cooperated with the BWA in opening all his records for inspection. He apparently had much earlier retained the same lawyer who had represented the pharmacist in the first sanction case but had dismissed him previously. This lack of representation was to puzzle the division's members but they could not account for it. Nor could they account for his compliant attitude. For example, after the provider had presented his case, Knight indicated that an immediate stop-payment on his current billings should be made. The pharmacist questioned this in a mild fashion but only to suggest that it might do him out of business if they were held up too long. He did not question the right of the division to take this action.

Y.E. and the BWA did question this action to themselves but Knight suggested that it was only "prudent" for the division to do so (i.e.

"to hold onto what you have when you're trying to recover money") and suggested providers might easily "run off to Rio or Bermuda" if such action was not taken. Y.E. found this hard to believe, but said nothing. The representative from the department's finance office agreed to hold up current payments since his office and his strong chief (see the initial development of the sanction powers) had always done this as standard practice. E.K. and D.L. wondered about the legality of this action and the latter later explained that such action might be reversed by a court injunction. But again they said nothing. Knight later said that, being prudent, he must take such action and that it was up to the provider to prove that the division did not have that right. In the previous drug case, the pharmacist had tried to get a court to restore his current billings but the request had been rejected due to a technicality in the filing of the request.

During the first meeting the initial $159,000 claim was negotiated downward. Firstly, the druggist had stopped the practices eight months previously (in February 1974) and thus only a 45 month, not 53 month period was involved. In addition the BWA had assumed that the percentage of his total volume had been constant at 60% Medicaid over the whole period. In fact, the pharmacy had started with no Medicaid business so an average proportion of 30% was used. The combined effect of these two was to reduce the amount claimed to about $69,000. Knight and the others readily agreed to the changes. The pharmacist also claimed that this represented all three violations and that, since the violations

concerning the filling of prescriptions more than five times and for greater than a six month period were really the fault of the nursing homes and physicians, these two, which represented about 10% of the total violations, should not be considered. Knight agreed to this also and thus only the prescription "splitting" would be considered - a total of about $59,000. This figure had been calculated by disallowing all dispensing fees greater than one per month per drug per patient but allowing the cost of the drugs delivered. Knight felt they had got just what they wanted. They would recover money, they had been fair in the process, and they would set an example for other providers.

But the total sanction was to be based on an activity not specifically disallowed in the regulations - although the sanction powers did permit sanctioning for "services not meeting professional standards." As mentioned, this continued to worry Y.E. and D.L. since they felt this was arbitrary and unfair, i.e., the rules of the game had not been well laid out nor had the division or DPH regularly enforced them. The sanction director, E.K., appeared to be somewhat upset but only because he did not have very solid grounds for a "case" if challenged. Knight on the other hand later expressed his attitude as being "we run into this often and it is only by judicious use of, and taking advantage of, the power that we do have that we're getting away with it. But I'm pushing hard to get as much as possible of this sort of thing into the regs." He also stated that he had an "easy conscience" about the case but would have thought more carefully about it if criminal acts

had been involved or if they had proposed suspending him from the program or forcing him out of business. The pharmacist however, as noted, challenged nothing during the first meeting and left saying he would consider the possibilities of payment of the $59,000.

A second meeting was arranged shortly thereafter. The Medicaid staff did not discuss the case amongst themselves but all knew the focus of the next meeting would be on how the pharmacist would pay back the money since he seemed to have accepted the inevitability of payment. Indeed he had and the second meeting began with Knight and E.K. telling him they expected the money to be repaid within the fiscal year (i.e. over the next seven months). At this point, he began to balk somewhat and it became clear that the nature of the repayment schedule was crucial to an acceptable settlement. Knight felt that if he had too long a period to repay he would simply pay it out of profits and that this was "no sanction at all." On the other hand to make it too short might force him out of business which Knight did not desire, nor did the pharmacy director, the BWA or the sanction director. D.L. added that to "push him to the wall" would force him into court where the whole sanction process might be questioned. Going to court might also put him out of business. D.L. even admitted to the pharmacist that the $60,000 figure could likely not be justified in court since it was based on a sample and not a complete accounting of all violations.

Y.E. continued to feel somewhat uneasy about the whole process. He had a feeling that he wanted "to upgrade the practice and morals of

the profession" but he "was not sure this was the way to do it." There was a danger "you would hit some of the good providers this way." Knight had begun to work with Y.E. on other problems and was later to say that he had had to lead Y.E. to "mistrust his instincts" during the case, that is "Y.E. knew what was right intellectually, but had a hard time accepting it emotionally."

Due to Y.E.'s and D.L.'s reticence to plunge fully into the case, the negotiating was conducted mainly by Knight, E.K. and the Office of Finance. The finance office representative said they might be able to let the pharmacy repay in twelve months but that this was contrary to policy. Knight was annoyed since he felt a negotiating position had been given away, i.e., Knight might not mind ending up at twelve months but did not want to start there. The pharmacist acted very compliant and only mildly suggested that he could not pay within twelve months. If he did he would have to close and then the DPW might get nothing.

At this point the BWA became slightly angry with the lackadaisical attitude of the pharmacist and asked him why he had not brought up any of the arguments he had previously made in private with the BWA. Similarly, D.L. suggested that he should consult with his accountant and come back with a proposed payment scheme. The speed with which he did initiate the next set of discussions indicated that the hold up of his current bills was probably hurting him considerably and that this tactic (along with the use of the press as in the hospital case) helped the division in the settlement process. He first came back with a proposed eighteen month term and in later negotiations with Knight, D.L. and Y.E. agreed

to a $50,000 lump sum payback (financed through loans).

Thus not only did the division achieve what it wanted but the effect of the case on other activities was not insignificant. While Knight had felt that the sanctioning of the nursing homes and physicians involved was an issue separate from the pharmacy sanction, Y.E., with Knight's backing, moved rapidly to deal with these two groups of providers. But they did not chose the sanction strategy. Knight felt that to sanction all the physicians involved in these and other homes would be too difficult at that time and it would not likely change their practice in any case. They thus saw it as being too big a bite to chew off at the time. But the problem could be approached by another strategy - assigning responsibility to the "charge nurse" in each home who would be responsible for getting the physicians in at the correct intervals to make correct prescriptions. The division then began an experiment with one of the local universities to assess this strategy. Y.E. also began to examine a system used in other states in which an IBM card with three detachable copies is signed by the physician with one copy kept by the pharmacist and one by the patient, a system designed to reduce similar abuses. E.K. also backed these and other approaches since he had begun to feel much more strongly that it was the nursing homes and physicians who were to blame in such situations.

The finance office and the BWA were also changed by the case. The BWA began auditing some of the physicians involved to see if there was any further legal ground for action and began to cooperate more closely

with E.R. in the investigation of cases. The case also indicated that initiative now lay with the medical division and not the finance office as it had previously in other years before the development of the sanction powers. Knight and E.K. were cheered by this new power but were still wary since their strength might have been partially due to the temporary absence of a strong finance director.

Of interest also is the feeling by the pharmacy director that knocking off the big abusers was not the correct strategy. He felt that much more abuse went on at a small scale among the middle and small size providers who took a calculated risk that they would not be audited. That is, they knew (or sensed) the division's strategy and were unaffected by the sanctioning of the "biggies." He felt that most of the pharmacy community ignored the first drug sanction case although it was well publicized. His alternate strategy was to have random audits of all the providers in combination with much more clearly defined and strong regulations. But he did not mention this strategy to Knight since he felt that although they had the same philosophies and goals, they differed about implementation. He felt had to "live with" Knight and so did not bring it up for some time. It should be added that he was new on the job, although with twenty years experience, and was undoubtedly still establishing the bounds of his "philosophical agreement" with Knight - the agreement which we have seen consists of general principles illustrated or worked out through specific problem cases such as this sanction.

Knight, when confronted with the researcher's version of Y.E.'s proposed strategy said that "he could be right," but with limited sanction resources, one had to go after the big ones, i.e., it cost as much to recover $3,000 as $30,000 and if one can only handle ten sanction cases per month then the big ones should be attacked. While Knight also followed this strategy in all other provider areas, there was some questioning of this by the medical director, N.B., in the proposed on-site audits of physicians' offices (see the next case). Here some evidence indicated practice rarely changed upon "setting examples" -- it must be changed directly, i.e. by regulation or punishment. Knight responded that this may be true but that each provider area is different. Indeed the first pharmacy sanction may have had an effect since the second pharmacist stopped his irregular practices abruptly in February 1974 -- the same time as the hearings against the first pharmacist began.

This case then is a story of how a situation arose which had been handled once before by the division. Two of the actors, Knight and the lawyer, D.L., were the same. They were confronted by a compliant provider who did not challenge their right to take action even when that right was questionable. The same situation had prevailed in the first pharmacy case and neither D.L. or Knight were upset about the bounds of their authority. After this second case, however, Knight appeared more confident about the division's strategy while the lawyer became less so.

Two other actors new to the situation followed Knight's lead (one rather forcefully and the other hesitanttly), in the use of the principles developed in prior cases. Thus the principles that intent should

be considered, that the sanction should not be severe if no patient harm occurred, that forcing a provider out might cause the division to lose its leverage, and that, in an authority "vacuum", the division should not fear to step in, were all envoked for the second or third time. Indeed in the many lesser sanction cases during the period they had also been utilized.

But after the conclusion of the case, Y.E.'s and E.K.'s positions were reversed. That is, E.K. appeared to be somewhat more hesitant after the case while Y.E. appeared less so as he resolved his misgivings about the division's "real" authority by plunging ahead to rewrite regulations and develop means to deal with the physicians and nursing homes involved. This stimulus to Y.E. was shared by E.K. in practice however, as he continued to take aggressive stands and to move against other classes of providers. But they had both began to realize the need to establish much more clear criteria for sanctions. The story then is one of a gaining of increased sophistication by all of the actors although it was a "fragile" sophistication. This was followed by increased activity to both "correct" the gaps in their strategies and to expand their range - to make real their espoused theory and to test its utility.

This gaining of increased sophistication and clarity was achieved through the pattern for learning seen previously. Knight first of all linked the case to an earlier analagous situation, assumed a strong role for the division and advanced an early,specific,working goal (a sanction). The division continued to "bend" the formal regulations

and to slowly and sequentially seek a satisfactory solution. The consequence of this pattern, the nagging ego often seen in other cases was here rapidly confronted as the various actors moved to relieve that uncertainty.

Knight's teaching of both Y.E. and E.K. was also clearly evident here. He had let E.K. watch him in action over the preceeding month and had very carefully explained all his decisions, as indeed he did with Y.E. in this case. He relied upon the past experience of the division and cited it (i.e. the other sanction cases) yet let Y.E. and E.K. come to their own conclusions about how the process could be improved. And the teaching occured, as usual, in a specific context (the case) in which a particular goal had been formulated.

Thus, the most interesting features of this case appear to be not Knight's specific management style as seen in the new services stream but rather his initial insistence on what was "right" and the existence of a cadre of competent staff who, while sharing that goal of acting as a responsible buyer, felt compelled to make it a more credible one by putting teeth into the sanction process. Whether the staff agreed or not on Knight's handling of the case (as opposed to the goal), each moved quickly to relieve the uncertainty the situation had created. Two of the three staff were to plunge rapidly into the next case where the division's powers and their capacity to act as a responsible buyer would be examined most thoroughly of all.

5. On-Site Physician Audits

This case describes the development of a program of on-site audits of individual physicians' (private practicioners) offices to determine if quality care was being delivered to Medicaid clients. It involved the initial genesis of the idea via a series of related monitoring activities with other types of providers, the search for a legal (and political) mandate for such a program, the development of a "technology" for such activity, and finally its testing in a few quite specific areas. It was the culmination of a year's activity in the sanction area during which the division's theory of itself was developed, was confronted by some difficult realities, and was then made more real and operational and, in the long run, more effective.

The case had its beginnings during the hospital sanction case although Knight stated that he had long had (and indeed had) quality of care as one of his primary goals along with financial and programmatic integrity and the assurance of good value for the department's money. The issue of quality care had arisen in the division before in several contexts. The events outlined here are the meeting points of two thrusts of activity. The first thrust involved taking some (any) type of monitoring stance against each of the various provider categories. Thus hospitals and nursing homes (over 70% of all care) were already "covered" (albeit not to the satisfaction of the division) by monitoring programs such as the contracts signed with DPH for nursing home inspection and the HMA program in hospitals. Other areas, such as neighborhood health centers, druggists and dentists were already covered by, respectively,

strong, personal relationships with most of the individual centers, a computerized payment system (see the two drug sanction cases) and a system of prior approvals.

Thus after completing strong sanction actions against the hospital and the second druggist, Knight felt that the only untouched area was the private physicians. While they constituted only 7% of all the division's expenditures, their symbolic value was high as they represented one of the mainstays of the profession and one that had traditionally been sancrosanct, that is, removed from any real review by peers, third party payors, or government. As the medical director was later to remark, they also had a large potential for causing harm since the 7% expenditures was composed of a large volume of (low-cost) visits and since they were also the entry point into the system for many clients and their neglect of Medicaid clients could be crucial.

The second thrust of activity in this case involved the content of monitoring activity. The department had, of course, always tried to monitor for outright fraud, i.e., non-delivery of services. In addition they had the authority to assure proper billing, i.e., to catch "boosted" bills where providers claimed procedures were (slightly) more complicated than actual fact, thus necessitating a higher fee. It had also begun to question the necessity of services as in the hospital program for review of length of stay and in the drug area (see drug sanction cases). But the issue of the quality of care actually delivered had only been attacked directly once before.

There had been concurrent nationwide battles within the medical community around such issues as what actually was quality care, how could it be defined and who, if anyone, was to monitor it. The only significant national efforts to attack the quality issue that had shown any promise had been through continuing education, hospital utilization review committees and, more recently, through federally-sponsored peer review organizations (PSRO's). The PSRO's, the latest effort, were, however, not to take effect for some three to four years (if ever, some skeptics doubted). Within the division, "quality" control had usually been disguised as something else or surfaced only in areas where the division had the provider's complete cooperation or their complete submission. The first real breakout into a previously untouched area had been the hospital sanction case and Knight then began to feel he could then legitimately focus on quality of care issues.

Thus these two thrusts, quality of care and private physicians, converged in late summer of 1974. Yet it was not enough to have the two thrusts converge - the development of a technology was an additional step needed after the issues had focused. Knight and the medical director began to explore this problem. The department of course received bills from each private physician, but Knight felt that these were inadequate raw material since they usually only stated "office visit" and the fee, although in cases involving complicated procedures these would be identified by a procedure "code." No diagnosis, treatment plans or results were submitted. Knight reluctantly concluded that the paper bill alone was inadequate for determining what actually went on

in the office -- did the person actually need treatment, did he receive the correct treatment, was it well performed, was it adequately recorded, what were the results, etc.? Thus some more direct means of examining treatment needed to be found.

The obvious possibilities included actually watching the physician practice, examining his office and/or records on-site, or requesting submission of records and back up material for the bill. The first possibility was tacitly dismissed by all since it would obviously involve a major political leap, would likely be illegal and would demand enormous amounts of time and money. The latter two possibilities were the only real contenders. But what was envisaged was an audit program, not a 100% monitoring; so that the option of having all bills submitted with detailed records and back up material was not considered. It seemed politically impossible (although it had been tried in a limited way in some other states) and the division had no administrative capacity to utilize such a deluge of material.

Rather an audit program of some randomly chosen providers and providers who had been singled out by field workers, the billing system or other means would be mounted. Recall also that Knight's strategy was to "knock off" the worst providers in each area so as to set an example -- a strategy chosen because of the limited resources of the department. Thus the method he proposed for examination was on-site examination of records and so, by early September, not only had the division assumed a strong position on the need for some type of program in the area but it (at least Knight) knew what the general shape of the program would be.

After the initial flush of success from the hospital sanction case, an important personnel change occurred. The sanction director, R.D., who had played an increasingly quiet role in that case and who had never gained the full confidence of Knight, was about to return to graduate school. E.K., who had aided Knight during the hospital sanction case, had impressed Knight with his performance and so he assigned him to the sanction area. His special mandate was to develop the program of on-site review of private physicians -- including the necessary legal backup since he wanted to be sure that the next sanction thrust was based on more sound legal grounds. Knight had grudgingly admitted that, while "not feeling uneasy" about the legality of the hospital sanction, more work was needed. E.K. was also to research the action other states had taken. Knight told him that private physicians were "uncovered" and sancrosanct but that he had every confidence that the new recruit could work something out and he was given a free hand to develop the program.

At the same time as R.D. was leaving, another new recruit, a pharmacist was hired to work in the sanction area. As was Knight's nature, the exact division of tasks between these two newcomers was not made precisely clear. There was ongoing sanction activity in all other provider categories, plus billing irregularities and fraud in the private physician area to handle. The two began to work on the complete sanction program with E.K. concentrating on the on-site audit theme. The pharmacist, however, after reading the file on the hospital sanction case and observing the second drug sanction case decided that Knight was taking

too bold, and perhaps unfair or even illegal, steps and so mentioned his fears to Knight. Knight apparently began to feel that this view was not really the kind that could be helpful in the sanction area. In addition, the pharmacist had been brought on at a low salary and it became clear that Knight would not be able to rapidly come through with higher pay. He thus resigned after a few weeks and the whole program area of sanctions fell to E.K. E.K. was young, ambitious, intelligent and personable and, after the exposure to Knight in his office and during the hospital case, much respected his style and direction. He fell to the task with gusto and began to confer with the department's lawyer, D.L.

D.L. researched the enabling legislation setting up the department and came to the initial conclusion that the division lacked authority to conduct such audits on quality of care grounds. The legislation stated that standards should be set for the "proper and efficient" operation of the plan (Medicaid) but that the division should not set "medical standards and criteria." These latter standards were apparently to be established by DPH in its licensing capacity. But DPH had only utilized these in a minimum way or, as in the case of nursing homes, under a contract with the division in which they would act as inspecting agents and enforcers of quality standards. Other state statutes had also stated that standards for hospitals and nursing homes were to be "formulated" by DPH.

E.K., discouraged by these findings and wondering whether federal law gave any powers to the division began to research it, to look for

a "general umbrella power" to set and enforce quality standards. D.L. also searched the federal statutes, but here the search was also unfruitful. The legislation said that the "state health agency" (i.e. DPH), should set standards and engage in quality of care areas (the agency administering the Medicaid program was referred to as the "single state agency" - although in some other states they were the same). They did find a clause permitting standard setting by DPW for "review of items of service" but this was not clear and apparently did not seem to provide a necessary (both strong and clear) power for the department.

They concluded that DPH probably had the authority but "does not want it or is unwilling to exercise it." They then conferred with DPH's lawyer who seemed to indicate that he felt DPH did not even have the authority to set, audit or enforce standards of quality for Medicaid. The two DPW staffers interpreted this to mean that DPH was willing to let DPW assume these responsibilities. An interesting shift of position occurs here as usually DPH (see the day care for the elderly case) was quite protective of its perogatives. The DPH lawyer was, however, a strong civil rights lawyer who appeared to side with DPW. The two staffers felt he represented the DPH position as a whole but Knight was more cautious. He felt that others (higher up in DPH) would not be so amiable and was not so easily impressed with this casual abrogation of power by DPH, although the medical director felt that "DPH had always been understaffed and never very interested in innovative areas."

It is clear that the question of legality had not been clearly understood (or admitted) in the hospital sanction case. D.L. had not

questioned the division's authority to sanction on quality grounds until it surfaced in the on-site audit case. He felt that if questioned on the hospital case he might have been able to legally stretch the utilization review powers granted to them for hospitals into quality assessments (i.e., the poor records cited in that case). But he realized the larger implications and thus cooperated in the search for adequate authority. He did not speak to Knight about the possible tenuous base for the hospital sanction case since he felt that Knight did not want to hear from him unless they were in agreement.

E.K. also agreed that the sanctioning of the hospital for "not meeting professional standards" (as in the DPW regulations) may not have been legal. He had sent Knight a memo to that effect stating that the sanction program might otherwise become an impotent program of reviewing bills in the central office. He was not sure that Knight understood the linking of the authority question in the audit case to the hospital case. But Knight, as described in that case, did grudgingly admit that the claim to authority was murky at best. Indeed his action since that time spoke louder than his words - as he had concentrated on the question of authority to the early exclusion of political and technological questions. There was no question here of much further "bending of the rules" unless a very thorough examination of the problem was made.

At this time, however, a technological (how to do the audits) issue arose -- that of the legality of an unannounced audit. The DPW lawyer felt that advance notice must be given otherwise the division would get sued the first time it happened and might well lose the case and have

many physicians drop from the program. This ability to arrive unannounced was felt to be important by E.K. since physicians could easily "doctor" the records or prepare elaborate exculpatory explanations in advance if they suspected poor care might be uncovered. The medical director however felt this would not likely occur since it would involve tremendous amounts of work on the physicians' part. Those who had something to hide would either contest the division's right or simply drop out of the program voluntarily. This aspect of the technology question was dropped at the time since no ready solution was found. Similarly the question of precisely what were the components of quality care was held in abeyance while the search continued for the legal mandate.

At this point some of the uncertainty developing around the authority issue began to be directed towards D.L. and his evolving position. Knight felt that he was inexperienced and somewhat conservative. E.K. also stated that he felt that to some degree but he nonetheless also began to feel uneasy about going ahead without a sound legal base. E.K. was thorough by nature and had indicated that he would probably like to go to law school sometime. Thus some of D.L.'s attitudes had apparently begun to rub off on him. He thought that Knight felt lawyers are "magicians who can manipulate the law to get what they want." And N.B., although not actively involved in the early stages, felt that D.L. had not given him satisfactory responses to an earlier query as to whether individual physicians acting for the department would be held personally responsible in any suit based on a sanction case or whether the department held liability insurance for them. D.L., for his

part wanted to see a program of audits in place, but felt that the authority was clearly lacking. Knight kept digging away with new suggestions which he would systematically have to "shoot down." He stated that he became discouraged after a while and began to feel he wasn't being consulted as often as before since he always had to respond negatively although E.K. continued to have good access. Here Knight's teaching style was not as effective as D.L. was from outside the division and had not been subjected to the selection or socialization process that the others had. But the discussions among these three continued in good spirits and with no hostility or rancor. Only Knight retained a high degree of optimism.

The trio continued to explore other avenues. D.L. suggested a joint DPW/DPH audit but Knight apparently did not feel strongly about that idea. E.K. (at Knight's suggestion) proposed fines as a possible lever but D.L. replied that again the department had no authority; they could only be levied by a court. About a month after he delivered this opinion, Knight replied asking for a more definitive explanation of why fining was impossible. The Bureau of Welfare Audits also suggested the idea and when told it was not possible decided to develop a bill on their own to submit to the legislature. Finally, a theory of the "dropped ball" was proposed by E.K., i.e., that since DPH had abrogated its responsibilities, DPW had "picked them up." D.L. felt this was a "foolish and unsupportable argument" since it was specifically prohibited by statutes. But he began to respond to E.K.'s request that he put the legal arguments in writing so that they could be

submitted to DPH and a formal reply from them generated -- hopefully one which would support the "dropped ball theory." This kind of activity continued for over two months. Knight obviously had the audits as a key concern but was letting his staff members develop the rationale. He refused to take no for an answer and kept prodding them to come up with new strategies.

Knight, however, kept an extremely low profile outside the division, contrary to his usual posture of bouncing ideas off close and trusted friends and informing his "constituencies" of their progress. But here he did not wish to divulge his strategy too soon. In fact he specifically instructed all his staff not to mention the possibility of such a program outside the department. He stated that he had not conferred with his two superiors on the subject, saying that he felt he was "within his perogatives to develop the program first."

Yet the commissioner of the department was aware of the activity, but did not intervene or mention it to Knight. His superior in EOHS, when informed of the program by the researcher, was ambivalent about it but not surprised to learn of the program development activities. He felt the responsibility might be a BWA or DPH one if it involved fraud or non-delivery or over-utilization of services. He was generally quite non-committal on the responsibility issue. But he was quite certain about other aspects. First he "would want to know who was going to do it and what the return would be." He was not convinced there would be a large return and felt that such programs were best contracted out, like the HMA and drug processing areas, i.e., to the professionals

involved. Knight felt the opposite, of course - that the profession would not police itself. But the undersecretary felt that the important thing was not who did it but that someone did it, i.e. look over the provider's shoulders, and that this demonstration effect brought 90% of the desired results. But they did not talk directly on the subject; he only gave a warning to Knight not to be so aggressive that "he might get into trouble."

The other obvious source for the division to touch base with was the Medical Society. Knight did inform them that he felt such a program of audits should be carried out but was deliberately vague about who or how they should be done. The society also felt they should be done but by some PSRO-like organization and not by "bureaucrats". Knight felt that they were not aware of his desired goal of sanctioning and suspending poor physicians and thus did not understand his overall strategy. This strategy, as we shall see later, consisted of testing the on-site audits in home health agencies and family planning clinics (both with little "clout") or with a few group practices who agreed to participate and later building up to "hit" the solo physicians.

Another obvious outside base of support was the formal political system. That is, if the legal powers are weak or unclear, the division might propose new legislation to change the situation. D.L. had proposed this as the only likely solution but Knight had rejected it. D.L. suggested he would thus "expose himself to attack." As Knight himself put it, "then you'd open a pandora's box and right now I'd rather wriggle

and squirm within it." It is this "squirming" that has been described above. And it continued with Knight convinced that while the enabling legislation did give power to DPH it also reserved some power for DPW such as the authority to do "random post treatment examinations of recipients" in order to assure that services were "actually performed as described" or that the providers must "provide evidence satisfactory to the department of their qualifications to provide such services" or the earlier mentioned "proper and efficient operation of the plan." While the question of legal authority was the first to arise, these political issues (backing within and outside the bureaucracy) soon added themselves to the agenda.

Only later did the question of "technology" loom up. In the process of defining what the auditors would look for, the need to define what good care is and how it could be determined arose. Each of the participants felt differently about the technology issue and all but Knight were awed at the difficulty of actually developing standards. As he said, "The technology is people; all we need is to get good people to sit down and work them out."

N.B., the medical director, had been approached by Knight in the early fall about the possibility of setting up the program. He said that he had felt not too enthusiastic about the idea and had expressed his reservations to Knight. Since that time he had participated passively in the idea with most of the discussion centering on the other participants. His reservations about the idea centered mainly on the

mechanics, or technology, of doing it although he also felt that it would be difficult to get the necessary "political" backing in such a sancrosanct area, and that they would have difficulty from the division's own medical consultants who felt nervous about touching on such a delicate area. He first of all felt the audits would be logistically difficult since they would disrupt the doctors' working hours. Also any standards they developed would be arbitrary since records in private offices are so poorly kept (there not being the need as in hospitals and clinic organizations for a document which can be read by many different practicioners). He also felt that the "grossest" abuses could be picked up in an audit of records mailed in to the DPW, i.e., they did not need to be on-site since these gross abusers would never make the effort to change all their records. He also felt a personal distaste at having to act as a prosecutor for his fellow physicians although if able consultants who would so act could be found, he would go along with the idea.

Despite these hesitations, N.B. agreed in November that the divison should try out the idea with the three individual physicians identified by the hospital sanction case but only to the degree of asking that they provide their complete medical records to the division. This brief experiment also led to some discussion around the adequacy of records themselves. E.K. felt that they were an inadequate base to determine quality of care. The division might not even have the legal authority to demand their production. Knight even backed down somewhat and began to feel that inadequate as they were, the records

could be focused on. That is, they had determined in the hospital sanction case that poor record keeping in itself constituted poor care and that they might have to "catch" the poor providers on the grounds of poor records alone.

Knight thus admitted the difficulty of doing the on-site audits so that the idea of focusing on a record review in DPW offices became a short run possibility as did his earlier strategy of doing on-site audits with other classes of providers. In the long run however Knight felt that the standards can be developed. He cited as standards the low quality of records, professional norms which could be "teased out" of the physicians themselves, and the protocols of the American Academy of Pediatrics.

The technology issue was further bounded by deciding to call the whole area "program review" rather than "on-site audits." Here Knight felt that if the random audits discovered good or excellent care then that would be highlighted and perhaps even publicized. The idea was to act in a "non-punative, educative" manner. But others within the division saw it differently. D.L. called it a charade (perhaps designed to get around the legal difficulties) and the medical director, a disguise. The real intent was punative and to set an example. This did appear to be the main thrust of the program but Knight when questioned said "no, wouldn't you be happy to find situations of good care? If we do, I'd then work with him as an ally." Again Knight's ability to turn problems into opportunities surfaces.

The next action in the case was to begin to direct the concept of on-site audits at either "weak" or cooperating providers -- home health agencies, family planning clinics, and a large group practice clinic as a start. In the first two cases, the providers had agreed to conditions of participation which stated that audits and inspections might be carried out. D.L. warned that even here the division might not have authority since two parties cannot, even by agreement, exercise powers not legislatively granted to them. Knight recognized this danger but moved ahead. As E.K. saw it -- "I agree it's a bluff but here we have more credibility", i.e., it was a cooperative situation and the two groups of providers were more dependent on the Medicaid program than most private physicians. Thus the political and legal streams merged and an acceptable short run strategy had been formed.

Work also continued on the technology area. At a meeting with one of the ex-directors of a prepaid group practice, Knight, N.B. and E.K. explored the possibilities for monitoring quality care. They concluded that the "hothouse" atmosphere of a teaching hospital or a group practice was all-important, but agreed that in its absence, it should be easy to establish "process standards of care" i.e., for a tentative diagnosis of say, pneumonia, certain tests and work-ups should be performed and recorded. While that discussion focused on hospital admissions and the 10 or 15 most common diagnoses (which constituted the bulk of admissions) they believed that the concept would be transferrable to private practice and Knight continued to work on his own to try to get agreements on some of these common diagnoses.

The larger issue of whether the whole strategy of identifying and removing a few "bad apples" was an effective one remained (see the development of sanctions case). N.B. felt it was not, since some published data had indicated that the "bad apples" continue to practice poorly even after sanctions and educative efforts. But Knight felt that with limited resources, the division had no choice.

The case now continued for nearly a month with action on all fronts, political, technical and strategic (i.e. testing) proceeding along although the uncertainty felt by all kept the process in a low profile despite Knight's keen desire to see it take prominence. However in late January of 1975 the initial testing of the quality concept ran into some snags. One of the lawyers for the three physicians offered up in the hospital case questioned the division's authority to sanction on quality grounds. Knight was, of course, quite upset by this challenge and his first reaction (to E.K.) was that, if necessary, he would take it all the way to court and make the issue so public that while he might lose the case, the physician's true quality would be revealed by the publicizing of the details of the case.

This veiled threat was never delivered to the provider and the next day E.K. prepared a lengthy summary of the division's position citing all the provisions of the enabling act which appeared to give the division some power. But he accompanied it with a separate memo showing how the position could be rebutted by a skilled adversary. Knight appeared despondent and suggested that they might have to let the three

physicians go "free" in addition to "laying low" on the on-site audits. E.K. had apprently clarified for Knight that the problem lay in two areas - one, the authority to sanction on quality grounds and two, the existing regulations which cited violation of professional standards as a sanctionable offense. The first problem, they decided, would have to be approached by pushing DPH to develop standards and also by seeking to have the clause "except medical criteria" removed from the DPW enabling legislation. As for the second problem, E.K. said that the "sanction office is closed for repairs for six weeks" while he combed the division's regulations and conditions of participation to put as much as was possible into written form which would define "professional standards." In the meantime the on-site audits with family planning clinics and home health agencies would continue. Later, two of the three doctors accepted a 2 month retroactive suspension and a 22 month probation while the third continued to fight his case. In addition, the division's nursing home regulations had included references to violations of DPH standards as sanctionable offenses and the nursing home suspensions continued without this roadblock in their way.

The case is characterized first of all by the dogged determination of Knight to do the "right thing" which in his mind was to act as an active purchaser of quality services. His perceived role was given a tremendous boost by the hospital sanction case and he quickly brought two issues together -- a sancrosanct provider group and review for quality assurance. In bringing the two together he utilized several of the principles developed earlier in the hospital sanction case, for

example that the medical profession will not police itself. But he not only learned these lessons but also undoubtedly realized in hindsight the audacity of this previous case for he not only instituted some exhaustive searches for a remedy but kept the whole process quiet, only selectively involving outsiders -- things he was not in the habit of doing as we have seen in other cases. He also, at first, ignored the advice of his medical director on the means of carrying out the program and instead substituted his own personal experience. That is, he knew that physicians did operate on the basis of tacitly agreed - upon standards of practice and that the only task was to draw these out and a technology would be available.

In the process Knight wore down his staff with a persistent leadership not as evident in other cases -- but the persistance paid off. A short run strategy was devised although it involved retreating on political grounds (i.e. approach weak or cooperative providers), on technological grounds (they could concentrate on the quality of records) and on the focus of interest (solo physicians would be approached later). Knight continued to seek out allies who can help him develop the technology. He was of course still "bending the legal rules" but realized that to break them on this issue might cause the loss of the momentum the division had gained and that the strength and the credibility he so much sought for the program must be approached more directly.

The leadership shown was not the pure "teaching" style so evident in other cases. Rather it was Knight <u>acting</u> on beliefs with which

he felt secure; that a way could be found to conduct the audits. Here he served mainly as a critic as the ideas his two competent staff brought to him were discussed. Some of his teaching style's more positive elements such as his ability to "read" correctly the style of staff members seemed to be absent here, for example, in his inclination to not listen to the department's lawyer or the inability to admit a "defeat", although with respect to the latter, the doggedness of his direction undoubtedly helped produce a more reasoned stance.

But the delicate momentum which had been built up and Knight's assurance of the correctness of this stance was finally challenged (in a mild manner). This setback could not be evaluated but the initial response of the division indicated that its long-run effect would be beneficial. The speed with which Knight reacted indicated that he felt the momentum gained could no longer be maintained by sheer audacity or cooperation from a few providers; it must be made credible by regulatory back-up, legislative action and inter-agency cooperation. Whether the division could learn new strategies to carry out the latter two tasks is an open question, but the evidence presented by the third stream of cases (Chapter V) suggests that the strategies of legislative back-up and DPH cooperation would be difficult to implement.

6. Overview

This stream of cases (the sanction stream) began with the actual development of the legal power of the division to sanction providers. This initiative was taken by the division with virtually no mandate or pressure from its environment and, after a year and a half, a series

of major sanction cases had been conducted in which the limited goal of suspending providers from the program and/or demanding substantial financial retribution was accomplished. In addition, several nursing homes were closed under threat of sanction activity. Evaluation of the ultimate goal of improving the quality of providers throughout the whole depth of the millions of services rendered each year to the division's clients can not yet (if ever) be assessed. Yet the strategy of setting an example by "knocking off" key abusers in each program area in the belief that other providers would voluntarily bring services up to standard can be tentatively characterized as being a success.

In addition to these major sanctions, several minor program abuses were corrected under threat of sanction. The routinization of both these major and minor thrusts is difficult to assess since their application was a matter of policy on the part of Knight's administration rather than a program consisting of a codified body of regulations and a large staff with specifically assigned tasks. Yet the continued emphasis of the sanction program over the course of a year and a half (and its neglect by the previous administrations) indicates that the policy was firmly held in the organization at that time.

Only one of the sanction cases (physician audits) was seen to be a "failure" but even in that situation the lessons learned were immediately applied to two other provider areas and also resulted in an attempt to further codify the sanction power in regulations, in interagency agreements and in legislation. This ability to transfer the momentum acquired by the agency was noticeable as the division moved

from pharmacies to hospitals, back to pharmacies and on again to private physicians and clinics and a large nursing home owner, each time with increasing confidence and a sense of credibility. Internally, Knight and his staff reflected this increased confidence as they developed procedures for handling the cases such as the use of provisional sanctions or the involving of the press when required.

While the above momentum was clearly directed by Knight, particular staff members were instrumental in the carrying out of the division's programs. Knight sought staff with a "prosecutorial" or "policeman" bent who could actively pursue the sanction policy. The first staffer chosen (R.D.) did not fit into the spirit of the momentum being created as he did not seem to adapt to Knight's teaching style and Knight's eventual response was to ease him (and another) out of the division. The next sanction director appeared to have absorbed both the spirit and the know-how involved in the program. Others such as the pharmacy director, the department's lawyer, and an adjacent agency extended their horizons to further clarify sanctionable activities and to pursue offenders. The remaining staff did not actively seek potential abusers but rather pursued those cases thrown up to them by a wide variety of sources. The nursing home director, however, using a system of DPW and DPH inspectors, continued to actively seek potential abusers.

While the momentum developed by this core group of the division was felt early on, their specific program for action was not so clearly enunciated, nor was its development unvaried as the stream progressed

and its demands changed. The division appeared to have learned that not only is such a program a necessary component but also that it must be adaptable to circumstances. Thus the initial cases showed a consistent willingness to accept inputs from outside the division (in the "tip-offs" for the case) and coupled this with a strong role assumption that the actions being taken were justifiably within the division's mandate even though that role was to be questioned later in the stream. These cases were approached in a relatively "rational" manner consisting of calculating the desired outputs from specific goals, for example, "develop regulations which will permit the division to suspend", or "Let's use the new regulations for this problem" (drug abuse I). The initial cases were handled somewhat cautiously and with a sense of uncertainty, as the division (a) relied on a large group of persons in both cases and (b) put considerable effort into examining the details of each case.

Obvious not only in the initial cases but throughout the stream was the haste and speed with which action was taken after the case first came to the attention of Knight. This is in contrast to other areas such as the development of new medical services where a considerable incubation period occurred after the initial assumption of the division's perogative. Similarly the early adoption of a specific goal for each case was apparent throughout the stream (e.g. "we're either going to suspend him or get more money back").

The initial uncertain strategy changed over the course of a year as the division, and particularly Knight, became more aggressive,

confident, and even audacious in their sanction activity. They much less frequently relied on a large group process to reach decisions; the regulations involved were interpreted more liberally; and the actual details of the cases examined less thoroughly (unless confronted strongly by outsiders). Despite this aggressive stance, multiple and occasionally conflicting objectives came into play in the middle three cases and the "rational" style of decision-making in the first and second cases developed into one involving more judgemental or compromise decisions as the division looked for "satisfactory" solutions. For example, it was not clear what the effect of a sanction might be on a provider in the drug cases, nor was it clear just how harsh the hospital sanction could be without an appeal being generated to the courts or the commissioner but a judgement had to be, and was made. This contrasted with the more "optimal" search patterns in the development of new medical resources and the "inspirational" strategy in the last sanction case which involved a great many variables about which the division had little knowledge (recall also the "inspirational" approach to the EPSDT case - one in which Knight was also very convinced of the rightness of his approach).

Concurrent with the above was a progressively greater involvement of the larger community through the press, the medical society and others (universities, provider groups, etc). In the last three cases, Knight also began to rely on his past experience or trusted friends for technical knowledge although in terms of the managerial knowledge necessary to carry out his strategy he remained confident of his own

skills. It was only after the second drug case concluded that this involvement of the division's environment was downplayed.

By then it was apparent that the elements the division had then chosen to confront were the most complex of all. This increased complexity had also been slightly apparent in the second drug case (c.f. the hesitation of the pharmacy director and the lawyer). The divison became less aggressive and confident and relied on Knight's inspirational style of decision-making ("there's got to be a way"). Specific goals for the last case were not as clearly outlined but the necessary internal homework was done with much greater thoroughness as the larger environment was temporarily "frozen out" of the process. Finally the division realized that while the various bases of its action needed more development, it could nonetheless propose a compromise short-run strategy to maintain momentum. Just as this occurred they were "called" on their previous aggressivity and forced to retrench, this time to prepare a long-run strategy to deal with each of the technological, legal and bureaucratic complexities.

While the nature of the program for action developed by the division varied somewhat according to circumstances, its overall approach did not. The division's approach was observed also in the new services stream and will be seen in the final stream (Chapter V). Recall that its main components were three-fold - (1) the development of shared principles, primarily through the teaching of young and inexperienced but competent staff as each case developed, (2) the development of credibility

and integrity through a management approach and (3) the conscious development of the organizational paradigm - a "responsible buyer".

It is also clear that the development of shared principles was aided by the division's program for action. That is, the division learned not only how to accomplish specific sanction tasks through the program but it also used the program for developing shared principles. The program for action not only permitted success in the various tasks but it also permitted the bounding of a very uncertain background in which more specific principles could be developed (through teaching). Thus, as in the new services stream, the learning of the program for action is not only what the division learned, it also begins to explain how it learned the principles. Knight's teaching style more fully adds to an understanding of how the principles were developed.

The development of these shared principles between Knight and his staff enabled the sanction stream to make rapid progress in the last three cases. And conversely the difficulty Knight had in establishing an agreement on these principles in the first eight months with his sanction director probably accounted for the initial slow progress. This agreement was generated through Knight's teaching approach in which general principles were developed during each case and then became part of the organization's working memory on how to behave in succeeding cases. The principles were, of course, all exercised in the service of the agency's paradigm - the responsible buyer.

The content of these principles was outlined in the case descriptions but will be highlighted here again. Firstly there was Knight's

belief that the best way to show the community that it meant to exercise (the negative side of) its buying power was to sanction one provider in each program area. This was clearly evident as each of the major cases was in a different area. As the stream ends, we see the division moving on to actually suspend a multi-facility nursing home operator, nor merely forcing a closing through threat of sanction. Similarly the sanction director began to devote less energy to a third pharmacy abuser charged with offenses exactly similar to the first two. Once this principle had been established, a second principle developed which stated that development of regulations and the direction of the cases should not be done by a "committee". This committee process in the first case so annoyed Knight that he stressed that development of joint DPH/DPW standards for solo physicians should involve as few people as possible.

The second case (pharmaceutical abuse I) generated several principles which were also to be invoked in the hospital and second drug case. These were: (1) that the provider's intent is a key feature in the proceedings. Thus he should only be sanctioned if his intent was to milk the program. The converse of this is that the charge could include something not specifically mentioned in the regulations as long as it was apparent that the provider was violating the spirit of the regulations or going against professional ethics or "standard practice". Another principle was that providers should not be forced out of business unless clients had been exposed to direct harm. For example, the drug cases did not indicate such harm but the hospital case did and Knight's

"blood went cold" when the possibility of the hospital being forced out of business was raised. The first drug case also generated the understanding that the division would lose all leverage with the provider if the sentence was so severe as to force him into bankruptcy. Thus the division might not recover any money (1st drug case) or might lose an opportunity to restructure the hospital's total utilization review system (hospital case) for Medicaid as well as for non-Medicaid patients.

The hospital case itself also saw the development of principles which were utilized in succeeding cases. Firstly the realization that quality care is different from quality treatment was developed here and used in the physician's audit case. Secondly, Knight also clearly tried to get across to his staff that often authority must be seized if no one else is willing to exercise it - which he had to do again in the second drug case and in the on-site audits case and indeed, in many of the new services cases. The converse of this principle is that professional organizations will not police themselves (the HMA turned the hospital case over to DPW) such that Knight deliberately tried to avoid an "HMA-like" organization for the on-site audits.

How were these principles generated and carried from one case to the next? The clearest answer lies in Knight's teaching style. While this style consisted of many elements, some six or seven are particularly relevant in the sanction stream. Firstly Knight would often simply declare a principle and hold it to be more or less self-evident, e.g. that the degree of sanction should vary according to the intent of the

provider. Secondly he would enter a case with quite specific goals which might or might not change during the case but which provided a direction for both he and the staff. (For example, the early feeling in the second drug case that a sanction or suspension was inevitable).

Thirdly, Knight often invoked his past experience in generating a principle, e.g. that providers' current bills should be held pending the case resolution seemed apparent to him from his business background. Fourthly, Knight very clearly explained his decisions to both staff and providers. There may or may not have been agreement but the reasons (and principles)behind decisions were open and available. All the staff interviewed felt this to be significant. Fifth, Knight would often openly admit his lack of knowledge about details of a provider system and eagerly try to learn about, for example, how nursing home prescriptions are filled and how one might define a bad nursing home. After the on-site audit case, he asked his nursing home director to "show me 3 good homes and 3 bad ones." Finally there was the use of an explicit learning vocabulary. Knight would often ask in public, "well, what did we learn from that?" or he would stress in staff meetings how a case or a cumulation of cases had developed (at least for him) a new principle - "we've learned that the medical profession won't police itself very well and particularly not on a decentralized basis." This learning vocabulary is so simple and obvious it may appear trivial but its effect was, I believe, quite significant.

Thus it was through Knight's teaching that the organization's principles developed and it was through these principles that the unrelenting

and unchanging goals which formed the paradigm of the division were translated into reality. However the success of such a teaching style also depended on the nature and quality of the "students". The overall staff was primarily young, competent, anxious to seek out poor providers and relatively untrained in medical care or management - ideal students for such a style. Yet it is still unclear whether Knight was able to fully teach his staff the principles discussed earlier to the extent that they would behave if acting independently of him. Certainly each of the staff directly involved came out of the experience with a different view than when they began. The two pharmacy directors adopted a more clear and strong regulatory stance than might be expected given that they were the only full-time members of the (professional) medical community in the division. The initial sanction director never developed shared principles with Knight but his insistence on a more rigorous approach was one eventually adopted. The second sanction director and the department's lawyer not only learned about the conducting of the sanction process but so thoroughly checked out the ramifications of many of the principles that Knight himself eventually made a considerable shift in direction in order to better achieve his aims in one of the particular areas. In the other areas the team continued to develop cases using the body of principles developed by Knight.

The second main component of Knight's approach which never varied throughout the sanction stream was his management style. Recall that the role of good management was two-fold. Firstly it enabled the

division to develop credibility with the external environment. For Knight this credibility was half of the paradigm of the "responsible buyer". Responsible meant not only searching out cost effective services and strategies but also acting responsibly and accountably towards the division's environment. Good management of the division's routine activity would give it the credibility it needed to move forward into new or innovative areas such as the sanction activity.

Good management of routine activity meant to Knight, and eventually to nearly all the staff, that the division should first of all have policies for each of the areas it was involved in, that these policies should be relatively consistent and coherent and that the division, acting through its local and regional offices should actually act on these policies (Knight - "by integrity I mean we should actually do what we say we do.") And finally, the division should be held accountable for all these activities. Simple concepts each of them, but given the lack of management, or under-management prior to Knight, their achievement (or lack of it - witness the continuing effort to assure the local offices performed as well in each of the above areas as the central office) is not a minor one. Thus, for example, it is unlikely that the division would or could have moved against druggists and hospitals without a sound fee schedule for both, adequate bill payment processes (for pharmacies) and the monitoring program (for hospitals) nor against nursing homes without the integrity shown (and acknowledged by the providers) by the nursing home director.

But of more interest from a learning point of view is how Knight used good management as a tool not only for routine activity but also to process new knowledge such as we are discussing here. The management approach thus served the dual purpose of developing external credibility which was then called upon to move into new areas where the same internal management style could be used to direct the transformation of new information into a learned response.

As with Knight's teaching style, not all of the management approach is observable in the sanction stream, but several of its more important elements are. Firstly, we see that Knight insisted on a "very careful delegation of authority and responsibility" with as many as possible of the key people reporting directly to him. He involved himself in each major sanction case (including the development of the initial regulations) and only gradually delegated authority - first in a circumscribed manner to the initial sanction director (who did not fully share his principles or style) and finally to the second director in whom he had more confidence and trust. Secondly, he continually manifested his abhorence of large working groups or committees (he attributed the necessary retrenching in the on-site audit case to the committee's output he had been saddled with in the development of the regulations) and of separate research, analysis and planning functions, i.e. planning and operations should be as close as possible. Thus each sanction case was developed by a very close functioning of the program manager and the sanction director and the charges grew out of operating

violations and not abstract principles such as might be developed by a separate research or prosecutorial unit (i.e. the MHA or even the department's own legal department).

Thirdly he insisted on "getting good people" and on down playing the emotional or political components of his staff's performance - there was little classical "organizational development" activity and surprisingly little internal political, power seeking activity. Thus Knight eased out two sanction directors until he found the one he wanted and only then delegated full authority to him and began to move with full confidence. Fourthly, he continually stressed both the general goals of the division, e.g. not to have to purchase from poor providers and the refinement of specific goals laid out by him, e.g. "we're going to sanction this provider" or "we are going to make an example out of this hospital." These specific goals were formulated through Knight's teaching and his continuing ability to ask "what do we want" or "this is what we want, isn't it?" or "what did we learn from that" in open dialogue with his staff.

Fifthly, Knight stressed the need for staff to be open to and cultivate as many sources of information as they could. While this is not as apparent in this stream as in the new resources stream, each of the sanction cases was evidenced by a willingness to accept both data and perceptions provided by the division's informants. Finally, Knight's insistence on cost/effectiveness as a basic management tenet was evident in the whole sanction strategy of selecting one big provider in each provider area. As each provider area was first covered, he moved

rapidly to the next, not continuing to use scarce staff resources in areas where, for the meantime, further payoff would be small.

Thus, not only were working principles developed through teaching but they were to be exercised through management, a particular style of management which the commissioner called unorthodox but which can also be seen as remarkably simple, and in this case, relatively effective. And the principles were to be in service of a mission - a paradigm to be made real and fulfilled. As with the development of principles and the use of management, the role of the conscious paradigm in directing the agency's program was consistent throughout the sanction stream. The new paradigm Knight held out for the division was unrelentingly evoked. The division was to be a responsible buyer of services. Not only was it a buyer (and could thus choose not to buy) but it was to do so in the service of a goal - efficient and quality care - for which it would be held responsible. This was held out by Knight both to the staff involved in sanctions and to the full staff, although not all the latter concentrated on sanctions as the vehicle - some, for example, stressed expanded primary care as their input to the goal of quality.

The stress on the buying of quality care at cost-effective prices was apparent in each of the cases as each one involved the recovery of money in addition to the cited charge of violation of standards of professional care. The other part of the paradigm, that the division be "responsible" and acquire credibility, was not as clearly invoked as it was in other more routine activities of the division. But in turning

the sanction program into a routine, it did begin to add to its existing credibility. It began to develop first general and then detailed regulations for what was sanctionable activity (it had a policy); it was more or less consistent and coherent although the need to selectively apply it would no doubt be seen as inconsistency from the provider's point of view; it did begin to act on its policy; and it held itself fully responsible for its policy, as witness the extended attempts to develop a legal, political and bureaucratic mandate for this policy.

It is clear that Knight initially perceived that to make this paradigm become alive and real, he must have the division act strongly, quickly, and publicly in a wide variety of areas. During the course of the year and a half he was to learn that such paradigms, while providing a strong momentum, were also essentially fragile and could easily be directed off course by a small force (i.e., the challenge by the hospital physician's lawyer) and that their direction and weight must be chosen carefully. Indeed, Knight was to learn that the initial existential act of "establishing" the paradigm must eventually acquire a base in the organization, in this case, in its staff (which he did accomplish) but also in technical, administrative/legal, and political areas (which he began).

To summarize then, the division learned how to accomplish specific tasks, i.e., it "succeeded" in each of the cases it approached, and it eventually managed to routinize this behavior as it began to develop

regulations for sanctions and to handle several cases of a similar nature to those described here. It also showed that it had developed general principles for dealing with a variety of sanction cases. And it did this first of all through a program for action which became more fully understood and tested as the stream progressed, and secondly, through Knight's teaching and management style. It is not possible to assess whether those aspects of his style had been fully learned by his staff. It is possible to assert however that a new paradigm was learned by the division and made real and that the learning of this paradigm was inseparable from the content of the lower level learning centered around task performance and the acquisition of general principles.

CHAPTER V

THE INTERNAL ADMINISTRATION STREAM

INTRODUCTION

This stream of cases is quite different than the ten examined in the new services and sanction streams. All cases were randomly selected as examples of new situations the division confronted and it was only after the whole fifteen cases were developed that it became apparent that the other ten fit relatively well under the rubric of either new services or sanction activities. These cases appeared at first to be a residue since the division's true main activities were in the other two,more policy-oriented,streams.

But it was soon evident that each of these cases dealt with some aspect of the internal administration of the division - that is how the division exercised a part of its monitoring power, how it received policy input from consumers, how it dealt with claims designs and how it dealt with its own and the department's field staff.

The first case (loss of controls) deals with what was at first viewed as a problem which was then redefined into a (potential) opportunity. The opportunity was not seized due to a clash of personal and management styles and by the time it was seized, a considerable cost in time and energy had accrued.

The second case (dental claims) involved the division being taken by surprise on a decision which it perceived nonetheless as at least a reasonable one. The division then simply sat back, washed its hands of the decision and let it be implemented.

The third case (consumer board) involved the rekindling of a long standing interest by Knight when he realized that an early choice of strategies had led the division to neglect a part of its environment. The division pushed through the initial stages of the idea but then eventually let it lag.

The fourth case (MA-7 form) involved the minor redesign of a billing form which went amiss and the smooth recovery the division made which enabled it to enhance its credibility.

The final case (field operations) was really the resolution of two problems, one intractable and one which was created by Knight's own management style. The intractable problem was, of course, not solved while the other simmered for a year and finally exploded after which a proposed adaptation was made.

Of the six cases (the last case is really two closely related cases), three involved activities which the division perceived as being beyond its control. One of these it simply downplayed for some time at a moderate time and energy cost; in another it simply accepted the uncontrollable nature of the activity and then ignored it; while in the final case it made a conscious decision not even to devote resources to the area.

Of the three cases considered to involve "controllable" activity, two were handled efficiently, one somewhat more so then the other since it involved a potential loss of the division's credibility. The third controllable activity was perceived as minor by the division and so downplayed for some time until a minor explosion forced it to reconsider and became more active in the area.

These cases, since they focus on issues of accountability and control, are a more direct way of exploring how the division's paradigm was translated into reality. They also suggest the outer limits of Knight's otherwise effective teaching and management styles. It is, however, not at all evident that there was any substantial cost to the division once it became clear that some limits to its style had been reached. Knight asserted that the cost was low, his staff felt otherwise, while the researcher took an intermediate position as did many members of the division's environment.

1. Loss of Controls

The Welfare Department consisted of several divisions, medical, financial, cash payments, research, administration, social services, etc. A network of 116 field offices provided both cash payments and social services and reported through seven regional administrators directly to the commissioner's office. (See figure 2 page 36). These local offices administered both the cash payments program and the medical program. The medical division set its own policy and wrote it up for the policy manual after which it was distributed to local offices by the administrative division.

The medical division's functions, recall were (a) to administer, i.e. set policy and assure that bills were paid, (b) to monitor the program for abuse, fraud or poor practice, (c) develop new medical resources, and (d) handle exceptions, primarily generated through(b). In fact most of its activity centered around (a) and (d). The local welfare service office (LWO's) acting under the administrative control of other divisions, did most of the actual monitoring up until 1973.

The division's main operational contact with providers, then, was through the local offices and any monitoring was provided by the LWO's.

This case involves an alleged awareness of the "loss of controls" which would be forthcoming when medical providers would send their bills directly to a central claims control office to be handled by computer. Previously each local office had received provider's bills, had noted any irregularities (often returning them to be corrected), filled in missing information, determined the fee if a provider was unaware of it, and had kept an eye open for provider abuse. Abuse might include such things as excessive usage of the system or simply poor medical practice, e.g., large numbers of dental x-rays within a given period. Local clerks would often get to know the patterns of the various doctors and their client's needs and could provide useful information on "whether Doctor X ran a reputable practice." Claims were then sent to the medical claims control center (MCCC) where they were processed and further basic checks and edits made for such things as eligibility of the provider, the recipient and the service.

However in 1973 a plan had been devised to bypass the local offices completely by July 1974, after which all bills were to go directly to the MCCC. The local offices only medical function would be to explain policy to clients and providers. The medical division would no longer be able to rely on these offices to monitor the program and "kick up" exceptions or problems. This changeover was called Phase II, Phase I being the centralization of the issuing of recipient and medical vendors' checks.

This case then, is the story of how the Medical Division dealt with the knowledge and realization that the focus of its monitoring activity would be changed. Externally, the structural separation between the Project Management Office (PMO) designing the changeover and the medical division lead to a highly charged debate between them over the style of interaction and the type of resource commitment necessary to deal with the changeover. Within the division, a mismatch of persons between those with knowledge of the problem and those with an understanding of possible solutions also existed. Over a considerable amount of "wasted" time, these imbalances and mismatches were confronted and a resolution of the problem was agreed upon.

Time stands out sharply. Over six months passed between initial awareness of the potential new problem by the medical division and its eventual definition (with PMO) into a more bounded problem. What occurred during that time and how the various actors processed their awareness is the main focus of this story. The case thus describes how the division "sat" on the problem, either not fully realizing the real nature of the event or awaiting a direction from its strong leader (who also waited). Eventually the division reacted to the possible loss of controls by taking the offensive, by fighting for and trying to redefine a power relationship with PMO and also with the local offices - this latter relationship having been somewhat illusory all along. And finally, the division began to redefine the event from one viewed as a "problem" to one of opportunity.

Phase I had been the initial development of the MCCC. This had been accomplished by a staff of consultants (PMO) on a long term contract operating out of the commissioner's office. The PMO had completed Phase I successfully, managing to cut the processing time for bills from several months to between 30-45 days. This feat had managed to considerably restore the confidence of the medical providers and PMO, with the full backing of the commissioner, was in the process of designing Phase II. The director of PMO was a highly experienced computer consultant. He was rumored to be the highest paid person in the state government and, this combined with what was almost universally viewed as an arrogant style and a "large ego", led to a somewhat abrasive relationship between him and others in the Department. While some thought that the PMO (and MCCC) should have operated under the control of the medical division, the initial development of it was seen as requiring the backing of the commissioner since it involved considerable cross division interchange around such questions as client eligibility.

In October of 1973, a meeting had occurred between Knight, the Department's finance director, and the head of PMO (N.E.) over the speed with which bills were being paid. Knight suggested, with some innocence, and a background of the cash flow problems of a businessman, that speed was of the essence and that 70% of each claim be immediately paid upon receipt and the remainder be paid after a more thorough verification of each claim could be made. PMO was surprised at this reversal of priority (i.e., speed over accuracy) and said it was impossible, although Knight had seen this system work in industry.

The commissioner rejected the solution. Additional sub-currents may have been present at that meeting, but one of the results was that the PMO head felt annoyed with Knight and appeared to pay much less attention in the future to the problems or needs of the division. PMO had "virtually run Medicaid" said one staffer during the 8 months prior to Knight's arrival and the new assertion of power by Knight was only to be the first of their many confrontations over both style and substance.

Another meeting was called in mid-November by Knight. He had long been concerned with questions of centralization and decentralization, having spent a major portion of his previous years in industry involved with such issues. He thus knew of the PMO's plans to completely centralize all bill-processing. A target date of July 1, 1974, had been finalized in September 1973. Previous contact with PMO on other Medicaid projects had been somewhat unsatisfactory according to Knight. He sensed that "something was wrong" on this issue and called the meeting to determine how the division could relate to PMO during Phase II. He said that he had no real conception of any specific problem, only the feeling that there was going to be a change, that the division had been ignored during previous changes and that his input was needed.

Others in the medical division had also known of PMO's work and were aware of the target date. But, as one long-time staffer said, "it was their target date, we were waiting for them to come to us." She wanted to get into the fray but when she had tried, PMO had always said, "that's not where we are right now." Rebutted by PMO and with no backing from Knight up to this time, she and others waited.

The discussion at the meeting was very general and everyone sensed that it was a "groping session". According to the PMO staff member, it was the first time many of the implications of Phase II had been realized. Up until that time, PMO had concentrated on its ability to build a complete file of medical vendors and recipients. Now they would have to build a "history" of those files and,more importantly, confront the issue of how to use that history - i.e. for any incoming bill, the computer could check it against the history of that recipient or vendor, but check it for what.

One of the few specific focuses at the meeting was the possible loss of controls formerly exercised by the local offices. The PMO staff recognized at the meeting that a loss would occur but the head of the PMO unit, N.E., appeared preoccupied. His assistant however, showed a willingness to cooperate with the division. At that time Knight did not have a very good feel for what any new controls might be. N.E. suggested that a staff person from PMO be assigned to work full time on the changeover to Phase II although not specifically on the "loss" issue.

This PMO staffer, B.M., began to visit several field offices and, after viewing the large backlog of bills, concluded that the local offices had never had the time to assure adequate control in any case. While this backlog had been somewhat rectified by Phase I, he concluded that even in the short run, between Phases I and II, control was very poor. He cited examples of improperly submitted bills and allowances of forbidden procedures which continued to be tolerated. In fact, "control" had been exercised at the local level but it was

unsystematic and on an individual case work basis. He had felt that local workers could not possibly retain a full history of individual clients or providers and that control was very uneven. He had been "primed" by his colleagues in PMO to believe that local control was chaotic and found this pre-conception confirmed. PMO's assistant director, S.N., concurred in saying that while control used to be "100%" for certain areas, "now, we'd make it less than 100% but over all areas." Whether there would be any net gain to be achieved by Phase II centralization was "impossible to say."

Knight and some of his senior staff agreed with the diagnosis but did feel that over time, the net gain would be positive as "we'll learn what to look for by looking at the good ones (providers)". He did admit that an initial loss of control might occur but this did not worry him. N.E. was even less worried since he said "we never even knew whether there was any real control in the local offices."

The problem still remained unbounded however. B.M. had been told to figure out what needed to be done and to do it. He tried then to "flush out" the medical division's goals, but had difficulty. The division often had no clear-cut goals and his approach of trying to elicit these by asking each of the division's staff individually only created confusion. Many of these managers were not yet ready to state what they thought the division's goals should be as they, along with Knight, were busy learning their routine tasks. Others, particularly the long-term staffers, were not geared to think in terms of overall policy or goals - "we didn't know what he was talking about nor did he make it clear what his needs were."

B.M. admitted that he had problems also. He "didn't know medical policy" or how responsibility was assigned within the division. Knight had begun to assign specific responsibilities but the staff was still developing shared principles as a group with much overlapping of technical capacities. It was an extremely fluid situation, one difficult for an outsider to understand. B.M. continued to tell people the kind of material he would need and said he'd come back to get it, expecting the division to "do its homework." Some in the division, however, expected that he would return and, in oral sessions, "hammer out the complete list of controls we needed." Knight was not aware of the problem B.M. was having nor did B.M. inform his supervisor, N.E. Knight thought "B.M. was getting what he wanted," while N.E. said he had "a half dozen other problems equally important." B.M. thus began to compile a set of desirable controls based on the "wish-lists" of some of the more articulate members of the division and on what he felt was responsible controls.

Since the PMO had an irrevocable commitment to the commissioner and the legislature for a completion date on Phase II, PMO decided to focus on "what had to be done in order to centralize." They would only correct those things that had to be corrected. Some of the PMO staff had not realized that some sacrifices would have to be made and that the division's complete "laundry list" of controls could not be utilized. B.M., however, did sense this and said "I began to think in priority terms." First priority then, was to get a system operating which would actually process the bills. This minimal strategy was born out of B.M.'s frustration, time pressures, and the view shared by N.E. and the commissioner who appeared to stress that first accuracy

of bill payment and then generation of evaluative material was of highest priority. They felt that speed of payment would automatically follow if any accurate centralized system was developed. Thus B.M. came to the medical division and began to talk about "accuracy", stressing double billing as an abusive error, an error which the division staff felt he chose since it was easily programmable. He began to pay less attention to the more general evaluative materials and controls (such as rejection of incompatible medical services) which the division felt it needed.

This discussion around the nature of the "problem" was accompanied by one on the scope of the problem. At first the discussions between PMO and the division centered around institutional providers such as nursing homes and hospitals, as well as ambulatory care, such as individual physicians, and clinics. B.M. included the institutional care providers in the problem definition since they represented a large dollar volume and because they had high public visibility. He felt that the medical division felt these institutions were important but never really checked this with Knight. The latter, B.M. admitted, appeared not to sorry about what would happen when institutions (as contrasted with individual providers) began to bill centrally. Later on, this was to become a problem boundary issue but at that time it remained unspoken. Knight apparently "did not worry" because institutions were being adequately kept under surveillance under a variety of pre- and post- service reviews and detailed reimbursement formulas already in existence or underway. The billing system was only one point of surveillance for institutions, but represented a major monitoring point for individual providers.

This first surfaced as an issue when a related problem was discussed. PMO had originally intended to phase in the centralization by bringing onto the system one provider type at a time. B.M. asked Knight what providers he wanted on-line first and Knight replied, "You're giving me a carrot to wave (faster payment to providers) and now the question is to whom do I wave it at first." He chose the primary health care providers, i.e., individual practicioners and neighborhood health care centers since they were the ones who had the most direct impact on how care gets delivered to recipients. According to Knight, improving relations with them would have the greatest effect on the recipient whereas doing the same for say, hospitals, might conceivably have no effect at all on the quality of care. The proposal to phase in providers was later abandoned but it was through this discussion that PMO learned of Knight's feeling that the actual leverage with institutions was either non-existent or of a type not exercised through the billing system. While this sub-event appears as a somewhat tangential story, it provides an explanation for the wavering attention of Knight to the problem. He appeared at times not to view it as a problem of wide scope.

In addition the actual <u>size</u> of the problem was unknown and, in the absence of hard data, had seemed less important to others in the division. At this point two staff members in the medical division became more involved. K.E. had, out of difficulty in understanding the complex system of prior and post service controls, developed a table showing the full range of controls for all providers. In discussions with other staff, he became aware of the forthcoming problem, particularly

with respect to individual physicians and dentists. He, along with a second staff member, tried to warn Knight of the problem since it had been apparent that few on the staff recognized its potential size. Knight, when approached by the two, suggested that some figures be developed. K.E. and R.D. then worked with PMO and the local offices to develop an estimate. Two weeks later they informed him that the potential loss of money involved in switching to centralized payment without a set of controls to replace those exercised by the local offices was much less than anticipated but might reach as high as $1,000,000 per year. Knight took no immediate action on the estimate.

At about this time, Knight sent a letter to the head of the committee on tax-supported medicine of the Medical Society advising him of the forthcoming Phase II and including a light but clear warning that improper billing procedures would be caught and corrected, by sanctioning if necessary. He had delayed this letter until then since the department had had low credibility due to the slow payment of bills. Phase I was now successful, provider checks were being issued more rapidly and a public show of power was appropriate according to Knight. Thus we see the use of a principle demonstrated in the new services stream that one could not exercise the division's needed powers until it had gained some credibility.

By early January an interim progress report had been prepared by B.M. It had been intended for internal PMO circulation but the PMO director, wanting a "rubber stamp of approval", called a meeting of the six DPW assistant commissioners and circulated the report prior to the meeting. At the meeting the principal PMO staff presented the

initial report and asked for comments. Few were forthcoming and it was agreed to meet again. The report was then circulated within the Medical Division and comments written directly on the report. Some staff were concerned with its "unreadibility" and "process orientation." A month later, B.M. came back to Knight and asked for the division's comments only to discover that the report had been lost. Knight did not suggest a new copy be recirculated and at this point B.M. said he "lost any motivation" he had had for the project. He complained that Knight did not appear to give any clear indication that the project was an important one.

At this point a whole backlog of resentment flared up in the PMO staff. They had always viewed the Medical Division as unconcerned with control issues and uninterested in working with PMO "unless something went astray." The PMO director felt that the medical division staff were not well trained and contributed to the problem. Yet B.M. continued to meet with the division's staff on an individual basis to sort out just what checks and controls were needed. Meetings were frequent (as before) but with little, inadequate and confusing medical input according to B.M. although a division member called the meetings "a waste of time - no meeting of minds." Finally a "beer and pizza" meeting was called in which PMO presented the type of controls it was capable of generating.

It was attended by only half of the medical staff invited. Knight was not present and PMO quickly focussed on "process" issues, i.e. the relation between PMO and the division and the kinds of control PMO was capable of developing. The medical staff who did attend

stressed that the division would tell PMO what they wanted and PMO should provide it by developing a "product" orientation. Thus the earlier public, offensive strategy of contact with the Medical Society was now being accompanied by this internal offensive maneuver in which the division began to request a product from PMO, suggesting that it had power and that it should make the requests of PMO rather than vice versa. Here the staff seemed to have learned what Knight had said to many of them before - that PMO should really be accountable to the division - how could the division act responsibly when an area of performance by which it was judged by providers was not accountable to it.

PMO was stressing a process orientation and the fact that the division needed to understand how "the car operates since you're going to be driving it," whereas Knight (at earlier meetings) said "no, we only need to know what kind of car we're buying." This was said despite his usual insistence on developing a shared philosophy. He simply thought that a philosophy had been developed and now it was time to ask for a "product". In fact, however the meeting did end up on a "process" basis, but with a defensive tone, e.g., what the division could be "required" to do after Phase II -- such as storing all the paper generated by MCCC on exceptions kicked out of the system. But the question of what controls would be developed and how B.M. was to improve the generation of these was not settled and a follow up meeting was cancelled due to the confusion at the beer and pizza event.

Here the history of the division and its relation with PMO should be explained. PMO's plans and timetable had been laid down 2 1/2

years previously and agreed to by Knight's predecessor. Then Knight's position was vacant for 8 months during which PMO effectively took control of much of the division. As the commissioner said, it took N.E. quite some time to realize that he now was dealing with a competent and knowledgeable equal. But the commissioner did not intervene in the battle as he felt it wouldn't do any good to "tell people to cut it out" if "they both had different operating styles." He was "inclined" he said, however to believe in Knight's stress that PMO should be a "service bureau" providing a product to the medical division, although he did not back up Knight in the fray between the two.

During the time, PMO, while stressing a process orientation continued to express frustration at having no one specific person assigned to "liaison" with it. Knight felt that liaison people were inefficient and that B.M. should get his information directly from the operating managers. B.M. continued his searching pattern, hoping to find the one person who could give him the most thorough assistance. At various times, Knight did assign staff to serve as a central liaison person but they soon drifted on to other tasks. B.M. did not talk with his boss N.E. about his problem and N.E. later expressed the feeling that he should have asked his staff to tell their problems sooner. But N.E. was an optimist and did not like to be told about "problems", particularly those involving the medical division. The structural separation of PMO and the division and their differing views on liaison functions continued to plague the process.

After the failure of the beer and pizza meeting, a staff member, Y.H., with experience in medical control systems came on the scene. He had previously (in October) written a memo to Knight suggesting that one of the things that would be required in Phase II would be the ability to select "profiles" of the activity of specified providers or patients. This had been his only involvement up to that point. Yet he had been aware of the difficulty in PMO's having to talk with such a large number of the medical division's staff and wasting considerable time hearing "anecdotal" evidence of abuse. He also agreed with B.M. who felt that many of these same people with the most knowledge (often anecdotal) appeared to be isolated from policy making and were interested in a case work approach or a post payment, physician-sponsored type of utilization review.

One new member of the staff advanced the explanation that these long-term staffers had neither the motivation to act, nor the vehicle (i.e., they did not understand the computer). Similarly it appears that those with a policy orientation and an understanding of the computer lacked a detailed knowledge of the potential types of abuse - a knowledge which was best built up by experience. These conditions were perceived by Y.H., but were not specifically discussed with Knight. Knight, while he appeared to be cognizant of the external structural "imbalances", did not agree on the proposed solution to the internal imbalances - a liaison person-nor did he feel he could spare a staff member. Such a solution appeared obvious to PMO, or as N.E. said, "Knight just doesn't seem to understand 'project management'".

In the meantime, PMO waited. The beer and pizza meeting had been led by the director of medical care, N.K., a long-term staff member who had been "parallelized" and who now functioned as an assistant director. But he had acted in Knight's name and B.M.did not wish to "go around him" to Knight immediately. Y.H. was then alerted by a staff member that PMO was "getting the short end of things." She was a personal friend of B.M. and felt irritated that he was not getting the "respect he deserved". She suggested that Y.H. speak with K.E. and together they should present PMO's case to Knight.

Knight had been, up to this time, trying to get PMO to commit the resources necessary for the job. While he understood the anecdotal nature of the input being received by PMO, he was counter to the idea of any type of a "liaison person" in principle. He had developed an aversion to liaison people and coordinators during his previous experience. In addition, he continually questioned the role of consultants such as the PMO staff. In this case, however, the need for consultants was clear and accepted (externally) but their proposed work methods were unacceptable ("process" and a "liaison" person). A meeting was called of the PMO director and staff, Knight, and some of his staff to discuss the level of resources the division could commit to working with PMO. Knight failed to attend and the personal antagonism between him and PMO's head grew more intense. N.E. had "been made to feel like lackey." No clear decisions were made at the meeting but agreement was reached on the need for a new classification of vendors, one of which any evaluative material would have to be based. This sub-problem was fruitfully handled in separate

succeeding meetings and seemed to take some of the edge off the hostility and to provide a focus for renewed activity.

K.E. and Y.H., together with B.M., shortly therafter approached Knight to alert him of the disintegrating nature of the process. Many of the other staff also shared their view of the process, although did not speak to Knight. Y.H. argued for a liaison person (a staff person to Knight) as did PMO, while Knight calmly but firmly resisted. K.E. proposed a compromise, one in which the Medical Division would meet "with the right people, with the right time, and with a clear focus" in order to provide PMO with what it needed. He proposed that key program managers would meet every two or three weeks with a mandate to come up with specific policy-related requests at the end of each meeting for PMO to consider.

Two weeks later Knight called such a meeting and presented it with a very strong piece of work which he had prepared himself "to start the ball rolling." He said that it made sense to do this because "the computer cuts across the whole system and now I'll have to sit down with B.M. and see what's important to each of the staff." Taking it into his own hands was a "logical" solution he said although N.E. felt Knight was taking too much on himself. Knight viewed this meeting as the necessary extent of his teaching - "I had reason to expect that my people would now know the benefit restrictions required". He ran the meeting very firmly and a considerable amount of useful output was generated. In effect, he became the central liaison person B.M. had been seeking -- the "top man" he was so used to reporting to in his previous consulting contracts.

A second similar meeting was followed by circulation of the assembled material for comment prior to transmittal to PMO. PMO's assistant director felt the material was useful and, while it could not all be accomplished, felt it provided a solid ground for "negotiation." Knight did not continue to provide this sharp focus himself however and PMO was worried that the initiative would be diffused. Indeed the initiative was diffused. The deadline for Phase II was pushed back 3 times (for other reasons) with a final target date planned for February 1975. B.M.'s work was delivered in June and the assistant director of PMO said it was "anti-climatic." PMO had made assumptions about the probable input of the division for Phase II and now found the work incapable of being used although Knight felt that this was essentially PMO's failure- i.e. the challenge was for PMO to program what the division had given them. But PMO was running out of budgeted personnel time and could not devote the needed time to redo the work. B.M.'s consulting contract ran out and he left PMO.

No one from PMO or the commissioner's office pushed the issue since PMO was short of staff and the commissioner apparently felt more strongly about the "political" success of the centralization - i.e. the bills were now being delivered directly to and paid by the central computer although much of the editing and controls were still being done by hand. But an important visible political effect - one which the providers had been clamoring for - had been made.

The whole issue, which was by then being referred to as the design of "benefit restrictions" as opposed to loss of controls, lagged as the division worked during the summer on many mechanical tasks such as the identification of the procedure codes for the computer and the design of forms. Knight did not pay much attention to the issue, saying that he "felt that[I]have no sense that the process is going well but also no real sense that we'd get any better results if we pushed any harder." Knight said he had been "burnt before" in his dealings with N.E. and tended to avoid pushing him too much. Finally, in early 1975, several staff from the division and from PMO (which had by then acquired more personnel) began to revise the benefit restrictions plan first devised by B.M. for computer acceptability, this time to the satisfaction of both PMO and the division. Thus an acceptable product was generated but at a considerable expenditure of energy and time although the new head of PMO, S.N., felt it "probably couldn't have been done at any less cost." Knight later felt vindicated in "having made an initial effort, and then backed off" (at least personally) since the whole Phase II planning, which included many aspects other than benefit restrictions, was aborted and plans made by a new commissioner to turnover bill processing to a more competent outside computer organization.

This case then is a story of how the Medical Division dealt with the awareness that the immediate environment in which its monitoring activity was conducted was changing. It is also the story of how the members of that new task environment asserted themselves as the new environment - confronting both pre-conceived management notions of Knight and a set of interpersonal antagonisms. The cost of this change

of environment and the conflict of managerial styles was measured in time and energy devoted to seeking a solution to these problems. An inordinate amount of time was required by the division to process this new awareness and for PMO to realize that the division needed that time.

Thus the learning evidenced in this case is not of a high order. Some of the staff did eventually learn how to design benefit restrictions but in the end this narrowed down to program areas of only two staffers. It is impossible to yet determine how, or if, this personal learning could be transferred. At another level we see very little evidence of general principles being developed (whether through Knight's teaching or not). The only "principles" consciously evoked were that staff bureaus like PMO should answer to line bureaus like the medical division, that liaison people are "ineffective" and that ambulatory care is more worthy of a high priority in the designing of benefit restrictions.

The division's usual program of action was not much in evidence here, due probably to the early stages of the division's growth in which the case occurred and Knight's unwillingness to involve himself in the case. While the division was, as usual, very open to the initial development of the issue, that is the perception that there was something "new in the wind" and they must deal with it, no one in the division made a strong assertion of the division's role. That had to wait several months and even then Knight only evoked that a few times externally (although he did stress with his staff that PMO was or should be a service bureau). As usual the division did "sit" on the issue for some time, trying to decide whether there really was a problem and what its scope and size would be.

Knight's usual pattern of direct delegation of authority and avoidance of liaison staff led to an excessive cost in time and energy and, even when Knight eventually (tacitly) realized this, he did not devote much continued effort to its resolution. Similarly, the failure of both Knight and N.E. to perceive the costs involved despite the awareness of most members of their staff and their failure to rely upon their considerable experience in dealing with similar problems in prior high level jobs can only be attributed to the interpersonal clash between them. Nonetheless the direct delegation of authority, the inexperience of the staff and the resultant costs did eliminate the nagging ego problem perceived in so many cases. The product finally developed by the staff and PMO was one they both felt confident with after 15 months of effort.

Why this length of time and the concurrent energy costs? In the other cases to date the division's success could usually be attributed to the overall approach of Knight. Does the failure to utilize this approach account for the pattern described here? Not entirely, since several features outside Knight's usual approach also help to explain the pattern here. Firstly the problem was not always seen as something which required action - but rather was an opportunity, thus permitting a somewhat slower response. Secondly, PMO felt no controls were really being lost, and Knight felt the scope was narrow and limited to solo physicians and dentists. Finally, the actual size of the "problem" could not be calculated and when it was, appeared to be less significant than first thought.

Yet other features which help to explain the resultant costs are attributable to Knight's style. And the costs were real, especially since, as described above, the whole issue came to be seen as one of narrow scope, probably of small size, and possibly not even a "problem". Firstly, we saw that those who had knowledge of local practices had either little policy (or policy change) orientation or no understanding of the computer. Those who understood policy or the computer had little knowledge of local practice. But Knight had stressed that "individual managers are responsible" for the generation of the necessary controls without realizing that most of his managers were inexperienced in that they each lacked at least one of the necessary inputs (knowledge of either policy, local practice or the computer). Secondly, a proposed solution to this reality, i.e. a liaison person, was seen as anathema to Knight's principles of good management. Thirdly, Knight rarely offered his inexperienced staff, through his usual teaching, much of the needed guidance as to how to deal with the problems or what output was desired.

This overall failure to keep his usual close check on the division's activities (especially at that stage in late 1973) can also be explained more directly by reference to the organization's paradigm - the responsible buyer. Knight felt that PMO should have been responsible (responsive) to the division but it was clearly not, e.g. the clash with N.E. and the failure of the commissioner to support him, (Knight - "reform must start from the top down"). Thus, since Knight could not control it, he would simply not assign much of his personal

energy to the area although the staff did consume valuable time and energy. Equally important was the fact that this particular aspect of the division's relationship with PMO likely did not affect either the division's policy-making activities (with new services) or its credibility with providers and thus any problem could be downplayed since they did not seriously harm the pursuit of the division's paradigm - that is Knight believed it would be foolish to devote his own resources to a situation of low potential payoff.

2. Dental Claims Processing

This second case, on the surface, has many features which might lead some to call it a non-event. However many of the actions taken in the case subtly illustrate the manner in which the division responded to what was universally viewed as a good idea -- although the idea was one which the division had little role in developing.

The case involves the contracting out to a private consulting firm for the processing of all dental claims submitted to the department. Not only was the firm to simply process claims by conducting the necessary eligibility and fee schedule checks, but it was also mandated to develop a monitoring system which would also have the capability to generate additional sophisticated management information. For example, the system would prevent the billing of two incompatible services considered to be "poor dentistry" and produce data such as a listing of dentists in the 10th highest percentile of all billings.

In the summer of 1973, the central claims processing center of the department (MCCC) had been experiencing difficulties in developing the capacity to handle the increasing volume of medical claims of the

division. One of the solutions had been to contract out the processing of pharmacy bills. These represented a large proportion of actual claims but a relatively small dollar volume. The claims involved thousands of discrete items and was the type of service lending itself easily to computerization. A private consulting firm had already designed a "package" for general use in such situations and easily convinced the department to sign a contract for pharmacy bill processing. Over two years this contract was executed efficiently and to the satisfaction of the department and the providers.

However, this contracting out of services was not a completely simple issue. The commissioner felt strongly against contracting out, particularly when the department might not have the capacity to monitor that contract. His boss in the Human Services agency agreed, but realized the pressing need to take some of the pressure off the new MCCC system while it was under development. And the head of the Project Management Office (PMO) designing the new system felt even stronger about letting his perogatives be taken over by outsiders. But all agreed it was necessary as a short run measure and so agreed to the contract. Knight had not been involved in these early discussions since they had occurred prior to his arrival, but after being briefed on the situation he recognized the problem and concurred in its resolution.

The pharmacy contract ran well by all accounts and the pharmacists were very pleased with the speed and accuracy of payment. The system was publicized by the department but received only minor attention from other provider groups who occasionally made comments to department personnel that it "would be nice if we could have such a system too."

But these comments were low-key and unofficial; and no provider groups (including the dental society) made official representations to the department for such a move.

The state dental society had established a good working relationship with the previous assistant commissioner and expected to do so with Knight. During the 8 months lapse between assistant commissioners, the division continued to build on this relationship and developed a strong staff of part-time dental consultants within the division. This group had elaborated a relatively sophisticated system of manual review of submitted claims and had also developed, and was managing, a system of "prior approval" and "individual consideration" claims -- claims which were deemed to be of borderline necessity or claims where the service was so unique that no established fee had been set. The dental program leant itself well to such a system since diagnosis and treatment could be reviewed through x-rays mailed in with claims. Also simplifying the management of this program was the fact that dentistry involved a relatively small number of discrete procedures as compared with the division's medical or surgical programs.

The consultants were well respected within the division and were seen as "running the program", although operating under the loose guidance of one staff member, R.Y. This situation seemed to be accepted by Knight and others. Knight appeared to pay little attention to the program since he felt it to be well managed. In addition, it was not "his" program, that is, he had not participated in its development. So he directed his energies elsewhere in the division.

The consultants, of course, "wore two hats." Most were concerned members, and often officials, of the dental society. They had seen the effects of the drug claims processing program and made occasional hints that such an idea would be good for "their program" (as providers). But they were somewhat ambivalent since, as regulators, they felt that the division might lose some of the excellent system of manual controls they had built up themselves. So they did not make strong representations, although Knight "had a feeling" that they (the dental society) had always wanted another third party (other than Medicaid) to process their claims by computer.

It was not clear precisely why the dentists may have desired this. There was no indicationthat dental payments were particularly slow -- certainly they were no slower than for other providers. Indeed the assistant director responsible for dental care, R.Y., stated that dentists were "notoriously bad counters" and thus any late or partial payments might have been as much due to their poor management as the fault of the department's payment system.

The MCC was under <u>additional</u> heavy pressure in late winter of '74. The flow of bills was much higher than expected and the PMO had been seeking a way to ease this pressure. Concurrently, the volume of claims in the drug system being handled by the outside contractor was less than expected. This contract had specified that the firm handle up to a specified number of claims per month. Thus there was slack in the system and the director of PMO made "a very pragmatic and opportunistic decision," to contract out the dental payments as these represented the next largest volume (after drugs) of claims in the system.

Thus the key actor in this case was not Knight or the dental consultants or the dental society but rather the director of the PMO, N.E., with whom Knight had clashed in the previous case. As mentioned earlier, he and others in the commissioner's office had little feel for the dentists' views on the question of claims processing. He was, however, aware of the commissioner's general attitude towards "contracting out" and he had checked with the assistant HSA secretaries to see if the idea for contracting out the dental program was feasible. He had also checked with the finance director of the department. In fact, he had touched bases with everyone but the medical division, although he was later to tell the commissioner that he had involved Knight in "discussions" concerning the subject. His assistant had also conferred with the commissioner on the subject, and the commissioner said he "thought that N.E. had cleared it with Knight."

Why should the medical division have been involved at all? Knight's position was that since it was "our bills" that were being talked about and since <u>he</u> was generally held accountable by much of the provider community, the division should be involved. If he was to be a "responsible buyer", he must have some control over those things he was being held accountable for. Additionally, a contracting out would involve not only the processing of bills but also the development of a monitoring capacity. While the programming for this monitoring could be done by PMO or by a contractor, the input for that system, i.e., what checks, edits, restrictions, etc. were needed, would have to come from the program personnel (and consultants) in the medical division.

But N.E. had a long history of clashes with Knight (see Loss of Controls Case). Both men were talented managers, both had large egos and both were viewed as quite competitive -- although Knight did not feel he was "competitive." N.E. felt he had been given the responsibility to design a payment system -- by the commissioner. This is certainly technically correct since he reported to the commissioner. However, one of the main "users" of the system was the medical division which would have to deal with the providers whose bills were being processed and which would also have to design monitoring systems. But N.E. just did not see it as "Medicaid's business." He felt he was a somewhat better manager than Knight and, in a competitive outburst, once stated that "this is gonna get him," although in a later interview he said he thought it was a very "mechanical" decision he had made.

Once PMO had made the "pragmatic decision", the director of the MCCC casually mentioned to R.Y. that the changeover (to the outside contractors) would take place in two weeks. She was amazed, had heard nothing about it, and quickly told Knight of the decision the next morning and informed him of a meeting which had been called to discuss the changeover. Knight was very chagrined and angry since the reasons for the decisions had never been discussed with him nor had the reasons for the haste. He felt that the decision was not necessarily a bad one since he understood the reasoning and had viewed the drug contract with some confidence. He did admit, however, that the dental program "would not have been his next choice to be contracted out." He was dismayed at the decision process however and sent R.Y. to attend the meeting. Apparently he did not express his anger to anyone in PMO,

although he later said "he may have mentioned it ot the commissioner." N.E. himself said that he never got any feedback from Knight on the process.

Here we begin to see some similar patterns to those taken with other cases of new knowledge. The initial energy invested in the new knowledge had been generated by a "turf" battle. But Knight was willing to accept the validity of that battle's resolution since an analogous situation had worked out well. He did try to assert the division's perogatives, but as we shall see, quickly acquiesed.

Knight did attend a second meeting to discuss the changeover but by this time he considered it a "fait accompli" and washed his hands of the decision process. The commissioner felt it was "only a 'fait accompli' depending on whose perspective you adopt" -- suggesting that he might have earlier been open to discuss the content of the decision if Knight had felt strongly about it. Knight then assigned the responsibility to R.Y. and dealt little with it until several weeks later when management reports began to be generated by the contractor. He said he had not seen a version of the contract, (nor had R.Y.) and "didn't know if there even was one." In fact the earlier drug contract had been amended to avoid the time consuming process of signing a new one and having it approved by budget officials and/or the legislature. Thus, as usual, Knight delegated responsibility rapidly when he felt an area was in "adequate hands." Only here he did so even more rapidly since he had become so irritated by the decision process.

After the decision had been made and Knight's anger cooled down, his staff began to design some of the restrictions which would have to be part of the monitoring system. Other parts of the system were similar to those in the drug contract -- for example, average costs per type of claim and the identification of high volume billers. The contractor was enthusiastic about the changeover since it was relatively easy to program and thus meant a high profit for them. They cooperated fully.

The question must now be asked, was the decision a success? Knight felt that in the short run it was acceptable since "we had the dollars available and it did make sense." His staff felt similarly, stating that the division had gained some of the much sought after credibility (although in this area they already had a considerable amount). Bills were soon paid within 20 days and no complaints were received from providers either on an individual or organized basis. The fear that one staffer had that "the programming people will make policy if we're not careful" did not come to pass here since policy had been well established and was under control by the division. The division's dental consultants had been worried about the possible loss of controls since most of the bills would not now be processed by hand, but this fear proved groundless. The PMO director had never even worried about this aspect since he felt that one "must do something, even if it is less than perfect." He felt that the development of evaluative and monitoring capacities would evolve naturally after an accurate and fast payment mechanisms was installed.

What were the long term effects of this action? Two reactions had been anticipated -- that other providers would request similar

treatment and that once such actions were taken it would be politically hard to "retrieve" the dental processing into the department. But to date there had been no pressure from the remaining providers -- nursing homes, hospitals and physicians - to farm out their processing despite the fact that they made routine complaints about slow and inaccurate payments. A new Governor, however, did begin to explore this possibility but primarily at the insistence of other bill processors who claimed that they could process bills even faster and more accurately than the MCCC.

Knight had stated that he would like to regain control of the dental processing (along with drugs) since he felt the department could do it less expensively -- although the contractor's prices were regarded as very reasonable -- and for reasons of "pride". This latter reason must be viewed as a part of Knight's strong desire to (a) build competence within the Department, and (b) to do so where it can be held accountable -- two features he continually stressed. However no plan to retrieve it was designed by him. N.E., however, felt "it would be easy" to get back the dental processing at any time. His assistant even stated they planned to retrieve it in October of 1974 but this did not occur due to the continued heavy stress on PMO and the MCCC in implementing Phase II. N.E. did admit that retrieving the drug processing would not be as easy, but also had not designed a plan for doing so.

Some fears remained however. Later that year, PMO asked the contractor to temporarily take over the processing of bills from laboratories, medical suppliers and hearing aid dealers. Knight was

consulted here and did agree to the changeover since it was in such a minor area. The contractor, however, resisted but felt that since they had done so well (and profited) with the drug and dental side they must give the other a try. Later when PMO wished to "retrieve" hearing aid processing, those providers began to put up some resistance. However since they were a small group, their resistance was overcome. Whether the resistance of the other providers could be overcome in the future remains to be seen.

There the situation stood. A decision which normally should have involved the medical division was made in haste and without its concurrence. But because it was perceived as a sound decision, Knight did not put up resistance. He had been "burnt" before by resisting PMO's actions with the commissioner and simply washed his hands of this decision after storing it away in his "mental" file and assigning staff to work on it. The clash of strong personalities in the case was somewhat muted after a year and a half of their frequent battles but it is doubtful that any real learning occurred other than Knight's negative learning of how to "deal with" PMO -- a long standing problem - and R.Y.'s learning how to manage such an exterior contract.

Knight's early responses to the situation were no different than his usual pattern of action (that is, linking the case to an analagous situation, asserting the division's perogatives,and delegating authority). However,he had no opportunity to utilize some of the other features of that pattern (e.g. consulting with trusted friends) since he had been so taken by surprise. There was similarly little opportunity to utilize his teaching skills, although his willingness to learn from the

drug contract was apparent. The principles declared in the case were not so much taught as observed. Thus Knight's feeling that the division must be accountable, that if "burnt", he would "lay low", and that excessive energy not be devoted to minor areas were all evident but only observed in a muted fashion. His emphasis on good management, here meaning cost-effectiveness and a willingness to clearly delegate authority was evident however. It is tempting to play up the clash of personalities as the focus of this case but Knight would respond that that was peripheral and that there really was no choice for him. He felt the decision was probably a cost effective one and since it had been made and was also operating well, he decided not to invest too much of his further energy in the area.

Knight did mildly attempt to assert his role as a responsible (i.e. accountable) buyer for the division but the washing of his hands of the decision seemed to forbode that it would be some time before an <u>active</u> effort would be made by Knight to reassert the division's perogatives and retrieve the contracted-out service. The departure of the PMO director in December of 1974 changed the situation. Knight did make some effort with the new PMO director to correct some of the faults uncovered in the contract but said that there was "no need to push for changes" if it seemed likely that the dental processing would be retrieved by the department. He seemed to feel however that that decision would also be out of his hands - "some decisions will be made no matter what I say."

This case, then, can best be understood as a direct application by Knight of the division's paradigm. Since he felt the division had not been permitted to act responsibly, i.e. to be involved in decisions affecting its performance, he invested as little energy as possible in the consequences of that decision. And since the decision had no demonstrable effect on either the division's benefit package or its credibility, he undoubtedly felt justified in the low investment of energy.

3. Consumer Advisory Board (CAB)

This case represents a minor attempt by the division to act more directly on its view that the welfare recipients' interest should be strongly represented. Although Knight had, during his first year fresh from the neighborhood health center, continually stressed the importance of thinking of "our clients", it became obvious to him and most of the staff that the formal channel for such expression by recipients - the local welfare offices (LWO's) - could not be relied upon nor did the division have any corrective control over the LWO's. Knight's next move then was to work directly with providers (to whom he and the division did have direct access) in attempting to get across the clients' point of view - in addition, of course, to his other concerns for quality, cost effectiveness, etc. While he felt confident that his carefully nurtured staff shared his view of acting in the client's interest, this work with providers alerted him to the fact that it was possible and necessary for clients to have some form of direct access to the division.

Knight had come from a strong background of consumer involvement in the direction of medical programs and he placed great trust in a "well run board". He favored not just any type of consumer input since he realized that such input could be unrepresentative or irresponsible but did feel that a well-run board could be useful. After some months in his Medicaid position he said he "realized that all the other pressure groups (mainly providers) have direct access to the division, why don't the clients have a crack too." His young assistant, R.K., had also come from the neighborhood health center movement and supported him in a proposal for some sort of consumer advisory board.

The division had had an advisory council for many years but, according to most observers, it had been generally inactive and had never provided much useful advice for the division. The council consisted of both providers and concerned citizens appointed by the governor. The DPW as a whole had also had such an advisory council which was perceived as somewhat more effective but still without any real teeth.

In 1973 federal legislation was passed abolishing a national Medicaid advisory council. The regulations accompanying the legislation were unclear however and it was understood by the commissioner's staff that the state councils were also being abolished. The state's council thus continued in its dormant state and it was not until early 1974 that the regulations were reviewed and clarified by one of Knight's staff, R.K. He consulted with the federal agency and determined that the old councils were not to be abolished.

Knight and R.K. thus consulted with the department-wide council and were told that the division could establish such a board or council. They began to discuss among themselves how to constitute a board. A technique Knight had used in his old grounds was suggested - a "steering committee". They asked several people in the capital city if they would sit on a steering committee to develop a plan for consumer input. None of those asked were welfare clients but all represented various community agencies and were all known personally by the two. All of the group were seen by Knight and R.K. as being "consumer-oriented" and the group, when convened, perceived those two in that manner also.

The group met during the summer of 1974 and Knight explained its purpose. Most of them felt that this approach, i.e. a "chosen" steering committee was an appropriate way to handle the question. Several in the group did feel that the process might have been different if the DPW staff involved had not had local community involvement or if they had been other than Knight and R.K. But the two had earned the trust of the community agencies and groups and they felt R.K. and Knight would "fight for consumers' rights". They had a total of 3 meetings at which several issues were discussed such as the role of the proposed board and some of the problems of the medical program. The only issue where any disagreement occurred was on what types of persons should be on the board.

The steering committee felt that other DPW bureaucrats and providers should be included in addition to clients. They felt that this was their only chance to get a "direct crack at the DPW hierarchy",

over such issues as differing and inconsistent (and occasionally discriminatory) action by local welfare offices involved in the Medicaid program. Knight disagreed with this since he felt that clients would be intimidated by their presence but when he saw the steering committee felt it to be important he agreed although he suggested that only clients should have a vote. This view that clients could be easily intimidated was one of the few principles developed by Knight and the group although they shared many others from their past experiences such as the need to "get good people on the board."

The steering committee discussions were brought to the attention of the state DPW council by the assistant to the commissioner. Both the DPW board and the commissioner felt that the Medicaid board should be constituted as a sub-committee of the larger council. This would insure further links with the DPW hierarchy and the commissioner even proposed that some members might also serve on both.

The steering committee then set out to select people who could serve on the council. They asked the local health planning councils and the local welfare offices to suggest nominees. In addition the steering committee itself would suggest names of "providers" although it appeared that these providers would be mainly community agencies and not generally <u>medical</u> providers, i.e. hospitals, physicians, etc. In other words, more of a "social work or social agency approach" as one of the steering committee members put it. No one appeared to think that this method of selection was inappropriate.

Alternative means of selection such as "slotted" representatives from specific interest groups or from the local office's advisory boards were dismissed. The first was seen as being too difficult to organize and the latter complicated by a lack of interest by the local boards in medical problems. Similarly, a plan to have local social workers select clients as representatives was rejected since it would place inordinate control in the hands of these workers. It was felt that no matter how representatives were selected, some "professional consumers would inevitably get involved" but that that was not bad as long as the proportion was not high and they were not manipulated by the local office. Thus one of the principles that was to come up again in other cases (see the field case in this chapter) was made more clearly here - that local offices were not really concerned with Medicaid problems and that the local social workers could not be trusted to be consistent and act in the client's best interests.

Knight felt that the board could be used for two purposes - to act as a sounding board for the division and secondly to "perhaps shape public opinion about Medicaid," although he felt the latter was less likely to occur. The steering committee expected that some of the issues which would arise would likely center around means of providing better information to clients about "just what the program was." A publicity pamphlet already in preparation by one of Knight's staff was tested with the steering committee but the committee felt "more needed to be done." The group also felt that the appeals process by which clients could appeal local decisions should be better

developed and that local offices should be better informed on clients' rights. Others felt the board would hopefully have a say if any benefits were to be cut and that they might be able to show the division how slow payments to providers by DPW affected the clients directly (through lowered access to care). Some also felt that the board might show how the "cheaters" - both providers and recipients could be weeded out since the board members "knew" who they were.

On the whole, the idea of an advisory board was felt by the steering committee to be a good one "since the system is so complex you can't put a finger on who's responsible." But the process of their getting action would not be so easy - "we may raise issues and the consciousness of a few providers but I doubt if we'll have real power - if we do we'll have to take it" (a member of the steering committee).

Knight for his part was awaiting the choice of clients and could not say how the board would function - he would only say "we can only act honestly and see what happens." Later in the year clients were chosen and several meetings held during which the main focus was an exposition by staff of the complex policies of the division. Few substantive policy issues were discussed in those early meetings. Thus, while it could not be ascertained if the idea was a success, some of the elements in its development are clear.

Knight took the initiative for the idea himself and had a strong initial view of what the board should look like (no providers or bureaucrats) based upon his past experience. He did not particularly worry at that stage about any details of how the board would work. The idea did take a long time to get off the ground; this however seemed not to be

due to the division's usual stance of "staking out turf" and then sitting on the idea, but rather it was due to the complexity of convening so many people in the steering committee. Both Knight and R.K. relied on old friends to start the process, but held firm to their view that the client was important and should not be swayed by providers or high (or low) level officials. But they did acceed to the group's desires and would "play the issue by ear" as they came up.

Knight in this case managed to combine all three of the elements of what I have called his overall approach. Since it was an area in which he felt that he (along with R.K.) was thoroughly competent, the role of the teaching of principles was not so evident here. That is, there was little teaching to be done since both had significant experience. However the other side of the teaching coin, i.e. learned or capable students, was clear. That is, if one did not teach, then one made certain competent people were involved. Thus Knight stressed the fact that both he and R.K. were knowledgeable and experienced, that the steering committee was also, and that the final board would only "work" if it had "good people" on it.

Similarly Knight did stress that the credibility of the division would be at stake here; but while he could likely not prove this to consumers by showing his usual management style, he could hope to do so by exhibiting the personal credibility of he and his whole staff, in whom he had confidence. And finally he was able to stress the accountability of the division (as part of his wanting to be a "responsible buyer") by providing a forum for the often bewildered consumer to focus his grievances.

Thus this case, along with the succeeding one (MA-7), illustrates not only the direct application of a part of the division's paradigm - the accountability theme inherent in responsibility - but also the degree to which that paradigm could be lived out. Thus in the first two cases, the accountability of PMO with respect to the division was not clear, therefore, the division could not act as responsibly as it wished and in fact forwent much action. In this case, acting responsibility was not only desired but, in Knight's view, was also possible; therefore energy could be invested in dealing with the new knowledge - and the result was the initial functioning of a consumer advisory board.

4. The MA-7 Case

This case could rather be called a vignette since it has not the depth or indeed breadth of the other cases. But it is interesting in that it outlines a problem involving both the internal and external behavior of the division and also indicates some of the relationships between managerial style and personality first discussed in the loss of controls case. Equally important, it was suggested by Knight as an example of something (i.e., some "new knowledge") which "we didn't handle very well."

It is a story of how one division of the DPW forced a decision on the medical division and how the latter readily accepted it. The decision "backfired" when its effects were felt by the medical providers and a short term adjustment had to be made. The adjustment was made with surprisingly little strife on all sides and with a mature, non-accusatory attitude shared by both divisions and the providers.

The "MA-7" form was one of three or four billing forms used by physicians to bill the division. It had been in existence for the preceeding few years and providers had grown accustomed to using it. It was, in the words of the PMO director, "not perfect, but quite adequate." Recall that the PMO, along with the Medical Claims Control Center, were the designers and operators of the computerized billing and payment process and reported directly to the commissioner and not to the medical division. PMO had designed many of the forms in use by providers, although not all - some having been carried over from before PMO's establishment. One of PMO's tasks was to bring some rationality to the bewildering variety of forms used by providers. Its policy had been to redesign each of the dozen or so forms as the current supply exhausted itself.

Thus in July of 1974, the forms expert for the PMO approached the division's director for provider relations, R.T., to discuss the new form he had designed for the MA-7 bill. Discussed is not really the proper word since previous forms had been designed by PMO and rapidly approved by R.T. with few or minor changes. In approving these previous forms, R.T. had primarily considered what the department needed in the way of information. The point of view of the provider did not take any precedence, but nonetheless the results had proven satisfactory to providers. That is, any complaints the division received came from either very small provider groups or from unorganized groups unable to exert much pressure. Similarly the PMO considered primarily the department's perspective and felt that the major changes proposed in the new MA-7 were those which

would facilitate the key-punching operations at MCCC. However, they did feel that the form would not present too much difficulty to a physician or his billing clerk -- as the assistant director of PMO said, "we knew it wasn't perfect, but we can't do everything."

There were additional circumstances surrounding the design of the MA-7. The supply of old forms was to run out within a very short time. PMO was under heavy time and budgetary constraints and had noticed the depleting supply rather late. Thus, there was an immediate need for action. Indeed when the director of PMO, N.E., was informed of the low supply he said to go ahead without even having Medicaid "sign off." But his assistant thought better of the matter and requested his forms designer to check with the division. The PMO stressed the urgency to R.T. and asked if he could sign off on the form within the next few days.

The PMO had also arranged a whole series of meetings with physicians across the state for August in which the complete range of billing forms (some new, some old) would be explained to them. While the idea for such meetings has come from N.E. with whom Knight had had a generally abrasive relationship, Knight readily approved of the idea. He was concerned that one of the few faces the division presented to providers was through the billing forms (and their processing) and he had not direct control over either the forms or their processing. Thus he made certain that R.T. would work closely with PMO on the meetings to smooth the introduction of the new forms and to present a credible public face. The schedule for these meetings produced an additional time demand. Thus when PMO came to consult the division the

pressure was strong. PMO had in fact already ordered the new forms while at the same time consulting the division, obviously hoping for a perfunctory approval.

R.T. stated that he had felt these pressures and should have taken more time to examine the form. He did not ask what the consequences of delaying or changing the form would be, although he had asked that question for the design of previous forms where, however, the consequences of a poor design were smaller. Nor did he examine the form from the point of view of the provider. He simply said "it looked OK" and approved it. In retrospect he said that he should have "said whoa" but was confronted by the assistant director of PMO telling him that they would redesign the form more thoroughly the next time around when they hoped to have more time and resources. The PMO assistant director did admit to "putting some pressure" on the division.

So R.T. signed off on the new form. As he realized this form would be used by many providers, he prepared a letter for Knight's signature explaining the new form to them. He had never done this before but thought it necessary now. Knight, for his part, having felt no bad consequences from earlier form redesigns, signed the letter after a casual examination of it. He knew that PMO had conceived the form and that they were not particularly provider-oriented but he trusted R.T., normally an extraordinarily thorough and inquisitive person. So some one and a half million of the forms were thus printed and distributed in time to coincide with the series of provider meetings.

At these sessions it became clear that "some serious mistakes had been made." (R.T.) There were not enough spaces for certain pieces of required information, the headings on the new forms were difficult to understand and, most importantly, the form did not permit a physician to bill for seeing a patient several consecutive days in the hospital. It is interesting that this latter area previously had been handled by permitting the physician to enter both the first and last dates of his hospital visits in one cell under "date of service." But PMO had said that this would not be permitted on the new form and the physicians would have to write out the complete set of patient information for each consecutive visit, thus unnecessarily repeating a tremendous amount of data. Thus it seemed that by saying that these new (and implicitly better) forms would be used, and by openly explaining their use by holding the meetings, PMO and the division in fact "generated provider criticism." If they had simply used the old forms, no one would have complained.

Yet providers did complain. They complained at the meetings and they complained directly to Knight on the telephone. He had not attended the meetings, but his name was on the covering letter. He immediately asked to see the form and went over it in detail. While R.T. felt it was a good form for what it did (i.e., permitted billing for many patients and few services) it did not permit billing for few patients and many services such as repeated, consecutive hospital visits. Knight felt that in addition, the layout was "unclear", some areas did not provide enough spaces for response, and no provision had been made for the retrieval of diagnostic information. The "space" questioned seemed to be clearly a

mistake, whereas the layout issue was "a matter of philosophy" according to the PMO staff. That is, one could sacrifice instruction space for information content on a form or vice versa, but one always traded off one for the other. Indeed the public meetings were a tacit recognition of this -- one could never make the forms "self-explanatory," additional material was needed, whether communicated via a covering sheet or via face-to-face meetings such as had been called. Thus the final focus of the discussion was on how to solve the multiple hospital visit problem.

Knight told PMO to change the forms. They replied that they had over a million of them already printed and that it would be impossible. He replied that PMO should then change or adapt the usage of the form. At one point, although this change was being smoothly negotiated by the assistant director of PMO, Knight stated that "if it comes down to me and N.E. (the PMO director) -- it'll come down to me and N.E." He seemed ready to draw swords over the "blatently" poor form, but the adaptation was successfully negotiated by the PMO assistant director.

This adaptation consisted of permitting the space on the form listed for the date of service to be used for the beginning and ending dates of a series of consecutive hospital visits. It was not designed this way but could be so adapted. PMO said that when the current supply ran out in some six months it could be physically redesigned. The PMO did indicate some hesitation about the need to do this as the adaptation seemed to be working adequately after a letter had been sent to all physicians notifying them of modification. Little

more was heard from the providers. Indeed a second new MA-7 form was redesigned and put into use several months later with better spacing and more clear headings and the continued use of an "adapted" space to indicate multiple hospital visits. Knight was still not pleased with this adaptation (since it involved more complex, rather than simpler instructions) although the providers were and he continued to discuss another version (the third) with the Medical Society.

When the inadequacy of the form first became known, Knight, as noted, was furious. But he refused to "point the finger" at R.T. R.T. appeared to feel guilty at his "mistake" and wanted to assume all of the blame. But Knight refused to let him, saying that he had signed off and therefore he must bear the ultimate public responsibility. He similarly refused to "point the finger" at PMO in public dealings with the physicians since he saw that, from PMO's point of view, two Medicaid officials had signed off on the new form. But he did bring up the whole incident in a general staff meeting as an example of "thinking of the provider" and of always being prudent when dealing with PMO. In private he also supported R.T. but said not to let it happen again.

R.T. characterized the case of a "series of indecisions." Yet it is more than that. Many of the patterns of action observed in other cases are also apparent here. Firstly, there was the generation of a problem because of the structural imbalance between PMO and the division and the greater degree of PMO's sophistication in form design -- PMO simply dumped a completed piece of work in R.T.'s lap saying that it was really too late to change it. There was the early, casual examination of the problem by both Knight and R.T. - by the latter because

things had always worked well (but also because of the pressure) and by Knight because of his style of investing full responsibility in his staff and then trusting them when they brought something for him to sign.

More importantly, there was the involvement of the division's provider environment, this deliberate exposure to physicians resulting in further dialogues about the new form and two additional versions. The division's usual method of first testing such a new idea with a few trusted friends was not tried here although Knight began to do so with the third version of the MA-7. Again, there was the strong role assumption that when changes have to be made, it was the division and not PMO who would dictate these changes.

Finally,there was the reliance on past experience - Knight placed himself in the provider's position in responding to their criticism. His staff did too,but it seems clear that the trauma engendered by the events would assure that such a situation would not reoccur. His staff similarly learned to be more formal and prudent when dealing with PMO. At the level of concrete results, the event "succeeded" -- a successful adaptation was made and it appeared that the third redesign of the form would incorporate the complete changes desired by both Knight, the providers, and PMO.

Thus the behavior shown by the division began to use a more full range of the tacit program for action which it had available and had exhibited in the sanction and new services stream where it had more control over the new knowledge. It had also begun to productively use some of the elements of this program in the consumer board case

where it was more responsive to its environment, yet strongly asserted its perogatives and then slowly and sequentially began to experiment with solutions with those affected. Here it did the same, only stumbling a few times on the way. This stumbling by R.T. may have been necessary to resolve the nagging ego problem which was similarly resolved in the day care case. R.T. felt confident that the final product would be a good one and that he had learned "the hard way" (by himself) how to go about the forms production process.

At the higher level of the division's more conscious approach to new knowledge, Knight's teaching style began to be more evident here than in the preceeding cases in this stream. While he was not involved early in the case, his handling of its later elements enabled the division to turn the problem into a qualified success. Thus he made himself readily available to both providers and to R.T. once the problem had been identified, he admitted the division's mistake and was non-critical and supportive of his staff. We used his experience as a provider to get across the nature of the "mistake" to R.T. and PMO and he stressed with his total staff what had been learned from the event. What had been learned - the principles as I have been calling them in earlier cases, was relatively simple - that the providers' point of view should be seriously considered and that staff should be more formal and prudent in dealing with PMO. While he had stressed the former in staff meetings, this was the first time the latter was stressed even after the experiences of being "burnt" twice before by PMO.

The management elements of Knight's style were, however, not much in evidence here. Indeed, his clear delegation of authority and use of inexperienced staff may have helped to generate the problem. But once it surfaced, he did become very concerned with enhancing the external credibility of the division by a rapid, open, and reasoned response to provider criticism. Behind this was the feeling that the division could not act as a responsible buyer unless this credibility was assured.

Knight also stressed the role of accountability in acting out the responsible buyer paradigm. Thus "responsible" seemed to mean being held accountable and purchasing services at cost effective prices while "buyer" signified, as we have seen, searching for a quality product and refusing to buy from poor quality providers. Here he stressed accountability by assuming the blame for the department externally, and internally refusing to "point the finger" at R.T. or even PMO since he had signed off on the MA-7 version.

This case then, while small in scope, taken with the CAB case and the eventual responses to the loss of controls issue and the dental claims processing, indicated some small progress in dealing with internal administrative issues over which the division had little control. The division was still not actively seeking out such issues but when confronted by them, began to develop a more consistent and reasoned response.

5. Field Operations

The field operations of the DPW and its medical division have a long and complex history. Prior to 1967, welfare payments were made and administered by each town and municipality according to their own standards and policies. In that year, the state took over the administration of the program. In practice, this meant using the same local staff while adding a centralized layer of administration. During the next seven years the department struggled to propagate a uniform policy throughout the state and assure that it was followed. It also centralized the payment of all bills, both cash assistance and medical, first in the regions and by 1972 in one central location. The problems of this changeover were immense. Policy had varied considerably from office to office and the local staff had often been reluctant in taking orders from a new, centralized administration. Moreover, the local offices were often extremely conservative in their interpretation of policy which went against the expansionist and client-oriented directions being pushed by many liberal forces in the late 60's and early 70's.

At the same time, in 1967, the Medicaid program began. Local workers then had not only to cope with the changeover to a state administered system but had also to learn the equally complex and evolving policies of a new medical program. Their tasks were not only to determine eligibility for cash grants and provide social services but also to process medical bills (see Loss of Controls case), counsel clients on the right to medical care and aid them in acquiring it. By all accounts the local welfare offices (LWO's) did this poorly, not

seeing Medicaid as being that important and being pre-occupied with the other changes then underway. The central and regional offices of the department, while naturally having more of an overview, were equally preoccupied. They, too, along with local staffs had been trained in the welfare, not medical fields, and never fully addressed themselves to the importance of Medicaid, although by 1974 it had climbed to over 40% of the department's budget.

The Medical Divison, headed by an assistant commissioner, could exercise little authority within the department. The local and regional offices reported up the chain of command to assistant commissioners responsible for cash grants and social services. (See figure 1, page 36). Thus any policies of the medical division had to first move "laterally" in the central office, then down to the local offices. The division had a staff of less than 15 in 1973 compared to over 1000 in the rest of the Department. The fifteen did include, after 1969, a medical assistance program advisor (mapa) in each regional office (7 in total) who reported to the assistant commissioner for medical assistance. Their role was originally designed to be the division's voice in the field - where they would help local offices interpret policy, process complicated or "exceptional" medical cases and alert the central office to problems of policy implementation. The mapa's rapidly became jack-of-all-trades having to be familiar with the total medical program. But their influence within the department was still limited due to their being outside its chain of command and their small numbers.

Some other states had handled the Medicaid program differently, placing it within their public health agency and relying on the welfare

department only for the determination of client eligibility. This of course created inter-departmental liaison problems, but at least the Medicaid Agency had control of its own field staff. But in this state, the "eligibility" link had been seen as crucial and so the Medicaid program was tacked onto the welfare bureaucracy. Previous welfare commissioners and the current administration up to 1974 had come from the welfare field and were said to be "only too happy" to get rid of Medicaid. But they were "stuck with the program" so continued to give it only minimal support in terms of personnel, facilities and interest.

The division's small staff thus carried on trying to formulate medical policy as best it could and trying to assure that policy was at least written down so that local offices could have something available. Much policy remained verbal however and the central office found itself continually responding to questions from the local welfare offices and "fighting fires." The mapa's and the central office staff were generally medical social workers by training and by experience. Most of the mapa's had been with the division several years and the relationship with the central office was harmonious as the two groups worked closely together in building up a "seige" mentality against the flow of client and provider problems.

By mid-1973, however, the situation was still far from ideal. The medical division had been without a leader for eight months and the LWO's were faced with increasing caseloads and overworked staff. Little attention was paid to Medicaid by the LWO's. The only Medicaid function that had to be carried out was the processing of medical bills before they were sent to regional (and later) central

finance units for payment. Interpretation of medical policy was still varied, adequate counselling was rare, and much policy was still unwritten. The mapa's had hardly begun to make a dent in educating the LWO's and were themselves swamped with administering the system of prior approvals (PA's)and individual consideration (IC's) items. These were two categories of medical bills which required additional processing by the mapa's, usually with a review by one of their regional medical consultants.

There was no assurance that local clients knew what services were available or that they were being delivered in an appropriate manner. One of the central office staff felt, however, that most clients knew about the basic hospital, physician and drug programs but were not aware of the broad scope of the Medicaid program. He had tried to produce a booklet for recipients, a simplified version of the 300 page policy manual, but said he had been "stalled by the department bureaucracy." The mapa's also tried to work with the LWO's but could never mount a systematic attack on the problem.

Knight's appointment in mid-1973 as assistant commissioner did little to change the situation at first. He early on attended a statewide meeting of local and regional administrators and said he "saw that the reason for violent disagreements between the LWO's and central office was poor transmittal of policy by the regional offices." Knight felt that "all the action is in the LWO's" and that the regional offices were only "distorting things." His previous experience (and success) in industry had led him to believe that regional field offices only hindered the flow of information and the implementation of policy.

He believed in a highly centralized policy making function with direct communication to the field - "sales" in his earlier experience and the LWO's in this case. Thus his initial view of the mapa's position was set. Not only should they not set policy but in this case they would have difficulty helping to execute it since they had to deal with regional (and local) offices of the department over whom they had no direct control.

Many of the mapa's were older, long-term employees of the division and Knight did not relate easily with them, particularly since they were rarely in the central office and he favored a very personal style of management. But their role was never clearly defined by Knight nor for that matter ever redefined by him. He did say that he hoped that the mapa's would become more involved in "promoting the program" as much of their paperwork (PA's and IC's) was due to be shifted to MCCC over the next two years and that they might become client advocates. But in general he adopted a policy of benign neglect towards the mapa's and placed his emphasis on reorganizing the central office, designing and redesigning the benefit the benefit package, and sanctioning. He felt so strongly about his view of the ineffectual role of regionalized administration that he even said at one point he would resign if some of the ideas being quietly advanced by the HSA secretary at that time for greater regionalization were to come to pass. But the mapa's role never became an issue nor even a problem at that time.

Knight's views towards the local offices were different however. While he realized (and was told) that interpretation of policy was poor and uneven and that clients were rarely receiving any counseling

about the use of the medical system, he knew it would be difficult to effect any change. Not only did he not have direct control over the implementation of medical policy, but the two other divisions (cash grants and social services)"didn't control the LWO's either." It was a classic case of "the vicious circle of bureaucracy" with the excess of central DPW policy gradually giving birth to considerable discretion by the local social workers. LWO morale was also low due to understaffing, and excessive concentration on "paper work." Half the LWO staff were long timers steeped in the culture of the department and viewed as unchangeable while the other half evidenced a rapid turnover and considerable difficulty in mastering the huge DPW policy manual - much less any Medicaid policy. Thus Knight said "I had to decide early on where I could get a reasonable return for a reasonable effort - and the LWO's didn't look like that place."

Knight also felt, although he never expressed it strongly, that accessibility of clients to care was not a severe problem since the state had a surplus of physicians. Thus one of the roles which might be expected of LWO's finding providers for patients - was not a priority function. Any effort to train the LWO's in better review of bills would not significantly affect the flow of dollars since the bill paying functions were soon to be centralized. The changing of the patterns of delivery of the medical system <u>was</u> viewed as important, however, but Knight thought that effort could best be conducted by central office working in concert with the providers. Similarly the idea of each the mapa's or the central staff taking a

direct (i.e. one-to-one) client advocate role was of course impossible with such limited number of personnel.

In addition, one of the strong forces usually motivating the division, the federal SRS agency, did not take a strong position on the role of either the mapa's or the LWO's. Only in the EPSDT and family planning cases had it concerned itself with the importance of the LWO. As we have seen, Knight ignored this for sometime in the EPSDT case. He did, however, assign one central staff member to the task of assuring that adequate outreach was being conducted for family planning although even then considerable emphasis was placed on the family planning clinics themselves providing the outreach in concert with the LWO's. Thus the division, acting under Knight's leadership and his firm beliefs, ignored the local offices and the mapa's and turned its attention to reorganizing central policy and developing new services in conjunction with the medical community.

The mapa's were, of course, not "ignored" on a practical basis since they each had daily contact (at least by telephone) with the central office. They were initially pleased with the influx of Knight and several new staff into the central office. It meant that some of the long-neglected policy areas could be redesigned, that much of the policy which had previously been verbal could now be formalized and that somehow they might get out from under the deluge of "paperwork" either through added clerical help or the redesign of the PA and IC system to coincide with the centralization of bills payment at the MCCC. However, two of the seven mapa's were newly hired and had to spend their first several months just learning their day-to-day work and the existing policy of the division. They had no time to think about changing their roles as did the others.

But the change was not to come about. The new and expanded staff in central office began work on design and redesign of policy. (Knight - "policy first, then implementation"). The two principle staff directors whom Knight relied upon were new to the division. They thus had no real concept of the role of the mapa's and followed Knight's lead in categorizing the mapa's. Both these two, the other new staff members, and the six or seven young staff who were being reassigned by Knight had participated in the early indoctrination period from April 1973 to beyond Christmas while the mapa's only came to central office once a month. The central office staff met at least once a week during this time and socialized considerably. Knight only occasionally stated his view that the regional staff need not be involved in policy design but his feeling was obviously transmitted to his central office staff through his actions.

A very few of the staff did however "bounce off" proposed policies with the mapa's (e.g. in transportation and in mental health). One central office staff member, O.E., said he felt that perhaps some of the younger members were more prone to discuss policy with the mapa's. This might be explained by the fact that the long-time staffers were initially very concerned with "proving themselves" to their new boss. While their jobs were not at stake, their responsibilities were as they saw new tasks being assigned to the younger members and it is possible that they simply concentrated on central office development during this stage. However the difference was not great. Even the young staff were perceived by the mapa's as being "wrapped up in their own policies", "fencing themselves in on

new policy." There was "no sharing of any kind". One of the mapa's even perceived a "sense of competition among them" (the younger staff) "which Knight seemed to push". Examples cited were the preparation of a new fee schedule for physicians and the new MA-7 billing form in neither of which the field felt they had been adequately consulted.

In many cases when central office staff thought about "the field", they lumped together both the LWO's and the mapa's. For example, information on a combined Medicare/Medicaid bill payment system was not sent to either the LWO's or mapa's since the responsible program director said he felt the volume of bills would likely be small in each LWO and he had no assurance that social workers would ever receive or even read the policy. Thus he sent the billing information only to providers and much later, to the mapa's. This theme was often repeated with the mapa's claiming they had to respond to questions of clarification of policy mailed to providers when they themselves had not seen or received the policy. The mapa's began to view the central office as diletentes - lacking in medical experience or even management capacity ("no one ever sat down and told the LWO's how to file their bills.")

Their view of Knight was less charitable. They viewed Knight as feeling that policy design was more important than implementation. Knight's response, of course, was that the policy making function was legitimately one for central office and that policy had to be first designed before it could be implemented. While his response here was clearly stated, the mapa's feeling that he viewed implementation

as not important would be questioned by Knight. On the one hand we saw how he felt that action with the LWO's was not likely to have results whereas working directly with providers would have some effect in insuring that clients had access to services which were of a high quality. Testing of this strategy would come about through the management reports produced by MCCC (total dollars spent by category, etc.) the monitoring about to be phased in by MCCC and through the day-to-day contact with providers around the issues of fees, conditions of participation, etc. Thus the mapa's were to be used only for interpreting policy, administering the PA and IC system and "tipping off" central office to problems.

But the litany offered to the mapa's by Knight was somewhat different even though he realized the source of their discontent "at the very first meeting". While Knight verbally downplayed the above view of the mapa's role in their presence, he upgraded the "new role" they were to begin to assume. They were to become intelligence agents, spotting gaps in the delivery system and helping to create new resources. For example, if a need for a new transportation service in one of the regions was apparent, they would identify the need and work with possible providers to develop the service. In practice, however, Knight saw the central office staff as having the technical capacity to handle this type of activity and, as seen in the new services stream, the mapa's were little involved. Knight's public exortation motivated the mapa's for only a short time however. While they were told they could and should fulfill this new role, the behavior and attitude of both Knight and the central staff led them to conclude that it was simply not meant. Their complete reaction later on in

the year will be discussed below; here I only wish to describe the anticipations and initial reactions of the mapa's.

Some responded to the new role held out for them..."Some are aggressive while others are scared" said R.K. of the central staff. Knight felt that "the role will change for those willing to change" and that perhaps "three of the seven had begun to respond" to this new role. But even among those who did respond aggressively, the attitude was not harmonious since some felt slighted when realizing they had not been promoted despite Knight's success at enlarging the central office staff. One of the mapa's was promoted, however, and this only underscored the gap between the mapa's and the central office since she was a "new" mapa and fitted in well with the style of the central office. In fact she had drawn attention to herself by her actions in the mapa position. Thus, rather than leave a competent person in that position, Knight pulled her into central office, although he did find a competent replacement. Several of the other mapa positions showed a rapid turnover of staff - one of the remaining mapa's attributed it to the "demeaning attitude" of central office and that "Don simply doesn't realize the pressure on us." Others said that they thought he considered the mapa "expendable". It was "not a creative job...it's just PR..We're a jack-of-all-trades... all we do is react."

And it was clear that by the first of 1974 Knight did consider them expendable. He proposed that the mapa's be "pulled into central office". He felt they could better be used on program development and could handle the "prior approval" and "individual consideration"

(PA's and IC's) functions centrally partly because the latter were due to decrease with the advent of Phase II. When he proposed this scheme to the commissioner and the other assistant commissioners, the reaction was strong - the regional administrators did not want this to happen. They knew they would still be stuck with the hundreds of provider inquiries the mapa's were then dealing with. While they had little concern for the program ("they were all 'mustangs', brought up through the system because they were hard-nosed administrators, oriented towards personnel and staff"), at least the mapa's acted as a buffer for them.

The commissioner then told them that "if they didn't want the mapa's removed they had better come up with some positions for central office medical" (Knight). Thus, Knight backed down upon the promise of an enlarged central staff but the eventual transfer was only of a few clerical and one professional position - not nearly what Knight had anticipated. By then, the mapa's were confused and demoralized. They did not doubt Knight's sincerity or principles ("he often takes our advice if a medical problem comes up") but did feel upset at the effect of his belief in the unimportance of the role of the mapa's. "I think he honestly believes that he knows how to administer the mapa's and that this is the best way to do it." They viewed him as unchangeable on this position.

The mapa's had no choice then but to settle back into their routine of coping with the onslaught of provider and LWO questions. They were to work with O.E., one of the long-time staffers whom Knight had previously appointed to be the "field coordinator". He was to

coordinate the work of the mapa's, act as their liaison in central office, and "trouble-shoot" any particular problems that came up in the field. Although it was not stressed, the fact that he had been in the system over 30 years and knew most of the local office personnel would perhaps aid in dealing with the latter. While Knight was also beginning to delegate authority in many other areas, this appointment was viewed as one of "getting the field problem off his back." In addition, Knight appeared to have difficulty relating to O.E. who knew the details of the DPW and medical system thoroughly but who was not perceived as having much "policy sense".

O.E. had been one of the 4 or 5 "old guard" who had previously run the whole program by themselves and he felt he had the capacity to contribute to policy. Knight felt otherwise and his relegation of O.E. to the role of only one of the 9 or 10 assistant directors "sharply affected O.E.'s ability to work and cut deeply into his imaginative capacity" (one of the central office staff). The selection of O.E. further complicated matters for the mapa's since his selection indicated a "low priority" for the field system.

O.E. began to work with the mapa's in establishing better relations with the LWO's and in boosting up their support (space, clerical help) in the regional offices. But he was seen by the mapa's as ineffective amd confusing. He failed to gain their respect and in an attempt to "prove" himself to Knight began to cut off communication between the field and Knight. The mapa's had been annoyed by the "lack of clear lines of authority and responsibility in central office" and now that they had it at least partially, it was ineffectively utilized.

So the mapa's carried on with their workload, "reacting and coping" as one of them put it. As it had in the past, their work consisted of responding to providers about unpaid or late bills, explaining billing policies to providers, administering the flow of prior approval and individual consideration items. They also took over some of the social service functions from the LWO's by default, for example, trying to obtain nursing home placements or calming worried relatives who feared for a patient's entrapment in the frightful world of hospitals and bureaucrats. The new mapa's, of whom there were four for two positions in the course of 2½ years, had to learn the ropes from the beginning and were thus even more overloaded. As one of them put it, "I had to learn how to get things out of central office. You people let a lot of things sit or bounce around between each other." But they too "learned to cope".

All of them tried to train what little clerical help they had (usually one or two persons) to deal with the more routine problems but this still could not stem the flow of work. In fact, the more competent a mapa was the more likely she was to become a magnet for provider and client questions. They began to rely on and to push their medical consultants harder. Each region, like the central office,had a staff of consultants it called upon for reviewing the PA and IC items, and many of these apparently noticed the changed atmosphere in a central office and begun to act as client advicates, taking the side of the patient more frequently. The mapa's continued to decry the lack of interest of Knight in the field, often at their monthly meetings, but Knight would gently brush off their pleas and

assure them that things were going to change. He did request several additional regional positions for the next budget but these were disapproved as were most of his other personnel requests. The mapa's did not see any change in things and continued to grumble. Knight even felt one of them was probably "bad-mouthing the program" in public.

The central office generally continued to ignore the mapa's although some of them felt they had made "some attempt" to involve the mapa's. In general though, central staff only dealt with them when a problem came up or when they wanted specific information about providers in the area. The mapa's complained that when central staff were coming out to the region to discuss a new service with providers, or even to do a field audit, they were rarely notified and they were upset that Knight himself never came out to visit them in the regions - "he should sit behind my desk for a day to see what it feels like." But most of the mapa's were energetic women, full of pride and did not, despite the low salary, consciously let their growing resentment affect their work output.

The division's relations with the local welfare offices did not improve over this period either. The sporadic attempts O.E. and the mapa's made to improve the LWO's knowledge and handling of the Medicaid program were overwhelmed by a series of other factors - not the least of which was Knight's continuing feeling that the division could do very little to improve the LWO's quality. The quality and size of each of the 116 LWO's varied enormously and this was perhaps the first factor in working with them - the division

could simply not count on any task given to the LWO's to be carried out with any reliability. Secondly, in June of 1974, the processing of all medical bills had been centralized in the head office thus taking the responsibility from the LWO's. While local social workers were still, of course, theoretically to continue to have knowledge of the program and advise clients and providers on policy, this major relief from the paper overload contributed to a feeling that Medicaid was now even less their responsibility. In addition, their familiarity with the program gained through bill processing was being eroded. And for the elderly clientele of the program, their cash grants had, since January, been flowing through a federal office (although still with state financial participation) and the elderly no longer had an "assigned" DPW social worker. They would only be provided a worker should they request one for a specific purpose.

In September of 1974, the department LWO's were also undergoing a court-ordered administrative change called "separation" in which certain workers would be designated to handle only cash grants and certain others only social services. The confusion and in many cases rancor, that this caused made it even more difficult for the division to rely on the LWO's to carry out their proper roles of advising and aiding clients in obtaining medical care. The cash payment workers had been designated as those who would counsel clients on the medical programs since each client had a cash grant worker but not each one had a social service worker. The cash grants worker would clearly be the only possible resource in such situations but likely knew the medical program, or even cared

for it, less than the social service worker. Thus several factors contributed to the LWO's increasing lack of involvement with the medical program. One result of this which illustrates the combined effect of these factors was that nursing home placements for the elderly were poorly made, often with significant delays.

While the LWO's no longer were involved with any formal screening of medical bills, the program for such screening had not yet begun at the central computer (Phase II). The slowdown of Phase II affected the mapa's since they had expected that their volume of P.A.'s and I.C.'s would be lessened and they could begin to take on their new role. But they not only still had to deal with the P.A.'s and I.C.'s, but they also had to handle an increasing number of calls, many of which would have gone to the LWO but for the latter's decreasing knowledge of, and concern for the medical program.

While the mapa's were "coping" under the situation, their frustrations were being aired more among themselves. One of them said that "Don's litany of how our role will change doesn't help us any - he doesn't even know what we do." And as a member of the central office staff remarked "You can't move the paper out of the regional office (to the central computer) until you understand what that paper is all about." Knight's continued discussion at the monthly meetings of the good things the division was doing was perceived differently by the mapa's and irritated them. While Knight obviously intended it as a morale booster and, if possible, (as observed in other cases) as a teaching experience, one of the mapa's responded by saying, "why does he always tell us about the good things central office

is doing, why don't we hear about the failures or mistakes; we don't need to hear how good central office is." One even felt that the division lacked professionalism - "no one reads any professional journals and we don't know what other states are doing." But their feelings of frustration were denied a real focus. One was to be provided soon however.

R.K., the director for ambulatory care had, earlier in the fall, thought that an attempt should be made to more formally involve the LWO's in a training program designed to improve their knowledge of Medicaid. He approached the social service division at central office and some of the regional administrators and tried to advance the idea. But he was brushed off by their remarks that they didn't yet have the time and besides, shouldn't they wait for the printing of a client handbook about Medicaid then being designed (see Consumer Board case). Knight encouraged R.K. in his endeavor, but never very actively, since he felt it would be difficult to "pull off".

Later in the fall, one of the mapa's had been asked to talk to some local workers about the medical program. That one event had worked out well and R.K. proposed that it be extended to other regions. He worked out a plan for such a training program with one of the mapa's and other staffer from central office and circulated it to all the mapa's. In this case he was going ahead without the concurrence of the central social services staff but assumed he would acquire that shortly. He also proposed that the mapa's become "advocacy centers", working directly with local agencies (other than DPW) and community groups to make known the Medicaid program and to become the voice of Medicaid in the regions.

The mapa's soon met with R.K. to discuss his proposal during their monthly day in central office. While he had sent out a second memo downplaying the "advocacy role", the mapa's nonetheless used this occasion to burst the bubble on their expanding, year-long resentment. They accused R.K. of not understanding what they were doing, of being arrogant, even lazy, and of not realizing they had no time to do any of the things he was proposing no matter how much they would have liked to. They surfaced all their concerns about lack of involvement with the central office and their neglect.

The meeting was an extraordinarily heated and antagonistic one which drew the attention of everyone in the office. R.K. backed down on the proposed advocacy role, but continued to hope that the LWO training could be carried out at least through the special child guidance unit with whom they had experimented so well. The training of the complete range of LWO workers (especially at their intake or entry into the DPW) was held in limbo as it still required the acquiescense of the other divisions and the DPW regional administrators.

Then while these two attempts to beef up the calibre of the LWO's had reached a temporary impasse, Knight had had another idea brewing. The commissioner and he had earlier had the idea that people from the WIN program (work incentives) for welfare mothers be employed in local offices and trained as Medicaid representatives. These would be welfare mothers hired outside of civil service regulations and reporting more directly to Knight. However this plan took several months before a decision could be made and in the meantime the federal CETA program (Comprehensive Employment Training Act) came into being. This was an emergency temporary program for unemployed

persons. Several dozen jobs were allocated to the department and the division received 14 of them. Knight eagerly seized on this area and said he would be "very involved in their training."

They spent 3 weeks at central office absorbing the program, then Knight assigned 8 of them to the various regional offices and in a few cases to large LWO's. In some cases they would aid the mapa and in other cases deal directly with central office on specific problems such as nursing home placements. The problem of assuring adequate performance from the range of LWO's still remained but the regional staff had been boosted up. The mapa's had received a dual-edged sword, however. That is, on the one hand the CETA people would aid them in their work but they also appeared to owe their loyalty to the central office and Knight. Knight appeared to feel pleased with the CETA people in the regions since he knew precisely what they were doing and he had had the opportunity to help train them. But the mapa's felt they didn't know what the CETA people were supposed to do - their resentment remained and would have to be handled by other means.

Knight had, of course, heard about the "blow-up" of the mapa's with R.K. and said that he would have to do something "even though R.K. was just trying to get them to do what they're supposed to do." He called such a meeting, the results of which were a memo to all staff saying that the mapa's should be involved in policy making where possible (all draft formal policy was now being circulated to them by then anyway) and that several of the mapa's specific problems with paperwork would be corrected. Knight also chose to assign the resolution of many of the mapa's problems to O.E., in whom they had little confidence.

The central office staff did seem to feel that they would "involve" the mapa's more. Knight however, while viewing the problem as solved did not appear to have changed his basic view of the importance of the mapas' role. An upgrading of the mapa's salary level was requested in the next budget and he requested they keep a log of their activities so he could more fully understand their jobs, but it unclear whether this interest would change their performance or their view that Knight is just one of a long line of assistant commissioners - "we'll be here long after he's gone." The effects of this shared neglect on the regional front were perceived as "gripes, not grievances" by Knight. The mapa's continued to do their assigned job competently and also pushed for more responsibility and resources. There was moreover, no indication from providers that the mapa's were anything less than competent.

And, of course, the intractable problem of the LWO's remained unsolved. This case of benign, even deliberate neglect, can be seen as how two potential "problems", i.e. how to deal with the local and regional offices, were so defined that in the one case its solution was a deliberate neglect based on the stress of environmental constraints and in the other case a solution of benign neglect built on Knight's principles and the inappropriateness of his style for solving that problem.

For the two situations Knight made an initially quick decision on the problem as he so often did. That decision was that the LWO's were relatively unmanageable by he or indeed others in the division. Since many functions were to be centralized and since clients had good access

to care, he would concentrate on working directly with providers. With the mapa's, he made an equally rapid decision backed by his industry experience and his general philosophy that regional staff involvement in policy making should be held to a minimum. He delegated responsibility for the mapa's and then shielded himself off from much further discussion involving either their roles or their problems. Each of these actions was consistent with the way other new situation- had been handled. Usually, in such cases, however a strong sense of positive principles was taught to the staff.

The principles which were developed or carried over from other cases or past experiences were in this case essentially "negative" ones. They were that local offices are uncontrollable, therefore the division should work with providers; that a careful nurturing of the latter would have a significant effect on care delivered, and that regional offices could and would not be much help in developing policy and only a minor aid in establishing provider credibility.

But here, not only were the principles evoked more negative in nature but Knight's teaching style was inappropriate for the mapa's since it was based on close daily contact and on a young, non-professional staff - conditions which did not apply with the mapa's. Indeed his "learning" vacabulary used at staff meetings backfired, since the mapa's perceived this as "boasting". However the central office staff acquired Knight's negative principles through observing him, through his appointment of O.E. and through his general stated reluctance to involve the mapa's or to make any systematic effort to control the LWO's. Thus the staff's close identification with Knight and his strong teaching style (at central office) led to a shared neglect by staff of both the LWO's and the mapa's.

His open management style so evident in other cases was clearly not called into play so effectively here. The mapa staff could not all report to him, as was his usual style, while his delegation of responsibility which worked well in other cases backfired here (with O.E.). He failed to keep a close check on the mapa's work, and the use of young non-professionals, while successful in the other two streams, created resentment among the mapa's. While he did let the mapa's "find their own slot" and he did stress the direction and integrity of the division, these positive management steps either could not overcome the other problems or were construed differently by the mapa's. Mapa reaction to this year long situation was to build up a mounting pressure which finally exploded.

On the LWO front, the LWO's of course did not see their neglect as a "problem." While community groups and providers did begin to comment on the low effectiveness of the LWO's, these reactions only reached any significant level by late 1974. As for the rest of the department, Knight had little internal credibility with the regional and local staff and besides, the LWO's "were uncontrollable anyway." Knight often said - "I'll listen to anyone's ideas if they come up with a better solution." No one could in this case - the problem was systemic - based on the history and culture of the DPW and its relations with its newly acquired, minor brother, Medicaid.

But the nagging ego feeling so often felt by Knight's staff in other cases led them to try a solution, one which would involve new roles for both LWO's and the mapa's. That proposed solution resulted in a partial resolution of at least the mapa problem as Knight began finally to listen to them and then to acquire new resources for them.

The LWO "problem" remained unsolved although many of the mapa's did indicate they would continue to try to improve the LWO's now that they seemed to have some central office backing.

Thus the problem of learning how to deal with the division's field operations can be evaluated in different ways. The LWO problem can be considered an unsolvable one in the short term in which case the division's strategy of working directly with providers must be seen as a reasonable adaptation to a situation in which Knight had no direct access to the LWO's (to use his teaching style) nor direct control over them (to use his management style). This strategy at least did not diminish the division's credibility. It also helped it to act in a limited way as a responsible buyer although it is not clear how the ultimate benefactors - the recipients-viewed this "responsible buyer." Here Knight's view of acting responsibly was to not waste energies in areas where he felt that neither he (or anyone) could likely have much effect.

The mapa problem also may be seen as an allocation of resources problem. In this situation the problem was not insolvable, however. Indeed it is not clear that it was ever a "problem" since the mapa's did perform as desired. Nonetheless, they forced a problem "definition" on to Knight and his staff despite Knight's preconceptions about the situation and the inappropriateness of his teaching style. What the division (particularly the staff) did seem to eventually learn from this problem forced on them is that, with a small change in attitude and a small shift of resources, the mapa's might be utilized even more effectively, thus bringing greater credibility to the division - which would ultimately help it to live up to its professed

paradigm. Knight however did not agree with this conclusion feeling that the potential payoff was still low and that he had been justified in conserving at least his own personal energies for other new areas..

6. Overview

In the assessment of the other two streams, criteria for organizational learning such as-was the new knowledge processed successfully once, was it routinized, were the principles developed in one case used in others in the stream (by Knight or his staff) or were these principles utilized in other streas - were applied. Similarly we looked at the evolution of the division's tacit "program for action" in dealing with new knowledge. Finally we examined the evolution of a discernible style, one based on teaching, the development of credibility through management and the evocation of a conscious paradigm.

After a first assessment of this stream, this framework appears to be somewhat less immediately useful in describing and explaining the agency's activities. The division appeared to be fumbling considerably, ignoring whole areas of responsibility and certainly not acting with the confidence and active stance that it did in so many other cases. Yet after a second assessment it is clear that there was a considerable amount of learning going on, but it was not evident in the lower level criteria of "success", tacit programs for learning or development of management capacity. Rather such learning was observable in and derived directly from the organization's paradigm - the responsible buyer. Responsible meant the search for cost effective services and acting "accountable" in their purchase.

It is the accountability element which links these cases together and around which some learning appears to have taken place.

It will be necessary to "muddle through" an evaluation of learning using the lower level criteria before we can properly understand the accountability theme in this stream of cases. Asking the question was the case a "success" in the view of those associated with it permits us to see no discernible pattern. The loss of controls case did succeed in producing an output but at considerable cost; the dental claims processing case was seen as a good decision, while the consumer advisory board development was also perceived as having set out on the correct path although the time it took to do so was probably excessively lengthy. The MA-7 design failed in its first version but was resurrected later. The decision as to how to deal with division's field operation was, on the one hand (the LWO's), probably inevitable, and on the other hand, (the mapa's) certainly not a success comparable to other cases. Thus there does not appear to be any obvious progress in the division's handling of these cases. Some succeeded, some did not, and the only variable which helps to explain these is the degree to which the division perceived the case as a controllable area or not (see page 279) - thus defining its interest and the energy to be invested in the case.

Using the criterion of "was the success (or lack of it) evidenced in the case routinized in any way" presents us with no significantly more interesting conclusion. The experience in the loss of controls case probably had an effect on each of the division's staff in that that was the first time they had had to deal with the PMO in any way.

Over the next year, they each had to interact with PMO on a variety of other issues. While there was not an overall concensus among the staff, there did appear to be a feeling that relations with PMO were better. Thus the six-month jousting with PMO may have been necessary (given Knight's avoidance of the PMO director and unwillingness to lay down any mutual ground rules) for the staff to establish a routine manner in dealing with the PMO.

The dental claims processing case appeared to be well handled after the initial decision was made. Similarly, a later contracting out of laboratory bill processing was made without the abruptness of this case. The effort to involve clients directly in the consumer advisory board was a one-shot affair and any criterion of routinization is irrelevant. The MA-7 design did indicate that successive redesign of the form could be made equally rapidly with the concurrence of all the parties involved. Finally the field operations case certainly indicated the division's capacity to hold itself to or routinize a decision (in this case to ignore) involving the local and regional offices.

The other criteria, those of a transfer of principles from one case to another and/or the use of principles by other staff members were also utilized in the other streams. The nature of the "principles" in the other streams were of the order of "avoid the use of interms where possible" or "do not sanction if it will do the provider out of business and if he has caused no direct patient harm." These had to do with health care delivery aspects of the case being examined. Occasionally they had to do with how to develop these delivery policies, i.e. "providers

should be listened to". But in this stream, what few principles that were developed had to do with much broader "postures" to be adopted by the division. These higher level principles or positions were much more directly related to the division's paradigm and were more conveniently applied than in the other streams. Knight believed that a variety of detailed responses to the question of how his staff dealt with internal problems was possible. What was important was the initial posture of the division in establishing a policy direction. And that posture was in each case set by him. It was these postures which he consistently held from case to case in this stream and which the staff partially acquired.

Those postures were basically quite simple. Firstly there was the view that the division must be held accountable for its performance and, in areas where its performance was affected by other bodies, then those bodies should be accountable to the division. This accounted for Knight's insistence that PMO was a "service bureau" which should provide a "product" for the division. It explains Knight's upset at the decision-making process for the dental claims processing and for the initial MA-7 designs. It also explains his ignoring of the LWO's since their accountability could not be assured and his view that regional offices are minor subsidiaries and executors of policy from the central office.

The second major posture was that since LWO's were unaccountable to anyone (and the mapa's unreliable), the central office of the division must deal directly with the providers and try to assure its credibility - which could be acquired by listening to providers and explaining the division's positions carefully. This second posture thus explains

both Knight's eventual ignoring of the loss of controls issue since it involved only a small set of providers and did not affect the division's credibility and his equally strong hand in the MA-7 case. It also explains his dealing directly with consumers (since the LWO's were of such low quality) and ignoring both LWO's and the mapa's in dealing directly with providers since he felt that neither had the capacity to perform that function. Thus the postures or very broad principles which were adopted or developed here were not a direct, evolved product of the working out of the cases as was evident in the other streams. They did not seem to flow from the success of any particular case or even from the usual tacit program of action of the division.

However, some of the features of this tacit program were visible here although they are not as significant. Indeed action itself, which was the common feature of the "program" in other cases, is not significant. Rather it is the lack of action, the reasons for this lack, and the responses to it which are the most relevant. Nonetheless the cases do show, for example, a progressively stronger assumption by the division of its "perogatives". In the loss of controls case it seemed to be caught off guard by what was happening to it, but finally Knight realized that his delegation and his failure to appoint a liaison person had not been effective. He then took some positive actions. Similarly, in the dental case, the division's perogatives, while abused by PMO, were reasserted to the commissioner by Knight. In the third and fourth cases, the division also asserted its "right" to be involved in those areas. In the field case, a possible assertion of authority with respect to the local offices was ignored not because

the division felt the LWO's were not controllable by the division but because they were uncontrollable by anyone.

Knight's technique of not breaking down a problem and "factoring" it among several persons,but rather assigning it to one responsible person was utilized as usual in most of the stream's cases. In the middle three cases either he or one of his staff handled the problem - with a relative degree of success. However, he did not use this tactic in the first case and the costs were significant. These costs were further complicated by the fact that the quality of the staff (with respect to this particular problem) was not equal to the task. Similarly, in the field case Knight clearly delegated responsibility - but to a person who did not appear to be up to the task, although Knight would explain this by his view that the field area was not a high priority one. The lesson which, of course, could be learned from this,is that a non-factoring of problems is acceptable if staff competence is high, whereas conscious or unconscious factoring of a problem among several individuals can be harmful if individual competence is low.

Knight's habit of utilizing his past experience as a guide was as clearly evident here as in the other streams. In fact, in all but the dental claims processing it seemed to be one of the main determinants of his action. For example, that liaison people should be avoided, that consultants should function as a service bureau, that consumer input is valuable, that providers need clear and simple billing forms and that regional offices are of minor importance - were all relics of his past two jobs. This strong belief in the value of his own experience also led Knight to

neglect one other feature of his usual program of action - "touching base" with the relevant environment (in this case PMO and the mapa's). This inability to come to some sort of philosophical understanding with both PMO and the mapa's was probably due to the lack of any real attempt rather than any failure in such an attempt.

The final relevant feature of the program which was evident here was the relative lack of any of the nagging ego problems seen in other cases. Thus, despite the fact that Knight ignored many of the areas, the staff still had to contend with the problems of dealing with PMO, the field and the providers and they were thus able to work out a relationship by themselves in which they had some confidence. Recall that without any real test for their personal competence, the surrogate used by many of the staff was early participation in the setting of the division's directions. When Knight usurped this function, staff would continually worry about "have we really accomplished anything." Here that feeling was much less prevelant.

As suggested then, the usual tacit program was not as clearly in view here. One or two elements of it appeared to show some development over the stream, while others were simply employed across all five cases. Certainly there is not the widespread progress shown in the other two streams. We must then look to the division's overall approach to see if any progressive adaptation or learning occurred. First of all, consider the element of teaching which elsewhere was heavily used to develop and elicit principles which accumulated in the division's individual or collective memory. The only case in which Knight explicitly used his teaching style here was in the MA-7 case where he was available for consultation, admitted his "mistakes",

carefully explained decisions, was non-critical of staff and used a learning vocabulary to some degree of success. Only with the mapa's was any further explicit "teaching" used and there it backfired since the ground on which it fell was so infertile, even hostile.

In all the other cases the teaching was tacit and conveyed through staff watching Knight act or listening to his pronouncements about administration. These pronouncements (or principles as we have been calling them) were not about medical care or how to go about getting it but rather about management, and more particularly, the importance of accountability in living up to the division's paradigm. Thus, as described on page 357, these principles had to do with the division being accountable to the public and PMO being accountable to the division. They were also concerned with the lack of accountability in the LWO's and the minor role of the mapa's both of which subsequently necessitated a greater involvement with providers. Credibility could then be established with the latter through a careful "listening" posture and a clear explanation of the division's eventual policies.

The importance of a complex set of management techniques used both internally and externally which was so evident in other streams was not as clear here since problems were generally ignored or given low priority by Knight - thus the use of his management style could not be called into play. That style involved Knight's interacting with his staff. Here there was usually no direct interaction and we see that either no action was taken (Field, Dental), action was taken unilaterally by Knight(CAB) or action was generated by and

often concluded by the staff acting relatively independently. (Loss of Controls, MA-7, Field). Only Knight's view that good management meant cost effective use of staff resources helps to explain his own lack of action.

Similarly, the use of competent management to produce external credibility was not as significant here. Indeed the opposite was true; for example, Knight would often bear the brunt of complaints about PMO's operations from providers, but only in 1975 did he begin to point out to them that he had not as much control over PMO as he desired or was necessary. External credibility here would be attained not primarily through competent performance of the division's tasks but rather through listening to and talking with providers and through serving providers as an intermediary to PMO and the LWO's.

Thus this stream of cases distills itself down to a story about the direct learning of accountability - a major element of the paradigm. The other streams dealt with living out the paradigm at the lower and more indirect levels of principles for service delivery or sanctioning, tacit action programs or techniques, while a gradual even hierarchial progress was made towards a cumulative set of actions which could be said to represent the paradigm. Here attention was directed directly at the paradigm itself with, as can be seen, a resultant "cost" at the other levels - although that cost was not directly observable to providers nor was it observable in any change of service policy. Indeed, this direct attack may have been accounted for by Knight's insistence on the importance of provider acceptance and a high quality service package - rather than on the manner in which these were internally

developed. That is, where such internal administration affected strongly the division's credibility, or the quality of its package of benefits, he was very concerned with the internal generation of credibility or benefit policy. When not, he simply ignored the relevant internal administrative problems (new knowledge) which were being thrust at him.

It is impossible to assess the correctness of this approach or even its real cost, if any. What can be said however, is that given the organization being constructed and the nature of its early dependence on Knight, the staff certainly learned that part of the division's approach having to do with the accountability and responsibility portions of the paradigm. They also learned how to pick up the fallout from such an approach and in a manner which may ultimately have been more personally satisfactory to the staff members since they could directly "test" the paradigm which Knight was espousing.

In one sense then, this stream illustrates the outer limits of the division's approach. That is, given areas deemed to be uncontrollable, the division ignored them rather completely. Deemed is the key word here since Knight would wade into battles with agencies over whom he had no control (e.g. the federal agencies in battles over EPSDT and later PSRO development) if he felt there was a high payoff to be acquired by a not excessive use of the division's resources. On the other hand, the staff still had to deal with many of the problems caused by these uncontrollable areas and their ability to do so gives some slight indication that, in Knight's absence, similar problems would be handled with a greater level of comprehension - not withstanding the fact that similar decisions might well be made in these cases.

CHAPTER VI

The Division's Learning

Several cases of new knowledge management have been presented and partially explained. That is, a framework for describing these situations has been developed and assessments made as to how those situations evolved. But those framworks and evaluative methods were developed gradually during the course of examining each of the three streams of activity. Now the complete framework must be laid out and the fifteen cases tested within that framework. This chapter thus attempts to answer the question, "did the organization learn and if so, how?" The additional question of what the organization learned is inseparable from the question of did it learn, since the definition of learning which I have evolved here (and which was first introduced on pg. 174) consists of the achievement of successive levels of behavior, with the achievement or reaching of each level being defined primarily in terms of the ability to process, generalize from, or evolve from, the level below it. For example, learning at the second level consisted of the routinization of behavior at the first level.

These levels consist of: a policy or action response to individual situations of new knowledge, the routinization of that policy or performance, the generation of general principles from each case which could be utilized in other service or problem areas, and the development of a program for approaching each of the first three levels. Each of these four levels of learning will now be described and an assessment made as to the degree the medical division attained those levels.

1. Developing and Routinizing New Policies

When confronted with situations which the division had not faced before, it was called upon to develop a stance or attitude toward that situation. The situations were not all simply "problems" being forced

upon the division by outsiders or by the natural flow of events within the division. Some were situations in which an event, or an awareness of the division's members, led the situation to be defined as an opportunity. The one common feature of all the situations is that either Knight or the division's staff felt it necessary to respond in some way, usually to develop a policy. The degree to which and the manner in which it responded are more fully explained by the program for action. (See previous chapters and Section 3 of this chapter.)

Thus the first criterion for learning at this level is, did the division respond - did it develop an attitude or policy towards the new knowledge. Secondly, was the policy considered a "success". The "success of the newly developed policy or stance is a difficult one to utilize since so little is known about the ultimate effect of medical care policy. Thus the test of "success" which I have used here is an <u>acceptance</u> by the provider or administrative area to which the policy was directed. Thus, for example, was the division able to act cooperatively with providers and other agencies, did such groups actively try to block development and implementation of the policy, did the status of the policy enhance or limit the division's general image (which could be used to extract other concessions)?

One might invoke a third criterion here, that the policy, after being developed and accepted (and routinized), be tested or evaluated in some manner. Here, the researcher was generally prevented from observing the organization during a long enough time period during which one might reasonably expect the division to begin to evaluate its policies. Equally important, the methodology was not, certainly in the short run, available

to the division for so doing and much evaluation either was simply ignored or the lower surrogates of development and acceptance of the policy utilized. In a division which had no coherent policies in its primary areas, this in itself was a considerable achievement. Nonetheless, one of the consequences of this confluence of factors was, of course, the nagging ego problem. This problem, which was not immediately observable until after the initial learning levels had been achieved, suggests that the division may have "sensed" that it had often omitted this criterion, a more rigid evaluation, at the initial levels. However, this was not always the situation and this third criterion will be utilized where possible with the limited data available.

These three criteria are necessarily general and process-oriented; that is, I am not concerned with whether a better day care policy could have been developed nor with the actual "objective" result of the implementation of the policy but primarily with, was a day care policy produced, implemented and accepted both by the division and its immediate environment of providers and other government agencies, and further tested if possible. In this sense then ultimate failure of the policy to better the condition of potential day care patients would not negate the process of development and routinization of a policy which I have indicated are two initial levels of learning. However, an attempt was made to respond to the question of how the actual quality of those policies might be evaluated and is presented in Appendix A.

The use of change over time as a third criterion here indicates that such a criterion could well be used for the other levels of learning. That is, one could ask, was the program for action developed and changed over time, did the management style or even the paradigm change over time.

However, that criterion was not utilized elsewhere due to the necessity of limiting the scope of the research and basic methodological problems in reconstructing with precise enough fashion, when events occurred. Rather, I concentrate on whether and how the various levels were reached and not whether they changed over the relatively short (1 1/2 years) span of the research.

In the new services stream, we said that in each of the cases, a policy was developed for the new service. In each case, that involved developing a response to the question of was there a need for the service, what was the target population, what should be the mode of delivery, who should provide it and at what rate, and making efforts at negotiating the acceptance of these policies with provider groups and other state and federal agencies. These questions were answered and policies developed for each of the service areas. In addition the second criteria for this level was met through the efforts made to gain acceptance of the policy from providers and other governmental agencies. In each of the cases, these members of the division's environment did concur with, and in all cases actively participated in the development of the policies.

Two of the cases in this stream do stand out, since the degree to which this environmental concurrence was achieved varied from that of the others. By the end of the EPSDT case, some outsiders were calling that policy a failure in that the division had failed to demonstrate to a component of its environment that its alternate philosophy had improved the delivery of care to children. In the HMO case, preliminary evaluation indicated that the original grandiose goals for the program had proven to be unrealistic and that the division needed to revise its goals. In both these cases, however, the failure was not a failure of learning;

rather, in one case, a failure to adequately demonstrate the success of a new policy and in the other case, a realization by the division and the HSA agency that the policy had been unrealistic. In both cases, moreover, the division did act on that evaluation - in one case it worked harder and in the other it retreated. The only reason we are able to even discuss possible "failures" here is that the policy was able to be tested fairly soon after its development. In all the other cases such testing was not possible except over a term extending well beyond the study period. These two cases, however, do indicate that when possible, the division could act on an evaluation and thus the third criterion for this level can be said to have been partially met.

In each case, the policy was also routinized to some degree. In general, this routinization meant considerable effort to propagate the policies to the rest of the welfare department, to providers and to clientele. It usually involved insertion of the policy into the agency's policy manual (EPSDT, FSMHC and 442) or the development of an experimental policy (HMO's and Day Care). It always involved the assignment of a specific staff member to the area, usually to certify new providers and to monitor the implementation of the policy.

In the sanction stream, the legal power of the division to sanction providers was developed with virtually no mandate or pressure from the division's environment. After a year and a half, a series of major sanction cases in which either substantial financial retribution was achieved or the provider suspended from the program had been routinely conducted. In addition several major providers (nursing homes) were dropped from the program and several dozen minor program abuses also corrected under threat of sanction activity. A strategy of "knocking

off" key abusers in each program area was accomplished and both this major thrust and the minor thrust just mentioned were accepted as policy by members of the division's inner environment of responsible government agencies. The policy was not codified in a body of regulations nor in a large staff with specific, routine assignments, but its continued emphasis over a year and a half indicated that the policy was firmly held by the division. While the first case failed to adequately define the powers of the division with respect to "quality of care" sactions - resulting in a last minute retrenching in the final case (physicians' audits) - that retrenching did lead to a more thorough examination and evaluation of the sanction process which ensured that future cases could be prosecuted with more vigor. Here, as in the first stream, the failure was not a failure of learning, but rather of the substantive policy and indeed the change of policy indicated a positive learning and further indicated that the third criterion, a change of policy, could be met.

In the internal administration stream, only three of the cases could be considered to have adequately satisfied the criterion for first and second level learning since the delineation and routinization of a policy was achieved at some cost; it is here that we begin to get some hint of the limits, whether imposed or chosen, of the division's learning model. The initial resolution of three of the situations, their acceptance by the division's environment and their development into a routine was, however, accomplished in the MA-7 Form, Consumer Advisory Board and Dental Claims cases. The MA-7 case even indicates that the third criterion - that of a testing and change of the policy - could take place as revised versions of the MA-7 form were sequentially proposed.

The loss of controls case was resolved but only at a considerable cost in time and energy while the mapa situation probably could have been resolved differently with only an incremental amount of effort or change of approach. Both these cases were characterized by the unwillingness of the division (primarily Knight) to take a positive decision on the problem (rather a policy of taking minimal action was gradually evolved), although that unwillingness did not result in harm to the division's ability to purchase services or to its credibility. In that sense then, these two cases cannot be said to have forced the division to deviate from the pursuit of its paradigm, the responsible buyer, and thus at least did not inhibit learning at the first level. Rather it occured, but either was costly or more could have been achieved with little incremental cost.

In summary then, the division did succeed in developing policies in each of the areas of new knowledge, and in developing a routine for acting on those policies which permitted it to move on to tackle additional new knowledge. In nearly all the cases that development was a conscious one in that the policy was rarely a "policy of default", the development was achieved at a low perceived cost to the division, and the policies were ones which had the support of the division's immediate environment of providers and government agencies. In addition, there were some indications that the division could even within the short period of the study, evaluate those policies and act on that evaluation. Thus the division can be said to have learned considerably in that it achieved or attained the first two levels of learning which I have suggested are appropriate bases for such judgments.

2. Development of General Principles

The third level in the learning framework which I have developed is that of the development of general principles which could be, and were, utilized in other dissimilar situations. Here I use dissimilar to describe cases which involved different sectors of medical services or different actors in the decision process. While all the cases examined did have similarities by which they could be grouped into "streams" (i.e., in that each stream approached a similar set of problems), they were sufficiently different from each other in the services they dealt with or in the actors involved to warrant any transfer of principles from one case to any other to be described as third level learning. For those cases which were essentially alike, we used the criteria of routinization in Section 1 to determine if learning occurred during those cases.

In each of the cases described here a search was made for principles which were indeed actually used in two or more cases. That is, the principles could not simply be stated but had to be actually used in two or more cases. This use could and did occur in two distinct fashions however. First, the principle could be stated and used in one case (e.g., "use sweetened fees to encourage particular providers"), and then evoked by Knight or staff in a second case and used to develop a policy for that case. A second, less obvious transfer of principles occurred in situations where a principle was used in one case, but never clearly stated as such, then "discovered" during a second case when staff would remember that tacit principle and determine it to be useful for the second case. During the second case, it would be explicitly

stated as a principle. Thus in the transfer of principles which I discuss here and in each of the overviews to Chapters III, IV and V, the transfer is an explicit one, in that not only were the principles used in two (or more) cases in the stream but that transfer was a conscious one.

Nonetheless, in each case, some principles were posited by the division members or behaved, but no evidence was found of their transfer to other of the fifteen cases I examined. These principles were, however, used in two other different manners. First, the principles would be stated or recognized and simply held in the division's memory. Thus a principle would be recognized in a given case and be declared as a learned principle even though it was not immediately used in routine activity or other new areas.(For example, that maintenance care, as opposed to therapeutic care, be avoided - as in the day care case - was informally discussed after the day care case, but not specifically utilized again within the time period I was observing the agency.) Secondly, the principle could be developed in a case and used either in routine activity or in the other new areas not discussed here. Used here means the same as outlined earlier, i.e., it was used to develop policy in two cases and explicitly stated in at least one of those two situations, usually during its first use, but often not until it was used again. These "non-transferred" principles were described in each of the particular case developments and are not stressed here. Within the fifteen cases, however, most of the principles developed were indeed explicitly transferred to other cases in the stream.

The evidence for the use and transfer of such principles was the same as that for all other material collected in the study. Either

staff members told the researcher that the principle was used, e.g., "we thought that, since comprehensive care is a valid idea, we should avoid the mass screening that SRS seemed to want"; or the developed policy clearly reflected the principle, e.g., the reorienting of the DMH clinics' policies reflected the division's principle of stepping into a vacuum of authority; or members of the division's environment confirmed that such principles had been discussed in the development of policy, e.g., that small provider groups should approach the division first and not vice-versa.

In each situation where I have referred to the generation and use of a principle, at least one of the above criteria was met. However, any one alone is, I believe, an adequate basis upon which to assert that a principle had been used. Thus, in two of the above criteria, it was not necessary that the final policy reflect the principle, only that the principle informed and advanced the decision process for new policies. The principles were thus a pool of available principles, and since they were not totally consistent, some were necessarily rejected in favor of others. Thus the simple suggestion of a principle as a possibility for policy development, and not necessarily its later adoption, could be considered valid evidence of use.

While these explicit principles were only sometimes referred to as "principles" by Knight and his staff (the categorization is the author's) each of the division's members involved recognized (either at the time or later) that some "generalization" was being made, applied or transferred, and was thus being "learned". Most of the staff, however, considered that learning to be a natural or inevitable product of their situation (i.e., young, competent, but inexperienced) and instead placed

more stress, when interviewed by the author, on management learning. (See pg.420.)

The new services stream showed the clearest development of principles, probably because the area of health delivery was relatively new to all the staff involved and was thus the area with the greatest potential for the shared development of principles. I will not repeat the complete set of principles here; the reader is referred to Chapter III, principally the overview. The nature of those principles is not what is the most significant here; rather the fact that they were developed and were utilized in other cases in the stream is important. Recall only that they dealt with the kind of medical care which should be delivered and how it could be attained; for example, the principle of medical accountability was developed as was the idea of using "sweetened" fee structures to encourage providers to follow the division's policies. Within the five cases sampled here, at least eight major principles were developed and used again in <u>two</u> other cases in the stream while several others were used in one other case.

Similar development occurred in the other two streams and was described in the conclusions to Chapters IV and V. The <u>range</u> of principles in the sanction stream was not as great since the cases were more similar in nature. But this similarity permitted the division to develop a considerable momentum and self-confidence as it learned principles which would help answer the questions that had to be asked in each case, such as: how much authority does the division have (if a vacuum of authority, step into it), on what should the charge be based (the provider's intent is key), how severe should the punishment be (base it on the degree of direct patient harm). In the internal administration stream, principles

were developed not out of the detailed working through of specific situations as in the other two streams, but rather by a direct invoking of the division's paradigm - that it must act responsibly and thus be accountable and avoid situations where it could not hold others accountable. Thus action was initiated or foregone based on this higher level touchstone rather than delayed for the case to generate and demonstrate the significance of some principle.

Thus in the fifteen cases sampled, some 39 discernible principles were developed and utilized some 118 times, mostly within that stream of cases I was observing,but also in other cases of new knowledge not described here,or in routine activity. (See Figure 3 for a summary table of principles.) Both these latter situations will be discussed later in this section. What is equally interesting is examining whether there was a utilization of principles not only from one case to another case in that stream, but also from one stream to another. One would expect any such principles to be of a high level of generality and few in number, since the streams were quite different in content. Upon examining the cases, those expectations were confirmed, but there were at least ten easily identifiable principles used in such a manner. Not surprisingly these principles, because of their level of generality, are more closely related to the division's paradigm where acting responsibly, accountably, and in a cost effective manner (both with the division's time and with the purchase budget) were stressed. They are paraphrased below with identifications of 1 (New Services),2 (Sanctions), 3 (Internal Administration), to indicate in which streams they were utilized.

a. "Listen carefully to providers' points of view and explain our policies carefully." (1,2)

Figure 3 - Use of Principles

PRINCIPLE (in paraphrased format) / CASE	EPSDT	FSMHC	442	HMO	Day Care	Dev.of Sanction	Pharmacy I	Hospital Sanction	Pharmacy II	On-Site Audits	Loss of Controls	Dental Claims	Consumer Boards	MA7	Field
1. Use good fees to encourage providers	x	x	x	x											
2. Comprehensive care is to be encouraged	x	x		x											
3. Washington's mind can be changed if professional allies developed	x														
4. We must have a philosophy behind each case	x			x	x		x	x		x					
5. Staff must be interested in health care	x			x											
6. Child care is a high priority	x		x	x											
7. Clients should not receive discriminatory care	x	x	x	x									x		
8. Invest only in well-managed providers		x	x	x											
9. Increase federal dollars		x	x												
10. If a vacuum of authority exists, step in.	x	x		x	x			x		x					
11. Stress medical accountability		x		x						x					
12. If possible, try to link new knowledge to an existing program	x		x												
13. If provider group is small, wait for them to come to us for change			x									x		x	
14. Stay away from the school health systems			x												
15. Clients have a right to privacy			x	x											
16. Don't give incentives to over or under treat		x	x	x											

Figure 3 (cont'd.)

PRINCIPLE (in paraphrased format) / CASE	EPSDT	FSMHC	442	HMO	Day Care	Dev. of Sanctions	Pharmacy I	Hospital Sanctions	Pharmacy II	On-Site Audits	Loss of Controls	Dental Claims	Consumer Board	MA7	Field
17. If high goals professed, hold providers to them				x	x										
18. You can't rely on local offices	x			x									x		x
19. We must respond to community groups.				x									x		
20. Be cautious with elaborate data systems.	x			x											
21. If we don't know how, go slow at first.		x		x	x										
22. Avoid encouraging hospital care	x	x	x	x	x						x				
23. Avoid encouraging maintenance (social) care					x										
24. Hit one big abuser in each area						x				x					
25. Avoid committees, task force liaison persons	x	x				x					x				
26. A provider's intent is key			x	x			x	x	x						
27. Don't sanction heavily if no direct patient harm.							x	x	x						
28. We lose leverage if a provider is forced out							x	x	x						
29. Hold providers' bills if necessary							x	x	x						
30. Good care not the same as good treatment								x		x					
31. The professions will not police themselves								x		x					
32. PMO must answer to us											x	x		x	
33. Exercise of power depends on provider credibility							x		x		x			x	x
34. We must be accountable												x		x	
35. If burnt, lay low												x			
36. Don't worry about minor problems									x			x		x	
37. Consumers can be overwhelmed				x									x		
38. Think about provider's concerns and explain our policies to them	x			x	x		x		x					x	x
39. Regional offices should not develop policy															x

b. "If there is vacuum of authority, do not hesitate to step into it." (1,2)

c. "There is a need to evidence credibility before our policies can be exercised." (1,2,3)

d. "Ignore small provider groups unless they affect our credibility." (1,2)

e. "Do not rely on standing committees, task forces or liaison staff to help us develop policy." (1,2,3)

f. "When evaluating providers, consider carefully their intentions and motives but also try to work with well-managed ones." (1,2)

g. "Ambulatory care should be emphasized rather than hospital care." (1,3)

h. "Local welfare offices are unreliable." (1,3)

i. "There should be a readily identifiable locus of medical accountability for each encounter between client and provider." (1,2)

j. "Clients should not receive discriminatory treatment - either medical or administrative." (1,3)

k. "We must have a philosophy behind each case." (1,2)

This extensive development in the cases of principles relating to the division's tasks and their transfer to other cases, indicates that the third level of the learning framework was achieved. But the description of the attainment of this level of generality in the division's systemic approach to new knowledge must be accompanied by an examination of the nature of the principles and their function in relation to other elements of that system.

The principles were not a philosophy in themselves although they represented a philosophy. Knight often said that he tried to reach "philosophical agreements" with his staff and then permit them to deal with situations on their own "as long as they don't go beyond the bounds of that understanding." But upon questioning the staff, I found that no one could recall sitting down with Knight and discussing any agreement, nor when asked what that agreement consisted of, could they easily reply. Knight's use of the term "philosophy" is at fault here. The understanding which was reached was one based on principles such as I have been describing. Taken in toto they may constitute a philosophy, but the staff perceived them at the level of working principles and, moreover, ones which were generated by the activity of specific cases.

More important, the principles were used as guides to the development of policy and are thus different from the elements of the program for action. That program's function was one of providing rules for behavior by which the division could narrow the possible universe of actions and place itself in situations in which the principles could be developed. The principles, on the other hand, were specific "maxims" which were imbedded directly in a policy of the division. For example, "touching base" with providers (a part of the program) did not necessarily mean that all their interests would be catered to. Rather, a principle that came out of "touching base" with both hospital and ambulatory providers was that ambulatory care represents a higher pay-off than hospital care. Similarly, assuming a clear role for the division (a part of the program nearly always observed) could result in the use of either of two principles: "step into an authority vacuum", but "avoid entangling the division with poorly managed providers or agencies."

In a few instances, an element of the program was so important to Knight that he would verbalize it (e.g., in his attempts to clearly designate responsibility and avoid the use of committees, liaison staff, etc.) in the form of a principle. Thus an element of the program could occasionally be used as a principle, depending on the context and the importance of the "rule" or principle. But, in general, the two levels, program and principle, are distinct and identifiable as different levels of generality. A thorough examination of particular overlaps between the two levels would not be useful here. The more important observation is that there were two distinct levels of learning and that they both served distinct functions.

The first function of the principles was to aid in the translation of the paradigm of the responsible buyer. While Knight and some others could specify that paradigm relatively clearly - i.e., it meant stressing the role of acting accountably and buying at cost effective prices - those directions still did not take concrete shape. They only did so in the specific cases by the translating of that paradigm into the principles. The paradigm, while clear and obvious, could be translated in many and even seemingly divergent ways. For example, the buyer function could be translated into holding providers' bills (if the "buyer" thought he were being "cheated") or conversely, helping to speed up payment to a favored provider if he were large and delivering good care but caught in an emergency cash flow problem.

But exactly how were the principles linked to the paradigm, since they were at such different levels of generality? An examination of Figure 3 will indicate that not all of the principles themselves appear to be at the same level of generality. For example, the principle

of not sanctioning too harshly if no direct patient harm were involved is clearly more specific than the principle which held that the exercise of power depended on provider credibility. Those ten principles which were identified on page 379are clearly at a high level of generality and more directly, indicate how the division's paradigm was translated into reality. Many of the "lesser" principles can also be shown to relate to these more general principles and to the paradigm, but first let us examine some of these ten.

Listening carefully to providers' points of view and explaining policies carefully can be seen as a manifestation of the responsibility aspect of the paradigm. Thus responsibility meant both understanding the division's environment (i.e., the "servant" part of the civil servant) and when policy had been set, making certain it was understood by those affected. Responsibility was a two way concept involving an agreed upon ("legitimate") course of action and an understanding between two groups.

Letting small provider groups take the initiative unless a possible poor relationship would harm its credibility can be seen as acting as a buyer, i.e., with scarce resources, one must concentrate one's efforts but must also maintain the confidence of the public -a facet of being responsible. The principle of avoidance of task forces,committees and liaison personnel is also seen as a partial definition of acting responsibly since such groups were perceived as not having the power to make decisions or not capable of being held accountable, two of the main functions of organizations.

Ambulatory care was to be stressed over hospital care since it represented a far bigger payoff (i.e., a better product for the buyer)

because it dealt primarily with mothers and children (the future generation) and since in some sense was defined as inherently more appropriate, humane and socially valid. Responsibility entered into this principle since the hospital arena was heavily controlled by other agencies and the division had little expertise; thus it seemed more responsible not to divert scarce resources to an area in which any payoff would, in the short run, be low.

A final example of the link between these general principles and the paradigm would concern the principle of having a readily identifiable locus of accountability for each medical encounter. If the division were to buy a product, it should know to whom it should turn to discuss the "product" (as should the patient). Similarly, if the division were to be held responsible for care delivered, it should others responsible and know just who those others were (not simply a signature on a bill).

Other examples could be cited but the prime function of the principles now becomes more clear - to translate the paradigm into a reality. The other principles of lesser generality can also be seen as part of a system of principles which constituted a working theory of how the division should act. One might describe the shape of that system as being one of a hierarchy of principles, but the evidence that a consistent hierarchy existed was unavailable. Rather I shall only suggest that some of the remaining principles can be seen as a subset of the major principles just described. For example, using "sweetened" fees was a way of encouraging ambulatory care, while stressing that clients have a right to privacy was a natural outcrop of their receiving discriminatory treatment. Similarly, sanctioning one big abuser in each

area was a way of establishing across-the-board credibility in the sanction area while avoiding school health systems stemmed directly from the principle of avoiding poorly managed providers.

Nonetheless, some of the lesser principles found their origins in a direct link with the paradigm. For example, encouraging comprehensive providers of care was perceived as acting responsibly since it was a basic and strongly held tenet of the health field. Similarly, "if we're not sure, go slow at first" was directly related to acting as a responsible, in this case, "prudent" buyer. Similarly good care not being the same as good treatment would be a natural principle for a buyer who would not simply examine elements of his product but its whole configuration.

While this link between principles and paradigm is a simple concept to understand, the role of principles is nonetheless often acted out differently in large bureaucracies where principles about task performance are often tacit and/or often in conflict with the espoused paradigm or mission of the organization. That is, principles may remain tacit and thus unavailable for conscious or directed learning. While the role of tacit learning cannot be disregarded (Polanyi), there is a compelling appeal to conscious and directed learning, particularly since it is so rarely observed in government bureaus and glossed over by students of "social development", cultural learning, and socialization. Similarly, there is frequently a lack of concordance between working principles and the organization's paradigm. The effect of such a lack of concordance between an organization's espoused theory and its theory in use has been shown to be inefficient for learning (Argyris and Schon) and is the major reason for highlighting this aspect of the division's model here and in Chapter VII.

Equally important here, however, is the principles' obvious function in advancing the division's learning. That is, they permitted the transfer of knowledge from one case to another and from one stream to another by highlighting what were the key points Knight (or staff members) felt was important in one case. Not only did they permit a transfer of knowledge but they did so in an economical fashion. Since the general schema for learning we have been using assumes that learning can be partially considered as the acquiring of patterns of behavior or thought and their economical recall or reuse, then the division's ability to so "learn" from one case of new knowledge to another was clearly facilitated by the use of the principles. For example, what was conceived of as important in the EPSDT case was that in a vacuum, the division could step in to fill it. That operative principle could then be tested (and was) in the other new service cases (except 442). Similarly, that the degree of sanctions should be related to actual patient harm first developed in the first pharmacy case , permitted the division to adequately determine the severity (much more severe) in the hospital case. The "economy" functions of the principles also need to be highlighted. Thus, the simple fact of <u>having</u> a body of working principles available meant that time and energy could often be saved in policy development. Thus in the cases mentioned above, not only did the principles tell the actors <u>what</u> to do, but it permitted them to use their resources more efficiently; for example, investing energy with poorly managed providers (as in the HMO case) could be avoided by simply invoking a principle.

While we have seen that the principles served an important role in the division's model, one might inquire into the <u>manner</u> in which

they were transmitted and the degree to which they were shared by all the staff. I shall consider the latter point first since the evidence is more clear on that point. Here the fact that the staff consciously "performed" them, that is used (according to my earlier definition of "use") the principles from one case to another, indicates they had been learned. In addition, few significant disagreements with the principles were ever voiced. Indeed, as Y.H. said, "there's not a lot of soul searching in this organization." Of course, the division's style facilitated this general agreement with the principles. The principles were reasonable, Knight was involved in each case of new knolwedge (a point to be discussed in Chapter VII), each unit reported directly to him such that he could resolve any conflict of principles and the division's open ended budgets prevented staff from feeling "their" principles were being displaced at the expense of other program's principles. Thus the principles were generally shared by staff members, not only by Knight and those involved in a particular case, and this sharing was facilitated by the division's style.

While this simple sharing by staff members does not, of course, indicate absolute concordance with the principles--since there is little data on the staff acting independently which would provide evidence of the degree to which the principles were internalized.- the reverse side of thes coin, that is the manner by which they principles gained prominence, may provide some clues. It cannot be denied that the principles represented aspects of Knight's philosphy. The principles served to extend Knight's control over the division's activities in that he participated in the generation of nearly all the principles and in the resolution of any situations in which principles appeared in conflict.

The latter situation was not observed frequently as most of the principles were consistent or at clearly-recognized different levels of significance (e.g., "avoid the use of school physicians", but "stress comprehensive care"). In those situations where a potential conflict of principles was apparent, Knight would take his "calculated risk", judge one to be more significant than the other, and proceed (e.g., "avoid poorly managed providers" but "step into a situation of an authority vacuum" in the FSHMC case). While the psychology of Knight and the manner in which he calculated risks and judged significances is an interesting avenue of exploration, it is more properly the subject of a complete and separate study. The important feature to note here is that fact that Knight had so structured the division that conflict rarely occurred, and when it did, he acted as the final arbiter.

But a more probable factor in answering the degree to which the principles were held is Knight's role as a teacher in eliciting principles. While the teaching (see Section 5) involved many levels of content (i.e., policies, principles and management approach were being taught), that style was an open and low-pressured enough one that it is difficult to conceive of its outcome as being one in which the staff did not concur. This is particularly so since while teaching, Knight commonly solicited advice from the staff ("what do we want here?"). And there was little evidence of conscious rejection by staff of any of the principles. Thus there is considerable, although not extensive evidence, that the principles were well imbedded in the organization. Additional speculation on the tenacity of the principles will be presented in Chapter VII.

The use and role of the principles developed was of course not limited to the cases described here. They also served as guides to policy

development in other situations of new knowledge and in routine activity. For example, in the development of a family planning program, the principles of stressing comprehensive care, of carefully working with providers and of using a "sweetened" fee were all invoked. In the development of a furlough policy to permit nursing home patients to leave the home for up to ten days and still have their bed reserved, the principles of stepping into an authority vacuum and of changing the federal agency's position if suitable local alliances could be formed were utilized. In a job switch between two staff members, Knight placed one staffer in a position where he need not have as great an interest in health care, and one in which his need to use consultative task forces and committee meetings would be lessened.

Similarly in routine areas, many of the principles proved useful. For example, in the nursing home area, Knight and his director stressed the principles of being open and honest with the home owners, of assuring that clients were not discriminated against and of moving with caution on "fancy" computerized information systems (in this case one to store information about the availability of beds in each area). In the hospital area, the stressing of ambulatory care led Knight to downplay the division's hospital involvement as did the fact that the division had little credibility at that time with most of the hospitals. Similarly, most were viewed as poorly managed and Knight had often stressed the view that those situations should be avoided unless there was an authority vacuum. In the drug area, Knight stressed the accountability principle in requiring the division's pharmacy manager to send out warning letters to providers - not the advisory review committee which suggested the warning. He also hired a professional as the second pharmacy director, thus stressing

the importance of being able to talk to providers even though it went against his feeling that the staff should be non-professionals.

Thus we have seen that general principles capable of utilization in a variety of new policy situations were generated and used and also employed in routine activity and that their use was imbedded in the shared memory of Knight and his staff. We have also seen that the principles served the functions of helping to translate the division's paradigm into reality, providing an economical pool of knowledge for policy development, and of permitting the transfer of knowledge between cases. The use of these principles thus constituted a third level of learning, one whose function in organizational learning is more clearly evident than the previous level's function.

3. The Program for Action

The program for action which has been described in the cases is similar to a computer program in that it is best understood as a set of "rules" for behavior, in this case how to approach a wide variety of situations of new knowledge. "Approach" means not only what initial stance to take toward the new knowledge but also what actions to take in order to develop a policy and to utilize principles developed elsewhere. The acquisition of such a program by the division would indicate that it had met the criterion of learning at the fourth level. From the earlier definition of those levels, it would also be a program for learning the first three levels.

It is clear from the case material that a recognizable pattern or program for action was developed by the division. Not only was it developed but it seemed to be developed very early in the division's new life and applied consistently throughout, although that program was

"fine-tuned" somewhat during the sanction stream. The function of the program for action was to provide rules for behavior by which the division could narrow the possible universe of actions and place itself in situations where principles could be logically evoked or generated. This role as a preliminary to principle development was clearly an important part of the division's approach to dealing with new situations.

Let us then summarize the nature of the program and examine its effects. First of all we saw that the division was open to many sources of new information and was always willing to have at least one meeting with those concerned about how to approach the situation (e.g., the mental health clinics). For example, Knight permitted staff to schedule meetings on his calendar without his specific authorization and thus a new issue always got at least one hearing. Even when it was felt that no action could be taken, initial discussions were held and those involved told clearly why their particular concern could not be addressed, usually because of a lack of resources (staff time) - for example, in the day care case or even the loss of controls case. This general openness served to establish some minimum credibility with providers, client groups or other state agencies.

Secondly, the division usually tried to first deal with a new situation by making an analogy to some previous situation or by trying to "squeeze" the new theme into an existing set of activities within the division; for example, EPSDT was seen as being only regular comprehensive pediatric care, as was the 442 service at first. The Consumer Board was seen as analogous to a neighborhood health center board and day care for the elderly was basically similar to home health care. Many researchers have stated that the use of analogy is so pervasive that it is one of the

prime features of (low level) learning and we should not be surprised to set it at work here. Its main purpose in the division was, of course, to conserve staff time and energy. If some new input was similar to something already in existence, it became very easy to deal with (at least conceptually) and energy could be devoted to routine tasks or other new situations.

Thirdly, the division would always strongly stake out its responsibility in a new area. It assumed that it had a "right" to be involved in the area and it assumed that right with some degree of "moral authority". In all the sanction cases and in most of the new service cases, Knight clearly stated what he felt the division's role should be; for example, in the HMO program he felt no compulsion to continue a contract which had not been proven viable to him nor did he want the HSA agency "committing" Medicaid dollars for the 442 program without his authority. This staking out of turf was not done in an initially detailed way - more often the staff would later have to "run back and forth over the turf to be sure it was not being trespassed upon" (R.T.). This whole strategy could, of course, have unforeseen consequences, particularly when the decision was made <u>not</u> to take action, as in the EPSDT or field case.

The next step in the program was usually to advance a fairly specific goal for the new area. The goal might well change over time and often did, but it gave some direction to the actors involved and insured some initial action. A complete "solution" did not have to be worked out right away. This gave staff something to focus on and an avenue by which they could learn by doing; for example, the decision to experiment with two centers in the mental health clinic program, to clean up some of the

monitoring problems in the HMO program or even to decide that "we're either going to sanction this guy or suspend him" (second drug case).

After setting an initial goal, Knight then clearly assigned responsibility for the new knowledge, usually to one staff member or occasionally taking it upon himself: "I very carefully delegate authority and responsibility" (Knight). He rarely assigned responsibility to a group or committee. This had the effect of insuring that outsiders knew who to come to for information and that they were not bounced around as is typical in many bureaucracies. This strategy, of course, was particularly useful with the young staff since they all felt a need to prove themselves and to deal "responsibly" with the new task. With an older staff, that strategy might not have been as effective since, when vested with full responsibility over a program, more entrenched staffers could always find reasons for not acting. Nonetheless the strategy worked well here and only backfired twice (the loss of controls and the field cases where the delegated staff did not have the required competence) and only created additional costs in one area (day care for the elderly) where the three staff members spent considerable time "muddling through" a problem which was nonetheless successfully resolved.

Knight next of all managed to impart to his staff that rules and regulations of either the federal or state bureaucracies were but fragile boundaries. They were seen as "bendable" or at least open to the interpretation of the division. The background of Knight and his staff did not prepare them for the usual heavy reliance by long-term bureaucrats on the "regs". He saw regulations as only one hurdle that had to be

confronted in a path of action, the prime step in that path being "knowing what to do". This bending and liberal interpretation of regulations was apparent in all the sanction streams, in the EPSDT and 442 cases and in most of Knight's activity in acquiring personnel.

The next step in the program for action was usually to rely upon some close trusted professional friends or on Knight's own past experience in deciding what the "right policy" should be. This was clearly evident in the selection of the division's consultants for all the new services cases and in his reliance on his neighborhood health center experience in the 442, HMO and FSMHC cases, and in his reliance on past business experience in the sanction and internal administration stream. This led some staff to feel that the agency was developing "tunnel vision" ("Don is always carèful to get consultants he agrees with") but there was no indication that this strategy adversely affected the division's performance. Rather, in a turbulent environment, it enabled it to deal with the uncertainties of new knowledge in a cost/effective way particularly since the relevance of that past experience and the personal credibility of the consultants was accepted by the providers and agencies the division dealt with.

It was only after <u>first</u> consulting this rather close knit circle in order to establish a position that the division began to involve the whole range of provider groups. This was done very consciously as Knight often told staff members to "be sure to touch base" with the dentists, clinics, hospitals, etc. This touching base involved explaining the division's evolving position and asking for additional input. The credibility the division so carefully built up through good management of its routine activity was thus embellished by their actions with <u>new</u> areas

involving providers. There was clearly a lesser felt need to do this when Knight "knew" he was acting correctly, as in the sanction stream (although he did involve the Medical Society on two occasions there) or in the internal administration stream.

Another feature of the program was the division's increasing willingness to experiment. In all the new services cases we saw that rather than implement a policy across the board the division would test a policy out with a few providers in order to see if it worked. In Knight's mind these were more "demonstration projects" than experiment , but the willingness to approach them that way meant the staff could learn from such experiments, before having deal with a full-blown program. This experimental posture was also evident in some of the sanction cases (e.g., physician audits) and to some extent in the internal administration stream with the consumer board and the mapas (after a year of neglect).

Coupled with this experimental attitude was the division's ability to turn problems into opportunities. That is, when forced to do something (EPSDT) or when cleaning up an administrative nightmare (HMO's and Loss of Controls) it used that problem situation to develop new policies in the area (i.e., pediatric standards, defining a good HMO and eventually programming incompatible medical procedures). Knight was an entrepreneur by training and in spirit and he saw each situation as, in addition to being a problem, an opportunity to learn. Thus in many of the cases, the original "definition" of the situation was considerably enlarged by himself and eventually by the new staff who had not experienced the "seige" mentality of the long-term staff.

An important consequence of the program was the existence of the "nagging ego" syndrome which I have outlined in each of the cases. This

was particularly strong when Knight usurped policy initiative or when the ability of the division to obtain direct feedback from the environment was constrained. It was nonetheless real, however, as most of the staff often admitted to the researcher that, despite what appeared to be an "efficient" program for learning and shared confidence in the rightness of the principles developed, "we don't really know if we're having any real effect". That is, were services actually being delivered to clients in the way their evolving policies specified? The nagging ego syndrome was behavior which was directly associated with each case and its resolution through the program. That is, the syndrome could be as easily observed (through dialogue and interviews) as the elements of the program. The syndrome will be considered again however, in dealing with the limits and possible future of the division's model; here I only wish to indicate its relation to the program for action.

I have suggested that this program for action was really a program for learning, that is, it provided rules for action in order to develop new policies or to utilize polciess developed elsewhere. But why should such a program of tacit rules be needed and how do they differ from the principles generated at the previous level. The response is that the program seemed to provide a way of initially dealing with the uncertainty inherent in new knowledge. Thus we can look at the dozen or so features of the program as a "program" for first deciding whether and how much effort to put into a new situation. Once a decision had been made to invest energy then, and only then, could a principle be developed, since the division was not given to "abstract" development of principles. Secondly, the program helped to remove uncertainty by placing it in situations in which it could eliminate the bulk of a much greater set

of possible, or inferred, principles, although these "particular" situations also generated additional principles.

The above observations come first of all from examining the degree to which the division was open to new inputs and the degree to which it assumed its "rightful" perogatives (the first and third features of the program). Thus both being open to all new inputs and then, at a first rough level, "selecting" those in which the division had a rightful perogative were ways of deciding whether to invest energy. Recall that while in most of the cases described those two features were present, but their degree varied. For example, the division was less open in the field case than in the FSMHC case and less strongly asserted its authority in the day care case as compared to the EPSDT case. The factors which best seem to explain this variance are the degree to which Knight "wanted" something (that is, the priority he placed on the area), the degree to which he thought it could be attained, and the degree to which it could be controlled if obtained. Thus he moved more strongly in the sanction cases than in the HMO case since he clearly wanted a sanction program, he avoided the 442 program at first since he was not certain he could be effective due to the program being run by another agency, and he moved more strongly in the HMO area than with the local welfare offices since one was clearly more manageable (controllable) than the other. These "rules" for assignment of energy seem simplistic of course, but many authors (e.g., Rogers, J.D. Thompson and even Stafford Beers) have suggested the importance of such simple rules in dealing with new situations.

Once a decision had been made to invest energy, a second decision had to be made; that is, how to develop a bounded response to the complexity

of factors in the situation. By "bounding the complexity", I refer here to the manner in which the division defined for itself those political, technical and administrative factors which it considered relevant. "Bounding" does not necessarily indicate a narrowing of alternatives, since some steps in that program were designed to generate alternatives. Other steps served to eliminate possible policies. One might construct a decision tree or "action tree" outlining how the division bounded the new knowledge. But analysis here cannot be that precise; the program for learning gives us only some indication of the branches of that "action tree", not the precise order in which they fit.

The first way of bounding a new situation was to directly compare it to another situation where possible, i.e., the use of analogy. Then, if it was not obviously similar to a current activity, the division could first of all "bend" the regulations since Knight often knew what he wanted and did not feel overly constrained by them. If, however, the knowledge of "right policy" was not immediately available, he would rely on a few close professional friends to further bound the problem. Still further work might be needed to convince doubters of the policy decision so an experiment could be made but one whose basic purpose was to demonstrate the viability of the chosen direction. Knight believed there were no right or wrong answers therefore one must make a "best judgment" and act. His "knowing" or appearing to know thus seemed to be partially responsible for the creation of the nagging ego problem among the staff. (See Chapter VII, page 450 for further discussion.) Finally, if all the above had failed to produce a satisfactorily bounded response, then Knight would touch base with a larger circle of relevant members of his environment if he thought it useful or if it fit

his style. By that point a "solution" usually had been generated.

While the responses to the problem of how to bound the new knowledge are somewhat more complex than the factors which determined how much energy should be directed to it, they are still easily comprehendible in that they are all rooted in action, not analysis. Considerable analysis might take place (e.g., with trusted friends) but the end result was to be a workable policy, not a "correct solution". Thus these two qualities of Knight, i.e., dealing with the possible and concentrating on producing a workable solution differ somewhat from the attitudes often underlying the crisis or guerilla models of change, a part also to be further discussed in Chapter VII. The program for learning then, despite its weaknesses, did present a set of actions which would ration scarce energy resources, bound the inherent uncertainty of a new knowledge situation and result in new policies and principles.

A notable aspect of this whole program for learning is that it was a generally tacit program. That is, no one stated clearly (as they did with the principles discussed earlier or the paradigm) that, for example, "we should try to squeeze this new service into an existing one" or that "we should ignore the regulations", or that "we should experiment". They simply <u>did</u> those things and were "observed" by the researcher through his reconstruction of the events which constituted the case. Only the delegation of responsibility and the touching base with providers were explicitly stated.

Recall that the <u>principles</u> developed were done so very explicitly. The distinction between the two levels (principles and program) is not

however based on one being tacit and one explicit, and thus we cannot say that such a distinction is necessary for learning to occur at the third and fourth levels. Yet the obvious difference in explicitness between the two levels in this particular organization does raise interesting questions. It is unclear why such differences occurred. On the one hand there seemed to be a choice by Knight to explicitly concentrate on principle development, the paradigm and management. Thus one would certainly expect certain features of a system of learning to be implicit or tacit and since these features in the division's system were so explicit it comes as no surprise here that others were tacit. Polanyi has suggested there is very likely a maximum amount of explicit learning which can take place, but unfortunately this theme and its relation to the division's learning cannot be explored with justice here. However, the significance and function of the tacitness of the program for action will be more fully considered in Chapter VII.

Because of this generally tacit nature, it is difficult to assess the degree to which the program for action was imbedded in the division's behavior since it was not codified in official policy or available in records or documents. The continual presence of Knight as the main actor in all the cases also skewed a possible assessment of the degree to which the program was held independently of Knight. In a sense the program was his program, although staff members willingly shared that program and acted it out under Knight's guidance.

A search for situations in which new knowledge was processed without a considerable involvement by Knight was made and proved to be generally unfruitful. What appeared to be the most common pattern

was for staff to engage in some sort of "holding pattern" in which, if Knight's attention could not be directed to a new area or if he told staff in less than clear terms to ignore the area, they simply did a minimum amount of work on it. That is, they would monitor the situation to make sure it did not "explode" in the division's face and generally do as little as possible. "We just try to keep on top of it...and be ready to go to Don if necessary." (L.A.) There was no significant concern on staff members' parts about the need for these holding patterns since it was clear there were usually other tasks at least equally valuable on which to work and staff knew they could always reapproach Knight if "trouble was brewing".

There did appear to be one exception to this general observation and that is the case of Y.H., the nursing home director. He had previously worked at the Human Services Agency and had designed several new programs there which he then implemented fairly independently when he was "parachuted" into the medical division. On some other issues he continued to rely on the HSA secretary and undersecretary as his mentors. Knight said that this situation was a "bone in my throat which I've had to contend with" but since he felt confidence in Y.H.'s competence, he had no choice but to tolerate the situation and simply kept himself informed about Y.H.'s action so that he would be assured "that I was acting responsibly" (Y.H.).

This continual presence of Knight thus prohibits making a strong assertion that the program was fully held by the division members although the HMO, Day Care and Loss of Controls cases indicate that staff members could evolve such a program on their own although it would take more time and energy. Here, in the absence of either

explicitly stated behavior or recorded documents as evidence of the program's degree of imbeddedness, we must consider the division as a system of relationships between individuals, ideas and structures. Rather than assert that Knight, or any individual or group did or did not learn the program, it's thus possible to suggest that a system of relationships was built up in which the division's actors, together, evolved a consistent pattern of action in which various concepts and structures were manipulated by them to produce policies and routine performances. Since the pattern of relationships is the organization, then it can be said that the division did have imbedded in it a program for learning. That that program may have been primarily due to any one particular feature (i.e., Knight's presence) and the effects of the absence of that element will be answered in Chapter VII.

The division then, can be said to have met the criteria established earlier for fourth level learning; it had developed and performed a pattern of behavior which generated additional behaviors and concepts at lower levels through its confrontation with situations of new knowledge.

The program for action then constitutes learning at the fourth level I have defined. Up to this point it has been possible to describe what the division learned; that is, the content of the four levels I have described were seen as successive levels of learning and the very achievement of each of the levels or plateaus indicated that learning had occurred. These levels, which were first described in Chapter III are roughly hierarchical in that the achievement of each level helped to improve learning at the lower levels. Thus:

Level I - producing a policy or attitude towards the situation of new knowledge, one which is shared by the division's environment

Level 2 - routinizing or implementing that policy

Level 3 - generating principles for the design of those policies or for their transfer to other cases

Level 4 - learning a "program" for learning levels 1,2 and 3

Each of the first four levels thus constituted not only "what" the division learned, but the "what" was also the "how" of the next lower level. But the program for action however is the last level of learning for which this can be said unequivocably. That is, beyond the fourth level we cannot be certain that the manner or approach by which the division learned at these lower levels was also learned.

Thus other features of the division also contributed to the learning at these lower levels but were not so obviously learned by all the division. These other factors, moreover, were not fully specified in advance of the research; rather they were induced from the fifteen case situations. This limited data base indicates that they cannot yet be legitimately proposed as further levels (criteria) of learning despite the intuitive appeal of some of them, e.g., the teaching style and their obvious use by Knight as a method of inducing learning. Their utility then lies in showing how this particular organization evolved the not inconsiderable learning at the first four levels. Whether these features would have utility in other situations and whether they might be seriously advanced as "necessary" criteria in defining a learning organization will be discussed in Chapter VII.

These other factors, which are three in number, constitute what I shall label as the overall approach of the division. That approach was composed of an obvious teaching style and the recruitment of competent

"learners", a unique management approach which won organizational credibility and permitted learning to evolve and a conscious organizational paradigm, all of which were acted out at roughly increasing levels of both generality and explicitness. That approach, as I shall describe it, was initially Knight's approach. Although it may be seen as his own program for learning in that it was his approach to developing learning at the lower levels, in some cases we shall see that that approach was shared, while in other cases it was impossible to assess the degree to which it had been internalized by all the staff.

4. Teaching Style

Knight's teaching style was, I have asserted, one of the primary factors not only in the development of specific new principles in the cases described but also in the division's success in managing routine activities, since that style was applied to the latter area where the content of what was taught was the management style and strategies which are described in Section 5. Conversely, Knight viewed his management approach as including the teaching style. The staff perceived them as overlapping somewhat but the two are distinguishable for several reasons. First, the teaching style better and more fully explains the development of new principles than the management approach, and I have thus separated it out for analysis here. Also the teaching style was primarily limited to Knight whereas the management style was transferred and acted out by staff members.

The teaching style contained many elements which could be considered more unconventional than those of the management style and is thus worthy of separate analysis. Finally, the degree of explicitness of elements

of the teaching style was less than that of the management approach although the teaching style was clearly more explicit than the program for learning. I shall later describe even greater degrees of explicitness as the management approach and the use of the paradigm are discussed. Here, by "explicit" I mean that both Knight and the staff were much more aware of the techniques being used than with the program for learning and were aware that the process constituted a "teaching" style. The style was not only relatively explicit but was consistent throughout; that is, Knight did not appear to develop any new elements of his style over time.

As was described in earlier chapters, we saw that the greatest use of teaching occurred in the new services stream. Here not only did the staff "need" to learn since the material being dealt with was new, but since much of that material was new to Knight, he, too, had to learn. Thus some of the teaching was clearly a self-education process for Knight. In the sanction stream, we saw less teaching since the content and the actors of that stream were more restricted in scope, since one of the students (R.D.) was not amenable to Knight's teaching style, and because Knight already "knew" many of the principles to be developed since they had less pure medical content. In the final stream, even less teaching was evident, primarily because, either consciously or unconsciously, little energy was devoted to much of the new knowledge or because teaching was not needed since Knight felt the staff was already competent (Lack of Controls, Consumer Advisory Board) or inaccessible to his style (Field).

The content of what was "taught" in each of the cases may be observed at three levels. Most obviously, Knight would, through the

use of that style, act in concert with the staff to generate the principles described in Section 4. Occasionally a policy might be directly involved by the teaching style (e.g., "let's use teams of evaluators from the neighborhood health centers for 442") but more frequently the general principles would be the observed outcome of the teaching style. The second common use of the style was to transmit the management outlook of Knight. This was more usually observed in the routine areas where, for example, Knight would often call on his past experience to deliver concise lectures, e.g., be sure to record all decisions made either by letter to the affected party or in a memo for the record. As I have suggested, it was then the division's adequate performance in routine areas which permitted it to engage in new areas. Finally, the teaching style must also account for much of the transmittal of the program for learning described earlier. This is difficult to prove, of course, because of the tacit nature of that program, but I would suggest that the teaching style, (primarily the element of permitting staff to "watch" the decision process) was the manner by which that program became imbedded in the division's repertoire of actions. It was initially Knight's program but the staff eventually came to perform it in concert with him.

Let us now consider the various elements of the teaching style. The style consisted of many elements, some of which might not commonly be considered to be attributes of teaching, for example "declaring" a principle to be self-evident. I suspect, however, that that element is more common in conventional teaching approaches than realized. But more important than debate over any particular element is the cumulative

nature of the elements; together they constituted a clearly recognizable style - which I have labelled "teaching".

We first saw how Knight used the informal matrix in late 1973 as a device to spread around whatever knowledge did exist in the division to all its members. This helped not only to educate the new staff but also permitted Knight to observe the relations between the new and old staff and redirect any irrelevant teaching by the latter if necessary. I will not dwell on this first element of the teaching style since it has been discussed at length in Chapter II.

The second element was Knight's general availability to staff. Rarely did he "turn off" a staff member and then he usually did so by saying, "well, what do you think is the answer to that problem". For example, in the HMO case, he was very available to N.E. for at least the first several months. Thus few of the staff felt he was unapproachable when a new situation arose and there was clearly an open background in which learning could occur.

A third element was Knight's habit of letting people watch his decision-making. This was most obvious in the use of his "fly on the wall" technique. Irregardless of the rightness or wrongness of those decisions, it is clear that this technique helped staff to understand and more importantly identify with the decisions and the style in which they were made. As one staffer put it: "The person then has to act like you or he's not accepted." Also important was his willingness to let virtually anyone from the staff, particularly in the early days, drop in on meetings in his office and just observe the decision process, often while waiting for a chance to talk to Knight on some other issue. These techniques could be analyzed in depth as socialization

of the most subtle and powerful order but their effectiveness in transmitting a style, a sense of priorities and specific principles, is highlighted here.

The next element of Knight's teaching approach was one of anticipating an individual's personal style so that they might learn by themselves. Thus, for example, with Y.H. and R.K. he permitted their recognizable brashness to flourish although it was not at all his style. This enabled staff to make mistakes as well as positive contributions, secure in the knowledge that Knight could reverse or adjudicate their mistakes if he had to. This is not simply the old and recognizable tactic of letting staff take a hard line on an issue and when the dissatisfied opponent seeks a higher level of decision, he finds the agency head to be more flexible on the issue. It was that, but it was also a way of letting staff make their own mistakes, but under supervision. The difficulty of permitting this freedom of style was that if a particular style was unsuitable for the agency (e.g., R.D. or some of the long-term staff), Knight had no readily available tool to change that style other than to ease them out of the agency or away from major responsibilities.

A fifth feature was Knight's continually asking, "what do we want here?" This was clearly evident in, for example, the 442, day care for the elderly, and sanction cases. This ability to start from scratch and to isolate the key elements of a situation was recognized by most of the staff and was appreciated. Moreover, while he might often have formed his own idea (e.g., in the FSMHC case), he generally used that style of questioning in a non-rhetorical and sincere manner with the staff. ("Don sees things in a logical way. He's able to isolate the bottlenecks and power plays and makes it seem more simple.")

Knight also explained decisions carefully. It was rare that a decision was not concluded by a "because". For example, in the FSHMC and second drug cases, the reasons for the downplaying of the independent role of social workers or for permitting a restitution of money and not a suspension were carefully explained and, in fact, became principles used in later cases. While Knight was only human, of course, and no doubt occasionally made decisions on obscure or personal grounds, a justification - if not a reason - was usally given. Coupled with this was Knight's habit of presenting principles within a specific context. That is, principles were developed first of all in specific cases, and their invoking at a later time was usually done in a related context. They were not seen as abstract principles to be learned, but rather were working principles. Even when the more general principles such as a belief in the effectiveness of ambulatory care were advanced, they were not done with any sense of messianic dogma, but rather the principles were clearly seen as relating to some goal and not important in themselves. Knight would, however, on occasion simply declare a principle to be self-evident, such as holding a provider's current bills while under sanction investigation. This was not done often but the clarity, and to Knight, logic of such ideas seemed to be easily accepted by the staff (Knight: "my view is a logical process").

Another feature of the teaching style was Knight's non-critical attitude. That is, he considered mistakes to be inevitable and part of the learning process ("so what if you make ten mistakes a year - I'm not a guilty person and I don't think in terms of right or wrong"). The sharpest example in the cases described was in the MA-7 case with

R.T.'s admitted "mistakes" - that is, his mind could be changed on an issue although he rarely publicly admitted "a mistake". Rather, like many strong leaders, he simply changed his behavior. A clear example here would be the use of the press in the hospital sanction case. He did not like to feel he had been "wrong" but clearly tuned down such prior contact with the press in future sanction cases.

Knight would often invoke his past experience as a very relevant criterion saying, "I learned in the sporting goods business that..." or "we learned at the XYZ health center that you can use nurse practitioners but they have to be under the strong supervision of a physician". Similarly, when a set of "past experiences" had occurred within the division he would often invoke these as a form of evolved precedents. That is, a cluster of principles which they had evolved would become apparent (as in the mental health field) and he would summarize them, usually at monthly staff meetings or to relevant outsiders, such as the federal agency (SRS) or the press, in the presence of staff.

The use of experimentation as a learning style has been discussed elsewhere so it will only be highlighted here as another element in the teaching style. While Knight often saw experimentation as a device for demonstration, it is clear that the staff learned from this (e.g., in the FSHMC and 442 cases) even if he felt his own personal learning to be less significant. Indeed, the increasing use of experimentation in the new services stream would seem to indicate that whatever its precise rationale, it was perceived as effective.

Finally, the vocabulary of teaching was important. Knight continuously used the word "learned" in his speech. He would ask "what

have we learned" or he would state it: "We've learned...". This observation is impossible to "prove" of course, but after noticing it for the first time, the researcher was struck by the continued frequency with which the word was used. Certainly the use of the word and concept is so intuitively appropriate for a teaching/learning situation that its importance was probably underestimated by the division. Indeed Knight was not even aware of his frequent use of a "learning vocabularly".

These elements then, constituted the teaching style of the assistant commissioner and were, I believe, a major factor in the achievement of the four levels of learning described in Sections 1 and 2. Most obviously the teaching style was used in the generation and use of principles (third level) but the style was also used directly in policy development for new or routine areas (first level) where Knight's prior health and industry experience were transmitted to the staff via his teaching style and in the build up of the shared program for learning (level four).

But this teaching could not have had its effect without the existence of a competent group of "students". The general characteristics of the staff have been extensively described in Chapter II and the case development, but it bears repeating that a cadre of young, well-education and inexperienced staff was <u>indispensible</u> for the success of this style. Most of the long-term staff also reacted moderately well to this style although their actual behavior showed less change. Each expressed to the researcher some variant of "Don's experience in the sporting goods business has been really useful" or "Don is really a good teacher". I suspect the long term staff reacted this way not

only because of the inherent utility and appeal of the teaching style but also because they sensed the situation could have been worse, i.e., other new political appointees in the state had been known to sweep out the old-timers or totally relegate them to obscure responsibilities.

While I have not suggested that the teaching style is a necessary component of a learning organization and thus subject to some of the same criteria used to evaluate the earlier levels of learning, one might apply one of those criterion, namely to what degree the teaching style was imbedded in the organization apart from Knight. From one perspective, the style was clearly a part of the division's routine set of relationships since the young staff willingly participated in that style and indeed were a necessary component of it. A more rigorous test might be to examine whether the teaching style itself was being acquired by staff members. Since so few members of the division had staff of their own (the larger span of control) this was impossible to assess. In the few cases (R.K. and Y.H.) where members did have staff, data which might confirm the depth of acquisition of the style was impossible to collect. Thus we can only state with surety that the teaching style was an important component of this learning organization.

The teaching style was, however, only one of the three components of Knight's approach which contributed to the division's success at developing new policies, learning new principles, and developing a program for learning. His management approach was another.

5. The Management Approach

The overall management style of Knight, discussed in the case material, bears some similarity to his teaching approach but I analyze it separately here primarily since the latter appeared to be relatively

unique and also since it contributed more directly to the way in which principles were developed in each of the new knowledge situations. The management style, however, was more explicit and was transmitted to the staff somewhat more thoroughly. It was also more conventional, and was used more directly in routine activity.

Let us first consider the conventionality of the management style. It was referred to by the Commissioner as "Don's unorthodox management style". Yet it was not all that unorthodox nor indeed was it difficult to understand although it was a style composed of many elements. Each element in itself has been used by successful managers since time began and each one "made sense" given the context and personal qualities of both Knight and the staff. What seemed to be the basis of the Commissioner's observation was that the elements, when combined, formed a naturally more individual style; but more importantly, their combination with the teaching approach did constitute a unique and effective approach.

The management style was also more explicit than the teaching style or the program for learning. Both Knight and the staff could describe most of its elements and indeed some of them were taught as principles both for new situations or for the management of routine activity. The management style was also more fully absorbed by staff than was the teaching style which we have just indicated was limited primarily to Knight.

The management style also had greater effect on the division's routine activity than the teaching style. Here competent management of the division's routine processes produced a "product" - organizational credibility. That product - which Knight defined as "having integrity" meant that the division should have policies, that they should be

available to providers and clients, that they be relatively coherent and consistent and that the division attempt to live up to them. That credibility then gave the division "breathing room" in which to explore and deal with areas of new knowledge without facing excessive external pressures or constraints.

In the new services stream, the importance of the management style in establishing credibility in routine areas was clearly significant since most of the new services were at the "edges" of some existing service (e.g., mental health clinics or HMO's) in which there was considerable contact with providers on a routine basis. In the sanction stream, the role of prior credibility was less direct since sanctions were a totally new effort, but the personal integrity and credibility of the staff during the sanction stream contributed much here to the success of that stream in the providers' and the public's eyes. In the internal administration stream, the management style was less in evidence since it required interaction between Knight and his staff, and, as we have seen, much of that stream involved little action at all.

For the new situations we have described, the management style was also useful. Since the new areas were more visible to providers, the way in which they were dealt with becomes important and here the division's environment saw the use of Knight's same managment style in dealing with these new areas as also being inherently credible. Equally important, the use of that style provided a fertile background of certainty and confidence in which teaching could take place and in which the division's program for action could transform complex new knowledge into workable policy responses.

The style consisted of many elements, all of which have been partially described in earlier chapters. Here I will briefly summarize each, but principally attempt to show how they helped in the building up of the division's credibility. First, Knight used a wide span of control - over ten people reported directly to him. What this primarily meant, of course, was that it gave him direct access to all the staff so that his teaching style could take hold. It thus meant that he could control the development of new principles and, also, since his personal credibility was high, the organization could directly share his personal credibility.

A second feature was his "open door policy". This assured, along with the wide span of control, that he could keep tabs on all routine activity, and serve as the integrator or resolver of problems. It of course also meant that staff would bring all new situations to his attention and is the main reason we found so few situations involving new knowledge where Knight was not involved.

But the credibility did not flow only one way. Knight's use of very competent staff gained credibility with the environment and even reflected back on him ("Don personifies the achievements of his office"). More importantly, however, was his technique of "letting people find their own slots" and the use of staff new to the medical field. These unconventional (for an understaffed agency) techniques insured both that people would "get their own egos involved" and thus become committed to an area and that, as newcomers, they would ask "naive questions" about established beliefs, e.g., why should physicians not be more responsive to clients and to those who pay the bills.

Another feature of his style was the creation of a climate of certainty in late 1973 by the use of the "informal matrix" which was discussed in Chapter II. Recall that this was a certainty about "how to go about our job" and not about the effects of that performance and thus does not respond to the "nagging ego problem" discussed earlier. The climate of certainty, while a part of the management process which generated divisional credibility, was also more directly related to that credibility, not only in that the confidence permitted the rest of the management process to be credibly carried out but also since confidence in itself may be seen as an element of credibility. Thus the environment would ascribe more credibility to the agency if it believed it to be acting with confidence. Here confidence is seen as an inherently positive feature, especially in a situation where the division had so long felt overwhelmed by its tasks.

This early structural setup then evolved in 1974 into a situation in which very clear delegation of authority to specific managers was made and in which the use of committees, task forces or liaison staff was minimized since those bodies avoided making decisions and could not be held accountable. This evolved structure also helped considerably in gaining external credibility since providers and other agencies knew precisely where to go for answers. It did, of course, begin to present some problems as the scope of activities of the division got larger and the staff maintained less contact with each other. For example, the sanctioning of a family planning clinic was carried out by the sanction director without routinely verifying with the planning director whether that action might cut off access to care in a particular geographic area.

Concurrent with this was a cluster of management outlooks which began with the avoidance of "non-line" units such as research, planning, or budgeting. On the one hand the small personnel complement hardly permitted such luxuries, but Knight firmly believed that "managing should be done by managers" and that overall long-term policy in an area was best set by those who understood it through operational experience. He thus tried to push information downward in the organization so that "things don't pile up on my desk" and saying, "you've got the necessary information to make those decisions". Since committees could not be relied upon and since staff units were a luxury, he encouraged staff to cultivate many sources of information outside the bureaucracy in order to acquire relevant "intelligence" often denied to a central office division.

Knight also kept a very close check on staff performances, particularly when he was assigning new responsibilities. He would utilize reports from providers who had dealt with the staff and he would often ask for generalized reviews by each staff member as to how he were progressing. He nonetheless thought "work should be fun" and permitted a very open, casual style of interaction in the office - as long as the job got done. He did worry about such transgressions as excessive coffee breaks but only because other DPW staff would see that as poorly affecting the division's credibility. There was, however, a significant absence of "human relations" type activities, i.e., inquiring of staff how their personalities and problems interacted with their jobs and how staff related to each other. On the one hand, such organizational development activities were clearly less needed since staff interacted mainly with Knight and not with each other and also since they were generally pleased

that they had been permitted to "find their own slots". On the other hand, Knight was perceived as a somewhat shy individual and appeared to feel uncomfortable with such personal problems. The result was that any personal problems were discussed by the staff among themselves. Such discussions usually centered on what it was like to be in their first responsible job or the intriguing character and style of Knight.

Before considering the final three elements of Knight's style, ones which were more directly related to the establishment of credibility, it is worth mentioning a "tactic" which was of considerable internal utility in maintaining a sense of what the division was doing. Here Knight continually stressed "putting things in writing". The potential for "slippage" in bureaucracies is so great that he stressed that requests and commitments made should be recorded in writing so that there would be less possibility to misunderstand these situations when they later came up for discussion. The use of "memos for the record" was also stressed. It is clear that these tactics helped the credibility of the division - particularly with providers - while within the bureaucracy it may not have won many friends but it did help to bring order to a complex set of tasks.

The first of these final three elements is, as we have seen, Knight's continual stress on the direction the division should be going ("management is knowing where you want to go"). The prior lack of leadership in the division had, along with other features such as late payment of bills, damaged its external credibility considerably. In a world where the choices were many, some kind of definite direction was perceived by providers as better than none at all. That sense of direction, evident in all the cases described earlier (save the loss of controls and field

cases) clearly also helped the staff in developing their own sense of direction. As most had had little experience, this feature was absolutely necessary, but it also had benefits for external credibility. Within that sense of direction, however, Knight permitted an experimental style (already discussed in Section 4) and advocated an "entrepreneurial" approach, one which was opportunistic (e.g., the joining of two streams of activity in the physicians' audits cases) but one which willingly tolerated "mistakes".

Knight also stressed that the division should act in "cost/effective" ways. Whether this meant stressing ambulatory care which in the long run would be cost effective, or simply meant not assigning resources to areas where it appeared the payoff was low (i.e., the local welfare offices) it made sense to providers. It also meant that the division could avoid doing a bad job in certain areas, thus further damaging its reputation. But more importantly, it simply made inherent sense to providers and other bureaucrats and thus helped to win their respect.

The final element of the managerial style was a <u>direct</u> approach to the importance of credibility or integrity. Knight simply stressed continuously that "we must act with integrity". He emphasized all the elements of that integrity, being sure that there were policies for each of the service areas, that they were written down in the policy manual and that they were coherent and consistent. This was a repeated theme and one whose blockage by, say, the departmental office in charge of distributing policy to the field irritated him considerably. This direct approach to the importance of integrity ("we are responsible for what we do") is perhaps the most indicative of Knight's overall conception of the division's role, at least half of it - the other half being

the achievement of goals. In fact, the two were inseparable since Knight was convinced that in the situation he found himself, purposes could only be achieved by demonstrating integrity.

But how widespread was this management style? Was it only Knight's way, in combination with his teaching style, of inducing learning at the first four levels or did staff members acquire that style also? It is difficult to assess this properly since I have not examined in detail the routine activities of the division where staff acted more independently, and since they usually acted in conjunction with Knight in new areas. Several ways of assessing the effect of Knight's management style can be utilized however. One would be to describe Knight's use of his management style in routine activity while a second would be to directly ask the staff involved about that style. A third possibility would be to explore that theme with informed outsiders from the division's environment. Finally one could explore situations where the division's "good management" failed it and then explore the consequences for the division's credibility. This combination of approaches is not an ideal one (e.g., the second approach focuses on the staff's "espoused" behavior but it is the best available one given the researcher's constraints). These four approaches, when combined, should permit us to make a reasonable assessment of the degree to which the staff had learned the style without examining the routine behavior of the staff directly. Thus we will examine the inputs to that process, the opinions of the actors, the product (credibility as seen by the environment) and search for a "negative" case.

Knight's use of his management style for both routine and new activity has just been extensively described and thus we can focus on

the responses of the staff directly. The division's staff responded to the operation of what they felt they had learned in many ways. Few responded initially with examples of "substantive" learning around issues like "how to deliver care". Most eventually did respond in this vein, e.g., that hospitals have complex accounting procedures and can thus manipulate costs easily or that nurse practitioners are best used if well supervised; but they clearly constituted this type of "technical" learning, not their most significant. Instead, and it is not surprising given their short job experience but obvious technical capacity, what they stressed were aspects of an overall approach. Thus some spoke of learning how to relate to the environment and to physicians, others of the importance of simply doing something, while others stressed more personal learning, e.g., acquiring a sense of confidence. But all stressed how they had learned pieces of Knight's management style.

Thus several stated that they learned"how to ask what we want" (L.A.) while even more said that they had learned "how to set priorities" (R.Y.). An equal number indicated they had learned to "look for results", "to follow up" and to "try to monitor" or to "get into situations where we can have some effect." Many also felt they had learned how to "cover themselves" although R.T. stressed that this was best seen as "backing yourself", i.e., being well prepared and getting things in writing. Several staff also felt they had acquired the entrepreneurial spirit, "I've learned there are no real answers...but taking risks and doing something is better than doing nothing." The degree to which this learning of Knight's style was effective in establishing credibility will be considered next.

The role of organizational credibility as perceived by members of the division's environment was discussed earlier in many of the case histories, indeed all of them save the loss of controls case, and it was clear from these assessments that the manner in which the division handled new situations was accepted as being credible by those agencies and providers involved. But most of these same groups also had to deal frequently with the division on routine matters and so over a dozen respondents who had contributed to the several case studies also volunteered assessments of Knight's management style and the role of credibility in routine areas. These assessments confirmed the climate of credibility which they had encountered in the new knowledge cases.

In order to confirm more conclusively the credibility described, additional members of the division's environment who had not specifically participated in any of the cases were also sought out in order to elicit their views on the organization's credibility. Such a group of "informed outsiders" was difficult to find; many observers of the national Medicaid scene had no knowledge of the local situation, most providers were only familiar with their own area of service, and the legislature was generally ignorant of the program save its cost; indeed the program was a true "sleeping giant". But at least seven informants ouside the state bureaucracy were finally uncovered and interviewed. They included the director of a welfare "watchdog" agency, the capital city's health commissioner, the financial director at a large hospital, an academic studying Medicaid, a legislative staff member, the president of the Medical Society and a staff member of the

federal agency overseeing the Medicaid program. Each of this latter group also eventually responded to general questions about the new programs the division was instituting, its monitoring and sanction activities, its fee schedules or bill payments and the future of the Medicaid division. But each of these eventual responses had to be "dredged" out of the interviewee or was affirmed only after he had offered his first impressions in response to the very general question of "how would you evaluate the Medical Division?"

The informed outsiders all willingly volunteered evaluations based primarily on the increased credibility the division had acquired. Credibility meant that the division had first of all gained the respect of its environment - "people dealing with a program have standards of efficiency and when they're not met, then the program loses its credibility; people know when they're beating the system..but the division is focusing on what the real problems are and getting some control systems working." It also meant that the division be responsive and not avoid issues - "People now get back to you and they have answers. - You can see the action generated." It also meant a personal credibility developed by the staff - "people are competent and stick to it...they get it done." Building up a base with providers was also seen as important - "We couldn't believe it, no one had ever listened to us for years. - Knight is having to pay the price of 25 years of neglect of the profession." Finally, it meant a clarity of response - "Knight is highly esteemed - he's a straight-shooter because he untangles what can be done from what can't be done. He's never kidded us around." Clearly, then, the members of the division's environment saw Knight's management style as being effective in producing a credibility which was,

if not sufficient, at least a necessary condition of support in their minds.

Even in those situations where the division's handling of some routine activity was less than ideal, the resulting product gave no indication that provider credibility had been adversely affected. For example, the mapa's often received policy material after providers did and were unable to respond to questions, but the mapa's were generally well viewed by providers. Similarly Knight's use of the press in the hospital sanction case was thought by some to be a prejudicial administrative action but the medical community as a whole did not appear upset at this tactic. Also, a series of long negotiations with various home health agencies broke down after, as described by R.T., it became clear that "we weren't speaking the same language although we were using the same words." However, this did not affect the division's ability to work with them on other issues. Nor did a stormy exit from a meeting of ambulance providers by a staff member (after she refused to discuss an item not on the agenda) affect her later ability to work with that group. It thus appears that these few instances, simply because they were few, did little to harm the division's overall credibility.

We may then take the results of these four tests (pg.419) as reasonable, though not ideal, evidence that the management style of Knight was indeed significantly absorbed by his staff and lived out by them in a progressively more competent manner.

To summarize this section on management style then, we have seen that, first, many conventional elements of management were combined

into a unique style by Knight. That style, also partially acquired by his staff, enabled the division to perform its routine activities such that it increased its credibility with its immediate environment. This credibility gave the division breathing room to tackle new areas to which they applied the same management style and to combine it with a teaching approach to develop and learn general principles of health care delivery.

6. The Organization's Paradigm

But teaching and management were not enough to ensure the success of the individual cases of new knowledge nor the generation of principles. Success with respect to what goal? Principles to what end? To the end of being a "responsible buyer" Knight would reply. I have described in the cases how the continuous and clear focus on this paradigm was, along with Knight's style, the element of unity which held the division together and permitted a coherent and economical development of a set of working principles which could be applied in new situations.

This paradigm did not spring from out of a void in 1973. While the public climate for health system reform in 1973 was just warming up, some of the more perceptive bureaucrats in Washington had seen the need for change and there were a few forces at the state level pushing for reform. (See Chapter II, section 6.) Thus the secretary of the state's Human Services Agency said that, "first we wanted to get some management control of DPW and Medicaid...then we wanted to make it into a good health program." The undersecretary said, "the second goal was to build a sophisticated program to get at the quality and

cost of health care and in doing that we could begin to get some innovation and change in the overall health system." Knight's directions thus fitted in with these goals. He wanted to act responsibly which meant being held (and holding others) accountable for the delivery of cost effective services. And he wanted to act as a buyer, which meant assuring quality services but not being forced to purchase from all comers. They all hoped to influence the larger system but knew that that could not be accomplished immediately. Knight then had made his own formulation of these goals: he would act as a responsible buyer.

We have seen in the cases of new knowledge described that that formulation or paradigm was indeed lived out. In the new services stream, the emphasis was continually placed on the purchase of only quality services and only on those situations or clients for which there was a need (e.g., did the division really "need" HMO's, or did welfare children really require mass screening programs?). In the sanction stream, the whole emphasis was on not having to buy from poor quality providers. In the internal administration stream, the stress was generally on acting responsibly, i.e., in two cases (MA-7 and CAB) responding to provider or client inputs, and in the other three cases, not taking on responsibilities which could not be exercised properly. We have seen that in one of the cases (Loss of Controls), there were differing definitions among the staff about whether Knight had properly assessed that situation, but Knight himself felt that he was acting responsibly. In each of the cases in the three streams, the staff also accepted the use of that paradigm and tried to live it out via their use of a new management style and the principles.

Indeed, the living out of that paradigm became more bold during the progress of each of the streams as both staff and Knight elaborated a large set of principles which defined what being a responsible buyer meant. At the beginning of the stream, however, it appeared that the staff did not really know if the division could be a responsible buyer - it knew it should, but could it live up to it? The use of the phrase "responsible buyer" was very common in late 1973, almost as if the staff was convincing itself that it was a respondible buyer. (Kuhn has suggested that such a paradigm may well be a prerequisite to perception - that is, in order to perceive what you are, you must state what you are, or think you are, or think you might become). Next the division began to "perceive" or develop an awareness (through the principles) that it could be a responsible buyer. The use of that term inside the division dropped off over several months but its use by Knight and the staff appeared to increase externally as if now the task was to convince others that it could live up to the paradigm. The effect of this paradigm is perhaps best illustrated by a comment from the commissioner - "Don's greatest contribution has been in his purchase of service definition. It's helped people to understand the role of DPW and its powers."

The paradigm's strength thus lay first of all in its very obviousness. The strength of all such "good ideas" probably lies first of all in their intuitive sense of "correctness" and appeal to a wide body of people. Who could argue with being a responsible buyer? It clearly served as a public or political rallying point either to gain resources or credibility or simply cooperation. The paradigm, as any paradigm does,

ignored some directions the division might have taken. It might have thrown up its hands completely and simply followed a minimum set of federal regulations; it might have set up its own delivery system. But the utility of the paradigm lay not in setting any "right" directions but rather that it provided a framework through which the organization can be evaluated by its environment.

The paradigm also has utility in that it provides a framework within which learning may (or may not) take place. Since learning is usually seen as "progress" from one state to another state, those states (in this case "what we are" or "what we can become") must first be defined. After developing this definition, then the relevance of vague or complex new inputs to the agency can be more easily assessed. Without it, all inputs to the division would become equally relevant, e.g., the "irrelevance" of the federal style EPSDT program would probably not have been perceived without the existence of the paradigm. As Kuhn has suggested, a fact is not a fact until there is a theory to explain it. But the paradigm not only helped to set an initial stance (as with EPSDT) but it also permitted the testing of the principles developed in moving toward that stance, and thus served as a litmus paper, a testing ground for the development of principles. For example, why should para-professionals in the mental health area necessarily be used with caution? - because there was no proof of their competence or quality as a class of providers (buying only quality services). But they existed; how should they be dealt with? By requiring that a psychiatrist supervise and be responsible for them and that the psychiatrist be responsible to the division through a series of regular

reports or problem-oriented records (acting responsibly).

The paradigm, then, while not a unique one in itself (others had suggested similar roles for government) served both external purposes in gaining and maintaining public acceptance and internal functions in fostering the growth of a set of principles which we have defined as a main element of learning.

* * * * * *

We attempt in this chapter to examine whether the medical division had met certain criteria of a learning organization (as defined in the levels of learning) and how it might have achieved that. We have seen that the division did generally meet those criteria. It developed policy responses to situations triggered by new knowledge, and it routinized those responses. It also developed and used a set of general principles which served as an economy device for learning and also for translating the division's paradigm. It also developed a pattern of action for developing those principles and policy responses. The degree to which those levels of learning were fully imbedded in the division's system of relationships was also assessed although here the evidence was not particularly strong.

The manner by which the division achieved these levels of learning was also explored, first by concluding that each level of learning was indeed operative in advancing the level preceding it, but primarily by examining the division's overall approach. That approach consisted of three identifiable components: a teaching style, a management approach and the use of a strong paradigm. The development of this overall approach could be said to constitute the achievement of additional levels of learning (see my definition of levels 6 and 7 on page 17), but the

question of whether that approach constituted additional levels of learning or more simply a means by which the particular organization studied achieved the lower levels of learning, was not examined in this chapter. Nonetheless the approach's function in the learning of the initial four levels was clear. It provided, through the paradigm, a background by which an initial direction could be set and later learning tested. It provided, through the teaching style, a method of developing the levels of learning. And it provided, through the management style, a means by which external and internal confidence in the division's learning processes could be developed.

The demonstrated success of the medical division in achieving these significant levels of learning and developing an approach to that learning, must now be assessed in terms of its relationship to existing models of change and its durability and possible transfer to other situations.

Chapter VII

The Division in Perspective and Some Possible Lessons

We have seen that the Medical Division developed, according to some general criteria I elaborated, what I have called a learning organization. But how is this descriptive model of the division different from the conventional models discussed in Chapter I (the crisis and guerilla models) which are most generally used to describe, analyze and account for actual organizational change? To what might those differences be attributed, and what can be learned from them? And did the division's model really represent a "complete" learning organization such that it might stand the test of more stringent criteria such as long-term durability, applicability to other organizations or ability to "self-transform" that model. These questions will constitute the major themes of this chapter.

1. The Division's Model of Change and Conventional Models

The crisis model serves to explain organizational change by asserting that organizations build up institutionalized sources of resistance to change to which they become wedded and which require a crisis state and a massive infusion of resources to effect substantial change. Such conditions are seen as necessary not only for major paradigm shifts but are also necessary for mid-level changes in activities since the organization has rarely built up imbedded "programs" for dealing with such changes (e.g., the addition of new tasks or technologies).

Some examples from recent years will help to illustrate how major organizational changes (or attempted changes) often follow the crisis model. For example, the Law Enforcement Assistance Admin. tried to "solve" the problem of crime in the streets and an archaic justice system by a massive infusion of funds into local criminal justice systems. Yet here

indications are that these funds are being diverted by, or absorbed into the traditional systems with little real impact. The welfare system in California was subjected to a similar turmoil by former Governor Reagan. There, the infusion of funds was minimal, but the injection of administrators with extremely conservative policies in order to"solve"the welfare problem, has apparently done little, as both costs and caseloads continue to rise. A third illustration of the model is the American automakers' responses to a clearly growing threat by smaller and cheaper imports ,which were basically ignored until the energy crisis forced Detroit to grudgingly make major shifts in its paradigm such that they could declare that the age of the big car was over and that major retooling would take place once every three to five years instead of annually. Finally, New York City's possible default on its municipal bonds due to its archaic tax structure and accounting methods has long been anticipated, yet it will apparently take a crisis on the order of default to force the necessary changes in methods and personnel. Observers of these and other similar examples can compellingly describe these and other situations and yet can only despair that such a short-sighted and disruptive model for change must be employed so recurrently.

But the model of organizational change developed by the division was clearly different from that crisis model. While the division in late 1973 enjoyed some general support from other state agencies and from some provider areas due to Knight's prior reputation, it was in disfavor with the legislature and seen as a troublesome "pest" by much of the provider element. The public, the press and the governor ignored the program. Thus the environment of the division was neither

excessively hostile nor excessively benign nor was the division's situation seen as a crisis requiring immediate solutions. Even those who did see the situation to be a crisis state (mainly the division staff itself and the HSA agency) were unable to secure any massive input of resources and/or public backing for an immediate renewal. What we saw instead was a very gradual build up of organizational competence and of a specific learning style. While it is true the staff complement nearly doubled over two years, this was in response to a series of many individual requests which Knight made and to his skillful manipulating of the resources he was granted. Thus the development of the division's model could not reasonably be attributed to institutionalized sources of resistance at either the paradigm or lower levels nor to an environmentally defined crisis or even a public mandate to "clean up" Medicaid. The crisis model then does not help to explain the division's success in developing an approach to organizational change.

Nor does the guerilla model help to explain the division's approach to change. That model describes how activists with strong goals try to "subvert" the system either acting from within the agency or, if the "guerilla" happens to be the agency head, within the larger system. They build up antagonism to change within the organization by their style and usually leave after short periods, with their reforms decaying rapidly.

Recent examples of that model in action are not hard to find. They would include, for example, the New York City infusion of several dozen young "whiz kids" operating out of the Budget Bureau, the Mayor's office or a RAND project grant during Mayor Lindsay's tenure. Their

attempts at institutional change produced little more than technical reorganization (e.g., deployment of firefighting equipment) and the climate for future change was hindered by their style. Even totalitarian governments have seen fit to use such methods; witness the recent"cleansing" activities attempted by young Red Army cadres in the cultural revolution of the late '60's and early '70's. Evidence indicates that slippage has occurred even there as, for example, children of peasants are being squeezed out of elite schools. Another example would be the movement within Boston to bypass the regular municipal bureaucracy through the establishment of several "little city halls"-- seen as the only way to effect major change- and yet those institutionalized guerillas have degenerated into a petty political role (Nordlinger).A fourth illustration of such institutionalized guerilla activity is described by Nelkin in her analysis of the federal agency organized on the agricultural extension agent model to effect changes in the technology of home building. Individual guerillas as agency heads is best exemplified by Jerome Miller's acting in the Youth Services Department of Massachusetts and Illinois in which (at least in the former state) he could only change the old system of institutionalizing youth by outrageous political movements, administrative fiats, lies and even midnight placement of youthful offenders in community based homes. A final example from the management literature (Burns and Stalker) describes how organizational change (in this case, firms in the radio industry in Britain)were basically changed by a new group of company scientists who had to fight strongly from within to get their own directors to adapt to a turbulent environment.

But the Medical Division bears little resemblance to the examples. Here Knight might be seen as a "guerilla", but in fact he took particular pains to assure that he had as wide a base of external support as possible. His manner outside the division was firm but not aggressive nor even abrasive like so many "committed" or "reform" leaders. Indeed, he even saw his style and methods as being very orthodox and seemed at a loss to understand how others could see him as unique. Nor was guerilla action by the staff members tolerated. Knight was very concerned that staff not appear like "bucanneers or vigilantes" and stressed that they should maintain the same mixture of openness, decorum and firmness when dealing with members of the division's environment that he displayed. And internally, guerilla action was clearly not tolerated. Knight could not bear the thought of "independent action" - which is why the reaching of a philosophical agreement became so important to him. Thus neither Knight or his staff felt themselves to be at odds with the system - they were trying to change it, but did not think in terms of "enemies". Some enemies were created, of course, but the division's stress on credibility and integrity muted the vast majority of other potential rifts.

Thus the division's model of change was somehow different from the conventional crisis or guerilla models of change. Not only was the method of change different but the consequences were different. That is, there was no signficant disruption of the division's routine activity. Such disruption appears to be a common feature of both the crisis and guerilla models and its effects, in terms of wasted resources, account for much of the search for alternative models of change. I do not suggest that such disruption is a priori dysfunctional; in some cases

it may even be necessary, but only that here, a model has been developed which produced a type of significant change (which I call learning) and yet the organization continued to be focused, to produce an output. It did not have to drop all its routine activities in order to learn; indeed it even managed to add to and improve those activities. As I have suggested, this competent management of routine activities even permitted and enhanced the division's learning.

This delicate, but deliberately created balance between competent routine performance and learning seemed to be one of the factors accounting for the lack of disruption of routine activities commonly found. That is, not only was a style created which placed equal emphasis on, and rewarded equally both routine performance and learning, but the execution of this style meant that when new knowledge confronted the division, it had a learned pattern or approach to deal with it. There was no need to drop routine activities, whether in the face of an external pressure, internal advocacy or more simply in the face of a "good idea". Other factors which also contributed to the division's avoidance of disruption included the extreme pragmatism of Knight and his staff and the climate of certainty built up by Knight, both of which are discussed in Section 2.

The division's model also differs from some of the other candidates which have been advanced as suitable alternatives to the crisis and guerilla models. The management science approach to change (Churchman, Beers, etc.) proposes that organizational functioning (change is implied or assumed to be inherent in that model) be grounded in the inherently logical appeal of new knowledge or technology. The new knowledge will be rationally integrated with the organization through intelligent men

working together. It considers the generation of organizational goals and managerial methods as secondary to the content of new knowledge. Its greatest applicability would seem to be in situations where the number of variables the organization chooses to deal with is few and much is known about them. It is a narrow view of management and yet one which has some credibility with today's public. Whatever its potential for success, the division's achievements cannot be explained by such a model. While Knight and his staff were convinced of their own competence and even acted with moral righteousness at times, this was not the source of their success. The content of their learning was not only subject to considerable stumbling and eventual change as it developed, but it also was subject to considerable influence from the division's environment. The management science model would posit a less hesitant and more comprehensive approach to learning and less routine acceptance of direction from the environment.

Neither does the organizational development model (Argyris, Bemis, Likert) account for all the division's success. While it does speak to a shared understanding between manager and staff, explicitness of purpose and method, and decentralized control, it does not address nor condone features of the division's model such as the usurption of goal setting by the agency head, the "moral" sense of rightness of both Knight and staff, the bending of rules, the considerable initial reliance only on close friends nor the existence of learning in the relative absence of good feedback.

The division's model does share some features of the contingency and neo-structuralist models (Lawrence, Thompson, Galbraith, etc.) in that its mode of operation and strategies are based on a carefully

worked out fit with the environment. Yet its formal structure is clearly not the source of the division's strength nor are the formal integrating devices suggested by the neostructuralists much in evidence. Rather the integration was achieved through formal devices (the informal matrix), personality features (the sheer force of the teaching style) and some similar personal qualities of staff members.

The division's development, then, can be described as an example of an alternative model of organizational change, a model which I have called organizational learning, and yet which differs from current descriptive models used to account for change and from some of the alternatives proposed to those models. There are no doubt other examples of organizational learning to be discovered and modeled but the rich example here should provide us with adequate insights upon which to understand how effective alternatives to the crisis and guerilla models can be developed in practice.

2. Sources of the Division's Effectiveness

The crisis and guerilla models are most commonly used to account for the process of change (if any) in government bureaucracies. The patterns of behavior existing in such bureaucracies prior to the activation of those models are what I shall call conventional patterns of behavior. I cannot assert that these conventional bureaucratic patterns alone contribute to the rigidity of bureaucracy and an attendant reliance on the more disruptive crisis and guerilla models of change. But the absence of these patterns in the medical division and its subsequent freedom from reliance on such conventional models suggests that it is these distinct features of the division that contributed to its

development of an alternative model of change. The division's new patterns are not complex in concept but the intensity of their application did seem to account for much of the development of the division's model and its effectiveness in achieving the levels of learning described in Chapter VII. Thus the manager wishing to avoid the conventional models might seek to understand not only the elements of the division's model as described in previous chapters, but also how they differed from the common practices found at work in his own organization and the lessons that could be learned from those differences. These unconventional elements of the division's model are not without their limitations, however, and these are also discussed in this section. The reader might thus view these limitations as costs associated with the adoption of any of the elements, a view which might preclude a wholesale, or unthinking adoption of them.

a. The division first of all avoided reliance on the crisis and guerilla models by a conscious rejection of the importance of those models as a basis for change. That rejection was based on a particular brand of pragmatism that differed considerably from the crisis or guerilla models of change in which, while change takes place, it either dies away or creates intolerable antagonisms. The "crisis" model, particularly in America, appears oriented towards a possible demand for "immediate" solutions to longstanding, deep-rooted, and vastly complex problems such as "poverty", the "environment", "race", or "education". It seems inevitable that massive and sudden inputs into organizations involved in such complex areas can only create frustration and later abandonment of the mission, particularly when

aided by the short attention span of the public, the media and elected officials. Yet the division chose to develop policies in areas which could be "solved" and in which real advancement could be shown. In addition, the division's pragmatism permitted it to avoid being caught up in the heady sway of a crisis atmosphere during which routine activity comes to a standstill and the agency becomes disorganized. That is, Knight simply did not believe most problems could be solved by crisis-like activity and took pain either to shield staff from such activity (e.g., budget reduction proposals in early 1975) or to simply explain to those around him urging immediate redeployment of staff resources, that problems were not solved by such short-term strategies (e.g., improvement of the local offices).

Similarly, the guerilla model, while often also directing its attempts at systemic problems, has as its most prominent feature, domination by passionate advocates , zealots or even dogmatists, who believe that they are "right". They often create such antagonisms that resistance to much needed change is often generated by their very presence. Here again the division's style in which it believed there "are no right answers" permitted it to achieve considerable environmental backing at a very low cost. Knight's distaste for overly zealous or dogmatic staff or for any guerilla-like, vigilante activity assured that no patterns would develop which would disrupt the routine work of the division. Again, a simple and obvious alternative to existing models of change but one which needs highlighting.

This pragmatic attempt to deal with the possible and with high pay-off situations did however lead Knight to avoid situations he

felt he could not control. Avoid is an excessively harsh word since by no means was contact broken off with the parties or agencies involved in such situations. Rather, as was shown in the internal administration stream, Knight simply had a tendency to avoid becoming too entangled with groups that he felt were poorly managed or that he could not hold accountable - "I try to hold people accountable in such a way that it doesn't mitigate my own accountability." For example, in response to questions regarding a possible greater level of energy devoted to improving relations with DPH, DMH and HSA, he replied "To what end would all this 'fine tuning' be? Should I run around to all these meetings and never be available for important things?" What this meant in the opinion of many staff is that while relations with the rest of DPW and, for example, DPH or the HSA, were not poor, they could be "fine-tuned" to a considerably greater degree. But "Don's need to have control" seemed to prevent such fine-tuning. And the method which might be used for such fine-tuning, for example, inter-organizational committees or task forces, he felt to be inefficient (and given his view of accountability, they were) or inappropriate (i.e., his teaching style could not be extended so far as to include those with whom he was not in regular personal contact).

b. A second reversal of conventional practice is also apparent in the division's model. While other organizations have met or matched the learning criteria that I have applied to the division, they have often done so at a price, not simply one of not performing their routine activity, but more importantly of losing their sense of responsibility. For example, witness those professional schools who develop too far

in front of the profession they are at least partially designed to serve; or social service agencies headed by zealots who, in their drive to change a system, either concentrate only on the most visible clients or so disrupt the agency that its clients suffer in the short run. Yet the medical division's model has shown that it is possible to both learn and act responsibly despite the fact that any learning model appears to have some inherent conflict with the need for public accountability (as pointed out by Schon when he alludes to the conflict between legislation and "public learning" as a basis for policy).

The method does not seem complex; it simply seems to be that learning and responsibility were held to be equally important by both Knight and his staff. Thus Knight saw himself as being accountable to the welfare clients, to the legislature, to providers and to himself (i.e. being of integrity) and he saw his staff as being accountable to him and to themselves. Indeed this stress on accountability and one of its associated products, credibility, fostered the (necessary) condition in which such organizational learning could prosper. Thus the division's emphasis not only on both teaching and management but on their inter-relationship should be viewed with appreciation by managers.

c. In many bureaucracies there is a considerable effort made to develop and enforce organizational behavior patterns or rules. Most commonly these are referred to as "the procedures" of the organization. In such bureaucracies, behavior at that level is often rigidly prescribed by manuals or manager's instructions or enforced through employee codes. The level of behavior I am referring to here is primarily the

same as the "program for learning" of the medical division described in earlier chapters. Usually considerable attention and energy is directed at that level of behavior at the expense, I believe, of the output of those behaviors or the goals to which they should, from a manager's perspective, be directed.

Recall that the elements at this level of behavior in the division's model were nearly entirely tacit. They were performed but no particular formal or verbal stress was placed on them. In the division's case, the output of those behaviors was the principles and the goal toward which they were directed was the paradigm. Both the principles and the paradigm were very consciously developed and considerable energy devoted to their propagation. I believe that both the division's reversal of priorities (principles and paradigm versus behavior codes) and the reversal of the status of the principles and paradigm from their usual tacit status to one of strong explicitness accounted for much of the division's success and is a lesson many organizations might stand to relearn - that it is indeed the ends for which the organization is created which are of prime importance, not the means.

Yet the emphasis on the propagation of a strong paradigm does appear to have some potential costs. The very fact of choosing that paradigm and of asserting it with a moral fervor as Knight did has as much potential as the guerilla model for leading the organization into serious conflict with actors within its environment and consequent loss of acceptance. In addition, since Knight's appointment was a political one, the potential for such battles seemed to be built in to the process. However, while these two factors would likely lead to considerable

conflict for other organizations trying to adapt this style, Knight generally managed to avoid such battles by choosing a fairly universal paradigm against which few could argue and by building up personal and organizational credibility. The lesson here is obvious: while a strong paradigm has many advantages, it must be accompanied by other features if unnecessary conflict is to be avoided.

d. The importance of the explicit nature of both the paradigm and the principle is a difficult one to assess. However, I would speculate that here again an important lesson can be learned. When an organization's paradigm is explicit and its working principles only implicit, it would seem that not only would a manager's assessment of learning be difficult but the organization's members themselves would find it difficult to assess their learning of either a simple development of principles or of a change of principles, since it is by these working principles that a paradigm is operationalized. Similarly when a paradigm is tacit and principles explicit, learning may take place; yet its actual contribution to a goal (the paradigm) may remain unclear since the paradigm is tacit. Thus, if we can assert that organizational learning must consist of some goal or direction (however vague) and a level at which that goal is grounded, then the connection between the two would seem to be more easily made if both are explicit. In the end this line of argument might be seen to distill itself to one of either valuing explicitness for its own sake or a tautological one of defining organizational learning as being explicit change. Both of these possibilities are ones that I cannot discuss here, but rather I shall only suggest that the division's explicit principles and paradigm clearly differentiated it from most conventional bureaucracies and thus may offer a promising line

of both inquiry and action for others to explore.

e. A fifth reversal of conventional bureaucratic practice by the division was Knight's considerable tolerance of a diversity of personal styles as long as their bearers followed the principles and worked toward the organization's goals. Again, in many organizations (certainly not all) there is considerable effort to develop a "company style". In the division, staff were free to manage in accordance with their own styles as long as they did it responsibly and were willing to submit to the teaching process through which principles and goals were developed. This tolerance helped create a relaxed climate where staff were clearly more receptive to learning; it eliminated wasted effort trying to assert a "division style" and it permitted the division to focus itself on the important tasks. Again a simple lesson, but one which is not always appreciated.

While there was a general tolerance for a variety of styles, Knight could not tolerate members of the division acting in either ill-defined "co-ordinative" roles or with no direct management responsibilities. This avoidance of "staff" (as assured to line) functions might be seen as a limit of the division's model. Clearly the division saw these roles as unnecessary, whether for relating to other agencies, for internally proposing innovative ideas or for coordinating internal tasks. But the agency could probably only grow but slightly before the need for such staff would become apparent. For example, deteriorating relations with PMO, the computer center, and the dental claims processor eventually led Knight to assign two people to oversee those functions. Similarly, the budget function in 1975 became more than the routine it had been in the past and only the loan of a person from another agency

and the creation of a small working group of Knight and his staff prevented a budget submittal lacking the necessary analytical backup and detail. In the future it seems that that function would be assigned to at least a part-time budget specialist. Similarly, the need to have a field coordinator with both competence and credibility and a "systems" coordinator was apparent even in late 1974 and Knight did acknowledge this. Here I am suggesting that this avoidance of "staff" functions harmed the division greatly, only that there was a need and that over time that need could not be ignored without greater costs as the division increased in size.

More importantly, however, this tolerance of a diversity of styles had associated with it an absence of any real conflict over both goals and principles. The absence of conflict within the division (which was described earlier) is a two edged sword. While it clearly permitted the division to focus on its task, the possibility remains that other possible goals or major directions were suppressed, not so much deliberately, as Knight was always willing to listen, but as a consequence of his style and choice of staff - "There's not a lot of soul searching around here", said one of the staff although Knight would respond that "you can't have real conflict unless you have people of equal knowledge" thus indicating his view of his role in the division as being much more of a generator of knowledge than a mediator. He thus begged the issue of cliflict, although he felt that with at least one of his staff, R.K., he often let him go ahead on certain issues even though they disagreed. But we have also seen in at least three cases where there appeared to be a conflict over program content (i.e. with I.N., the first pharmacy director and with two assistants in the sanction unit), those persons left the division.

While I do not wish to delve deeply into the function of conflict in learning and innovation, one spectrum of theories ranging from the psychological to the political, believes it to be a signficant and necessary component. Wilson has found, however, that while decentralization (and potential conflict) of an organization leads to a greater number of innovations being proposed, proportionately fewer are adopted, thus suggesting that a successful learning organization must find a balance between the heady conflict involved in the generation and advocacy of ideas and the concensus needed for their later adoption and execution. Knight would claim that adoption and execution were his prime focus and thus the assessment of where he chose to set on the spectrum between the generation of innovative ideas and responsive action is one which cannot be made easily. I only wish to point out here that the potential cost of a strategy skewed to one side of that spectrum (in this case, towards an absence of conflict).

The absence of conflict has implications for the durability of the division's success in that less rapid concordance with the goals and principles might assure that these elements would not only be successfully taught but that they would be held with greater convention such that they could endure Knight's departure from the division. (This will be discussed further in section g.)

Thus Knight's tolerance of a variety of personal and management styles did create an air of openness and freedom not often found in more rigid bureaucracies but the concomitant need for much greater adherence to organizational goals, principles, and occasionally cultural mechanisms may have denied the division some of the benefits

of more internal advocacy of dissenting positions.

f. Theorists and thinking managers have stressed that organizations must develop staff who can "tolerate ambiguity" but they rarely describe how this is to be done. The division's approach, however, did permit it to deal adequately with the considerable amount of uncertainty and ambiguity inherent in a turbulent environment. The division handled this by creating a very secure sense of certainty about its approach, that is, its goals and its management style, and to some degree its principles also, since the principles were strongly held but nonetheless seen as flexible. It was this certainty of approach which both Knight and his staff held which permitted them to tolerate the inherent ambiguity in a large set of principles and their difficult application to real situations. The staff clearly felt proud of this new style they had learned (see Chapter VI, Section 5) and this permitted them (and Knight) to remain relatively open to innovative areas and to not feel the need to close or terminate discussions on proposed approaches to new situations too rapidly.

g. The guerilla model of change is explicitly based on the central role of a key (or of a few key) persons and the crisis model is implicitly based on a strong leader executing a public mandate arising out of a crisis. The centrality of Knight within the division's model must thus be assessed since all of the sources of effectiveness discussed in this section, while shared by Knight and his staff within a set of relationships, had their origins in that one central person. Some would claim that Knight was the key to the effectiveness of the whole model and that, without him, it could not function efficiently. To what degree, then, does the model's success depend upon the central role

of a person with somewhat unique and very personal leadership qualities?

This issue is examined from one perspective in the succeeding section on the durability and transferability of the division's model since each of the situations discussed there are ones in which either Knight would have less centrality in the organization or would confront situations over which he would, almost by definition, have less influence. But the issue may also be addressed here directly, first by considering the issue of Knight's personal qualities, secondly by examining the problems created by Knight's key role in policy decisions and then by speculating on the effect of Knight's inevitable departure from the medical division.

Three rather personal features of Knight might be seen as key to the successful operation of the model. First of all his clear need for philosophical agreement among staff. But this was really a desire to have shared and explicit working principles, a desire which led to considerable learning as we have seen. Nor is it different from the desire of any manager to have a body of working principles which can be related to an overall goal. In this sense Knight's personal style was neither idiosyncratic nor harmful. Secondly, his need to avoid conflict. While it is likely that conflict would harm the particular balance the division had built up, it is not clear that an increased level of conflict would be harmful to another organization or manager attempting to use that same model. What would occur in the latter situation, I suspect, would be an only somewhat greater amount of policy conflict; but if all the other features of the division model were maintained, the absence of conflict fostered by Knight would

not be central to the model's success. Finally, the nagging ego syndrome. While it is clear that the partial usurption by Knight of the program for action and principle development could be said to have prevented adequate and valid testing by staff of that pattern and principles, it did lead to early success in learning. But that success could not be attributable to Knight's personal usurption alone, since many other "strong leader" managers have adopted such a style. To this degree, then, other managers could equally well adopt these portions of the division's model.

Thus the most personal qualities of Knight's style, while clearly affecting the division, do not appear to be prohibitive to the adoption of the overall model by another organization. Other positive features of his style (e.g., the teaching style) are not unique to Knight. They do existed (however muted) in other managers as do the personal qualities of staff members which I have described. Thus while Knight himself does not appear completely central to the model's success, a person with similar qualities does appear to be a key to its success. Thus it is probable that another group of staff and another manager could apply the model provided that the favorable conditions to be discussed in Section 3, could be maintained.

Yet Knight's centrality and his usurption of policy control did contribute to a problem - the nagging ego syndrome. Both the division's role as a central office policy maker and the uncertainty of medical technology also probably significantly contributed to this syndrome but here we are assuming also the effect of Knight's particular style in the creation of that syndrome and the costs associated with it.

That problem was the feeling by staff members that they were not really certain if their activity, particularly the newer activities,

were having any effect. Even when no action was taken, as in the loss of controls and field cases, staff worried that that lack of action was creating further problems. I have already discussed some of the surrogates used for evaluation in Chapter VI and in Appendix A, but the effects of these must be examined more fully, if only because some members of the human relations school would assert that the staff had been "bought off" by the alluring prospect of a responsible job, a wide scope of problems, and a personable boss, but that firm control still obviously rested in Knight's hands and that the staff were not living up to their full human potential.

I am less concerned here with "true potential" than I am with the probable organizational effect of that nagging ego syndrome. Recall that I suggested that with few sensitive output criteria for evaluation, staff would turn to "process" for a sense of fulfillment and that one of the major ways in which staff could satisfy their egos would then be through involvement in new areas. We then saw that most of the areas of new knowledge were strongly influenced by Knight while those (also those routine activities) which were not, appeared to be ones in which the staff had more confidence (e.g. the day care case). I then suggested that this likely meant that, given the competent nature of the staff, the result of this situation would likely be that either they would eventually leave the division (being unable to tolerate the situation), or would develop some sort of pathology within the division and become much less effective in their performance.

Knight's response to this potential problem was interesting. He said that "there's no <u>right</u> answer to any question, only whatever the

person in charge wants. All that (the day care case) means is that it was a better product for the person involved." Thus he clearly did not see the syndrome to be a real problem. I believe that his assessment of it not being a problem may be correct but I believe so not on any moral grounds of who should make decisions but only because, in effect, the nagging ego problem was more of what Knight would call a "gripe, not a grievance" - that is, it did not appear to affect staff performance.

The reason for this is relatively straightforward. Knight gave staff considerably more freedom in routine areas and since these constituted by far the larger part of the division's action, staff could involve their egos in competent performance there. In addition, they not only had the opportunity to learn a management style (as discussed in Chapter VI, Section 5) but also stressed that they had learned about the specifics of health care delivery (e.g., how nurses and phsycians work together), how to relate to the environment of physicians and other providers ("you must give technical assistance if you expect providers to change") and much about themselves ("I learned not to be overwhelmed by things"). Thus there is some indication as long as this learning could go on and there were routine tasks to be mastered, the nagging ego problem was not a severe one.

Knight's centrality to the model's success may also be examined from the perspective of what might occur should he leave the division after having "installed" a learning system so effectively. His departure is almost inevitable - the political nature of his appointment and the importance of the program in the state budget almost preclude any other possibility. Knight himself recognized the problem this presented when he mused about the durability of his creation, saying that

"much would depend on who replaced me" and "I can't train my replacement". He did believe that it is possible to train people to be responsive and that he had done that. But notwithstanding that possibility, it would be unlikely that any new assistant commissioner would be similar to him; indeed each of the previous occupants of the position had had considerably different styles. The departure of Knight would also touch off subsequent departures among some of the staff, particularly those who felt personally loyal to him. Balancing this would be a few who indicated they would deliberately remain in order to prove that they could manage and learn without Knight. It is in the former situation, however, that one might begin to see the real effects of Knight's teaching (according to Knight himself), that is, when his students would fly on their own, away from the wings of the master.

It does seem possible that the current remaining staff could continue to live out the management style and the paradigm initiated by Knight, but whether they could impart that style to others would be problematic although I suggest in section 3 that some other style for learning might be developed. One certainty is that without Knight, the process of learning would likely be much more consuming of time and energy (see the day care and loss of controls cases). The principles already developed would, of course, remain but the division's ability to generate new ones would be lessened.

Both Knight's usurption of policy decisions, his avoidance of conflict and the nagging ego syndrome might well be suggested as reasons for declaring that even those existing principles were not well imbedded in the staff's minds since they had little chance to develop them on their own and they were thus not held with the

conviction necessary for continued application should Knight depart. The evidence suggests otherwise however. Knight was willing to accept policy initiatives from staff even though final decisions were usually made by him. Nor was he unwilling to accept advocacy of independent positions; he simply stressed that once a decision had been made, divergent opinions and actions should cease and staff work to implement that decision. And, as I have suggested, the nagging ego syndrome was as much due to the division's distance from the field and the nature of medical technology as to Knight's policy control and would thus remain to some degree even after his departure. Additional direct evidence presented in earlier chapters also suggests the principles were held with conviction by staff; thus what the departure of Knight would mean would be that there would be no one to assess the relevance of each principle and to choose the "appropriate" one in situations of conflict. Thus, as I suggested earlier, the division's learning process and its application of existing principles would be more consuming of time and energy as the staff sought out a perhaps different learning style.

The issue of Knight's centrality then is one which cannot be completely assessed by examining this one slice of organizational space and time. I have suggested that others could operate the division's model, and even that it might endure and evolve without a strong leader. Possible problems arising out of his centrality were also assessed (e.g. the nagging ego problem and the "tenacity" of the principles). That centrality, however, is clearly of a different nature from that evident in the more conventional models since it did contribute to the

development of an effective system of learning.

h. The observations made in this section 2 are not intended to present a "rosy" picture of the medical division nor to suggest that its model differs entirely from conventional managerial models (e.g., the emphasis on a strong leader and a clear system of accountability is even suggested by the scientific school of administration of the '20's). They are only intended to serve two purposes. First, to suggest how the division's model differs from conventional "change" models (in its explicitness, its stress on accountability and its pragmatism) and yet avoids some of the stresses and disruptions of these models. And secondly, to suggest how other organizations implicitly desiring change, but legitimately viewing the crisis or guerilla models as inappropriate in their situations, can break out of the conventional bureaucratic model through a re-emphasis on a paradigm and associated principles and the creation of a climate of tolerance for style and for ambiguity in initial policy development.

The costs associated with the division's model could be assessed much more critically but it must be borne in mind that the division did fulfill two very important roles - it carried out its routine tasks competently under severe constraints and it did learn new tasks which were then routinized. Rather than assess in greater detail the "current" strengths and weaknesses of the division's model, a more fruitful area of inquiry would be the application of somewhat more stringent learning criteria to that model.

3. Extension of the Division's Model

I have suggested that the division's success in creating a learning organization cannot be adequately explained by traditional models.

I have also highlighted some of the sources of effectiveness of the division's model of learning and their associated costs. However, a reasonable rejoinder to that analysis might be that the organization would not endure under the stress of time or the absence of several conditions favorable to the installation of the division's model. Such a query is indeed a reasonable one and I shall attempt to address it in the section dealing with the durability and the transferability of the division's model, that is, its extension in time and space.

a. Durability

As mentioned in Chapter I, many authors have noted that while "learning organizations" have been created in the past and may even have done so without disrupting their routine activity, their durability is short-lived since their capacity to learn dies when the environment around them changes or when key staff leave. It was not feasible to observe the medical division for an extended period of time in order to test the durability of its learning model. However, speculation on that theme is possible and can be carried out by describing what the division might look like under three inevitable situations which will occur in the future.

1) The first is most simply the passage of time. Over time one might expect the distribution of resources in the division to be differentially made. In the early stages of the division we saw that there was a considerable feeling of equality since no staff had control over any particularly large set of disposable resources, many were able to work on pet projects, and all had equal access to Knight. But over time, these conditions will likely change. First, some staff will begin to (and already had begun to) acquire staff

members of their own. As Knight began to set priorities or as they were forced on him, this inevitably occurred. Thus the ambulatory care and nursing home units grew. Even the small HMO program had two people in it. While Knight was not one to play favorites, it seems inevitable that certain staff would acquire more status and be permitted more freedom to work on what they deemed important or on the more "interesting" projects. Similarly as Knight gained an understanding of the various programs and his staff and began to decide what he felt was important, access to him (another scarce resource) would begin to be differentially distributed.

What this differential distribution of resources might lead to is more internal "political activity". By political, I refer to those actions where people become protective of both their programs and their status - what are called their vested interests. As has been adequately documented (Downs, Tullock, etc.) internal action based on vested interests can be disruptive of any attempts at change, be they learning or otherwise. It is much easier, however, to assert that over time vested interests will develop than to assess the probability that resultant political activity (primarily manifested in resistance to change) will occur. Nonetheless, the possibility is there and it must be faced. Knight's only indication of the strategy he would adopt in such situations was that he would simply "try and be aware that such behavior exists and try to stop any distorted information that resulted from it." His demonstrated ability to cut out conflict would no doubt be helpful here and routine tasks would most likely still continue to be performed well; but the continued learning climate would probably lose some of its vitality.

2) A second inevitable condition is an increase in size of the agency. As we have seen, a considerable portion of the success of the division's learning centered on Knight himself. He was involved in all the new knowledge activities and the program for learning was a program that he and the staff acted out. The development of principles for use in those situations was also achieved primarily through Knight's teaching style. As the division grows in size (at this writing a size of anywhere between 100 to 250 persons was being considered by a new governor), access to Knight will inevitably decrease, the strength of that program for learning and the teaching style will be diluted while the philosophical agreement Knight sought so much will be harder to maintain. This is not to suggest that the division's routine activities will suffer, only that its ability to manage new tasks using the approach it had developed will, since inevitably most of those new tasks would be assumed by the new increment of staff, be ones who would be distant from Knight. Not even the utility of the informal matrix for socialization purposes (which was used in late 1973) will be repeatable, as size alone will prohibit that. Knight believed, however, that his"hiring powers were great" and that a sensitive use of these would enable him to carry on the mold of astute personnel selection and development. But a main component of that mold involved an access to him which could not possibly be maintained with increased size.

Increased size will also likely mean the addition of "staff" (as opposed to line) positions since it seems inconceivable that the legislature or the new governor (who had a strong research-planning-budgeting orientation) would vote new positions without adding several of these "staff" positions. Knight would undoubtedly seek competent

people for these positions but it seems likely that competent people in "staff" positions would develop crticial and independent positions. Knight's ability to handle this internal independence would be strongly tested.

The division did, however, have some qualities which would enable it to cope with an increase in size. The sense of unity of the members was high and the easy-going nature of most of them indicated that new members could well "absorb" that spirit fairly easily. In addition, if Knight were to permit new staff to "float", to watch others and "find their own slots" as he did with his initial cadre, this would bode well for a promise of continuity in style. It is also possible that given the overall competency of the staff, their actions without Knight might avoid that part of the nagging ego problems attributable to the strong role Knight played in policy development. Also important is the fact that many of the current staff have indeed learned many of the aspects of Knight's management style. As we saw that it was this style, applied to routine activity, which produced credibility and breathing room, there is no reason to suppose that an enlarged staff might not use this breathing room to create their own style of learning, perhaps one based on teaching, but perhaps not.

3) A third inevitability over time would be the departure of Knight himself from the organization. The probable effects of this have, however, been already discussed in section 2.g. and will not be repeated here. The conclusion remains the same though, that parts of the division's model (the principles and management approach) would likely be utilized less efficiently while the division sought a new learning style, one not inevitably based on teaching.

I have suggested that the durability of the medical division's approach to learning as it was constituted in early 1975 is problematic. I shall discuss in section 4 whether indeed that criterion is a too stringent one but before that, I will address the question of whether the division's model is applicable in other organizational settings.

b. Transferability

I have already alluded to the possibility of individual staff members transferring the learning model to other situations, but since the model essentially describes a whole system, it is more appropriate to consider the transfer of that whole system to other settings. A final consideration, one based on the criterion of the capacity of the division's model to transform itself (e.g., learn a different program for learning, or a different paradigm) will be addressed in section 4. What I am examining here is the possible applicability of the division's model, including a person like Knight, but not necessarily he, to other agencies such as, say, the DPW as a whole, or a non-human services agency (e.g., a department of transportation), or a purely regulatory agency (e.g., the FCC or FAA). My speculation will conclude that the model, as described here, would be considerably difficult to utilize in other situations. This is not to suggest that Knight or individual staff might not be successful in such situations, but only that the model's use in such situations should be understood with caution.

Consider the general situation the division found itself in - general environmental support, small but expanding size, a professional staff, a simple and non-revolutionary technology, no institutionalized independent power bases within the organization, and a mission to develop

policy rather than to deliver services. Let us examine each of these conditions and speculate on how the division's model might function if each of them were relaxed.

1) First of all, consider the general environmental support. While this support was not munificent, neither was it hostile. Much of the division's strength was based on the "integrity" of the program and its managers. If, however, the environment of the agency simply did not support the program or did not believe it to be worthwhile, then no amount of personal integrity would be sufficient to gain support. In such a case, it is likely that many staff, particularly those with the greatest integrity who would face the greatest frustration in such a situation would leave, not being willing to face provider or public abuse for too long a period. Nor would the style of a person like Knight be much help in an extrmely hostile political environment; first of all because that style basically avoided political "lobbying" or obvious "public relations" and secondly, since his principle style (teaching) is clearly not appropriate in such situations where hard-nosed confrontation is the norm.

Knight responded that this development of his former health center had been conducted in a hostile environment and that he could be hard-nosed, as his sanction activity had shown. Both his responses seemed to be true; however, his first success was in an environment which, while partly hostile, also desperately needed the services he was developing, while the sanction activity was not the bulk of the division's work. Had the sole function of the division been one of punishment and not one oriented toward policy development, I believe that the style of a person like Knight would not be effective.

2) Consider also the small but expanding size of the division and imagine how the division's model could be applied in a large and/or contracting agency. The relevance of a small sized organization has been discussed earlier in this section; we need only consider the fact of an expansion of activities here. Consider an agency being forced to cut programs and staff complement. The luxury of letting people "find their own slots" as Knight did, would likely not be available in such a situation and inevitably some staff would be squeezed into situations they did not prefer. Their openness to learning would be correspondingly diminished and possible conflictual situations would develop, situations which neither Knight nor his staff desired or handled well. Indeed one might even question the need to have a learning organization in such a sutuation. The most relevant factor in determining the model's applicability in such a situation would likely be whether task responsibilities were being diminished. With fewer people, a steady or non-diminished task level could maintain the learning style; with diminshed tasks, however, it is unlikely that either Knight or his kind of staff would react well to the potential of such "negative" learning, e.g., how to diminish their responsibilities.

Knight's response here was that he had stood up to a governor and HSA secretary when cuts in the division's benefit package were proposed and that should he be charged with diminishing the responsibilities of a particular agency, he could well go "the other way". Again there appears to be no doubt to this part of his response. However, I would doubt his ability to attract or maintain a competent staff of integrity in such a "cutting" operation. Since much of Knight's style was

ultimately translated through his staff, his ability (or indeed anyone's with a similar teaching style) to gain credibility in depth within such a diminished organization would be lessened.

3) The personnel the division utilized were all college educated, many with advanced degrees. Most were generalists and found pleasure in dealing with areas they were unfamiliar with. Indeed for many it was their first position of any responsibility. This combination of circumstances, in some cases deliberately created by Knight, produced an ideal situation not only for commitment to routine tasks, but also for receptiveness to new situations and to Knight's teaching style. Suppose, however, that an organization contained personnel, a majority of whom had been on the job a long time, who were not as well educated or who had specialized in their careers.

Such a typical organization might be the welfare department as a whole or perhaps any number of municipal bureaucracies. Knight's style would likely find much more difficulty in such situations, although if he could "buffer" himself from such a personnel system with staff that approximated those of the division, this would likely prove to be a way of at least assuring that there was one "layer" of learning somewhere in the organization. Knight responded here that "you've posed a situation that no one has yet learned how to deal with." In a sense this is true. The crisis and guerilla models have been the only "effective" models seriously shown to have any impact in such situations. Again it can only be stated that the division's model is thus no panacea and might reach its natural limits in such a situation.

4) The technology of the division (health care delivery) was relatively simple to master - witness Knight's success in teaching it

to his staff and the cynical comments of the one staffer with a Masters in Public Health degree that his formal education had not been of great utility. Similarly, that technology was not totally new nor was the technology, as a whole, threatening to the environment. Consider a situation where the technology of an agency was very complex (such as the regulation of nuclear power) or involved the injection of a brand new and threatening technology (such as air pollution control) into the environment. The former situation would require the greater use of specialists and professionals, much more likely to take positions independent from Knight and much more likely to seek support for their positions both inside and outside the agency. The second situation would likely produce a much greater level of political conflict between the agency and those with vested interests in the old technology. But these situations (internal independence and external political conflict) are ones for which the division's model does not take adequate account. That is, the strength of the division's style - an extraordinarily sensitive and personal teaching style - may also be seen as a weakness in situations of such sharp conflict.

5) Another situation in which such sharp conflict might arise would be if there were organizational units under a teacher like Knight, which whether through tradition or law, were able to maintain indepdn-dent power bases. For example, if there were other appointed civil service levels below Knight or if resources for specific programs (i.e. staff, funding, etc.) were either strongly controlled by the legislature or a federal agency or simply seen as the "property" or an outside constituency. Examples might be the Rate Setting Commission where many of the civil

service staff were seen as being "owned" by the nursing home industry or by Blue Cross, an educational institution with a legitimate and decentralized decision-making system, or a branch of a state highway agency whose strength lay in its ability to bring federal dollars into the state irregardless of what an appointed commissioner might desire. All these situations would produce conditions in which such units would be unreceptive to Knight's teaching style and which he would avoid, given his wariness of areas he could not hold accountable. Thus the effectiveness of the model would be lessened although in Knight's personal case he would likely not even create such a problematic situation by accepting a long term appointment to a position with too many independent power bases within the organization.

6) A final condition which might be relaxed in testing the transferrability of the division's model would be the emphasis on policy making as opposed to production of goods or delivery of services. Suppose the organization in question was one which required that the top executive concentrate mainly on the production of routine, detailed goods or services, say a manufacturing plant, or funds collection for a charitable organization. Knight himself did not appear to be terribly interested in the day-to-day details of such operation; he preferred to be building an organization. While this is a personal quality of Knight, it is probably necessary that a model like the division's be directed by a "builder" and not a "detail man". Thus there is some doubt as to whether that model could be useful in such a production situation. Much would depend on Knight's ability to maintain linkages with, and retain people, who were proficient in this detailed style of work. In one sense the division's <u>model</u> would find easier application

in such a situation since philosophical agreement could be as easily achieved while the possibilities of both conflict and the nagging ego problem would likely be diminished. In some situations, however, this concern with production organizations might be a "straw man" in that such organizations may not even need to be learning organizations - but this will be discussed in the next section.

Thus it seems likely that, given a wide variety of other organizational situations different than those found in the medical division, the applicability of its model to these situations would be problematic. This conclusion that the success of the model in other situations is not assured is, of course, speculative and I do not wish to cloud the obvious strength of the division's approach, only to alert those who might attempt its wide scale transfer to the problems they might face in such a transfer.

We have now asked whether the division's learning model could maintain itself over time and whether it could be transferred to other settings. A concluding question centers around whether the division's model allows for its self-transformation.

4. Conclusion

I suggested (in Chapters III through V) that criteria for a learning organization included the development of new policies, their routinization, the development of general principles and then the development of a program for action, a program for learning. I then showed (in Chapter VI) that the medical division had met those criteria and that it had done so using a particular approach.

Might we then not suggest that that approach, since it was clearly successful in creating a learning organization at levels up to my

fourth level (the program for action), be advanced as a criteria for a successful learning organization. The case study method used here probably prohibits against such an assertion. All that can be said is that the model developed is one effective way of creating a learning organization. There are some elements of that style which appear to be very powerful - particularly its teaching element and the use of the paradigm - but here we are a prisoner of the methodology.

If we believe (and the methodology does not disprove it) that there are possibly other methods of creating learning organizations, then we might well ask the question, could the division's model transform itself into one of those other models, i.e., could the division change what I have called its overall approach consisting of the teaching and management styles and the use of a paradigm. One might first suggest that ability to transform that style would be a criterion of a successful learning organization, particularly since at this stage, knowledge of what constitutes a "good" learning organization is very unclear and an approach successful in one situation may not be in another, as I have suggested in the previous section. Thus, one could evaluate the division's learning using this criterion. Could it, for example, shift from a teaching style to one based on a technocratic, comprehensive/rational model as suggested by, say, Beers or Churchman? Could it change its style to one involving an "organizational development"mode, or could it become much more political? Or could it transform its style into something as yet not well described, some newer model still to be invented?

One way to explore the utility of this criterion for the division would be to examine the behavior of the division's staff members in

situations not involving Knight. However, we saw that there were very few of those situations in the period we examined and we could not, for practical reasons, follow the careers of staff members as they moved through other organizations. One could also imagine other methods for exploring whether the criterion of self-transformation of style is a useful and generalizable one (such as an examination of the organization that had changed its style with the same personnel) but neither of the above methods could be applied here. Thus for the purposes of this study, such an exploration must remain unfulfilled.

But a more interesting criterion would involve asking whether the division could change its own paradigm or mission. On the one hand this seems to be a more complex and demanding criterion than that of simply changing the division's approach to learning as discussed above. For example, could the Corps of Engineers add an ecological perspective to its primary, existing entrepreneurial/exploitative paradigm? Could the Department of Transportation adjust its prevailing highway mentality? Yet in the division's case, that question is actually less demanding than the one based on its changing its style.

That is, I suggest that both the very learning capacity built into the division and its explicitness would permit it to change or adjust its paradigm if necessary. Thus the paradigm, while strongly held by the division, had strong roots in a learning system of which it was only a part. While a paradigm was necessary for that system to succeed, the exact nature of it was not. In organizations which neither have an explicit paradigm nor a method for living out the paradigm and for integrating new knowledge inputs with that method, then the difficulty of changing that paradigm is considerable since

the paradigm may be the only feature shared by the organization and a feature to which it clings tenaciously. What I am suggesting is that the very depth of the division's learning system permits it to change a paradigm since it is not wedded to that particular paradigm.

The value of the explicitness of parts of that learning system and of the paradigm (and the conjuncture of the two) may also be seen here. In organizations where either (or both) the system and the paradigm are tacit and/or in conflict with each other, it would appear that energy which might otherwise be devoted to a necessary paradigm change would be devoted to either identifying it's current "learning" style and paradigm or reconciling differences between the two. It seems, then, that the division's model is one which might well be able to "self-transform", that is, change its very paradigm should that be necessary.

But I believe that that criterion, along with the earlier criterion of transformation of the division's learning approach are much too stringent ones. While I would not wish to preclude others from applying such criteria, it is the reason I have done so only summarily here. If we refer back to sections 2 and (primarily) 3 where we discussed some of the limits of the division's model, it is clear that most of those limits were not limits in the situations in which the division found itself, but rather reflected some presumed inability of the model to deal with all organizational situations. From this observation I suggest that the application of such a stringent criterion as ability to self-transform (change its style or paradigm) in order to confront all possible situations is likely to produce findings that very few organizations can meet such a test.

The call for a universal learning model which I referred to in Chapter I can now be seen as containing three perspectives - the first of which we have just discussed - namely, that an organization learn not just at one level (e.g., developing new tasks) but that it learn at many levels, including changing its very approach or paradigm. Its two other perspectives are 1) that all organizations be learning organizations, and 2) that they be so at all times. This calls for such a universal model for organizations is not surprising. The meager history of organizational theory has shown that such unrealistic solutions are not uncommon (e.g., the "scientific" administration of Taylor, the human relations school). However, later work in the "contingency" school has suggested that differing organizational models are appropriate in differing situations. The two most clear formulations of this approach are by Burns and Stalker and Lawrence and Lorsch.

Burns and Stalker's distinction between mechanical and organic organizations is a powerful one but needs to be extended to include a wider (non-binary) variety of situations. Lawrence and Lorsch tacitly recognized this when they suggested that the structure and performance of an organization is related to the degree of uncertainty in the environment. Even the literature describing the crisis and guerilla theories of change seem to recognize the need for a spectrum of organizational models since, for example, neither of those two theories corresponds to a pure mechanical model, nor to a pure organic one but rather to a third type, one grounded in a turbulent environment. Other appropriate prototypes for turbulent environmental

situations have been described as organizations headed by a charismatic leader with highly centralized authority but using few formal rules and a flat hierarchy - in effect a mixture of the mechanical and organic organizations (the former utilizing centralized authority, many rules, and a steep hierarchy with the latter using decentralized authority, few rules and a flat hierarchy).

What I am suggesting here is not that any one of these models is "the" appropriate model for organizational change but that a wide variety of models seems appropriate and that that variety is one which should be based on a match or "fit" of organizational models with environmental conditions. Thus the degree to which all organizations should be "learning organizations" would be seen to be dependent on the organization's environment. From this assertion, an admittedly less idealistic and universal search for learning organizations would be that search for situations in which particular change or learning styles are evaluated as being well suited (or not) to particular environmental situations.

Earlier I suggested that the criterion of self-transformation might be too stringent - is not performance of the organization's routine tasks and learning at the first four levels I have described enough. The reason I suggest that that criterion may be too stringent lies in an examination of the latter two perspectives (pg470) of the call for a universal learning model. That is, our society (the environment) does not "require" all organizations to change their tasks, much less to change their approach or paradigm. Even when both society and the organization agree on the need to change and learn, their joint need and ability to cope with such learning follows cyclical patterns over time.

First of all, take those organizations which need not become learning organizations. Since organizations are mechanisms designed by men to achieve certain ends, some of those ends must inevitably be routine, non-changing over a long period of time. Many production organizations such as factories or even some white collar organizations such as insurance companies perform such tasks. While one might occasionally here cries questioning the "ultimate" purposes or consequences of large factories or insurance companies, once the purpose of that organization is accepted, then the need for it to carry out those functions efficiently and to do no more than that seems to be recognized. Society does not ask that insurance companies become learning organizations. Indeed, to attempt to force a learning style on such an organization may well be as disruptive of the organization's routine activities as those situations where change is required and it is effected only through the crisis or guerilla models.

Secondly, there seems to be an organizational parallel to human learning, that is, that organizations need periods of reflection where they absorb the learning they have just completed and come to internalize it. Since organizations are composed of individuals (who also appear to need such periods), this is not surprising. In addition, there may be more systemic reasons for the cyclical ability of organizations to absorb and manage new knowledge. As Schon has described, ideas and thus a mandate to use them, come into good currency in some sort of cyclical fashion. Ideas about any one organization's task area may only fit into this cycle, i.e., hold society's attention, once every 5, 10 or 20 years. The public's ability to focus is not unlimited and given this, it is not surprising that environmental demands for change come infrequently to a particular organization.

In addition there is the increasing problem of public accountability. This is a significant problem since many of the proposed and existing methods for creating learning organizations rely on being somewhat shielded from the public view e.g., the guerilla model or even the more mainstream model in which (as described by Wilson, Rhenman, etc.) the rate of innovation is controlled by elite or centralized authorities. Since traditional bureaucracies are conceived as uncontrollable (Downs, Tulloch, V. Thompson, Nelkins, etc.) and thus unaccountable, grafting on of a somewhat inherently "subversive" learning paradigm without an attendant accountability paradigm may be viewed as socially irresponsible.

Even if an organization attempted to force it's own ideas of what was an"idea in good currency"on the public, the ability of the public, in the form of legislators, the press, academics, etc. to evaluate and monitor that learning is limited. Not only do these public bodies have limits of scope, but much of the product of such learning activities requires considerable periods of time for such outside bodies to become familiar with and to fully evaluate. Recall that this was one of the stronger points of the medical division's model - its balance between accountability and change held by both Knight and staff. If, in an age of increasing complexity, we believe in public accountability, then not only the extent, but also the pace of learning may have to be somewhat less rapid than that called for by some idealists.

Thus we have seen that it is possible to create a "learning organization", one which can develop an approach to learning, succeed in the application of that approach and yet avoid many of the disruptive effects commonly found in other methods of change, methods which we

would hesitate to call learning. Thus, the model developed here is an example of the learning organization sought by those who either wish to avoid the weaknesses of the crisis or guerilla models or who do not possess the types of resources that the normative alternative models require.

Nonetheless, the division's model does have some inherent costs or limits, which I have discussed. The significance of its success was also assessed by examining the possible range of circumstances in time and place to which it may be applied. We saw that that range is a restrained one even though the possibilities of its eventual self transformation appears to be bright. But I have suggested that an application of excessively stringent criteria (such as ability to self transform) in assessing what constitutes a true learning organization may be both unproductive and unnecessary. From this same perspective, even the criteria I examined in section 3 (universality in time and place) may be too stringent. Thus the obvious success of the organization combined with its (speculated) difficulty in meeting such stringent criteria for learning suggest that completely "self-renewing" organizations are extraordinarily difficult to create and that the search for such pure and universal models is a vain search since the environment does not require that all organizations in all circumstances be perpetual learning organizations.

If the viewpoint that organizations are not simply rudderless units shaped by their internal social structures or whose behaviors are fully explained by molecular analogies (such as systems theory) is accepted, then one need not return to the mechanical views of Taylor or the organic but paternal views of Barnard to assert that organizations are at least partly goal-directed bodies. Thus they may more

profitably be seen as tools in the service of these goals - whether generated by the environment, by organization members or more frequently by a combination of the two (Perrow). This implies that they are not always like individuals, who may seek such learning for its own sake. Thus the normative search for models of organizational change might more profitably be directed away from its implied analogy with the "ideal" world of the highly educated individual, always craving new knowledge, to a more subdued search which would not yet seek those organizations which might self-transform, i.e., change their very methods of learning. Rather it would stress how any such models developed dealt with the organization's "fit" with environmental conditions. Such organizations would accomplish their routine tasks and learn only when required to by specific environments and public.

Such a search would, first of all, recognize that an exploration of how such "requirements", i.e., organizational goals, are formulated and transmitted need be a necessary area of that search. That exploration has regretfully been minimized in this study. However, such a study conducted by others might be more politically oriented and would examine how organizational goals are generated and diseminated by usually small clusters of individuals inside the organization or from a specific,limited section of its environment.

Such a search would then be directed towards mid-level, case study explorations of organizations (such as this study) which examine <u>actual</u> learning alternatives to the "crisis" or "guerilla" models, but still alternatives within a goal achievement framework.

The language developed in this study to describe several levels of learning might then be applied to assess whether those putative

learning organizations met those restrained criteria. The levels of learning described in this text may well be found to have a more general applicability as criteria for learning since they are intuitively appealing, are logically consistent and have been useful in describing an actual learning system. The manner by which the medical division met those criteria might also serve as useful sources of inquiry or experimentation by both researchers and practicing managers.

APPENDIX A

The Ultimate Purpose of the Division's Learning

I have described an organization which learned to successfully develop new policies and tasks, to routinize them, to develop more general principles of health care delivery and a program for learning these principles. It did so with a relatively unique style consisting of teaching, en emphasis on management and a strong organizational paradigm. But the analysis here gave little consideration to the ultimate effect of all this activity - did clients receive better health care through the methods developed by the division in its response to situations of new knowledge. The underlined phrase is significant since I have made no attempt to assess the Medicaid program in general, only to discuss how it managed new knowledge. Nonetheless, the ultimate effect of those new policies on providers and clients outside the division should and can be explored. I do not intend to make a comprehensive assessment of the division's effect on the health care system and on the health of its clients. That would necessarily be the subject of another complete and lengthy report. Thus, while such an exploration is not a major thrust of this work, the researcher feels a responsibility to respond to the reader who legitimately asks to what end was all this learning devoted.

Some of that exploration did already take place. The evaluation of the division's own members as to its ultimate effect has been discussed in several places, including the references to the nagging ego problem. In addition, in each of the individual cases I have described how particular providers, agencies or clients dealt with the division and their general attitude of cooperation or acquiescence in the situation.

Those descriptions alone indicated that those most specifically involved viewed the division's actions as making adequate progress toward the goal of improved health care. A third evaluative source might be more generalized members of the division's environment, ones who might be expected to make a more dispassionate and macro-level assessments of its performance.

As indicated in Chapter VI, section 5, it was difficult to find well informed members of the health or welfare communities. Those that were identified did not place particular stress on the specifics of each of the cases of new knowledge described. Indeed, most of them were not even aware of what had transpired. Instead they offered evaluations of the division's general processes or spoke to the performance of the division in its routine activity. None were concerned with "learning" by the division. They first of all placed stress on the increased credibility the division had acquired. This has been described in Chapter VI and its role in giving breathing space suggested. However, they were concerned in general terms with some new services, with monitoring activities of the division and with some aspects of the division's internal administration, all areas which I have described in the specific cases.

First, the new services. The outside observers, if they had any comment on new services development, dealt with issues such as - is the state out of compliance with federal regulations, or will the new service bring more federal dollars into the state. These issues particularly concerned the legislature. Few were concerned about the ultimate effect of the new services on clients' health or indeed even knew about the services. Even the citizen's advocacy group in the EPSDT

case seemed to base its criticisms more on the fact that the state was not following federal guidelines, despite the fact that some ten or so of the other richer industrialized states were also involved in battles over the appropriateness of the guidelines.

The division's monitoring activity, or "gaining control of the program" (of which sanctions was one method)was a highly political arena. As suggested in Chapter II, most providers simply wished the division would not interfere with its work. Federal officials felt that "he has achieved, to a degree, a better climate of control over the general administration of the program." Others felt that credibility was the key - "people won't play ball with you unless you monitor well...There's some indication he's doing that well... with the drug and dental contracts..and with sanctions; although the hospital sanction case was a proprietary hospital so everyone could say 'we're not like that.'" These vague and general comments indicated that any real and precise effects of the division's monitoring could not be felt until phase II of the computer control system (see loss of controls case) came into operation and more sanction activity could be undertaken. Only then would the political impact be felt as providers began to question the right of the division to muddle in its affairs.

The internal administration of the division concerned the providers only as they saw its product, that is, a check in the mail. Their actual fees were seen as being adequate;therefore they cared primarily about how their claims were processed, that is, the amount of paperwork they had to do and when or whether they got paid. The president of the medical society said that "bills are now paid promptly if they're filled out properly. There has been great progress in this area."

The problem of possibly not getting paid at the end of each fiscal year came around was a real one for providers, but as one hospital official said, "most of the sophisticated providers know this is the legislature's fault and not Medicaid's" (i.e., for not voting enough funds). But "unsophisticated" providers remained vocal and Knight never "went public" on this problem - that is, he never developed a public strategy of wiping that potential blemish from his credibility. He did, however, respond eagerly to individual inquiries from providers and, with a new commissioner, began to become more involved with establishing relationships with the legislature. But much still remained contingent on the results of phase II since accurate budget requests were difficult to develop unless a sophisticated information system was in operation.

Thus, other administrators and providers in the division's environment either 1) were not aware of what the division was doing in the realm of new activity or 2) focused in on very specific aspects of that activity that concerned them, or 3) evaluated the division on very global grounds, such as increased credibility.

Nor was the client segment a much better place from which to judge the effect of the division's learning. The technology for evaluating whether, say, EPSDT was having a real effect on child health was a primative one, much disputed, and Knight distrusted the academicians and analysts ("Public Health types") who might conduct such evaluations. But he had no money to do so himself and there remained the larger question of whether any financing mechanism could effect the quality of care or the way it was delivered to welfare clients. In other states this would be easier to evalute since, for example, a raising

of fees might be followed by increased utilization or an addition to the benefit package could almost a priori be considered favorable for clients. But the program in this state had operated for several years in a favorable environment of a large number of providers, adequate fees and a comprehensive benefit package. Thus it is difficult to assess Knight's particular contribution to the situation other than on process grounds such as credibility, monitoring, etc.

But the clients themselves, might not they feel the effects of removing shoddy doctors or paying for 442 evaluations for their retarded children? How would they evaluate the division's progress towards the four goals of quality services at cost effective prices in an equal and accessible manner? Many studies have indicated that patients have considerable difficulty in judging whether they are receiving quality care. The welfare recipient is, in addition, usually at a cultural and educational disadvantage. Rather than make this kind of evaluation directly, Knight chose to approach it by developing credibility such that providers would offer at least as good care as they did to anyone else, primarily middle class citizens. Once having achieved that credibility he could then begin to impose conditions (i.e., division regulations) and monitor their implementation. The question of access to care is also difficult to evaluate. The clients' prime source of information on the program was the local welfare offices and these were perceived as being generally unreliable by both the division and clients. Thus the division's alternative was again to deal with providers to assure that they would be receptive to seeing Medicaid clients - since most of these clients knew, at a minimum, that they were eligible for some type of medical care.

The criterion of cost was, of course, irrelevant to the client since he paid no fees at all. Cost was only relevant to the bureaucracy and here evaluative material was lacking. The state had, until 1973, not produced the kind of data which could be adequately compared with other states. When such material was finally produced, it was barely comparable since the benefit packages and client mix varied widely from state to state. Even Knight's general strategy of stressing ambulatory care to reduce institutional costs would take several years before effects could be seen. As one observer said, "that's not something you do in one or two years, much less overnight."

All this lack of immediate output criteria for evaluating the program nonetheless worried the division. As Knight said, "that means if we could fake the integrity or credibility, we could get away with a lot - that's really scary, isn't it?" The staff worried too as I have described in the earlier discussion of the nagging ego problem. Knight's personal response was to continually stress the paradigm since he knew it to be right and to feel confident that, since he had been a provider, he could place himself in the providers' shoes and evaluate his own performance from that role. The staff also lowered their level of uncertainty by believing in the paradigm and by seeking involvement in policy development, irregardless of the quality of evaluative material which could be gathered from the vague and/or unconcerned members of the division's larger environment of clients and the general public.

The the ultimate effect of the division's actions remain unclear since any rigorous assessment was either impossible to make or was simply not conducted by the division or by its environment. What I

have tried to indicate is that when the medical, welfare or political environment of the division even bothered to evaluate the ultimate effects of the "black box" which was the division, it did so using process, not output, criteria and even then did not apply these criteria to the learning going on within that black box, but rather to the division's routine activity. While the lack of output criteria may be unavoidable in situations like this (Rien and Weiss), the general, even inappropriate, process criteria applied to the division are light years away from a more rational evaluation of policy development such as suggested by say, Dror.

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