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An exploratory study of market strategy configurations in for-profit health care clinics

Mick A. Sheppeck Ph.D.

University of St. Thomas - Minnesota, masheppeck@stthomas.edu

Jack F. Militello

University of St. Thomas - Minnesota, jfmilitello@stthomas.edu

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AN EXPLORATORY STUDY OF ORGANIZATION DESIGN CONFIGURATIONS IN HEALTH
CARE DELIVERY ORGANIZATIONS

Author(s): MICK SHEPPECK and JACK MILITELLO

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AN EXPLORATORY STUDY OF ORGANIZATION DESIGN CONFIGURATIONS IN HEALTH CARE DELIVERY ORGANIZATIONS

MICK SHEPPECK
JACK MILITELLO
University of St. Thomas

ABSTRACT

Organizations are configurations of variables that support each other to achieve customer satisfaction. Based on Treacy and Wiersema (1995), we predicted the emergence of two configurations, one supporting a product leadership stance and one predicting the customer intimate approach from a set of 73 for profit health care clinics. In addition, we predicted the emergence of a configuration where the scores on most variables were near the mean for each variable. Using cluster analysis and discriminant function analysis, we identified three configurations: one a "master of two" strategy, one "stuck-in-the-middle," and one showing scores well below the mean on most variables. The implications for organization design and manager actions in the health care industry are discussed.

INTRODUCTION

Work organizations are open systems whose components interact to produce a whole entity, i.e., a configuration. As noted by Lei and Slocum (2005, p.31), organizations "constitute configurations of mutually supporting parts that are organized around stable themes or strategies." In other words, organizations function as complex systems comprised of interdependent sub-components that are best understood when treated holistically (Ackoff, 1981).

Health care has been one of the most dynamic industries in the U.S. from the 1980s to the present

resulting from extreme pressures to control health care expenditure growth (Clifton, 2009) and dramatic public expectations regarding clinical quality and patient care (Lega and DePietro, 2005), requiring changes in organization strategy and structure (Bazzoli, Shortell, Dubbs, Chan, and Kralovec, 1999; Ginter, Swayne, and Duncan, 2000). At the same time, Lega and DePietro (2005), focusing on large multispecialty hospitals in industrialized countries, noted the paucity of research dealing with organization design in hospital settings. They note that as these organizations developed, they assumed a skill-based structure built around discipline-based specialties that permitted the growth of specialized knowledge in the various clinical disciplines and power alignments between the various units. However, as external pressures intensified, changes were required in how medical delivery organizations integrated in a macro sense and the continued evolution of coordination between physicians and administrators toward a more patient-focused organization (Lega and DePietro, 2005).

Designing organizations is a complex and divergent activity. According to Greenwood and Miler (2010), a design tends to impact the manner in which market strategies are formed and how those strategies will be implemented. Only those designs that are appropriate given the organization's external environment are likely to successfully manage resources to achieve competitive advantage.

Studying organization design in health care delivery organizations is especially difficult due to the realization that these organizations are what Rouse (2008, p.18) termed "complex adaptive systems." Such systems possess the following characteristics.

- They are nonlinear and dynamic often without achieving a state of equilibrium.

- They are composed of independent agents who often operate outside the fixed rules of the organization.
 - The goals and behaviors of various stakeholders are often in conflict.
 - The agents within the system are intelligent: they learn and show new behaviors over time.
 - Patterns of behavior tend to emerge over time rather than being inherently designed into the system.
 - It's often difficult to identify a single point of control.
- In other words, broad sets of organizational variables are needed to model the various interactions that comprise a successful organization in the marketplace (Ketchen, Combs, Russell, Shook, Dean, Runge, Lohrke, Naumann, Haptonstahl, Baker, Beckstein, Handler, Honig, and Lamoureux, 1997).

STUDY PURPOSE

Our research question is: utilizing general systems and configuration theory is it possible to delineate organizational configurations in health care provider organizations focused on the Treacy and Wiersema (1995) trio of market strategies (operational excellence-OE, product leadership-PL, and customer intimacy-CI)? These configurations are supported by a broad array of organization design variables (Greenwood and Miller, 2010) and identify the relationships of the configurations to market performance. We recognize that this study can only be exploratory due to the size and the convenience nature of the sample.

However, we believe this project adds to the health care market strategy and organization design literature in two ways. First, we are not aware of other studies in which the Treacy and Wiersema market disciplines (1995) were used to measure market strategies in health care clinics. In addition it is our intention to introduce to health care

organizations a new framework for strategic thinking that goes beyond the neoclassical economic theories which currently dominate health strategy development (Wells and Banasak-Holl, 2000). Our approach places market strategy at the center of the configurations being developed (Becker, Huselid, and Beatty, 2009). Second, by using a larger array of variables than is typically found in most configuration studies, we hope to optimize the chances of identifying empirical configurations that are currently being used in the health care delivery industry (Ketchen, et al., 1997) and measure their association with market performance.

The Alignment Concept

Competitive advantage in an industry comes from a firm's ability to consistently create and deliver value to its customers (Chan, Shaffer, and Snape, 2004; Roberts, 2004). Configuration theory has a long history in administrative and organizational science focused on producing competitive advantage. Early works such as Burns and Stalker (1961), Mintzberg (1973), Miles and Snow (1994), and Porter (1985), tested various approaches to organization configurations, especially focusing on the role of strategic groups in differentiating among organizations. These studies were predicated on the notion that some organization configurations fit better (in a given environment and industry at a particular point in time), and thus lead to greater financial and/or goal-based success.

Firms seek to seamlessly align their external brand with their internal operating practices/assets (Kaplan and Norton, 2006). Organizations that use configurations in this manner hold a clear place in contemporary business lore. For example, Starbucks aligns the values of its employees regarding customer engagement, friendliness, work schedule, and participative work design with the customer's desire for a comfortable and friendly "third place." In general, managers understand the value that the alignment

of specific components into a clear configuration provides in the marketplace and the probable costs of non-alignment.

Until the mid-1990s, much of the published literature regarding organization design in health care delivery organizations dealt with case studies focused on a small number of organizations. While rich in content, little in the way of empirical results were available. However, in a study conducted by Bazzoli et al., (1999), data taken from the 1994 and 1995 American Hospital Association Annual Surveys for hospital-led health systems was used to cluster organizations using the three macro variables of: centralization (activities taking place at a central versus dispersed sites), differentiation (the number of products/services available to patients), and integration (mechanisms used to achieve coordination across organizations). The clustering was completed within two organization types, hospital-led health systems (all organizations owned by a single entity) and hospital-led health networks (organizations owned by different entities but working in collaboration). The results showed reliable cluster solutions within both organization types that were primarily focused on differentiation and centralization.

A follow-up study (Dubbs, Bazzoli, Shortell, and Kralovec, 2004), using data from the 1998 version of the American Hospital Association Annual Survey of Hospitals and focused on hospital-led health systems, found results that were similar to the 1994 results but with the emergence of additional new strategic/structural combinations. These results showed both the stability and the emergent nature of the organization clusters over a four year period.

RESEARCH VARIABLES

Organizational researchers have attempted to identify the variables and configurations associated with organization market performance. For a configuration to

be postured strategically, it must provide a means of gaining and sustaining competitive advantage for a firm in its markets. For the purposes of this project, we chose to focus on the following broad variables: an organization's environment, market strategy, organization culture, employee capabilities, workforce practices (including senior management perspective regarding employees), and business processes. The centrality of these variables for organization success has been strongly advocated by numerous authors (Chan, Shaffer, Snape, and Collins 2001; Roberts, 2004; and Skrinjar, Stemberger, and Hernaus 2007).

Variables

Environment. Success in an organization's marketplace starts with an understanding of the external environment leading to a response to shifts that occur within the environment (Ginter, Swayne, and Duncan, 2000). A significant feature of an organization's operating environment is its degree of market volatility (Miller, 1987). In other words, an organization's environment plays a critical role in its success by establishing both constraints and opportunities that require identification and then appropriate adaptation.

Market strategy. The concept of market strategy is a central element in management practice focused on the marketing concept. It is presumed to contribute to long-term competitive advantage and sustained profitability (Porter, 1985). An organization's market strategy determines how to best add value for the firm's customers.

National health policy as directed by the Affordable Care Act (ACA) demands that health care organizations open themselves up to market forces. The goal is that providers establish brands which differentiate themselves from others in their marketplace. In addition, medical

tourism and regional expertise have expanded the range of service venues. Marketing is now entering the arena of contemporary health care management like it never has before and competition of service delivery organizations will continue to develop unabated (McLaughlin and Militello, 2011).

Based on their observations of successful organizations across multiple industries, Treacy and Wiersema (1995) identified three generic market disciplines: OE, PL, and CI. The OE (*best cost*) approach attempts to achieve a low cost of goods sold and thus low prices delivered to customers. On the other hand, the PL (*best product*) discipline includes organizations that are first to market with new or upgraded products/services or the movement of products/services to new markets. Finally, CI (*best solution*) firms utilize a discipline of providing tailored solutions to customer needs at a premium price. We used these market disciplines to represent the generic market strategies in this study.

Organization culture. Corporate culture is the pattern of shared beliefs and values that develop over time within an organization, is viewed as “correct,” and is taught to newcomers as the appropriate way to behave in the organization (Sorensen, 2002). Successful companies, in general, exhibit strongly held cultures (Schein, 1985) that are appropriate to their industries and specific markets. As noted by Chan, et al., (2004), the combination of organization culture and human capital appropriate for a firm’s industry provide organizations with the necessary capabilities to rejuvenate their resources in line with changing market conditions. Organization culture serves to allocate and leverage resources to achieve firm goals by directing rituals, employee behaviors, management systems and planning actions to focus on competitive goals (Barney, 1985; and Ginter, et al., 2000).

Finally, organization culture possesses an inherent tacitness, complexity, and firm specificity that makes it very difficult to imitate by competitor organizations and so offers high potential for creating sustainable advantage (Barney, 1985). Without the support of an appropriate culture, management systems and workforce practices would not function at their fullest potential (Chan, et al., 2004). Aligning organization culture with market strategy is an essential but often neglected practice in organizations.

Employee competencies. Collins reminds managers that in good-to-great organization transformations, people are not the firm's most important asset; the right people are (2001). The resource based view perspective (RBV) posits employee competencies as a key intangible resource that drives a firm's market performance and competitive advantage (Barney, 1991). The need for specific employee competencies emerges as a function of both a firm's particular market strategies and the industry in which the firm operates (Becker, et al, 2009; Hitt and Ireland, 1985). There is growing realization that achieving sustained competitive advantage through workforce capabilities depends, in part, on the inability of organizations to understand and imitate competencies found in competitor organizations (Barney, 1992).

Failure within a firm to recognize and act upon the value of workforce competencies may have serious repercussions, particularly in knowledge-based organizations, on a firm's capability to compete long-term in its markets (Arthur, 1996). Finally, Campbell, Coff, and Kryscynski (2012), point out that employee knowledge and skills may be central to a firm's resource-based advantage in the marketplace.

Aligning employee competencies and organization culture with market strategy is essential to a firm's competitive advantage. For example, the OE market

discipline calls for employee competencies and a culture that reflects efficiencies. The PL approach needs innovators and a problem solving culture. The CI discipline demands good communication skills combined with a customer-oriented culture. In other words, the firm's market strategy and culture should align with employee competencies and workforce management practices to serve customer needs (Beatty, Huselid, and Schneier, 2003).

Workforce (HR) practices. The past two decades have seen an explosion of research dealing with strategic human resource management (SHRM), i.e., the impact of valuable and rare human capital and the alignment of workforce practices into bundles that support a firm's market strategy to achieve market success (Becker and Gerhart, 1996; Combs, Liu, Hall, and Ketchen, 2006). Workforce practices affect organization performance by increasing employees' knowledge, skills, and abilities, by empowering them to utilize their capabilities for the firm's benefit, by increasing employee motivation to contribute to the firm, and by impacting the firm's internal social structures to aid flexibility and coordination (Combs, et al., 2006).

Combs, et.al, (2006) identified via meta-analysis the workforce management practices that have the greatest impact on a firm's market performance. These include: incentive compensation, training, compensation level, participation, selectivity, internal promotion, HR planning, flexible work designs, grievance handling procedures, teams, information sharing, and employment security arrangements. They found that these practices impacted both operational and financial performance measures and that the effects were stronger in manufacturing than service organizations. In this study, the workforce practices

identified by Combs, et al., (2006) were used to represent the workforce practices construct.

We also identified the leadership construct of senior management support for human capital as an important variable within the overall set of human resource practices utilized by the organization. Results from a Society for Human Resource Management/Commerce Clearing House study showed that this variable influenced the relationship between organizational strategy and the outcomes of organizational productivity and market/book value (Human Resource Management, 1995).

Business processes. Finally, all organizations are engaged in processes designed to obtain market intelligence, convert information into products/services, and deliver the organization's output to customers (Roberts, 2004). As noted by McCormack and Johnson (2001), the management of an enterprise means the management of its processes. Childe, Maull, and Bennett (1994, p. 24) defined a business process as "a series of continuous actions or operations which are performed upon a commodity. It may also be regarded as a conduit along which a commodity flows." It is a horizontal flow of activities designed to accomplish a specific objective within the firm. Finally, the alignment of processes into a unified whole has been viewed as a source of competitive advantage (Kaplan and Norton, 2006).

Market performance. The dependent measure is a business-oriented self-rating based, in part, on Quinn and Rohrbaugh (1983), and containing the following elements: ability to obtain capital, performance of fixed-assets, acquiring resources for operation and growth, performance of the organization's technology, level of financial performance compared to competitors, and occupying either a #1 or #2 position in the market.

HYPOTHESES

We chose to focus on the following broad variables: environment, market strategy, culture, workforce competencies, workforce (HR) practices, and business processes. The specific scales found in each broad variable together with their factor analysis results are presented in Table 1.

Our hypotheses were generated utilizing the theoretical configurations suggested by Treacy and Wiersema (1995), OE, PL, and CI, and by the theoretical assumptions of O'Toole and Lawler (2006) and Sheppeck and Militello (2008). Collectively these authors note that a firm must have distinct points of differentiation in its markets and that market strategy, culture, workforce competencies, workforce practices and business processes need to be aligned for the firm to experience above average performance. The hypothesized rating levels for our set of 22 scales for each hypothesis are shown in Table 2.

Table 1
Scales Under Each Broad Variable

<u>SCALE</u>	<u># ITEMS</u>	<u>EIGENVALUE</u>	<u>ALPHA</u>	<u>MEAN</u>	<u>S.D.</u>
Environment	14	8.14	.83	3.76	.86
Market Strategy					
Product Leader	6	4.77	.77	4.00	1.12
Customer Intimacy	8	2.24	.71	4.27	1.08
Oper. Excellence	5	1.52	.66	4.67	1.17
Competencies					
Creativity	8	9.40	.87	4.00	1.14
Efficiency	7	4.05	.88	4.85	.91
Customer Solution	9	1.44	.90	4.86	1.03
Culture					
Information Sharing	7	7.60	.83	4.56	1.13
Risk Taking	5	2.71	.82	4.00	1.53
Teaming	3	1.89	.76	5.28	1.25
Reward Focus	3	1.25	.87	4.65	1.51
Competitive Orient.	3	1.14	.72	3.37	1.36
Results Focus	3	1.07	.70	4.26	1.09
Workforce Practices					
Strategic Practices	13	3.84	.81	4.07	1.24
Performance Mgmt.	7	15.26	.87	4.71	1.18
Staffing	3	1.65	.70	4.84	1.16
Training & Development	7	1.21	.84	3.91	1.39
Hi Commitment Design	6	2.05	.80	4.59	1.18
Positive Emp.Relations	4	1.15	.75	5.34	1.15
Pay-for-Performance	3	1.11	.64	3.60	1.46
Mgmt. Support for People	3	2.53	.78	5.21	1.22
Business Processes	9	6.23	.82	4.89	1.06
Market Performance	6	4.33	.79	5.22	.99

Table 2
Hypothesized And Empirical Configurations

Scales	Hypothesized			Empirical		
	PL	CI	Stuck	No Direction N=10 14%	Stuck N=34 46%	Master of Two N=29 40%
Environment	60	60	60	50.9	50.7	53.4
Market Strategy						
Oper. Excellence	54	54	50	39.1	48.4	53.0
Product Leadership	59	55	50	38.0	49.2	56.4
Customer Intimacy	51	59	50	38.9	48.2	57.1
Competencies						
Efficiency	50	50	50	37.6	51.0	51.5
Creativity	55	55	50	36.5	49.8	54.0
Customer Solution	55	55	50	35.8	50.5	54.2
Culture						
Information Sharing	58	58	50	43.1	46.6	57.0
Risk Taking	55	54	50	36.7	47.2	53.5
Teaming	55	57	50	36.3	50.2	56.2
Focus on Rewards	55	56	50	43.4	46.6	56.4
Competitive Orient.	55	55	50	44.1	46.0	56.0
Results Focus	56	55	50	46.2	46.2	55.0
Workforce Practices						
Strategic Practices	57	57	50	40.0	47.0	56.2
Performance Mgmt.	57	56	50	40.2	47.3	55.2
Staffing	57	56	50	41.4	46.3	55.6
Training & Develop.	57	57	50	41.0	45.7	57.3
Hi Commitment Design	52	57	50	37.6	48.2	56.5
Positive Emp.Relations	55	55	50	42.0	48.2	54.9
Pay-for-Performance	54	55	50	40.0	47.5	55.9
Mgmt Support for People	56	56	50	34.1	49.3	54.2
Business Processes	52	56	50	38.8	48.1	57.4

Note. Mean = 50 with a s.d., of 10.

As noted by Ginter, et al., (2000), health care delivery organizations report a never ending emphasis on cost reduction. However the patient focus of choice is typically differentiation by quality, research and

development, or patient care. Therefore, it is unlikely that a configuration focused strongly on cost leadership, i.e., OE, is likely to emerge from the database. However, configurations focused on Treacy and Wiersema's (1995) differentiated strategies of PL and CI are likely to emerge. Therefore, we stated hypothesis 1 as the following.

Hypothesis 1: Two empirical configurations will emerge with one clearly focused on the product leadership value discipline and the other focused on the customer intimacy discipline.

Given the dynamic nature of the health care industry today, we predicted that organizations using either a PL or CI strategy would perceive the environment as somewhat volatile. For PL organizations we predicted an above average emphasis on the PL market strategy and a more moderate emphasis on the OE and CI strategies (in keeping with Treacy and Wiersema, 1995). In addition, we predicted these aligned factors: PL market strategy with above average creativity competencies, above average scores on the cultural dimensions of information sharing, risk taking, teaming and results orientation (Miles and Snow, 1994; Studer, 2009), and above average scores on all workforce practices excluding high commitment work design (given the difficulty of redesigning jobs in the health care space), pay-for-performance and including a greater emphasis on senior management's belief in the importance of the workforce for organization success. Finally, we envisaged a moderate focus on business processes in an environment where employee actions are considered a higher priority than business systems. There is recognition that business processes remain a difficult focus of attention because of the inherent nature of the health care delivery system (Christensen, 2009). Yet, employee actions as they relate to leading others have received positive attention in

the field over the past few years (Health Care Leadership Alliance, 2009; Griffith, 2009).

For the CI configuration we predicted a high emphasis on the CI market strategy with above average workforce creativity and customer-solution orientation workforce competencies. We also envisaged a culture with a strong emphasis on information sharing and teaming, all focused on unique patient interactions, together with an above average focus on all the workforce practice factors including senior management's perception of the importance of the workforce for success. We believed the CI configuration would show an above average score on the practice of high commitment work design due to the high participation needs of providing unique patient care (Studer, 2009). Finally, as predicted for the PL strategy, CI firms would have a moderate focus on business processes.

Porter (1985) identified the strategy phenomenon he labeled as "stuck-in-the-middle." This outcome occurs when an organization states that its market posture is both low cost and simultaneously highly differentiated in quality, speed, etc. In a previous study, Sheppeck and Militello (2008) encountered this phenomenon with reference to the Treacy and Wiersema (1995) market disciplines (i.e., OE, PL, and CI). In this case organizations reported the same level of emphasis on all three of the value disciplines. In addition, the dynamic nature of the health care industry today may lead many organizations to adopt a safer approach to organization design that results in moderate focus on the constructs used in the study: culture, workforce competencies, workforce (HR) practices and business processes. The industry is only beginning to focus on these constructs, with adoption of a safe approach being understandable (Studer, 2003). Therefore, we stated hypothesis 2 as the following. The predicted results for this hypothesis are also shown in Table 2.

Hypothesis 2: One empirical configuration will emerge that shows all variable means within a band of 1/2 a standard deviation above and below the overall mean.

Alignment adds value to a firm by creating a system of mutually supporting factors that yield stable themes over time (Lei & Slocum, 2005). Clearly aligning organization assets around the Treacy and Wiersema (1995) disciplines would be expected to impact organization performance. In this study we defined organization performance as a self-report by firm managers regarding the firm's quality of fixed assets, ability to obtain capital, supplier relationships, and overall financial performance in their markets compared to competitors. Therefore, we stated hypothesis 3 as follows.

Hypothesis 3: The predicted product leader and customer intimacy configurations will show levels of market performance above other configurations.

METHOD

Data for the 73 clinic organizations were obtained via student projects in human capital management courses in two graduate MBA programs at a mid-western university between 2008-2010. We focused on obtaining data only from the largest clinics (number of employees > 100) in Minnesota, Wisconsin, North Dakota and South Dakota. The geographic dispersion is important since the HMO model of health care delivery is particularly common in the upper Midwest. We recognize that this approach produced a convenience rather than a statistically random sample thus introducing the possibility of selection error in the sample of firms (Cook and Campbell, 1976). However, we found this to be a more controlled approach for gathering the data as the students involved also worked within the

target organizations and the distribution and collection of surveys were completed under the same instructions for all courses. Each of the 73 clinics represented either an operating unit in their larger corporate organizations or a stand-alone business. The larger corporate organizations typically had more than one clinic operating unit and sometimes a hospital as well. The size break-down of the sample is as follows: >100 but <200 employees--22%, 200-499--19%, 500-999--15%, 1,000-4,999--16%, and greater than 5,000--28%. Therefore, this is a sample that has a fairly even spread of clinics with greater than 100 but less than 5,000 employees and its greatest concentration is in large (> 5,000 employees) organizations. Overall, 72% of the organizations have less than 5,000 employees and 28% have greater than 5,000 employees. A total of 57% of the clinics are single specialty while 43% are multispecialty. The majority of clinics (81%) practice in metropolitan areas while the remaining 19% are outstate.

Using Minnesota as a benchmark, due to its greater number of clinics than western Wisconsin and North/South Dakota, we found in total that 70% of all clinics have greater than 100 employees (MN Community Measurement, 2012). Therefore, our sample, with all the clinics greater than 100 employees, is representative of the majority of clinics in the state. In addition, 57% of the clinics in our sample are single specialty compared to 32% in the state. Therefore, our sample is overrepresented by single specialty clinics compared to all clinics in Minnesota.

Participating firms were presented a packet of six surveys: environment, market strategy, culture, workforce competencies, workforce (HR) practices, and business processes/market performance. The survey instructions requested that the contact person (either the HR manager or the MBA student) distribute the surveys as follows: environment--to marketing managers; market strategy-to

the COO or marketing managers; workforce competencies--to HR managers; workforce HR practices--to the head of Human Resources; and culture and business processes/market performance--to members of the senior management team. We believed that this selection of evaluators would yield the most valid ratings for each organization factor. Finally, a minimum of two or more individuals in the participating firms completed 75% (n=55) of the packets. In the remaining 25%, the HR contact and the MBA student completed the surveys after consultation with others in the organization. All respondents were either members of the senior teams in their organizations or direct reports to senior team members.

Variable Scales

All survey items used a one to seven rating scale. All scale scores were derived from principal components factor analysis using a varimax solution and an eigenvalue of 1.0 per factor. Fourteen items were adapted from Miller (1987) to measure the features of organizational volatility. We define volatility as comprised of three elements: uncertainty, heterogeneity, and hostility. In combination these factors lead to higher transaction costs for an organization interacting with its environment. Uncertainty deals with the amount and unpredictability of change in customer tastes, production or service technologies, and the modes of competition in the organization's principal industry. Heterogeneity deals with differences in product/service lines, channels of distribution, and competitive tactics across an organization's respective markets. Hostility deals with price, technological and distribution competition, regulatory restrictions, shortages of labor or raw materials, and decreasing markets

The market strategy survey was comprised of 21 items suggested by Treacy and Wiersema (1995) measuring

the OE, PL, and CI market approaches. The culture survey contained 24 items across six topics: information sharing, risk-taking, teaming, rewards focus, encourage competition, and results orientation. Our intention was to look at items commonly used in culture measurement (Cummings and Worley, 2005) but also related to the Treacy and Wiersema strategies. The workforce competency survey was comprised of 24 items suggested by Treacy and Wiersema (1995), focused on the non-manager population in the organization and was intended to reflect the market strategies: OE (i.e., efficiency), PL (i.e., creativity), and CI (i.e., customer solution orientation). The workforce (HR) practices survey contained 64 items measuring the seven practice and one senior management factors shown in Table 1. These items came from the CCH Incorporated report (Human Resource Management, 1995) supplemented with items from Becker and Huselid (1998) and Huselid (1995). Finally, a total of 18 items dealing with typical aspects of organization functioning and performance were developed based on Quinn and Rohrbaugh (1987), and supplemented by items dealing with resource acquisition (people and capital), position in the market, maintaining customers, and overall financial performance. Quinn and Rohrbaugh (1987) described a set of 17 items to measure these critical processes taken from Campbell's (1977) work dealing with organizational effectiveness. We expanded on this item set to develop the business processes scale used in this study. The business processes scale and an overall market performance scale were derived from these items.

RESULTS

Variable scales were developed within each broad variable, with the exception of environment and business processes, by factor analyzing the survey items using a

principal components solution with a varimax rotation (SPSS-X, 1988). The environment and business process items produced single factors. A summary of the scales is provided in Table 1. (The full scales are available from the authors.)

The scale raw scores were converted to standard scores with a mean of 50 and a standard deviation of ten. The emergence of distinct configurations predicted by the hypotheses was tested by clustering the 22 scale scores (market performance not included) for each organization. A group structure was obtained using the Ward complete linkage method. This method is a rigorous approach that requires all members of a cluster to show a strong resemblance to all other members of the cluster (Aldenderfer and Blashfield, 1984). Visual inspection of tree-plots was used to define the final number of clusters. Three clusters were obtained using this method. A discriminant function analysis was also performed using the scale scores from the cluster analysis results. The first discriminant function had an eigenvalue of 6.30, a canonical correlation of .93, and significance at the .05 level, with 89 percent of the variance accounted for, and 97 percent of the grouped cases correctly classified (SPSS-X, 1988). Based on the results of the clustering and discriminant function analyses, we were comfortable with the three obtained configurations.

Hypothesis one predicted that separate configurations would emerge that reflected the two Treacy and Wiersema (1995) value disciplines: PL and CI. Instead, a single empirical configuration (i.e., #3—40% of the sample) emerged which combined the market strategy elements of the two predicted configurations into a form described by Treacy and Wiersema (1995) as a “master of two” where an organization is high on two market strategies and moderate on the third.

We tested hypothesis 1 by correlating the *predicted* PL and CI configuration scores with the second *empirical* configuration scores labeled Master of Two. Because we could not be certain that the variables in the predicted PL and CI configurations were distributed normally, we used the Kendall's tau_b and Spearman's rho statistics. The Pearson r for the empirical Master of Two and the predicted PL and CI configurations were .132 (ns) and .516 ($p=.05$) respectively. The Kendall's tau_b for the same correlations (empirical configuration #2 and the predicted PL and CI values) showed that the predicted PL correlation was -.066 (ns) and for the predicted CI it was .470 ($p=.01$). Finally, Spearman's rho for the empirical Master of Two and the predicted PL and CI configurations were -.07 (ns) and .549 ($p=.05$) respectively.

Overall, hypothesis 1 received partial support. Only one empirical configuration (#3—Master of Two) emerged from the data that approximated the predicted PL and CI configurations. However, the results for the Pearson r, Kendall's tau_b and Spearman's rho were significant for the predicted CI but not the PL configuration.

The emergence of empirical configuration #2 (Stuck—46% of the sample) supported hypothesis 2: a configuration where all or most of the scales would show scores within one-half a standard deviation above and below the sample mean (see Table 2). Finally, hypothesis 3 was supported in that the anova ($F=13.05$, $p=.00$) for the mean market performance differences among the three empirical configurations was significant. Subsequent post hoc tests using the Tukey method showed that the difference between the means for the empirical Stuck (mean=48.9, sd=9.6, n=34) and Master of Two (mean=55.9, sd=7.9, n=29) configurations was significant ($F=3.19$, $p=.016$) and the difference between the means for the empirical Master of Two and the No Direction (#1,

mean=39.8, sd=8.9, n=10) configurations was also significant ($F=2.24$, $p = .008$).

The emergence of empirical configuration #1 (No Direction) was surprising given the importance of the health care industry in the U.S. today. Organizations that show very little emphasis on any of the three Treacy and Wiersema (1995) market disciplines, a non-descript culture, little emphasis on workforce (HR) practices, little interest from senior managers regarding the workforce, and little emphasis on business processes would likely ensure that the workforces in these organizations would exhibit limited engagement and commitment.

DISCUSSION

Our hypotheses rested on the theoretical foundations of Miles and Snow (1994) and Treacy and Wiersema (1995) suggesting that unique configurations would emerge focused on the PL and CI market strategies together with aligned variables in the workforce competency, culture, workforce (HR) practices, and business processes areas (Lei and Slocum, 2005). Instead we found a single empirical configuration, #3--Master of Two, 40% of the sample, with high scores for the PL and CI market disciplines and a more moderate score for the OE strategy. This empirical configuration may represent an attempt by some clinics to differentiate themselves either by developing new services not found at other competitor organizations or to develop unique forms of patient care. The health care industry is currently shaped by public policy constraints, an aging patient constituency, costly technological developments, and a well-informed public. Strategic change has become an imperative. The ACA puts pressure on providers, insurers, and government funders to continue to cut costs, while expanding markets. It is reasonable to assume that organizations are attempting

to master both sides of the cash flow equation. At the same time, quality measures must be met. Health care organizations might be scrambling to address the most useful strategy available. The result could be a failure in a more systemic strategy direction that picks a leading strategic focus but, at the same time, does not neglect other parts of the system which play a more supportive role.

The large collection of clinics with variable scores near the mean of each variable (#2—Stuck, 46% of the sample) may represent firms headed by senior managers that are taking a very cautious approach to the branding of their organizations given the current volatility of the health care industry. This lack of distinctiveness strongly supports Porter's (1985) notion that creating clear and differentiated market approaches is the exception rather than the norm for many firms. This may be an uncomfortable notion for managers to accept. Our data point to firms that have not vigorously engaged in the process of strategic differentiation. Therefore, it is likely that managers pay more attention to individual elements within our model than the overall configuration, thus showing a clear non-systems oriented managerial approach. There is also a tremendous uncertainty regarding federal funding of health care. Caution may be a reasonable approach for those organizations that are waiting to see what happens in Congress or that are dealing with such limited financial resources that the risk of failing in any strategic endeavor would have strong negative consequences for the organization's future.

Our third empirical cluster represented clinics (#1—No Direction, 14% of the sample), that exhibited very low scores across most of the variables in the study. These organizations may be structurally unable to move in any direction. This constraint may be rooted in the role of a safety net provided by the organization to the local community. In these cases, the health care provider is urged

by its community to assume a greater number of charity cases. These providers may also be greatly restricted by government reimbursements, (which have limited balance from private insurance payments). There may be no way out of this predicament at this time. Finally, they simply may not be well run. They may be waiting passively for some economic or political up-turn to change their economic fortunes.

LIMITATIONS AND SUGGESTIONS FOR ADMINISTRATORS

The major concern we have with this study deals with the size and the convenience nature of the sample. Our failure to identify clear examples of PL and CI organizations, two important configurations in the Treacy and Wiersema (1995) model, may be due more to sampling bias and a low number of firms overall than their existence in the US marketplace. We believe that firms showing patterns that resemble theoretically articulated models may require a much larger and diverse sample. However, we believe these results have applicability to for-profit moderately sized (>100 employees) and large (>5,000 employees) clinics, either stand alone businesses or operating units of larger organizations, and either single specialty or multispecialty (despite the oversampling of single specialty clinics in our sample). All these organizations have a fairly well-developed approach to both market and workforce strategy and HR units that provide service beyond the basics of employee enrollment in the organization's employee database and basic compensation/benefit administration. On the other hand, given the different organization structure, sophisticated accounting practices, and business planning, we do not believe that these results generalize to the hospital environment.

CONCLUSIONS

The ACA includes a wide variety of provisions designed to provide more health care choices, to enhance the affordability and quality of health care for all Americans, to hold insurance companies more accountable, and to lower care costs. However, the ACA does not give direction to health care organizations regarding how to implement its legislation. Implementation becomes the strategic challenge of every health care provider.

Two strategic conceptions underlay the expectations set by the ACA. The first is that, with the proper incentives in place, costs can be contained as better service is provided. The second is that a fully functioning and competitive market for health services will achieve the goals of the legislation. Any strategic response to these theories of funds-flow and markets has to be taken in relationship to each other and in the context of the broader health care system. A discrete response to the administrative pricing directive of the ACA is quite simple: cut costs and retrench to meet pricing constraints while seeking new venues to gain revenue. The former is currently undertaken through a number of initiatives that are prominent within the industry: analytically based cost containment, operational improvement protocols, and employee motivation programs. These initiatives are necessary but not sufficient to strategically succeed in the reform environment urged by the ACA and must be teamed with revenue generating initiatives. The latter demands the application of each of these tools with the addition of an engagement with competing business models, potential partnerships, community and governmental relationships, generational culture differences, and the power of the consumer. In short, it demands a systems perspective on a cash flow strategy that addresses both costs and markets. This type of management intervention demands an

understanding of organizational alignment. The cash flow model needs a well-defined market strategy with aligned operating components.

Therefore, it is becoming critical for health care organizations in general to understand the value proposition they offer to the patient/consumer. Aligning that value proposition with internal functions is essential for the fulfillment of the promised brand. This research project should help to educate clinic providers regarding the market effect within the health care industry. As our research enters its next iteration, we are confident that it will have a positive impact in assisting health care administrators across diverse healthcare organizations to meet the goals outlined in the ACA by appropriate cost cutting and more knowledge regarding the organization's markets and the value propositions sought by patients/consumers.

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