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Article *in* Public Management Review · January 2012

DOI: 10.1080/14719037.2012.686230

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Abstract

This paper examines the implementation of large, transformative change in the Medicaid offices in New York City to improve efficiency and consumer-friendliness. A bottom-up process was engaged to design and implement the needed changes from those who were most affected by the change. Key informant interviews and observational site visits were conducted to assess the extent to which the change efforts were successful. We found that the changes impacted both quantitative measures of success (such as client processing times and number of clients served) as well as less tangible qualitative indicators of success such as staff attitudes and office climate.

Key words

Change, human services

WHEN CHANGE BECOMES TRANSFORMATION

A case study of change management in Medicaid offices in New York City

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This work was completed under contract to the Human Resources Administration in New York City.



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The organizational change literature frequently stresses the difficulty of motivating frontline employees to accept and implement change initiatives. Employees presumably have a vested interest in maintaining status quo for a variety of reasons including institutional pressures, power, comfort level and ambivalence towards a proposed change (Cyert and March 1963; Piderit 2000; Tucker 1993). However, new research refutes the traditional view of frontline employees as recalcitrant obstacles to change, and instead sees their position and resourcefulness as a generally untapped opportunity to make change efforts successful (e.g. Ford *et al.* 2008; Kelman 2005).

One of the environments where it is thought that change is difficult to accomplish is in public organizations. Public organizations are often structured to emulate Weber's ideal bureaucracy – control through rules and technical adherence to those rules is prized (Mashaw 1983; Weber 1946). Inertia and adherence to rules can make it difficult for real change to happen. Further, Federalist systems can exacerbate inertia through creating layers of rules and regulations at each level of government. And in locations with strong organized labour unions, whose main purpose is to protect their members' interests through negotiations of workload and pay scales, inertia can become intractable. Under these circumstances, the management of change can be just as important as the content of change itself.

We present a case study of change in one highly bound bureaucratic organization – New York City's Medicaid Offices. Medicaid, the United States' public health insurance programme for the poor, serves about 19 per cent of the US population (Kaiser Family Foundation, <http://www.statehealthfacts.org/profileind.jsp?ind=199&cat=4&rqn=1>) and is highly regulated at the Federal and State levels. Further, in New York City, the Agency is operated in a fairly traditional 'command and control' environment where directives are passed down from the highest levels of the organization and street level bureaucrats implement them with little or no input. And since the regulations surrounding Medicaid are fairly well specified, street level implementers do not have much discretion in meting out exceptions (Lipsky 1980)¹. In this study, we sought to understand the extent to which sustainable change was implemented in this organization and whether the change process was managed effectively enough to achieve desired outcomes. The findings illustrate the potential for transformation that effective change management processes can yield, even in a highly intransigent environment.

RELEVANT LITERATURE

While there are many disciplines that study change and change processes, in this paper we draw from the management, organizational, and public administration literatures. In particular, the concepts of leadership, garnering support, managing uncertainty and organizational climate are highlighted. This is not to imply that there are not other relevant streams of literature that could be brought to bear on our empirical case study.

Rather, we point to only those concepts that help us to leverage our understanding of the case presented here.

Leadership

Throughout the change literature, there is one constant: leadership matters. [Kotter \(1995\)](#) suggests that leaders are the key to getting change implemented through their visioning, coalition building, and empowerment strategies. The literature often depicts leadership for change as a singular person, usually with a cohort of high-level supporters surrounding him or her. However, recent work has suggested that change leadership can also be more distributed among a coalition of peers ([Isett *et al.* 2011](#)).

One of the most important dynamics a leader or leadership team can bring to a change initiative is their consistent support and sustained attention ([Isett *et al.* 2007](#)). Leadership needs to be consistent in their support for the changes and provide tangible evidence to frontline employees that this is the case ([Collins and Porras 1996](#); [Isett *et al.* 2008](#); [Kotter 1995](#); [Kelman 2005](#)). Studies have illustrated that when leaders falter in their long term attention to a change initiative, and/or they have ‘thin’ attention due to many different initiatives, it is interpreted as a signal that the change is not critical ([Isett *et al.* 2007](#); [Strauss 1981](#)).

Leadership also plays an important role in signalling what is desired under the new change. One important signalling mechanism is the creation of a ‘safe’ psychological space for implementers -indicating that behaviour consistent with the change is valued and accepted ([Kelman 2005](#)). Creation of safe psychological spaces can include empowerment to act on change, creating acknowledgement and reward for change, and minimizing messages that promote the status quo. These three elements help to minimize the anxiety individuals feel about their efficacy to do their jobs during times of change ([Armenakis *et al.* 2007](#)).

Garnering support for change

One aspect of implementing change in complex organizations is the necessity to garner support for the change. This includes creating a guiding coalition where its members serve as the principal ‘cheerleaders’ for the change outside the leader/leadership team. The guiding coalition members not only promote the change, they also recruit ‘foot soldiers’ throughout the organization ([Isett *et al.* 2011](#); [Kelman 2005](#); [Kotter 1995](#)).

There is increasing recognition that these ‘foot soldiers’ are particularly important for successful change efforts. The ‘power of lower participants’ ([Mechanic 1962](#)) to facilitate or impede organizational processes has been well acknowledged for many years. However, only recently have they been characterized as resources for change ([Ford *et al.* 2008](#); [Kelman 2005](#)). In these new characterizations, frontline

implementers of change are harnessed to help design change, create momentum and act as proselytizers for the change effort. Frontline workers are no longer obstacles, but rather necessary change agents.

A second component of garnering support for change is creating opportunities for inclusion in change processes. One way to do this is through co-optation (Selznick 1953). Co-optation works whereby those in opposition or potential opposition to change are brought into the process. They can air their concerns and help shape what the change will ultimately look like. People generally feel that decisions are fair, even if they disagree with the decision on its merits, so long as they are involved in the process (Selznick 1953; Stone 2002). Thus, this process neutralizes fear and disarms opponents. There is some evidence that involvement in process is an important aspect of the support for and sustainability of change (Howitt 1997; Isett and Miranda 2008).

Managing uncertainty

Change, no matter how well it is thought out and planned, involves uncertainty. It involves uncertainty for individual implementers (how will this alter my daily tasks and will I be effective at them?) as well as the organization (will the change improve performance or some other important organizational outcome, and what are the unanticipated or unintentional externalities that result from the change?). Effective change management includes managing these uncertainties for the organization and its participants.

At the individual level, there is extensive information about what works and what does not with regard to employee acceptance of change. Primary for acceptance is that individuals need to feel as if the change is salient to them and that the change is appropriate for what they do (Armenakis *et al.* 2007; Kelman 2005). Part of helping individuals feel self-efficacious in times of change is to have good communication about what the change is and how their particular job fits into the broader change initiative (Kotter 1995; Wanberg and Banas 2000).

At the organizational level, change champions need to ensure that the organization will continue to deliver the services required by their missions during and after the change. Including key stakeholders in the change processes ensures that those stakeholders know what the change is and why it is happening. This broad communication about change is consistent with ideas of managing uncertainties in organizations through buffering core technologies and understanding relevant power bases (Thompson 1967; Milliken 1987).

Organizational climate

Organizational climate is the concept that describes the working environment of an organization and includes six key aspects: flexibility, responsibility, standards, rewards,

clarity and commitment ([Goleman 2000](#)). While many things impact climate, the importance of climate is that it affects workplace compatibility and job satisfaction ([Glisson and James 2002](#); [Glisson *et al.* 2006](#); [Glisson *et al.* 2008](#)), which in turn impacts turnover, absenteeism, and organizational identification ([Foreman and Whetten 2002](#); [Kim 2002](#); [Mitchell *et al.* 1997](#); [Wright and Davis 2003](#)). As we also know from the organizational change literature, experience with change, particularly positive experiences, engenders a willingness to make further changes ([Dutton *et al.* 1997](#); [Hall 2002](#); [Kelman 2005](#)), and is a sign of flexibility in organizational climate – a positive attribute.

BACKGROUND

Ongoing dissatisfaction with Medicaid enrolment offices in New York City prompted City officials to focus on how to make the offices more efficient and consumer-friendly. Clients and advocacy groups complained regularly about the Medicaid offices' physical plant, client wait times and eligibility processes. Improving offices, rather than the programme itself, allowed the city some autonomy since it did not require State or Federal Medicaid approval. Thus, the main goals for the redesign were to improve eligibility renewal procedures as well as to reduce the paperwork and time burdens for initial enrolments.

With help of an organizational consultant, the City was encouraged to implement a bottom-up procedure to design and roll out the new changes. The change process included three basic steps: letting the employees of the offices develop ideas for change, testing the ideas, and creating a model office based on the innovations. During the early change process, the consultants asked Medicaid management to allow their employees to take a full role in the re-design effort without pressure to implement any specific set of changes. This was done to give office staff full ownership and creative input into the change process.

Each office formed a 'change team' by selecting four or five individuals to represent their Medicaid Office in the re-design process. Representatives from the consultant organization began visiting offices and talking to staff and advocacy organizations about the changes these stakeholders thought were necessary. Initial meetings of these groups were challenging as staff struggled to find their role. Staff members were reticent to provide ideas and feedback since the organization had historically been very hierarchically driven. Although some high-level managers became anxious about the extra time the new approach was taking, leadership in the City was patient with the process. Staff eventually started offering ideas after several weeks of meetings. The ideas from the staff were centred on two types of changes: process and physical plant renovations. An iterative redesign began in two pilot Medicaid offices to test different ideas. After eight months, the change redesign process was completed and a new model for the offices had emerged and was presented to agency leaders.

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Between 2002 and 2004, 15 offices were transformed to Model Offices, and by October 2007 all 19 Medicaid offices were using the Model Office System. Once the system had been developed, middle management then played an important role in sustaining the change. Upper management empowered their middle managers to re-train existing staff to implement the new processes, and to do extensive training with new staff to understand the new roles they were to fulfil.

METHODS

Data were collected over a two month period during the Fall 2006 as part of an evaluation of a series of discrete changes within the Human Resource Administration (HRA) in New York City. The HRA is a large social service umbrella agency that has authority over both temporary and long term support for its clients that includes 'food, shelter, financial assistance, medical care, counseling and other essential services' (City of New York 2008). The evaluation team consisted of four researchers with expertise in economics, political science and public management. We collected qualitative data to assess the extent to which the Model Office redesign met its goals of improving the efficiency while reducing burden on clients. Data consisted of interviews, document analysis, site visits and some (limited) administrative data. Interviews were our primary source of data with the documents, site visits and administrative data serving as corroborative supplements.

Initial interview participants were selected by the HRA executive staff and consisted of senior and mid-level managers in Medicaid and HRA responsible for implementing the change. As names of individuals were consistently mentioned in interviews as playing important roles in the redesign, these individuals were added to our interview list. In all, we interviewed 18 individuals, mostly through group interview format, in-person, at the HRA central offices.

We recognize that the initial selection process and location of interviews could potentially bias our data collected. However, our approach to using as many public and internal documents as we could find, as well as using a snowball sampling approach for interview participants, mitigated the potential bias of these procedures. We do feel confident that our findings reflect at least the perceived reality of the change and its outcomes.

The interview protocol was open-ended and was intended to hear the 'story' of the Medicaid Model Office changes. The researchers provided several general probes, but let the interviews be focused by the participants. All researchers present took notes during the interviews. After the interviews, one of the researchers provided a set of initial interview notes for the other researchers to revise and amend. Discrepancies were resolved through consensus. A research assistant and one investigator documented the site visits in thick descriptive format. The researchers were able to watch the new model office processes and to ask follow-up information about how the process worked

and about staff impressions about implementation. The two descriptions were combined and synthesized for analysis.

The set of notes was then used in conjunction with documents in an iterative process to develop the model of change used. The junior researcher created a set of initial theoretically relevant themes thought to be contained in the interviews. Then the interview notes were used to either confirm or discard the thematic codes, while new themes were added when appropriate. The same process then was used for analysing the documents collected. The process was repeated until the analysis was saturated. Any uncorroborated themes in either the interviews or documents were asked about in follow-up conversations with interview participants or in subsequent interviews. This process was implemented by hand rather than using analysis software.

Limited administrative data were obtained from the agency. The data obtained were intended to yield process metrics of the Model Offices prior to and after the transitions. The purpose was to describe the changes to supplement the qualitative data analysis, rather than be a focus of the evaluation. We obtained information at the site level with relation to site, number of applications processed, and timing of the transition from a traditional Medicaid office to a Model Office. Given the goals of the redesign, the process measures made available were deemed appropriate. We used both descriptive statistics and fixed effects regression to analyse these data.

FINDINGS

We highlight here our findings on the four components of managing change highlighted in the literature review: leadership and signalling, garnering support for change, managing uncertainties, and organizational climate.

Leadership and signalling

Interestingly, in this case, leadership actually meant the absence of a visible leader, contrary to the existing literature on leadership and change. Executive leadership faded away into the background of the change process in order to allow the frontline staff the opportunity to generate ideas that made sense to them. Further, once those ideas were brought forth, the executive management implemented those changes. Thus, their leadership was to let the bottom-up process actually happen and to follow through on it.

One of the ways that the executive management exerted their leadership and commitment to the new process was through signalling. Upper management leaders used signalling to create a 'safe' psychological space for staff. Specifically, managers provided a venue for the change teams to freely exchange and try out ideas without

interference. Once frontline staff started putting forth ideas and saw that their ideas were implemented, they realized the new process was genuine. Employees moved from being timid to a team that made invaluable suggestions, tested them, and finally created a system that was effective enough to be rolled out 'system wide'.

A further positive signal in the new Model Office system was through new rituals created to recognize outstanding employees. The Medicaid programme implemented a new employee-of-the-month-like system and the honourees are recognized through a breakfast event. This reward and recognition ceremony fundamentally serves to reinforce the culture of the model offices and provides a positive ritual where good performance is valued and acknowledged. Rituals are an important strategy in organizational life that tangibly highlight what leaders value (Bolman and Deal 2003).

Garnering support

In this transformation effort, co-optation strategies were effectively employed. Executive management, led by the change consultants, developed a process whereby frontline employees themselves designed and implemented needed changes. It was recognized that frontline employees had the best understanding of the problems within the old system of operations and that they were in the best possible position to fix them (Lipsky 1980). This made the changes salient to the work that they do on a daily basis (Isett *et al.* 2006; Kelman 2005). It also increased commitment to the outcomes of the change processes (Stone 2002).

Managing uncertainty

Executive management buffered their core technologies and managed uncertainty through two processes during the change design and implementation. First was the inclusion of the labour unions early in the process. This reduced uncertainty for management through reducing the probability that the unions would object to changes and halt or slow down work in the offices in protest – thus core technologies were buffered (Thompson 1967). Inclusion of labour unions also reduced uncertainty for frontline workers. Knowing that the labour unions were engaged in the process and had agreed to the scope of change, provided reassurance to frontline workers that the changes were appropriate for them (Armenakis *et al.* 2007).

The second process that helped to manage uncertainty was the bottom-up change process itself. Since the frontline staff proposed the change, there was limited confusion about what the change would be since they designed it themselves. This process reduced the burden on communication channels to relay change content, and increased change-related self-efficacy (Wanberg and Banas 2000).

Climate

The participative processes also transformed the climate in the Medicaid offices. This is clearly seen in the change from the initial reticence of frontline workers, used to operating in hierarchical control systems of a traditional bureaucracy (e.g. Weber 1946), to their fully embracing participation in change teams. Climate change continues to be revealed through on-going alterations made in model offices, making the facilities dynamic.

The model office process also increased employee commitment to the workplace by giving them a sense of ownership. In the new model, staff rotate through every workstation and task in the office in two-week increments. The rotation system reduces burn-out and helps staff learn to address each of the issues and problems that arise for an individual's case. As our key interview respondents noted, because everybody does each job, there is little incentive to shirk on a given duty since that same duty (or duties like it) may be awaiting them at the next rotation. Therefore, the staff work more collaboratively with one another to solve problems and work proactively on client-related issues – contributing to a more positive workplace climate ([Maslow 1943](#); [McGregor 1960](#); [Goleman 2000](#); [Bolman and Deal 2003](#)).

Change outcomes

The overall goal of the Model Office project was to improve the Medicaid clients' experience through the reduction of burden and improving efficiency of processing times. One way to do so was to reduce the time clients spend in the Medicaid offices cycling through the relevant workstations (called client cycle time). Currently, HRA staff report client cycle time averages about 35 min for the processing of applications – the most involved process handled in the offices – reduced from 60 min per client under the old system. This is important since processing applications comprises approximately 35 per cent of activity in the Model offices. Other key process achievements were the elimination of a need for two visits – clients no longer make an appointment for new applications and then return for the actual appointment. Further, scanned documents eliminated the need for clients to show the same documentation for multiple services (e.g. a birth certificate) since these documents were now available through a new electronic network system within HRA.

The model office physical reconfiguration has improved staff efficiency. The traditional offices were overcrowded and processing paper applications was inefficient, so staff often had to work overtime. In the new model offices, the accessibility of documentation and client files through the availability of computer workstations at each desk, and improved triaging and queuing processes have resulted in staff completing work more quickly with fewer errors. For example, even though the offices are processing many more individuals than in the years prior, customer wait times

decreased, processing times for applications are now around 22 days (federal mandate is 30 or 45 days depending on application type) – including the mandatory 5-day wait for electronic match results, and the total number of employees has fallen, according to HRA internal reports.

We also analysed the administrative data provided by HRA to examine time trends in case of processing and service patterns. Our main focus was simply on the number of applications received by a site, an indicator of how many clients were seen at the office. The results of the analysis are presented in Figure 1 and Table 1. We found that the number of applications received by an office increases by an average of about 122 when the site becomes a model office, after adjusting for differences by month, year and site. Moreover, the number of applications received continues to increase in the months after the office undergoes redesign, increasing by about 60 further applications in the first year after becoming a model office and by a further 50 applications in the second year after becoming a model office.

DISCUSSION

The redesign of Medicaid offices had benefits both in terms of process and outcomes, suggesting that the employee-led redesign process was effective. This new change process resulted in a sense of employee ownership of the changes and a high level of

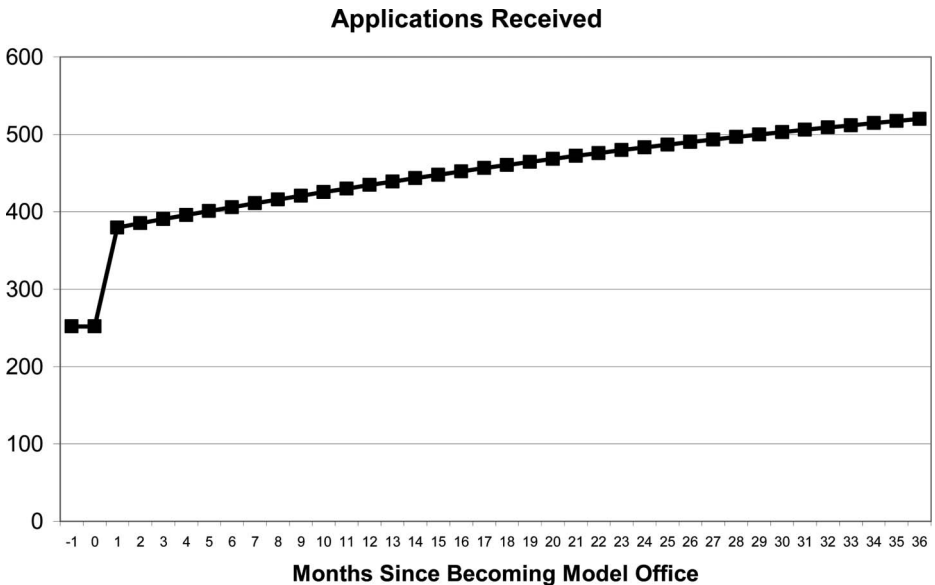


Figure 1: Number of applications received since change to Model Offices

Table 1: Applications received as a function of Model Office Status (HRA data for 22 Medicaid Offices from 2001–2006)

	<i>Coefficient</i>	<i>Standard error</i>	<i>T-Stat</i>
Model office	122.0	19.5	6.3
Months since becoming a model office	5.5	1.4	3.9
Square of months since becoming a model office	−0.04	0.02	2.4
R-squared	0.8		
Number of observations	1310		
Regression also includes dummies for each site, for each month of the year, and for each year (a total of 37 dummies).			

buy-in and conformance once the change was rolled out. Executive leadership implemented strategic co-optation with relevant stakeholders in the process and were able to genuinely invest in a bottom-up process. Each of these elements was consistent with prescriptions for change in the public management and organizational change literature, but as noted by many, these strategies are neither simple nor easy to implement.

So on the surface, this case study is not remarkable. Executives at a large bureaucracy implemented change that conformed, more or less, to the prescription in the change literature. They exerted leadership, garnered widespread support for the change and included the participation of ‘lower participants’ in the organization. None of this is new. However, we posit that the way in which these elements were implemented, and the emphasis put on the participation element created synergies that fundamentally changed the character of the changes taking place.

A good amount of the change literature talks about including participatory processes to increase acceptance of change. But little of the existing literature talks about participatory processes driving internal organizational change. Participation is typically circumscribed to making marginal changes after the change programme is already designed, or to a limited number of organizational representatives. The participation is, then, actually managed and altered at the margins. At times, we also can see the impact of insincere participation effects which are deleterious to broader efforts (Heikkila and Isett 2007).

In this case however, the level of participation by frontline employees during this change was extensive. We saw ‘lower participants’ be the centre of the change initiative through both identifying *what* needed to be changed, and then *how* it ought to be changed. Their processes were guided by experienced consultants, but not directed to a particular set of issues or processes. The extent of the participation enabled the frontline staff to internalize what would happen in their offices because they were in control of the change. This case study extends the organizational change literature to

illustrate that extensive participation of lower participants is feasible and can be productive and yield effective solutions. Participation does not need to be managed so extensively or circumscribed as extensively as is typically seen in change initiatives or as described in the current change literature, and particularly as is usually done in large bureaucratic organizations.

Our study also questions some of the existing literature on leadership and change. The existing literature places a premium on the role of visible leadership and their vision of planned change (e.g. Isett *et al.* 2008; [Kotter 1995](#)). This change is then championed by an individual or group of individuals' herds other organizational participants into accepting or conforming to that change.

In the New York Medicaid office case study, we witnessed a different form of leadership. Instead of the leadership being in front of the change, they were in the background. Their support for change was manifested through signalling to frontline workers through acceptance of their process, implementation of the models put forth, and (later) a recognition ceremony for high achievers. Signalling, rather than championing, was the dominant process of leadership here. Thus, the prescription for change that there needs to be a strong and visible leader is not supported in our case. Rather, strong processes were present, but not the leaders themselves.

The street level participation in the design of change and the leadership process of signalling combined together to create a change that fundamentally overhauled the way things were done in the NYC Medicaid offices. Frontline workers embraced participating in the change initiative so much that rather than making marginal changes that could have satisfied the change goal, they fundamentally altered their own work processes and client responsibilities (see Appendix 1 for a description of the operational changes), known as a technological discontinuity in the business literature ([Tushman and Anderson 1986](#); [Romanelli and Tushman 1994](#)).

This transformation is consistent with Theory Y models of employee motivation. In Theory Y, employees rise to the demands placed on them. They tend to be creative when left to their work and respond well to responsibility, challenges and reward. By allowing the frontline employees to drive their own change, executive management 'unleashed' change. The changes therefore were controllable, not anxiety inducing, and salient to their daily work. This dynamic was enhanced by the fact that management did not interfere with the process.

It is important to note that the combination of signalling and frontline processes were particularly generative in this change environment. It does seem to make sense that if frontline participatory processes are to be the primary process for change, then management ought to be in the background supporting that change. This needs to be done in a genuine way – which may be difficult culturally. But the processes, if executed well can feed into one another and create synergies that catalyse a simple change to become transformation.

CONCLUSION

While the existing change literature has served us well in defining the general precepts of change, it is now imperative that we start to explore the nuances and exceptions to the theory (Isett *et al.* 2011; Kuhn 1962). In this case, we saw that leadership was not the prototypical visible and agenda setting leadership as promoted in the literature. Further, we saw that the participation by frontline workers was taken past the typical level of marginal input to become the driver of changes. Both of these dynamics fed into one another and synergistically created an organizational transformation.

Based on our findings, we posit that a more balanced approach between the traditional view of champion-led change and more genuine participation from frontline staff could yield significant benefits with regard to buy-in, uptake, and sustainability of change efforts. However, it is likely that participatory approaches to change and a less visible leadership methodology would not be appropriate for all change events. Rather, there is likely a continuum of appropriate pathways to change including at one end the traditional approach to change, as described in the existing literature, and at the other end a more devolved and decentralized participatory approach. Further, we do not assume that a particular type of change approach is most appropriate in particular circumstances. More likely is that a cluster of dynamics could be successful in a given organization at a given time. Next steps for change researchers ought to include empirical research to understand when and under what circumstances it is appropriate to apply particular approaches to change, especially with regard to leadership and participation.

NOTE

1 The change under study here preceded the recent healthcare reform taking place in the United States (the Affordable Care Act, or ACA) at the national level. Regardless, the Medicaid programme is separate from the ACA and will co-exist with the new programmes under the Act. The ACA is market-based and captures those individuals who earn too much to qualify for Medicaid, but do not receive healthcare coverage through their employers or by other means.

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Appendix 1. The Model Office System

Process

One of the most significant changes implemented as part of the Model Office was a streamlined process for serving customers. Prior to the introduction of the model office system, Medicaid clients entered offices and were served sequentially on a first-come, first-served basis. Under the model office arrangement, a 'customer service' agent triages all clients who enter an office and assigns each a number in a particular queue corresponding to the purpose of the visit (e.g. temporary cards, new applications, services such as address and name changes, surplus payments, etc.). The dedicated queuing system allows employees to focus on providing a particular service and allows cases that require very little effort to be processed quickly.

The new process allows for more efficient staff deployment. Each employee handling a queue undertakes a specific task, which is designed to increase efficiency in serving customers. However, it was recognized that specialization could also lead to knowledge segmentation and possibly staff burn out. To avoid these pitfalls, employees are cross-trained and rotated through all workstations. Each employee rotates in two-week intervals through the triage, process desk, interviews and back office. This way, they

avoid intellectual fatigue from repetitive processing and become sympathetic to the workloads passed to other parts of the office.

Technology

The technological improvements in the model offices complement the customer service changes in triaging and queuing. Prior to the changes, frontline staff did not have individual access to computers and had to access client files through paper files that may not have been available at their particular office – clients either had to bring the documentation with them to the new office, or it needed to be physically sent from one office to another. Now, each employee has a computer where he or she can readily access all of the relevant information about an individual and their benefits. All supporting documentation is electronically imaged and can be viewed by staff. This technology speeds up the process of addressing client needs and reduces redundancies. For example, in cases when an applicant had previously applied for Medicaid, certain unchanging aspects of their case such as date of birth would not have to be re-documented.

The information system is networked across the entire NYC Medicaid system rather than within a single office. This networked system has several benefits. First, any client can show up at any office for service because their information is stored on the network accessible to all offices. Second, this system allows workloads to be shared between offices. With a networked system, busier offices can rely on less busy offices to help close applications and provide other services. The newly reconfigured model offices, with their enhanced technological capacity, make it possible to gain the greatest advantage from this inter-office operability.

The improvements in information technology have also improved quality and monitoring capabilities in the offices. A tracking system can now show who came in, for what purpose, the duration of the visit, and by whom the need was addressed. This can be tracked across as well as within offices. The system is used to generate a wide variety of summary reports by looking at a range of dates of service, office locations, and types of customers, allowing office managers to identify any trends and changes that might need additional support.

Physical plant

The physical plant renovation constitutes another major change that resulted from the Model Office re-design process. The physical renovations were needed to facilitate the new customer service triage and queue process, as well as to create a more inviting atmosphere. In the new offices, a customer service station is set up near the door for an employee to triage the needs and requests of incoming clients. Clients are then directed to a waiting room with chairs. The new offices all have heating and air conditioning (a

feature that was lacking in some earlier offices). A processing area is set up beside the waiting room with appropriate colour-coded signage for the four types of needs most frequently addressed at the office. The staffed area where interviews occur is behind the processing area, improving the privacy to clients.

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