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The voice of public health physicians, guardians of the public's health

Preventive Services ToolKit Project
Instructor's Manual
Module6 – Power Structure Analysis

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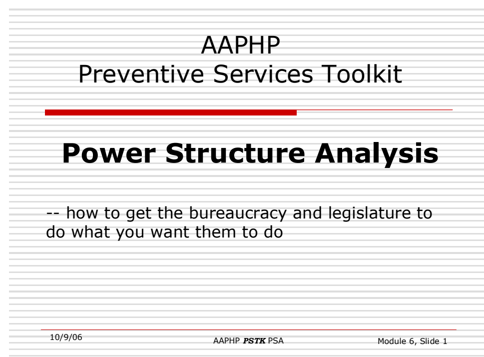
Slide 1 – Title



In organizational settings, power is often not related to the chain of command. All of us have been in situations in which the nominal boss or supervisor had little or no control of what was going on, and lower level staff – sometimes secretarial staff actually ran the organization or program.

▪Power structure analysis is a form of stakeholder analysis – figuring out where people stand relative to any given issue, why they stand there – and how to use this knowledge to move your agenda forward. In the 20 to 30 minutes available for this presentation, we will briefly present the major theoretical underpinnings of PSA, as listed on the slide, and teach you how to use them.

▪Not everything you would like to do in your organizational setting may be possible, at least at this point in time. When faced with that situation, PSA will provide into what must change for your proposal to move ahead so that, if and when such changes occur – you can rapidly take action. Sometimes it may be a matter of waiting for one individual to die or retire. Other times it may relate to a change in external environment – relative to federal policy, reimbursement or accreditation guidelines, or other. Results of a PSA analysis, with regard to such barriers is often surprising – and brings to light options you might not otherwise have considered.

▪As we go through the slide set, please be thinking about proposals you would like to present in your home institution. After the presentation, I will solicit proposals from the audience to serve as the basis of one or more power structure analyses during the discussion period.

▪PSA is a skill, not a didactic exercise. In the discussion period we will try to quickly move through one or more PSAs on proposals suggested by members of the audience.

▪Finally – I think it important to share with you the source of the material in this module. It is based on a lecture given by Dr. Abraham Fishler, of Nova University, in 1974 – to students in the Doctor of Public Administration Program. Dr. Joel Nitzkin, Principle Investigator and Project Manager of this Preventive Services Toolkit Project was one of the students in that class. Over the past 30 years, Dr. Nitzkin has successfully used PSA on a number of occasions, and taught it to others in public health and health care settings. To our knowledge, with the exception of one paper published by Dr. Nitzkin – we know of no literature or published descriptions of this procedure. It is, indeed a quintessential “trick of the trade.”

Comment:

Nitzkin, JL: Doing the Impossible, How the Louisiana Office of Public Health Revitalized its Safe Drinking Water Program. Journal of Public Health Management and Practice. Vol. 1, No. 2, Spring, 1995.

Slide 2: Power

Power

- Power, in an organizational setting, is ***the ability to get other people to do what you want them to do***

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▪Having a high level administrative or supervisory position is but one of many ways to secure power within an organization. Some do it by charm, some by skill, and others by playing roles and games – some positive, others destructive.

▪In this module, we will outline certain elements of the anatomy and physiology of a complex organization, as if it were a living organism (which it is) – and present some very useful tips for using this knowledge to get your organization to do what you want it to do.

Slide 3: Definition of PSA

Definition of PSA

- Power Structure Analysis (PSA) is a rapid and user-friendly protocol for stakeholder analysis designed to
- Develop advocacy strategy
- Determine feasibility of adoption of proposals
- Identify stakeholder-related leverage and barriers

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Slide 4: PSA Rapid and User Friendly

PSA Rapid and User Friendly

- Initial 1-2 hour meeting
- Half-dozen phone calls
- Follow-up ½ to 1 hour meeting

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Slide 5: PSA – Teaching Objectives

PSA - Teaching Objectives

- Describe concepts and tools of Power Structure Analysis (PSA)
- Address mindset-related barriers to preventive services
- Conduct a Power Structure Analysis

10/9/06 AAPHP ***PSTK*** PSA Module 6, Slide 5

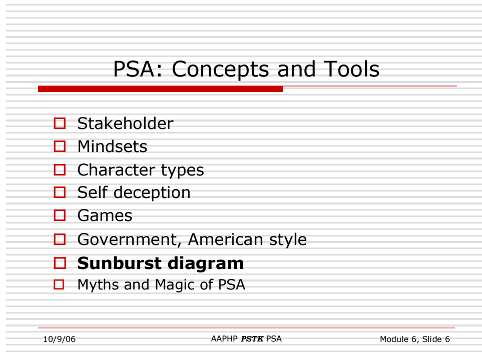
Describe concepts and tools of Power Structure Analysis including the issue of multiple sides to every issue, character types in organizational settings, hierarchy of domains, Federalism, and use of the sunburst diagram.

▪Address barriers to preventive interventions that had previously been considered "off limits" because they were considered "political" or "administrative“or organizational

culture domains and therefore inappropriate for the organization.

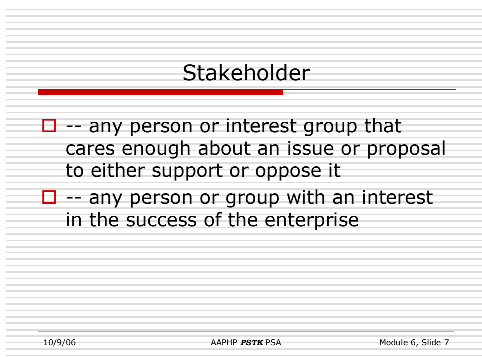
▪Conduct one or more Power Structure Analyses in the workshop session on problems brought up by audience members.

Slide 6: PSA: Concepts and Tools



These are the topics to be addressed in this slide presentation.

Slide 7: Stakeholder

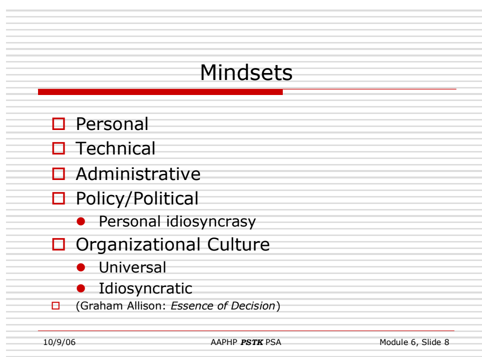


(the second bullet on the slide is from Webster's New World College Dictionary, Fourth Edition 2004)

▪Some potential stakeholders may not even realize they have an interest in the proposal, until their "stake" is pointed out to them.

▪An example could be the marketing department in an HMO not realizing the potential of a newly proposed program to either be of value for marketing – or, if oriented toward extremely ill individuals – result in adverse selection (encouragement of high cost patients to transfer into the plan)

Slide 8: Mindsets



A mindset (or domain as Allison called it) is a field or sphere of activity or influence (per Webster's New World College Dictionary, 4th ED 2005).

Technical -- what you learned in school – science and evidence

Administrative – rules and regulations

Policy/Political – value orientation – who pays, and who gets the benefits

Personal idiosyncrasy, organizational culture and personality types – what feels good to me (us)

▪Most of us (as medical or public health staff) are so deeply engaged in the domain of medical science that we have great difficulty dealing with issues in administrative and political domains – even though

we understand that we need the support of decision-makers in those domains if we are to provide high quality medical care and if our ideas for new programs and projects are ever to see the light of day.

▪Even worse – our focus on the domain of medical science often leads us to the impression that decisions by administrators and politicians that conflict with our impression of good medical care represent either ignorance or possible evil intent. We can easily become so focused on technical correctness in medical science that we loose sight of the possibility that there might be such a thing as administrative or political excellence in its own right – a form of excellence that sometimes might legitimately overrule our notion of medical excellence.

▪As physicians, nurses and public health workers (to be modified by audience) most of us live most or all of our professional lives in large organizational structures, and with the support and limitations of state and national law and regulation. It therefore behooves us to better understand how these bureaucratic and political systems really work.

▪Organizational decision-making can generally be done in one of four domains – technical, administrative, policy/political and personal idiosyncracy/organizational culture.

▪The **technical** domain reflects science, technology, and what we learned in school. For instance – determining the correct dose of the correct antibiotic to treat a specified infection is a decision in the technical domain.

▪The **administrative** domain reflects budget, personnel and standard operating procedures. For example – the decision on which positions to fill and which to leave vacant represent administrative decisions.

▪The **policy/political** domain is the domain of elected public officials in government, and the Board and CEO in the private sector. The decision by a healthcare system whether it will be dedicated to serving the medically underserved, or it will purse maximum profit – is a decision in the policy/political domain.

▪The issues to be addressed within the policy/political domain are as follows:

▪The mission and vision of the organization.

▪Who pays, and who receives the benefits.

▪Hires and fires the major administrative leaders – personnel and finance directors, department heads, etc.

▪Liaison with the outside world.

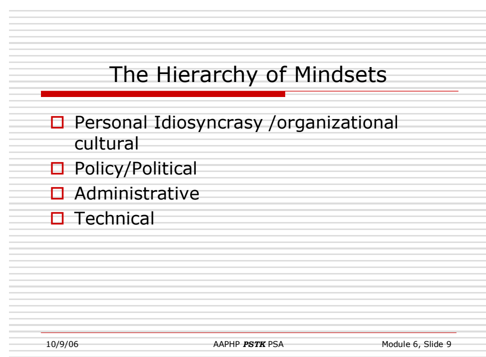
▪Elected public officials and Boards of Directors are clearly, and mostly purely operating in the policy/political domain.

▪Chief Executive Officers are hired to translate the goals of the elected officials and Board into daily practice. As such, they have one foot in the policy/political domain, and the other in the administrative domain.

Finally there is the domain that reflects **personal idiosyncrasy/organizational culture**. Decisions in this domain often conflict with the stated mission of the healthcare system or what would otherwise seem to make administrative sense. For example – decisions in healthcare settings relative to which cases of sexually transmitted illness get reported to public health authorities or go unreported often reflect the personal idiosyncrasies of the attending physician. Decisions within a hospital system

relative to whether given leadership positions are filled with physicians vs. nurses vs. administrators may reflect local custom and organizational culture.

Slide 9: The Hierarchy of Mindsets



Here is where things get messy.

▪The **list of domains is upside down** – with technical correctness at the very bottom.

▪There is a **universal and inflexible hierarchy** of decision domains.

▪Let's work our way from the bottom to the top.

▪When an **administrative** guideline or standard operating procedure conflicts with what **is technically** best – the administrative guideline or standard operating procedure holds sway. For example – if, when setting up a new high-volume primary care clinic, it becomes clear that the most cost-efficient way to manage some of the patients would be with a physician assistant or nurse-practitioner – rather than a physician and the personnel office has no classification for nurse practitioner or physician assistant – the clinic manager, if unable to convince the personnel department to create the new job slot – will have to either leave the position vacant or fill it with an RN or MD.

▪Another example – more direct – if, when evaluating a closed head injury, it becomes clear that an MRI would be the best means of evaluating the patient – and the facility has no such machine – the doctor and patient will simply muddle through without it.

▪Yet a third example deals with the conflict between physician productivity and needs for patient counseling. While all profess a commitment to quality of care – in most places, the pressure for productivity will simply eliminate any thought of any such counseling.

▪Perhaps the clearest example of destructive **conflict between the administrative and technical domains** comes into play during times of major budget shortfalls – when staff must be fired to reduce costs. Under these circumstances, in most public and private organizations – the rule of seniority holds sway. Rather than fire the least productive and least energetic staff – the old ones are retained and the new ones are fired. Sometimes this is the functional equivalent of pruning your garden by cutting off all the vigorous green shoots – and leaving only the dead wood.

▪Given those circumstances, the physician or nurse seeing the problem, if unable to convince their supervisor or personnel department – has but two choices: 1) live with the unsatisfactory situation; or 2) go over the head of the supervisor and appeal **to yet higher (ie political/policy) authority**. This latter step is likely to be effective. It is also likely to cost that physician or nurse his or her job.

▪**Personal idiosyncrasy and organizational culture often hold the secret as to why things go wrong in organizational settings – or why entire organizations are or become grossly dysfunctional.**

▪**Personal idiosyncrasy**, in this context, is a value or strongly held belief by a person within an organization that conflicts with what that organization is supposed to accomplish. For example, a hospital administrator, in a public hospital dedicated to serving the poor and underserved may have, as a personal idiosyncrasy, the desire to make his or her hospital the largest and most respected facility in

the community. To do so, he or she may institute policies that fill the beds with paying patients, thus blocking access to the poor and underserved – largely negating the mission of the facility.

▪One of the most destructive aspects of a personal idiosyncrasy is that, more often than not, it is invisible to the person with the idiosyncrasy. In his or her heart of hearts, he or she sincerely believes he or she is doing the job he or she was hired to do in the best possible manner. Others can see it, but the person involved cannot – making any appeal to reason all but impossible.

▪**Organizational culture, when dysfunctional – can be the equivalent of personal idiosyncrasy writ large** – and affecting many, if not all the key people in an organization. A shared unwillingness to consider new ideas or take chances with new approaches often reflects such a dysfunctional organizational culture. The "entrenched bureaucracy" syndrome where key leaders, often reinforced with solid job security and an almost paranoid sense that others are out to get them, or diminish their privileges can create an atmosphere in which everyone else in the organization just goes along with the way things are, rather than suggest new ideas or advocate for change. Another variant of this theme – most recently demonstrated by FEMA's response to Hurricanes Katrina and Rita – was the change in organizational culture induced by a change in administration and reorganization inadvertently resulting in a situation in which lower level staff had to choose between task competence and loyalty to those higher up within the organization. Under these circumstances, lower level staff who desire to stay employed within the agency obsessively "follow the rules" (to try to assure their continuing employment) rather than do what makes sense in serving the people devastated by the hurricanes.

Slide 10: "Out of the Box"

Error! Objects cannot be created from editing field codes. The box is the restrictions on thinking and action imposed by the prevailing organizational culture – the restrictions that create the situation in which actions done within the organization make no sense whatever when seen from the outside world. For example, failure to deal with an apparently incompetent or abusive nurse or physician or an obsession with paperwork that prevents nursing staff from providing caring patient care are common examples. On the public health side, the unwillingness of public health leadership to recognize or address an obvious need for clean air regulation, or from aggressively addressing a public health emergency are other examples.

In 1993, the city of Milwaukee was hit with a massive outbreak of Cryptosporidium enteritis (diarrheal disease) due to Cryptosporidium in the drinking water. When the city had experienced an estimated 400,000 cases of illness and 10 deaths, the local health director pursued negotiations with the city water supply. The mayor finally had to issue the boil water notice needed to bring this outbreak to an end.

In 2003, (2.5 years pre-Katrina) in New Orleans, when faced with a major state budget cut, the model diabetes clinic and "My Doctor" clinics were eliminated by LSU, on the basis that they were not teaching programs – despite the fact that they exemplified the cost-efficient "medical home" which were the stated highest healthcare priorities of the Governor, State Legislature and Medicaid program. This also eliminated a third of the outpatient clinic "safety net" of the New Orleans metropolitan area – a gap which no other provider was in a position to fill. They were eliminated because LSU was thinking within their "box" in terms of their educational mission, and the state director of DHH and City Health Officer were also thinking within their respective "boxes" in terms of not interfering or even considering addressing actions by another state agency (you run your program, and I'll run mine).

Had anyone in the system thought "outside the box" it seems clear that it would have been easy to transfer these programs from LSU to either the City or Medicaid, with financial support from the Medicaid program.

To think "outside the box" one must recognize what the box is and have the capability to remove the blinders imposed by the prevailing organizational culture. Thinking in terms of the mindsets, as presented in this PSA workshop is an excellent way to begin this process.

"Inside the Box" thinking is strongly encouraged by recruitment and hiring guidelines that have as their top priority, the ability to get along with everyone in the organization. This, in turn, translates to iron-clad and unquestioned support, in most cases, of the prevailing organizational culture. This is often further enhanced by having candidates screened by high-level persons already within the organization.

Slide 11: Character Types

Character Types

- Zealot
- Advocate
- Statesman
- Conserver

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A **zealot**, in this context, is an individual so passionately committed to a certain idea or course of action that he or she is willing to put their job on the line to fight for what they believe. Sometimes this may be a department head just trying to make his or her department bigger or more prominent. Sometimes it is someone at a lower level fighting for a new program or piece of equipment. The zealot is the bureaucratic equivalent of the suicide bomber – with a pretty good chance of getting what he or she is pursuing, and an even better chance of loosing his or her job in the process.

▪An **advocate** is a zealot with softer edges – with strict limits as to how far they will go to advocate their position – but with a strong commitment for positive change.

▪Next down the line is the

▪**Statesman** (or stateswoman or statesperson). This is an individual whose passions are evenly divided between creative change and a desire to maintain smooth and high quality relations with all involved.

▪**Mixed Motive** – most of us are "mixed motive," in that we will be willing to stick our necks out for some proposals, but not for others. Finally, the

▪C**onserver** is a person who is totally unwilling to even consider any changes -- out of comfort and laziness, or out of an overwhelming desire to maintain the status quo. Persons often become conservers over time as they approach retirement – or if they have been promoted into a role in which they are now incompetent – and just want to hold on. They will sometimes act covertly and behind the scenes to thrwart change proposed by others.

▪Zealots most often know they are zealots and recognize the role they are playing and (usually) recognize the chance they are taking with regard to their own continuing employment. For all the others, however – people are truly blind to their true personality type – with almost all considering themselves advocates or statesman – when many are really conservers.

▪Contrary to the prevailing conventional wisdom, young people, early in their career, and dependent on recommendations from current supervisors for career development, are likely to be conservers, and staff near retirement with iron-clad job security are likely to become zealots for programs and policies important to them – with little to fear in terms of job loss, or loss of future job opportunities.

▪**The point to this exercise, in the context of PSA – is not to classify others within the workplace, but to honestly consider what may be your own true personality type, as reflected by your actions and decisions in the workplace.**

▪**An individuals character type will vary over time, and vary with the proposal in question**

References

The character types model presented in this slide is drawn from Downs, Anthony: Inside Bureaucracy – a 1967 book published by the Rand Corporation (Library of Congress Catalog Card No. 67-18259)

While not addressed in terms of character types in an organizational setting – the concepts implied in these character types are reflected in a trilogy of books by Peter M. Senge – The Fifth Discipline (1990), The Fifth Discipline Fieldbook (1994), and The Dance of Change (1999) – all by Doubleday

Slide 12: Games

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(read slide)

the tendency toward self-deception is truly phenomenal, and, in many organizations, where supported by the organizational culture – more the rule than the exception

- ***Belief by Medicaid staff that the best way to reduce infant mortality in Louisiana is to move prenatal and other MCH clinics from public health to private sector.***
- ***Belief by newly appointed public health director (1990's) that the best way to stimulate creation of FQHC's, across the state is to gut the public health MCH clinics, in the belief that their presence inhibited such development. The predictable result was just the opposite – and that the best way to develop the desired FQHC's would have been to build on the base provided by the public health clinics.***

Slide 13: Games People Play – Technical

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Low priority activities – extensive chatting in examining room

▪Academic habits – overly extensive workups to rule out really rare possibilities

▪Productivity for the sake of Productivity – seeing as many patients as possible, without regard to quality of care or cultural sensitivity

Slide 14: Games People Play – Administrative

Error! Objects cannot be created from editing field codes. (***read the slide; then focus solely on reorganization per narrative below***)

▪**Reorganization** is probably the most destructive of the games – where a new agency leader, to give the image of doing something substantive to address the problems at hand, will reshuffle the pieces on the organizational chart rather than address more deep-seated problems such as inadequate staff or

funding, or an agency mission that can't possible succeed because of lack of political support or inadequate state of the art. Recent experience at the federal level with the Office of Homeland Security and FEMA clearly demonstrate how reorganization can make an agency leader look good for a while – when actually making things worse

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▪***A similar story can be told about the reorganization of CDC – from that of an academic center to that of a corporate structure; decreasing the power of the technical experts and dramatically enhancing the power of ideologically-oriented politically appointed new leadership.***

▪***Story of 3 letters***

Slide 15: Games People Play – Policy/Political

Error! Objects cannot be created from editing field codes. Policy/political games are easiest to see in campaigns for elected public office.

▪The first two of these – glib assertions and simple myths reflect the electorate's desire for simple solutions to complex problems and tend to see genius in those who propose them. In this context, the candidate's role is to "dazzle them with brilliance and baffle them with bullsh-t." Unfortunately, once elected, these individuals tend to pick their appointees on the same basis – with resultant severe dysfunctionality of the type so clearly demonstrated by FEMA, Louisiana State Government and New Orleans City governments during the recent Katrina/Rita disaster.

▪Once these failures become obvious – these same elected and appointed officials (and I say this as an individual who has spent much of his career as an appointed public official) – then take the next step and **blame the problem on lazy and ill-intentioned mid-level staff** (the "invisible bureaucrats" who supposedly control everything).

▪**In truth – the staff are rarely, if ever at fault – but take the blame for their boss's ineptitude.**

▪Does this same phenomenon also occur in **the private sector and in healthcare delivery systems** – absolutely, and, in most cases, even more egregiously. It is not as visible, however, from the outside, because these organizations can hide it much more effectively.

▪Healthcare delivery systems have their own set of dysfunctional policy/political **games.** These are:

▪**Skimming** (selection of clients based on financial desirability)

▪**Dumping** (termination of service when reimbursement runs out)

▪**Inappropriate Utilization** (provision of more service than necessary, or failure to provide needed services and support)

Slide 16: Games People Play – Personal/Organizational Culture

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(read the slide)

Slide 17: Government, American Style

Error! Objects cannot be created from editing field codes. "Federalism" is a political science term referring to how national, state and local governments relate to each other.

▪How this works varies considerably from country to country.

In the United States, our concept of federalism is hard-wired into our Constitution.

▪At the risk of considerable over-simplification, it works like this:
▪The national government has the money
▪The state government has the legal authority
▪The local government has the problem

▪**This structure is hard-wired into our constitution**. Our government is a federation of states – and all authority not specifically assigned to the federal government rests with the states. Therefore issues like medical and health facility licensure rest with the states, not the federal government.

- The federal government literally prints the money– and is the only level of government that does not have to balance its budget. It is the only level of government that prints money and is authorized to go into debt – which it does with alarming passion.
- All of the money for Medicare, most of the money for Medicaid and most of the money for medical research therefore come from the national government
- Any and all powers not given to our national government by our constitution are reserved for the states.
- Thus, medical and facility licensure and much of our regulation are at the state, not national level.
- Given modern technology, communication and transportation – having such licensure and regulation vary from state to state makes no sense.
- Congress is generally unwilling to take this on, however, for two reasons. One is entrenched special interests at the state level. The other is that, doing so would fly directly in the face of the stated intent of our founding fathers – and, if taken to the supreme court, the feds would loose to the states.

▪Local government is not recognized in our constitution. It exists to meet the needs of the people as best it can, given its needs and resource base and the support it can secure from state and federal governments.

- Local governments have to solve the problems – but without either the taxing authority of the feds, or the legal authority of the states.
- They therefore largely rely upon money from the feds, often channeled through state government, state regulation and a variable amount of local regulation and taxing authority to meet the needs of their constituency.
- Some local governments fund or directly provide healthcare and public health services. Others do not. As a general rule, most private sector healthcare entities are deeply involved in state and national governmental affairs, but with relatively little contact with local government.

▪Layer Cake v Marble Cake Federalism

- Prior to the **Johnson administration (1960's),** federal, state and local programming and funding were quite discreet and easily identifiable. Johnson, in the context of his "great society" programming introduced the concept of **block grants and other forms of federal/state/local partnership** where the feds would give dollars to states and localities, with matching requirements, and with substantial additional discretion at state and local levels. This way (or so it seemed) the program initiatives could be better coordinated at state and local levels. This difference is illustrated by the difference between the Medicare program, which is entirely federal, and the Medicaid program – which is run by each state – with very different requirements, and guidelines from state to state.
- For better and for worse – this concept was turned on its head in the **Reagan Administration** when they introduced the concept of **"budget reconciliation."** With this new approach to budgeting – the federal government first decides how much it is going to spend the next year – then distributes these dollars among and between programs. The previous procedure was to look at needs program by program first, add them up, then negotiate the budget and tax rate. This new budget reconciliation procedure, in combination with the block grant funding mechanism basically set the stage for the federal government to reduce its contribution to state and local block grants without taking responsibility for which services got cut, and which recipients of service are excluded from program benefits. Thus, a budgeting procedure that was originally intended to benefit the states and localities was transformed into a mechanism to saddle states and localities with unfunded mandates – forcing the states and localities to either take the heat for cutting services or take the heat for raising taxes.

Slide 18: Sunburst Diagram

Error! Objects cannot be created from editing field codes. The smiley face in the middle is you – the advocate who would like to move the agency or the legislature to adopt a new or expanded policy, program or project.

▪Each of the rays extending outward connects to a stakeholder who cares enough to be concerned about this proposal and might take action to support or oppose it

▪The sunburst in this presentation is shown with 16 rays (ie perspectives) – three to five per domain. Depending on the proposal at hand, the sunburst will always have the four domains, and at least one or two perspectives per domain – but it might have 15 or more – again, depending on the proposal.

▪The essential point is this – there are never only two sides to any health policy issue – there are always a minimum of 8, and, not infrequently, 15 or more. Since we are simply not accustomed to simultaneous consideration of more than two sides to any issue – the sunburst diagram is used as a vehicle to think through all pertinent sides of a proposal or health policy issues to enable us to develop the best possible advocacy strategy.

▪That having been said, for most proposals, most of the perspectives will be of little importance. The purpose of working through the sunburst diagram is to make sure you have identified all of the really pertinent perspectives, so that you can consider how they impact each of the others.

▪The ultimate goal of the PSA exercise is **leverage.** This is the identification of an advocacy strategy by which one can use the perspective of one or more of the major stakeholders to influence the others on your behalf

Comment

The sunburst, as shown has 16 rays, like compass points; the graphic is repeated in each of the following slides, in sequence in which they are to be considered in PSA. As the slides are shown, they are to appear one at a time (as if bullet points) in the sequence of the small case letters.

Some are very purposely opposite one another, others more randomly distributed

A summary table of the rays of the sunburst are as follows:

Direction of Line	Domain	Item
N	Personal	Values
NNE	Technical	Professional Goals
NE	Policy/Political	Funding and Authorization
ENE	Admin	Budget and Personnel
E	Admin	Boss
ESE	Policy/Political	Interest Groups
SE	Policy/Political	Legal/Liability/Tort
SSE	Technical	Colleagues
S	Personal	Character Type (opposite Values)
SSW	Technical	Peers
SW	Personal	Family
WSW	Admin	Standard Operating Procedures
W	Admin	Subordinates (opposite Boss)
WNW	Policy/Political	Community Image
NW	Policy/Political	Clients
NNW	Administrative	Regulation and Accreditation

Slide 19: Personal Domain

Error! Objects cannot be created from editing field codes. The personal values relate to the relative importance you put on your professional,, vs family, vs other and social life – with regard to the time and energy you wish to invest in each of them.

▪For some individuals, there are other elements of strongly held personal feelings about the sanctity of life, desire for extreme personal wealth, social justice issues, and other value propositions.

▪The slide is shown in three stages – with the rays of the sunburst to appear as bullet points, one at a time, in rapid order. The other slides are shown as a single slide, with the sequence of appearance of the bullet points shown by lower case letters in the narrative.

▪The first ray represents personal values and personal idealized goals.

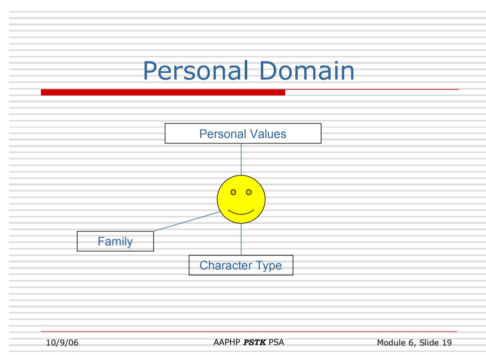
▪The character-type issue is presented opposite (180 degrees away from) the personal values.

▪This issue addresses the degree to which you may be willing to put your continuing employment at risk, or sacrifice family and social life in pursuit of the particular proposal at hand.

> Very few of us have been hired to be change agents, and most have demanding full time jobs that consume all of our on-the-job time. This means that any time devoted to pursuit of any kind of new initiative is likely to come out of family and social time. The question here

is the degree to which your family, or other significant others will be supportive of your supplementary job-related efforts – and where you might reach the point where putting too much time into the job might put your family and social relationships at risk.

Slide 20: Professional Culture (Technical) Domain



In the context of the PSA, the technical domain issues relate to the rigor with which you adhere to the most recent evidence-based and quality improvement guidelines, as opposed to doing what has been traditional in your community.

a = Professional Goals – what you want to do with your career (practice, research, high administrative position, lots of money – or some combination of the above.

b= Peers (at the national level – as per physicians in your own specialty)

c = Colleagues (at the local level – as per physicians in other specialties who might refer to you)

Slide 21: Administrative Domain

Error! Objects cannot be created from editing field codes.a= Boss and

b= Subordinates – how supportive are they of your proposal, and why – and if not, why not?

c= Budget and Personnel – what are the budgetary and staffing implications of what you are proposing, and what will it take to secure approval?

d= Standard Operating Procedures – is what you are proposing consistent with or inconsistent with current SOP?

e= Regulatory/Accreditation Requirements/Guidelines – if what you are proposing can be construed as required by a regulatory or accreditation body – you may get a "free ride" to implementation of your proposal

Slide 22: Policy/Political Domain

Error! Objects cannot be created from editing field codes.a= Authorization and Funding– governing board, legislature, elected executive, external funder or other

b= Patients and/or other clients – direct recipients of benefit of proposal

c= Interest groups external to healthcare system who might support or oppose project (pharmaceutical company, church, other)

d= Community Image/ view from marketing department/ view from news media – a good preventive services program might be grist for the marketing mill; but a quality assurance program might imply poor quality of care.

e= Legal/Liability/tort – a major issue here is the identification of patients who could benefit from a specified preventive service, and how to identify them without violating privacy or confidentiality. This will be discussed in greater detail in the data module

Slide 23: Leverage

Error! Objects cannot be created from editing field codes.Leverage, in the context of PSA, is **in the policy/political domain**. It refers to the power of someone in an organizational setting to recognize and effectively use the values and perceptions of more powerful stakeholders to move their agenda forward.

▪One **example**, in a healthcare setting, might be the ability of a clinic manager to directly or indirectly influence the CEO or the Board to "encourage" the personnel department to create ***classifications for physician assistant and nurse-clinician*** for more cost-efficient clinic operations – or someone in radiology to enlist the assistance of the marketing department to encourage the CEO to purchase an MRI machine, PET scanner or other expensive device.

▪***Another example, this time at the level of a state legislature – is the published real-life experience of Dr. Nitzkin in trying to prevent the state environmental agency from taking over the health department's safe drinking water program. This played out in Louisiana during late 1989 and early 1990, when Dr. Nitzkin was State Health Director. The environmental agency was a favorite of the then-current governor, and could get almost anything it wanted from or through the governor. It wanted the entire collection of health department environmental health programs. Dr. Nitzkin, feeling strongly that such programs would better serve the community if under public health rather than a strict regulation-enforcement-only agency, conducted a PSA, exactly as we will be doing in just a few minutes. By doing this PSA, he discovered that local governmental officials despised the state environmental agency because of the harshness of their enforcement of dump-site regulations – by issuing notices and fines, but not lifting a finger to help these local governments secure the funds needed to meet the environmental requirements. Dr. Nitzkin also confirmed his impression that state legislators knew and respected their local elected colleagues. With this knowledge in hand, he then formed a coalition, along the lines of a COPC cluster committee, but consisting of water system operators and leaders of the state associations representing elected officials at the local level, and set up a process by which top health department engineering staff would work with local water system operators to provide technical assistance and assist in the capturing of federal and private funds to upgrade local water systems – all this with no compromise (in fact a strengthening) of our law-enforcement capabilities with regard to these systems. The result was a law drafted by the LMA (municipal association) and rapidly adopted by the legislature not only to retain the program within the health department, but to increase its field staff and laboratory capabilities and eliminate all inspection and licensure fees. All this, from start to finish, played out over a five month period, from November to March, from the first move of the environmental agency to take over the health department program to passage of the law.***

▪Such is the power of leverage – a state appointed official, working through a voluntary organization to secure support, funding and staffing far beyond anything anyone would have considered possible prior to the conduct of the PSA.

▪Leverage is what the PSA is all about – how to find it, and how best to apply it.

Slide 24: Examples of Leverage

Examples of Leverage

- Tobacco Control Legislation
  - Getting hotel owners to advocate because of reductions to their cleaning costs and property damage
  - Getting restaurant owners to advocate to avoid installing costly air handling systems
- Health club services and nutrition counseling
  - Getting marketing to advocate to help attract low-risk enrollees

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(read slide)

Slide 25: Group Exercise

Group Exercise

- -- conduct one or more brief PSAs on situations proposed by participants

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Slide 26: Stepwise PSA Process

Error! Objects cannot be created from editing field codes. Define the proposal you wish to pursue

1. Work through the PSA, as an armchair exercise – alone or with colleagues
2. Preliminary stakeholder reserch: Make a list of questions you need answers to relative to the perspectives of key stakeholders
3. Reconvene the PSA session (usually within a week or two) to complete the analysis and propose an advocacy strategy.

▪If not feasible at this time – identify in very specific terms what needs to change to make the proposal feasible

▪If feasible now: work through the constituencies – for determinants of support and opposition to proposal in question

▪Identify opportunities for leverage and synergism (how constituencies interact with each other)

▪Gather additional information (almost always opinion and perception – easy to gather)

▪Consider pulling together a cluster committee for working this through a COPC process

▪Develop advocacy strategy

-- an anecdote relative to item 6: While health director in Rochester, NY, Dr. Nitzkin waited for an opportunity to propose tight restrictions on indoor smoking (early 1980's). The County Executive was a conservative Republican very friendly to the business community. The opportunity presented itself shortly after the County Executive quit smoking, and became sensitive to the smell of second hand tobacco smoke. Being prepared in advance, Dr. Nitzkin was able to rapidly propose and secure adoption of one of the (then) toughest set of restrictions on indoor smoking in the nation – and do so in a matter of a few short months – and, have it fully implemented from day 1.

Slide 27: The Magic of PSA

The Magic of PSA

- New Ideas and program options
- Leverage
- Health outcomes not otherwise achievable
- Prevent you from being "blindsided"
- Political support for yet other initiatives

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- Ideas that would otherwise not have been considered
- Health outcomes previously considered unreachable
- **PSA can be of substantial value in preventing you from being "blindsided" by opposition** to your proposal that you might not otherwise have anticipated – especially when dealing with legislative proposals at local, state or federal levels
- Political support for yet other initiatives

The post-Katrina experience in the New Orleans metropolitan area provide multiple examples of agency leadership and elected public officials being blindsided by perspectives that should have been considered, but were not:

1. ***Charity Hospital of New Orleans*** suffered basement and ground-floor flooding that destroyed electrical systems and other central utilities. The building above that level, including the emergency department patient areas, operating suites and clinics were undamaged in this 1930's era fortress of a building. The LSU system, that ran Charity Hospital, had been trying for many years to build a replacement facility, up to modern facility standards. They saw the damage caused by Katrina as their chance to do so – and, to bolster their long term plans, they opted not to invest a cent into the old building, and, instead, create de-novo, temporary facilities in an assortment of other buildings to provide a minimum of clinic and trauma care. By doing so, they seemed to forget the critical need for safety net services, especially for psychiatric care. And the clinical needs for residency training. This created a sitruation in which, rather than get the desired financial support for a new hospital, others are pressing (probably successfully) for elimination of the hospital, and distribution of the funding that supported it through the Medicaid program to other facilities.
    a. Likely lost by this failure to consider other stakeholders:
        i. Residency training slots
        ii. A level 1 trauma center for the state of Louisiana
        iii. Safety net inpatient and outpatient services
        iv. Possibly the entire Charity state system
        v. Failure to consider that the costs of setting up the temporary interim services in alternative temporary locations would likely exceed the cost of the interim repairs that could have rapidly reopened at least portions of the Charity structure.
2. A non-medical example is the ***"smaller footprint" proposal*** to simply turn the 9th ward and New Orleans East to unoccupied "green" zone without regard to the opinions or perceptions of the residents of those areas. This was generated by an elite panel of outside urban planners, without community input.

Slide 28: True or False

Error! Objects cannot be created from editing field codes. There are never only two sides to a health policy issue – there are always at least 8, and often 15 or more.

▪The primary currency is **not money** – but the **political will** of potential funders to dedicate funds for what you want to accomplish

▪People, both staff and clients, are your most valuable resource, not the dollars

▪What is good for me or for my agency is good for the community – sometimes it is, sometimes it is not – you must consider the individual proposal, and work it through the sunburst diagram.

Slide 29: Q and A

(end of slide presentation)

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