Knowledge Management Practice in a
Community and Allied Health Setting

David Meacheam

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"Forget the wah wah, just give me a yes or a no"

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Abstract: Using a grounded theory approach, the author examines knowledge management practice in the Community and Allied Health Division of Central Coast Health, a public health service in New South Wales. Prime issues are maintaining process improvement within a very tight budget, and negotiating meaning across disciplines. The organisation is seen as coping with remarkable issues of cross-disciplinary communication and co-ordination, with a focus on client welfare being the unifying factor.

Keywords: Knowledge Management, Organisational Theory, Public Health Service

Introduction

KNOWLEDGE MANAGEMENT HAS been a matter of enduring interest over the past 20 years, pioneered as a concept by Peter Drucker and extended by others (Drucker, 1988, Nonaka, Byosiere and Konno, 1994). Recent attention has been toward such topics as 'communities of practice' (Brown and Duguid, 1991, Iverson and McPhee, 2002, Wenger, 1998), and the role and power of storytelling within organizations (Denning, 2001, Snowden, 1999).

To date, very few studies have focussed on the consequences of organisational type for the practice of knowledge management. Many journal articles are quite prescriptive of how knowledge should be developed and applied by organisations, but few take account of organisational type. The most notable exception is the work of Hansen, Nohria and Tierney (Hansen, Nohria and Tierney, 1999), who took a strategic view of organisational type, and through a fairly simple linking of problem recurrence rates, urged organisations to adopt either an automated (high problem type recurrence), or person based (low problem type recurrence) system for addressing those problems. For practicing managers, there is little guidance in their conduct of knowledge management as to how they need to take account of other factors, such as the professional backgrounds of staff, or managing a mix of disciplines in the workplace. This paper focuses on how one organisation manages such a mix.

The author's interest arises from teaching organisational theory and knowledge management over a number of years. The organisational typology developed by Miles and Snow of Defender, Analyser,

Prospector and mixed type organisations (Miles and Snow, 1978) hasn't to date been assessed for its impact on modern knowledge management practice. Defender type organizations have to defend against the entry of other service/product providers by paying continuing attention to costs and process improvement, Analyser organizations are the 'me too' variety, sometimes first on the scene with a new product or service, but with easy competitor entry to their ground, cannot secure control of a market. Prospector organizations are first to offer a service or product, and may be able to dominate the market through protection of its intellectual capital, or through a reputation for excellence. While Miles and Snow's work does examine strategy, it pre-dates much modern knowledge management awareness and research. This paper makes the links between one instance of a 'Defender' organisation and its knowledge management practice.

Relying on a grounded theory approach, the author interviewed 10 middle to senior managers in the Division of Community and Allied Health, Central Coast Health authority of New South Wales. The same process was undertaken with two other organisations that fitted the 'Analyser' and "Prospector' types. The results of those studies will be reported in other papers, with conclusions from all three studies likely to be the subject of a larger journal publication. The Central Coast Health interviews were undertaken shortly before a merger of Central Coast Health with Northern Sydney Health service. The findings reflect the state of knowledge management within the Division at about February 2005.

The author used the interviews to test how the separate concerns of sense making, knowledge creation and decision-making were handled by inter-

viewees within the organisation. Interviews were transcribed, and the transcriptions analysed using Nvivo qualitative research software.

Emerging from this study is a compelling pattern of highly adaptive, multi-disciplinary, professional practice, that both confirms the expectations of behaviours anticipated in a Defender organization (budgetary constraints, a focus on process improvement, decisions based on strong, empirical evidence), and a very specific, local health care culture that is concerned with holistic health care, takes reasonable risks and has pride in the creation of a unique set of services.

Study Methodology

Participants

The author's initial contacts within the Division were three persons that fitted Yin and Sarantakos's ideal of elite, expert sources (Sarantakos, 1993, Yin, 1994). These people in turn were asked to identify others that Morse refers to as 'good informants' (Morse, 1998). Interviews were concluded with the author asking for tips as to who would make a suitable next interviewee within the Division. The sampling approach can be characterised as being of the 'snowball or chain' type (Miles and Huberman, 1994 p. 28) As the data accumulated, and characteristics of knowledge development and use became apparent, the questioning process converged on the handful of key issues reported below.

Research Strategies

Data Collection

Beginning with the author's key contact within the Division, three separate interviews were conducted with three senior managers within the Division. At this stage of the research process the questioning was very general, beginning with "Tell me what you would typically do in a working day", then increasingly focussing on those parts of their responses that gave clues to their methods of sense-making, knowledge development and decision making. All interviews were with single individuals, who were assured of anonymity in the reporting of the interviews. Interviews typically took 45 minutes to one hour. The conclusions of the initial three interviews were written up in brief form and relayed back to the interviewees for comment. The interview findings and the responses of the first three interviewees to the initial analysis informed the subsequent interviewing of seven other persons within the Division.

How the Data was Analysed

The audiotaped records of the interviews were transcribed by research assistants. The transcripts were then interpreted into the software program Nvivo. Nvivo served as a tool to both analyse and manage the data, enabling ready recall of pertinent parts of the interviews.

Central Coast Health

Division of Community and Allied Health Background

At the time the interviews were conducted, the Division of Community and Allied Health was one of 13 divisions within the Central Coast Health structure. Central Coast Health has subsequently been combined with Northern Sydney Area Health. Employing approximately 580 fulltime employees, the Division encompassed a broad variety of services, ranging from physiotherapy and dental services delivered at both the central (Gosford) site and satellite sites, to child protection and domestic violence prevention services, predominantly delivered off-site. The largest part of the Division was Community Nursing, employing a fulltime equivalent of about 130 people.

Findings

One of the key tasks for the researcher was to identify whether in practice the Division of Community and Allied Health fitted the criteria of a Defender organisation, i.e. one that competed primarily on the basis of cost.

While the interviews did confirm that the Division was a Defender type organization, there was a huge diversity amongst the interviewees as to how they viewed those competitive pressures. The push or threat of the entry by private providers to some service areas was dismissed by some:

> "Yes, I have actually given way to all of the personal care and the housework and I say let them do it. Let them have the problems, let them have the issues with the manual handling. It leaves us freer to do what we ought to do, providing quality nursing care … (Interview B-10-1, relating to community nursing).

Others felt that it was actually desirable in some instances to go to other providers:

> "In Mental Health in particular, we have the learning… that there are partners of us out there who can better perform than we can in [social support of mental health clients and their families]…We've learnt that we're not good at providing residential care for mental health cli-

ents and we can outsource that. We welcome private providers as partners in those areas." (Interview B-9-1)

The associated high levels of concern for client welfare is an issue further developed below.

Larger than the threat of the entry of private service providers was the very limited scope for any growth in funding:

Having established that the Division constituted a Defender type organization, what then characterised the processes of sense making, knowledge creation & decision making in the Division? The processes identified fit into two broad streams. The first stream, process improvement, (associated often with a concern for budgets), reliance upon empirical evidence (enabled by technology use, in particular), even in those areas of service delivery where empirical evidence is scarce, fit well with the expectation of the behaviour expected of a Defender organization. The second stream is specific to the circumstances of the Division, and includes a strong focus on cross-disciplinary communication, assisted by technology use, on risk-taking and high levels of concern for client welfare, a sense that what the Division does is unique, at least in Australia, effective networking within professional circles and what the author termed 'management of community political issues'. Each of these will be explained below.

Stream One: Process Improvement, (Associated often with a Concern for Budgets), Reliance upon Empirical Evidence, Including Technology Use

Miles and Snow's definition of the Defender type as having a continuing concern with process improvement was verified in the interviews. All interviewees reported a high concern for keeping within the bounds of budgets. Any push to either alter the 'slices of the pie', or grow the pie, needed to be backed with a strong body of empirical evidence:

"Allied Health practitioners have taught us to re-engineer our outputs for the best bang for the buck, because they've been doing it for years. They've been forced to do it for years …" (Interview B-9-1)

"You do rely on advice from the experts in the profession. You certainly do look at the evidence in the literature and I certainly consult with other area health services in terms of just to see how they're going to develop. … there is a …push … in evidence based practice and things like that." (Interview B-6-1).

This insistence on empirical evidence as the basis for decision-making was supported by use of external conference and academic paper databases, and use of highly developed databases. These databases are not off-the-shelf systems, but rather devised in-house to mesh and support the processes that the Division see as quite unique to their service type and circumstances:

"[Database use is resulting in] Saving time, increasing efficiency, productivity, saving frustration. The nurses would much rather be providing a high level of clinical care, both in volume and quality, than be sitting at a computer or getting a writer's cramp from writing things over and over again" (Interview B-7-1)

Stream Two: Cross-Disciplinary Communication, Risk-taking, High Levels of Concern for Client Welfare, a Sense of Uniqueness, Effective Networking within Professional Circles and Management of 'Community Political Issues'

In all interviews, the issue of communicating across the disciplines was a prime concern. This is illustrated by the subtitle to this paper:

"And he [the Business Manager] would come to me and say "What should I do about this or that?" and I'd start to give him a response and he'd say "Don't give me the wah wah, just give me a yes or a no". The thing is [laughing] my job's all about the wah wah." (Interview B-1-1).

Inter-disciplinary communication was enabled in part by a practice of moving people to manage those within other divisions:

"I'm not a clinical expert for any of the areas that they work in. What I have developed over the years is a mechanism for supervising their process without being an expert in their clinical area." (Interview B-5-1)

While cross-disciplinary communication proved a challenge for many, all interviewees acknowledged the importance of what Leonard Barton termed 'creative abrasion' (Leonard-Barton, 1995), the learning possibilities that come when people from unlike disciplines are compelled to work together:

"So [I thought] there was nothing left for me to learn and I came into Community Health and found a whole new world. Like, I was dealing with people with mental health [conditions] and psychologists and they said queer things." (Interview B-10-1)

This theme of continuous learning was echoed by most interviewees, and was seen as a source of satisfaction in their work:

> "… the consumer or the carer of that consumer is by far superior in their knowledge to the clinical people that work here and I'm blown away so frequently by the aptitude, the capacity, the depth of knowledge, the wisdom of carers. … our learning breakthroughs have commonly come from hearing complaints and concerns from carers and clients, and learning from the pain of their experiences" (Interview B-9-1)

All interviewees showed a high reliance on conversations with peers as a prime source of sense making, knowledge creation and decision-making. The author's previous experience of health and social service providers in Hong Kong suggests that this reliance on personal exchanges comes out of the professional cultures within these disciplines, and is only weakly mediated by national culture preferences (Meacheam and Lee, 2004).

The concern with process improvement commonly gave rise to wholly new ways of delivering health care. There is a sense within the Division that what they do is unique in the health sector. This sense of creating something new, unique, was pervasive:

> "Our practice in wound management was a world [first] practice. So it wasn't like Central Coast was doing the wrong thing, the whole world was and today the whole world still is." (Interview B-10-1)

Being a large, public authority, bureaucratic constraints sometimes have to be avoided, and some in the Division do well in this respect: Staff are commonly members of interest and lobby groups that address broad community concerns – child protection and domestic violence being two instances, - where that external body can, collectively speak out on issues.

Such risk-taking has sometimes proven a key to process improvement:

> "Now we had some support from the manager we had at the time, but she was hot and cold. …I would just ignore her and keep [the registered nurse] doing wound management. So, it was a struggle a lot of the time." (Interview B-10-1).

The outcome of this out-of-bounds behaviour was the establishment of a wound care system that costs the Division with high spending of special dressings, but saves much more in paid time for community nurses.

Sense making sometimes takes place under extreme circumstances, a need to cope with high ambiguity. A senior manager concerned with domestic violence and child protection issues gave a rich account of sense making in crisis situations: When asked if she documented actions immediately in a crisis, she responded:

> "Very minimal scribe, I tend to do it in my head, it's a picture. It really is a picture until you have to write the report and then it'll just be from the dot points. There's a picture in here" [points to head]. (Interview B-1-1)

Her practice matches well the complex process of sense-making described by Brenda Dervin, where the sense-making process is seen as complex and iterative, rather than linear (Dervin, 1992, Dervin, 1998).Coupled with this is a system of information sharing between these child protection and domestic violence workers that does more than simply inform key other stakeholders. It also works to address what the author coined as 'community political concerns'. Interventions in child protection and domestic violence situations carry the possibility that they will be seen as heavy handed, or too little action, too late. The risks can pay off well:

> "… one of the reasons we have … success … in getting more positions and getting kudos is that we actually bring a lot of attention and kudos to higher up the line for some of the things that we do that are a bit innovative. They like that they can see that we're doing things and … getting credit and looking good." (Interview B-2-1)

This management of the political aspects of organisational life is an aspect long recognized as significant (Pettigrew, 1973, Pfeffer and Salancik, 1974). Quinn sees political skills as being essential in modern management (Quinn, 1988). All those interviewed showed sensitivity to the political implications of their work, in particular to the possibility of unfavourable press coverage of health issues.

For those within the Division concerned with so-called 'soft' services (counselling, harm prevention), there was commonly a background agenda of change:

> "…often we are … advocating for people who don't advocate well for themselves. Intravenous drug users, … people who perpetrate sexual violence and other forms of violence upon others. …I don't see it as managing the agenda; I see it as changing management. I don't think the agenda, even momentarily, focuses on those people who are most disadvantaged". (B-9-1).

Balancing this is a sense of responsibility for the services delivered:

> "So, in fact, if you look at it, the community is the buyer, it's where the money's coming from. They put the money in and we [are accountable] to them…." (Interview B-1-1).

The key factor that binds so many people from such diverse disciplinary backgrounds is a strong focus on client welfare:

> "The most impressive person in that whole group was Dr [X], who was just total aged care, don't talk about anything else but aged care, give all the money to aged care, when he went through that [program budgeting marginal analysis] process with us he could see that the highest need [in] Community Health was for youth health …and he was prepared to give up something in aged care to give to youth health." (Interview B-10-1)

> "It's actually in looking at how do we create a service so that the client at the end of it gets the best possible service. That's what I'm about." (Interview B-5-1)

The Implications of these Findings

This research has clear implications for managers in public health service settings. First, it is likely that employees will be quite capable of meeting the bulk of their knowledge needs through existing networks.

In the case of multi-disciplinary health service settings, the instance of 'creative abrasion' (Leonard-Barton, 1995) will ensure continuing innovation in the organisation. Mixing disciplines in the workplace may create some discomfort, but it also creates new knowledge. Second, direct appeals to strategic concerns (the pursuit of growth as an end in itself), is unlikely to succeed. Managers will more likely succeed through appeals to advancing client welfare. Third, it is important for managers of 'soft' health services, those with less tangible outcomes, that they have the skills to politically manage the growth of those services, when the empirical evidence for their success may be scarce. This reinforces Quinn's notion that modern managers need to be both aware, and capable in the political aspects of their work (Quinn, 1984).

Conclusion

This research shows a complex picture of service provision within an allied and community health division of a public health body. Most of the findings fit the expected patterns of behaviour in a 'Defender' organisation, with a high concern for budget, a close focus on process improvement, and attention to hard evidence in making decisions. In other respects this research shows less influence of the 'Defender' type. The high levels of concern for client welfare, high levels of professional responsibility, bounded risk-taking, and an agenda of social change, are factors that are probably quite unique to this health service, and probably not generalisable to other Defender type organizations.

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