

Leader Perceptions of Multi-Sectoral Healthcare Alliance Response to Health Reform

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ABSTRACT

OBJECTIVES: The purpose of this study was to investigate multi-sector healthcare alliance (MHCA) leader perceptions of responses to the Affordable Care Act and whether responses differed as a function of 2 different political environments—states supportive of health reform and states unsupportive of health reform.

STUDY DESIGN: Holistic, multiple-case study.

METHODS: Using interview data collected from MHCA directors, we analyzed 3 types of responses—programmatic, instrumental, and resource—and whether the types and sequence of responses differed between MHCAs in the 2 environments.

RESULTS: Leaders from MHCAs in both political environments were more likely to perceive the need for response in areas of the organization related to resources, while responses related to programmatic issues were less likely to occur. Leaders from MHCAs in supportive political environments believed the changes brought about by health reform reinforced their collaborative activities with participants by providing an opportunity to work more closely with participating organizations and to potentially collaborate with new types of partners such as the state. In contrast, leaders from MHCAs in unsupportive political environments believed that health reform was having a disruptive effect on their collaborative strategies.

CONCLUSIONS: Changes in the political environment, even when consistent in their objective, are not uniform in their interpretation, application, or consequences. Rather, changes are transmitted through multiple levels of an MHCA's external environment, and variations across these different levels can amplify or attenuate how much change occurs and can also affect the types of changes undertaken by MHCAs.

Multi-sector healthcare alliances (MHCAs) are voluntary nonprofit organizations that bring together a diverse array of stakeholders (eg, physicians, hospitals, insurers, employers, government agencies, and consumers) to work collaboratively on health-related issues in a community. MHCAs and other types of collaborative organizations—such as learning collaboratives, chartered value exchanges, partnerships, and coalitions—play an increasingly prominent role in the US healthcare system by addressing the fragmented nature of healthcare financing and delivery through collaboration rather than competition.^{1,2}

Like other organizations, MHCAs operate in a political environment, defined as the government and its institutions and laws, as well as the public and private stakeholders who operate and interact with that system. It also includes the widely held views, beliefs, and attitudes concerning what governments should try to do, how they should operate, and the relationship between a government and its citizens.³ Major events and changes in the political environment can have a wide range of consequences for organizations.⁴ Therefore, organizational leaders pay close attention to the political environment to assess how government actions may influence their organizations, and they try to make changes to their organizational structures and strategies accordingly.^{5,6}

Passage of the Affordable Care Act (ACA) in 2010 was a significant event in the political environment for healthcare organizations, including MHCAs. On one hand, this legislation provided a vision of what the US healthcare system should be working toward. On the other hand, the mechanisms by which the policy should or would be implemented were not altogether clear. Differences in expectations and clarity influenced whether leaders in MHCAs believed the legislation provided opportunities or constraints on existing strategies

or practices.^{7,8}

These different expectations stem in part from the fact that an organization's political environment has multiple interwoven levels (local community, state, and national). Thus, national policy events such as the passage of the ACA may interact with or be mediated by state or local political conditions that amplify or attenuate their impact on healthcare organizations. Organizational leaders play a pivotal role in scanning, organizing, and interpreting information provided by the external environment, such as changes in the political environment.⁹⁻¹¹ Therefore, the purpose of this study was to investigate MHCA leader responses to the ACA (hereafter referred to as health reform) and whether these responses differed as a function of 2 different political environments—states supportive of health reform and states unsupportive of health reform. The findings are of relevance to policy makers and researchers interested in understanding the interactions between government regulation and organizational response. The findings are also of interest and importance to advocates, sponsors, and leaders of multi-sectoral efforts, such as MHCAs, charter value exchanges, and public-private partnerships, who are concerned with identifying ways to foster more effective collaboration and to mitigate threats to those collaborations.

Background and Conceptual Framework

A considerable body of research has explored the importance of the political environment as a correlate of organizational change.^{12,13} Tolbert and Zucker,¹⁴ for example, showed that the rate and timing of the adoption of civil service reforms initiated at the federal level were determined by state-level laws related to such reforms. MHCA responses to changes in the political environment may include actual changes such as organizational restructuring or the development of new programs and procedures. Responses may also entail non-action, such as a decision to not pursue new programs or revenue sources.

Significant changes in the political environment tend to create uncertainty for organizational leaders in determining what goals to pursue and how to pursue them.^{12,15} In the context of such changes, systematic differences in political environments can affect how organizational leaders interpret these changes and their implications for their organizations. These differences derive from the fact that organizations operate in a multi-level federalist system set forth in the Constitution.^{16,17} While federalism has a number of advantages—such as the distribution of power and experimentation across levels—it also increases the potential for conflict between levels when there are disagreements about the rights of the state vis-à-vis the federal government.¹⁶ Furthermore, the government and other actors within these respective levels may assume different roles (eg, state as supplier of resources, state as regulatory body) and carry out these roles with different levels of intensity due to differences in the dominant political parties and the different values associated with

these parties. As a result, changes in the political environment may be perceived as presenting opportunities for an organization, or as constraining its plans and activities. Therefore, we expected differences in the MHCA's political environment—in particular whether the state was supportive or unsupportive of health reform—to affect the types of responses perceived as necessary by MHCA leaders following health reform.

We focused on 3 types of perceived responses in our study^{18,19}:

- *Programmatic responses* relate to decisions and actions regarding the goals and objectives of the MHCA.
- *Instrumental responses* pertain to the strategies or procedures used by MHCAs to achieve their goals.
- *Resource responses* relate to actions and decisions regarding the prioritization and allocation of resources (eg, funding, staffing, continued participation).

These responses represent the primary factors that organizations consider when adapting to their external environment.²⁰ We hypothesized that the mixture of actions and decisions across these categories would be determined, in part, by the amount of uncertainty, opportunity, or support perceived in the political environment. That is, leaders of MHCAs would make decisions and take certain courses of action based on how well they met the particular requirements of their political environment.

In addition, scholars have called attention to issues of process and the sequence of responses that may occur, which is often determined by the difficulty or disruptiveness of the response in the organization.^{21,22} The more disruptive responses, such as those that alter the core goals or technology of the organization, are less likely to be undertaken by organizational leaders.^{20,23} In the case of our study, programmatic responses may be considered the most disruptive as they potentially change the goals and objectives of the MHCA. Instrumental responses are not as likely to change the mission or identity of the organization, but rather change how the organization accomplishes that mission or establishes a particular identity. Finally, resource responses may be considered least disruptive, as these types of changes are most likely to influence the speed with which the MHCA achieves that mission or establishes its identity. Together, these arguments suggest that MHCAs may be most likely to respond in ways that affect MHCA resources, followed by instrumental responses; changes in programmatic areas may be least likely to occur.

Methods

Study Context

This study was part of a larger investigation of Aligning Forces for Quality (AF4Q), the Robert Wood Johnson Foundation's signature effort to lift the overall quality of healthcare in targeted communities, reduce racial and ethnic disparities, and provide models for national reform. The premise of AF4Q is that the greatest improve-

ments in the quality of care can be achieved when aligning the efforts of key forces, including healthcare providers (eg, physicians and hospitals), healthcare purchasers (eg, employers and insurers), and healthcare consumers (eg, patients), through multi-stakeholder alliances.^{24,25} As participants in the AF4Q program, all of the MHCAs studied here operated under the same general vision of improving the quality of care in their respective communities and were expected to utilize the same general strategies to pursue that vision. These strategies focused on initiatives related to public reporting, quality improvement, consumer engagement, and equity associated with race and ethnicity. The operational aspects of these strategies, such as how the initiatives were developed and implemented, however, differed across the MHCAs. The MHCAs also utilized different organizational structures—including partnership among local organizations or a single organization coordinating efforts of other organizations—to implement these strategies (Table).

The analysis focused on 8 MHCAs in 2 different political environments. Whether an MHCA was located in a political environment supportive or unsupportive of health reform was based on the Kaiser Family Foundation’s summary of the states that were challenging or supporting health reform.²⁶ Based on the data presented in this website, an unsupportive political environment was defined as one in which the state contested the constitutionality of the individual mandate, and in most cases, contested the constitutionality of the Medicaid expansion. In contrast, a supportive political environment was defined as one in which the state backed the constitutionality of both the individual mandate and the Medicaid expansion. Using these definitions, our analysis included 4 MHCAs from political environments supportive of health reform (California, Maine, New Mexico, and Oregon) and 4 MHCAs from political environments unsupportive of health reform (Kansas, Michigan, Ohio, and Wisconsin).

Data Collection

The data were drawn from telephone interviews conducted in fall 2012 with MHCA directors. These interviews, which are conducted every 6 to 12 months in between in-depth site visits, assess changes (eg, progress towards goals, turnover in key members) that occurred since the last interview was conducted. The interviews used in this analysis were conducted approximately 2.5 years after the passage of the ACA and included questions about the effect of the legislation on the MHCA. Interviews were systematically coded and prepared for computerized text search using ATLAS.ti software, version 7.5 (ATLAS.ti GmbH, Berlin, Germany).²⁷

Analytic Strategy

The purpose of our analysis was to describe in detail whether and how leaders in MHCAs from supportive and unsupportive political environments have responded to the passage of health reform. To do so, the full interview transcripts were first coded with predefined, macro-level themes (eg, goals/vision, policy). In the second step, we pulled the data coded as policy, which captured any reference by MHCA leaders about various political/policy factors (national, state, and regional) that impact their alliance, and its planning, strategies, and activities, or healthcare in the alliance’s community, into a separate report for each MHCA. Investigators then reviewed these reports independently to examine what informants said about how the MHCA was responding or anticipated responding to health reform. The investigator comparison of this initial open coding yielded a consolidated set of emergent themes that were organized into the 3 categories of responses: programmatic, instrumental, and resource. In the third step, 2 of the team members wrote a short memo for each MHCA that more fully described these themes. In the fourth step, the first author consolidated these themes and wrote a memo

Table. Alliance Characteristics by Alliance and Political Environment^a

POLITICAL ENVIRONMENT	SUPPORTIVE				UNSUPPORTIVE			
	Albuquerque, New Mexico	Humboldt County, California	Maine	Oregon	Cincinnati, Ohio	Detroit, Michigan	Kansas City, Kansas	West Michigan
Alliance location	Albuquerque, New Mexico	Humboldt County, California	Maine	Oregon	Cincinnati, Ohio	Detroit, Michigan	Kansas City, Kansas	West Michigan
Partnership or single organization	Single	Partnership	Partnership	Single	Single	Single	Single	Single
501(c)(3)?	No	No	No	Yes	Yes	Yes	Yes	Yes
Years in existence	3	5	5	11	20	68	12	64
No. of participants	102	33	44	79	106	150	31	80
Market population (in millions)	0.66	0.13	1.33	3.83	2.21	4.70	1.69	1.52

^aAt the time of data collection.

for each MHCA, and the second author reviewed these memos to ensure that the memo accurately reflected the themes identified by the respective memo writers. Finally, the first author used these consolidated memos to identify consistent themes across MHCAs within similar political environments (ie, supportive vs nonsupportive), which were subsequently used to contrast MHCAs in these different environments.

Results

Characteristics of MHCAs and Their Service Areas

The **Table** includes select characteristics of MHCAs and their service areas. All of the MHCAs included in the study were nonprofit organizations (6 MHCAs) or partnerships among mostly nonprofit organizations (2 MHCAs). Five of the MHCAs were incorporated as 501(c)(3) organizations, including all 4 of the MHCAs in unsupportive political environments. MHCAs in supportive environments had been in existence for an average of 6 years (range, 3 to 11), while MHCAs in unsupportive environments had been in existence for an average of 41 years (range, 12 to 68).

MHCA Leader Responses to Health Reform

Programmatic. Consistent with our hypothesis, substantial changes in programmatic areas were not observed for any MHCAs. Instead, most leaders, regardless of the political environment being supportive or unsupportive, believed that the changes brought about by health reform were consistent with and reinforced their goals. Moreover, several leaders from MHCAs in both political environments noted how they had already either expanded or were planning to expand primary care programs, such as patient-centered medical home initiatives, as a result of health reform. In fact, the leaders in both political environments reported a galvanized belief in their goals as a result of health reform, in part because it stimulated dialogue within the MHCA and between stakeholders in ways that forced them to reassess the critical “value added” by the MHCA. In most cases, this meant maintaining existing programs, but there were exceptions in both environments in which MHCAs either discontinued certain activities or placed a moratorium on them. For example, one MHCA leader in an unsupportive political environment described their decision to revisit the purpose and contents of their public reporting program as:

“*We think where we can add value to the [member] organizations is reducing some of the noise that they're hearing in terms of CMS wants us to focus on one thing, [the MHCA] is asking for something else, and trying to help them make sense of it. And so we're looking at what's coming out of CMS and not using it as marching orders but definitely looking at how does it connect to what the [member] organizations need to be doing.*”

Instrumental. In contrast to programmatic responses, MHCA lead-

ers from the 2 political environments diverged in their views of how health reform has and would continue to influence their approaches to achieving their goals. Leaders from MHCAs in states unsupportive of health reform reported more confusion about who should be doing what, and believed that this confusion was disruptive of established collaborative efforts. For example, one leader described how health reform requirements regarding hospital community needs assessment may thwart efforts to work collaboratively:

“*When I came into this job, one of the things that [the MHCA] was looking at doing was...a community needs assessment, which is mandated by the Affordable Care Act. So I found out that 3 other organizations were also doing community needs assessments. So the question is how many of these do we need, and who should be doing it? And then how do we collaborate in the community to make sure that we're leveraging those resources and that it's only being done once?*”

One contributing factor to this confusion was a concern that health reform is changing, or will change, provider behaviors in ways that make them more competitive and fearful of what is to come. Leaders from these states were more likely to report believing that healthcare reform will lead to greater competition, either between partnering organizations (eg, hospital competition in the local market) and/or potentially between partnering organizations and the MHCA itself, such as duplicative services. Notably, leaders in these states reported that consolidation had already started occurring among providers, especially physicians and hospitals, in response to healthcare reform. For these MHCA leaders, there was a belief that this consolidation was going to make it harder to engage in activities consistent with their goals. In particular, a number of leaders noted how the emergence of accountable care organizations (ACOs) and consolidation more generally might challenge the MHCA's ability to continue to engage in public reporting and quality improvement activities. One leader, for example, described recent efforts to create a public report with common metrics across the community:

“*I have this personal philosophy that these organizations [ACOs] are not going to openly share a lot of data with one another. I don't think they're going to have full population data flowing into a community registry. I could be entirely wrong, but what I do think is that these organizations are going to become very insular and very inward-focused.*”

Interestingly, this leader described this fear even though the ACO in question had already agreed, at least in principle, to adopt the same measures being used by other providers in the community.

In contrast, MHCA leaders in states that were supportive of health reform reported less confusion and felt less threatened about how they would achieve their goals. This is because they believed

that the MHCA was structured in ways that positioned it to take advantage of the changes being brought about by health reform, by either incorporating new programs into existing programs or leveraging partnerships to pursue new programs. For example, a leader from one of these MHCAs noted the potential for these new opportunities to be a distraction, but overall felt that the MHCA had positioned itself to limit these distractions while making the most of the opportunities:

“ Yes, you know [health reform] is distracting in terms of another opportunity every day but I think states, like ours, have seen those as an opportunity to further the work that we are already doing. So I would say [opportunities] would be distracting if each one went off in a different direction and set a new priority for the state. ”

Leaders in these political environments also believed that the changes brought about by healthcare reform increased awareness of MHCA activities among community members, and helped members to see the value of the MHCA, in part by normalizing the MHCA's existing programs and activities. One outcome of this increased awareness and perceived value, at least for some of these MHCAs, has been the attraction of new partners or the solidification of relationships with existing partners, especially around areas of core competence. For example, one leader noted that their work on payment reform made them the “go-to” source for issues related to payment reform and Medicaid expansion when federal health reform was passed:

“ I think the federal health reform has made it clearer to people about what needs to occur and that's where I think it has opened up their eyes a little bit more about ‘Well, maybe we don't have to start from the ground up or reinvent this.’ We may have the building blocks through the work that [the MHCA] has been doing to be able to do what we have to under some of those major pieces of reform... But it's been clear that our messaging has gotten them to see that we're sort of the go-to people when it comes to that... ”

Even when leaders from MHCAs in the different political environments reported new partnerships, the types of stakeholders with whom they reported new relationships were different. New partnerships were either started or anticipated more often with the state government or agencies for MHCAs in supportive political environments. In contrast, in unsupportive political environments, new partnerships were more often with insurers, employers, and providers.

Another outcome of increased awareness for MHCAs in supportive political environments has been a change in member behaviors outside of the MHCA in ways that are consistent with MHCA goals. For instance, a leader from one of these MHCAs described how some of the disincentives from health reform have increased collaboration among providers in ways that align with some of the

goals of the MHCA regarding readmissions:

“ ...hospitals are now being dinged for readmissions...they're starting to work with long-term care centers to help reduce the readmissions coming from nursing homes. There's no way we could have got them doing that without that incentive there. ”

Resources

Consistent with our argument that resource-related decisions and actions would be least resistant to change, leaders believed that health reform had, and would continue to substantially affect MHCA resources. MHCA leaders in both political environments generally believed that health reform provided additional resources to support existing programs and the MHCAs were actively pursuing these resources. Where MHCAs tended to differ, however, was in leaders' opinions of the level of opportunity afforded by these resources and from where the limitations on these opportunities originated. Leaders from MHCAs located in unsupportive political environments were more ambivalent about the additional resources and more likely to report them as “both a blessing and a curse.” On one hand, the additional resources helped reinforce existing programs, and in some cases stimulate new ones. On the other hand, leaders tended to believe these additional resources stretched the MHCA and its partners in new directions that could become a distraction or even overwhelming. Leaders from these MHCAs were also more likely to attribute limitations of these additional resources to external forces, namely state-level decisions regarding discretionary components of health reform. For example, state governments in these environments were often embroiled in debates about whether to accept funds to support Medicaid expansion, which raised questions for MHCAs in these environments about whether additional resources would be available to engage in access-related work, despite a widely accepted goal to do so.

In contrast, leaders from MHCAs in supportive political environments were more likely to describe the challenges of applying additional resources as related to local and MHCA-level limitations. In particular, there were concerns that the resources made available by health reform may be geared toward initiatives that could not be easily implemented in their geographic area, such as a rural location, or could not be taken advantage of because of their size. For example, one MHCA leader in a state supportive of health reform described the challenge of responding to health reform while operating in a rural community as:

“ ...the fact that we are not very densely populated sometimes it makes it difficult to take advantage of some of the opportunities that might be available or come down from federal law. ”

Discussion

The findings of our study highlight differences in the 2 political

environments in the means by which MHCA leaders expected to achieve their goals. Leaders from MHCAs in supportive political environments believed the changes brought about by health reform reinforced its collaborative activities with participants by providing an opportunity to work more closely with participating organizations, and to potentially collaborate with new types of partners such as the state. In contrast, leaders from MHCAs in unsupportive political environments believed that health reform was having a disruptive effect on its collaborative strategies. Given the importance of member participation for conducting the work of the MHCA, such consequences would likely lead MHCAs to work with fewer partners, work with different partners, or change strategies altogether. Our findings also suggest that, even when members of MHCAs in different political environments share similar views about the value and intended effect of healthcare reform, its actual effect on the MHCA may differ.

Consistent with the principles of federalism, one explanation for the differences between the 2 political environments is that different levels of the political environment work in combination to create different amounts of cumulative ambiguity and task conflict for the MHCAs. For example, greater levels of political ambiguity can increase goal conflict for organizations, and that ambiguity at different levels of the political environment can exacerbate goal conflict.^{15,28} Assuming leaders of organizations act upon their interpretation of the enacted environment,²⁹ such differences would produce different responses from MHCAs.³⁰

The differences between the 2 environments likely have implications for leaders trying to implement and sustain programs due to their dependence on collaboration for carrying out their work, which in turn may mitigate their effectiveness.³¹ For example, one of the signature programs pursued by MHCAs in our study, regardless of political environment, is public reporting. Public reporting is intended to promote transparency that facilitates better provider choices by consumers and quality improvement activities by providers. To maximize their effectiveness in achieving these goals, MHCAs had generally pursued data from multiple health plans and providers in the community to populate these reports. However, a challenge to getting buy-in from health plans and providers to provide data was a concern that disclosing such information threatened their competitive position in the community,³² resulting in a somewhat tenuous commitment on the part of these members. Conceivably, changes in the political environment that increase perceptions of competition hold the potential to erode these earlier commitments and undermine the robustness of these public reports and the value that they provide to the community.

Similarly, our finding that different MHCAs approach the design and implementation of their work differently as a function of the political environment likely has implications for funders and program designers. Specifically, programs that are uniformly designed

and promulgated by external entities may face greater implementation challenges when the political environment is complex or varies greatly across sites. Future research is needed, however, to assess whether these differences truly do translate into slower or stalled implementation, lower fidelity to intended programs, or failure to sustain these programs over time.

The findings discussed above also underscore the need for more leader attention to multi-level issues that other organizational and MHCA researchers have noted.^{33,34} They also begin to shed light on how changes in the political environment are interpreted differently when filtered through multiple levels of an organization's external environment. Such possibilities highlight how similar policy changes can have such varied influences at local levels. More research is needed, however, to understand why organizational leaders may pay more attention to or put more weight on certain levels of their external environment.

Our analysis also pointed toward some commonalities in how MHCAs responded to changes in their political environment. First, our findings indicate that leaders from MHCAs in both political environments were more likely to respond or perceive the need for response in areas of the organization related to resources, while responses related to programmatic issues were less likely to occur. One potential explanation for this response is that MHCA leaders were simply unwilling to pursue adaptations in areas of the organization that were disruptive to its core goals. Support for this explanation is provided by the fact that the MHCAs included in this study were participants in the same program and had a common set of goals established by the sponsoring organization. Likewise, most of the organizations shared similar structural attributes that may have allowed the MHCAs to respond in a similar manner to protect these goals and programs when confronted with change in their political environment. Another explanation, however, is that responses to changes in the political environment occur in sequence and because programmatic areas are most disruptive, the MHCAs have yet to take on the challenges associated with change in these areas of the organization. Future research that examines these responses over time will be required to assess which explanation has more merit.

Our finding pertaining to how leader perceptions of the attitudes and responses of participating organizations influenced the MHCAs, in both political environments, also highlights how MHCAs may be directly and indirectly affected by changes in the political environment. Specifically, given the diverse multi-sectoral, volunteer-based membership structures of MHCAs, pressures for change may come directly from changes in the political environment, but they can also emerge indirectly from how changes in the political environment affect participating members. Furthermore, the indirect effects of this uncertainty are amplified or dampened depending upon how this change is interpreted by members. This mediated relationship points to a significant challenge that all MHCA lead-

ers likely face when dealing with changes in their political environment—multiple sources of uncertainty—only some of which are under the control of the MHCAs and their leaders.

Limitations

There are a number of limitations to be considered when interpreting our findings and their implications. First, our analysis focused on 8 MHCAs that were all participating in the same program, and thus, we cannot claim that the findings are generalizable to all types of MHCAs. Likewise, our analysis focused on a single external event: the passage of health reform. Nevertheless, we believe that our focus on 3 different areas of MHCA functioning—programmatic, instrumental, and resource—are likely to be areas of interest for most organizations, including other types of collaborative organizational forms. Our analysis also focused on responses at a single point of time and does not fully assess how these responses may have changed or will continue to change over time.

Future Research

Future research could build on ours by examining the evolution of MHCA responses throughout the process of implementing health reform. Similarly, our data were drawn from interviews with a single leader from each MHCA. We believe that these individuals, as leaders of these organizations, were in the best position to provide insights into how the alliance had responded or anticipated responding to health reform. Nevertheless, we cannot be sure that the opinions of these individuals represent those of all MHCA members. Finally, our analysis focused on responses as a function of 2 political environments and it is possible that factors other than the political environment may account for some of the observed differences. We controlled for some of these factors by examining MHCAs within the same program and with a number of similar structural and service area characteristics; however, it is possible that other factors may contribute to differences in MHCA responses to health reform. Likewise, our classification of the political environment into 2 categories likely does not fully capture the complexity faced by most MHCAs, especially with respect to an event such as health reform.

Conclusions

Organizational researchers have long acknowledged that changing political environments put pressure on organizations to respond in ways that allow them to continue to meet the needs and demands of customers and other stakeholders.^{15,35} Less is known, however, about how collaborative, volunteer-based organizational forms such as MHCAs may change in response to significant shifts in their political environments, despite the growing prevalence of these organizations, especially in healthcare. Furthermore, organizational change scholars have called for more research that attends to issues of context, process, and sequence when considering questions of

change, to build upon the issues of content that have dominated the literature to date.³⁶ Our study found that changes in the political environment—even when consistent in their objective—are not uniform in their interpretation, application, or consequences. Rather, these changes are transmitted through multiple levels of an MHCA's external environment. Variations within and across these different levels can amplify or attenuate the type and number of changes undertaken by these MHCAs.

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