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Research Article

Infrastructure, clinical leadership, and organizational culture enhancing KRIS implementation readiness in hospitals

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Abstract: The implementation of the Standard Inpatient Class (KRIS) policy presents challenges for hospitals in ensuring equitable service delivery. Organizational readiness depends not only on adequate physical infrastructure but also on an adaptive organizational culture and strong clinical leadership to guide change. As a referral hospital, RS BM must ensure alignment across organizational components to meet KRIS standards sustainably. This study analyzes the influence of infrastructure quality and clinical leadership on organizational readiness for KRIS implementation, with organizational culture as an intervening variable. A quantitative cross-sectional design was used, involving 136 healthcare and medical personnel working in the inpatient units of RS Bhakti Mulia. Data were collected through structured questionnaires and analyzed using Structural Equation Modeling–Partial Least Square (SEM-PLS) to examine relationships among variables. Infrastructure quality and organizational culture significantly and positively affect organizational readiness. Clinical leadership, while not directly influencing readiness, has a significant positive effect on organizational culture. KRIS readiness at RS BM is shaped by infrastructure quality, clinical leadership, and organizational culture, with culture acting as the main mediator. The hospital shows strong readiness but still faces gaps in progress monitoring, inpatient room layout and privacy, leadership direction, and team participation. Strengthening monitoring mechanisms, improving room design according to KRIS standards, enhancing clinical leadership capacity, and fostering a collaborative organizational culture are essential to support comprehensive and sustainable KRIS implementation

Keywords: Organizational readiness; quality infrastructure; clinical leadership; organizational culture; hospital

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1. Introduction

Modern healthcare organizations, particularly hospitals, face increasingly complex pressures arising from both internal and external demands. External pressures stem from evolving government regulations, rapid medical technology advancements, and rising public expectations for high-quality care. Internally, hospitals must improve operational efficiency, optimize resources, and maintain organizational sustainability. In this context, organizational readiness for change becomes essential for successful innovation. According to Weiner (2009), readiness reflects a collective psychological state in which members share commitment to change and confidence in their collective ability to implement it effectively, encompassing change commitment and change efficacy.

Indonesia's progress toward Universal Health Coverage (UHC) has accelerated with the National Health Insurance (JKN) program, which now covers more than 278 million participants. A major reform supporting equitable care is the implementation of the Standard Inpatient Class (KRIS), which replaces the class-based system and mandates standardized inpatient services for all participants. Presidential Regulation No. 59/2024 outlines twelve mandatory facility criteria, including ventilation, lighting, room density, bed standards, partitions, accessibility-compliant bathrooms, and oxygen outlets. Although KRIS sets clear regulatory expectations, its success depends heavily on hospitals' internal readiness supported by adequate infrastructure, human resources, and organizational culture.

Research shows that hospital readiness is influenced by infrastructure quality, clinical leadership, and organizational culture. Adequate facilities reduce resistance to change, while strong clinical leadership highlighted in the Clinical Leadership Competency Framework drives collaborative, adaptive environments that support innovation. Prior studies Busari et al. (2020; Khan, 2020) emphasize clinical leaders as agents of change who enhance system adaptability. Organizational culture further strengthens readiness by establishing shared values and norms that encourage openness, teamwork, and innovation, as demonstrated in studies by Anwar (2021), Haffar et al. (2023), and Metwally et al. (2019).

RS BM, a Class C private hospital and long-time JKN partner, faces significant challenges in meeting KRIS standards, with only 50% of the facility criteria fulfilled as of April 2025. Major gaps remain in bed partitions, in-room bathrooms, and accessibility standards. Preliminary findings also show low readiness among 30% of staff, along with suboptimal clinical leadership (40%) and organizational culture (50%). Despite the strategic importance of KRIS, no prior studies have integrated infrastructure quality, clinical leadership, and organizational culture simultaneously in assessing hospital readiness. Therefore, this study examines the influence of infrastructure quality and clinical leadership on organizational readiness for KRIS implementation, with organizational culture as an intervening variable.

2. Preliminaries or Related Work or Literature Review

Organizational readiness for change is a fundamental concept in change management within healthcare institutions. Weiner (2009) defines readiness as a collective psychological state in which organizational members share a commitment to implementing change and confidence in their collective capability to do so effectively. In hospital settings, organizational readiness reflects the mental preparedness, commitment, and confidence of all personnel to carry out transformational policies such as KRIS.

This readiness encompasses several dimensions, including monitoring implementation progress, resource preparedness, communication effectiveness, and stakeholder engagement. These dimensions are reflected in instruments commonly used to evaluate readiness for KRIS implementation, such as indicators related to progress monitoring and alignment of organizational direction.

Infrastructure quality is a major determinant of organizational readiness within hospitals. The KRIS policy requires compliance with specific physical standards, including ventilation, lighting, room density, patient privacy, accessible bathrooms, and oxygen outlets (Peraturan Presiden, 2024). Meeting these facility standards is essential for hospitals to deliver equitable inpatient services under the JKN system.

Previous studies emphasize that adequate physical facilities enhance staff confidence in supporting change initiatives. Sitepu et al. (2023) report that proper building conditions, available medical equipment, and comfortable inpatient rooms significantly contribute to the successful implementation of KRIS. Conversely, inadequate facilities can increase resistance to change and reduce organizational readiness.

Clinical leadership is another key factor influencing hospital transformation. The Clinical Leadership Competency Framework (Clark & Armit, 2010) highlights the role of

clinical leaders in guiding teams, motivating colleagues, and improving service systems. Indicators such as empowering self, providing direction, and operational judgment are often used to assess clinical leadership effectiveness.

Busari et al. (2020) found that clinical leaders act as change agents who facilitate organizational adaptation. Similarly, Khan (2020) argues that visionary and collaborative clinical leadership supports the successful adoption of technological and process innovations in healthcare systems.

Clinical leadership also plays an indirect yet important role in strengthening organizational readiness through its influence on organizational culture. Effective leaders foster collaborative environments, encourage open communication, and support team-based problem-solving conditions that enable organizations to adapt more easily to policy changes such as KRIS.

Organizational culture itself forms the collective values, norms, and behavioral patterns that guide day-to-day operations in hospitals. The Organizational Culture Assessment Instrument (OCAI) identifies key dimensions such as dominant characteristics, leadership style, employee management, organizational glue, strategic emphasis, and success criteria—that collectively shape workplace behavior.

Research consistently shows that a positive, adaptive culture enhances organizational readiness. Anwar (2021) highlight that supportive values promote openness and adaptability among staff. Haffar et al. (2023) find that group-oriented and adhocracy cultures strengthen employees' emotional readiness for change. Likewise, Metwally et al. (2019) report that innovative and collaborative cultures enhance motivation for adaptation.

Tiu and Picardo (2025) emphasize the importance of shared organizational values in the adoption of evidence-based practice, while Wardani et al. (2024) demonstrate that a healthy organizational culture promotes proactive behaviors during the implementation of digital systems such as EMR. Collectively, these findings affirm that culture is a critical predictor of hospital readiness for KRIS.

Implementing KRIS requires hospitals to undergo substantial adjustments, particularly in facility layout, workflow changes, and service standards (Kemenkes, 2022). Evidence shows that many hospitals including RS BM still face challenges in meeting KRIS criteria, especially regarding bed partitions, in-room bathrooms, and accessibility features.

Overall, the literature demonstrates that organizational readiness for KRIS is shaped by three interrelated determinants: infrastructure quality, clinical leadership, and organizational culture. Culture often acts as a mediator, strengthening or weakening the effects of leadership and infrastructure on readiness. This integrated perspective highlights the need for a holistic approach to KRIS implementation that addresses physical facilities, leadership capacity, and collective organizational values.

Hypothesis Development

H2: There is an influence of infrastructure on organizational culture.

H3: There is an influence of clinical leadership on organizational culture.

H4: There is an influence of infrastructure on organizational readiness for KRIS implementation.

H5: There is an influence of clinical leadership on organizational readiness for KRIS implementation.

H6: There is an influence of organizational culture on organizational readiness for KRIS implementation.

H7: There is an influence of infrastructure on organizational readiness for KRIS implementation through organizational culture as an intervening variable.

H8: There is an influence of clinical leadership on organizational readiness for KRIS implementation through organizational culture as an intervening variable.

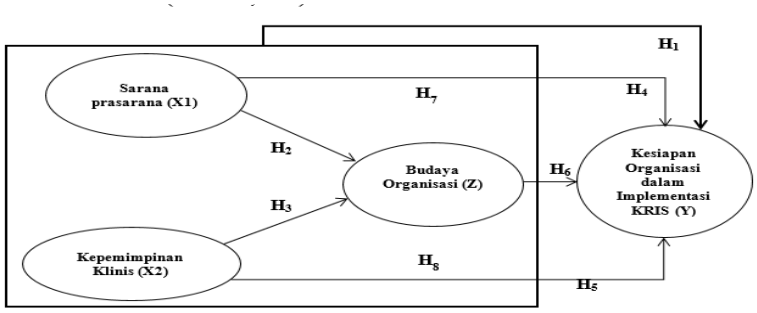

Figure 1. Research Model

3. Proposed Method

This study employed a quantitative research design using a cross-sectional approach to examine the relationships among infrastructure quality, clinical leadership, organizational culture, and organizational readiness for KRIS implementation. Data were collected at a single point in time from healthcare and medical personnel working in the inpatient units of RS Bhakti Mulia through a structured questionnaire developed based on validated measurement indicators. The sample consisted of 136 respondents selected using total sampling to ensure representation of all relevant professional groups involved in KRIS implementation. The analysis was conducted using Structural Equation Modeling–Partial Least Square (SEM-PLS), which allows simultaneous testing of direct and indirect effects among variables, including the mediating role of organizational culture. This research design is appropriate for identifying causal patterns and evaluating the predictive relationships required to assess the factors influencing organizational readiness in hospital settings.

Data Analysis

This study was carried out using Structural Equation Modeling–Partial Least Square (SEM-PLS), which is suitable for predictive modeling and analyzing complex relationships among latent variables. Prior to hypothesis testing, the data were examined through descriptive statistics, followed by assessments of validity and reliability, including convergent validity, discriminant validity, and composite reliability to ensure the robustness of the measurement model. The structural model was then evaluated by examining path coefficients, t-statistics, and p-values generated through the bootstrapping procedure to determine the significance of direct and indirect effects, including the mediating role of organizational culture. Additionally, the R-square, effect size (f-square), and predictive relevance (Q-square) values were analyzed to assess model strength and predictive capability. All analyses were performed using SmartPLS, allowing a comprehensive evaluation of the factors influencing organizational readiness for KRIS implementation.

4. Results and Discussion

Results

Respondent Characteristics

A total of 136 respondents participated in this study after meeting the inclusion criteria. Their characteristics were categorized by gender, age, educational level, length of employment, and professional background. The majority of respondents were female (77.21%), with the largest age group being 21–30 years (53.68%). Most respondents held a bachelor's degree (42.65%) and had worked for 3–5 years (33.09%). In terms of professional roles, nurses constituted the largest group (41.91%), reflecting their central involvement in inpatient care and KRIS-related service processes.

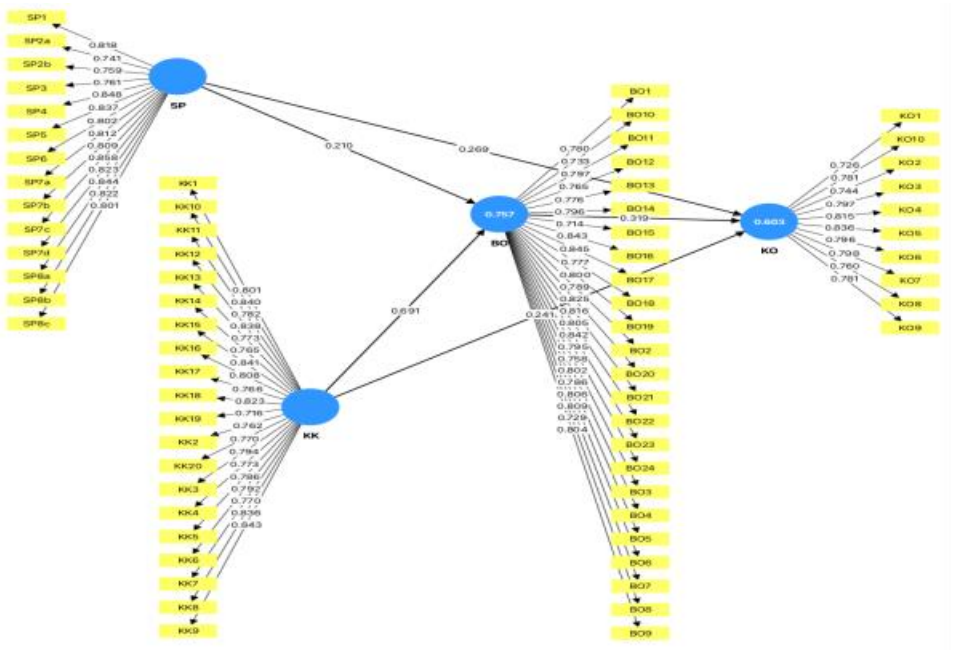

Figure 2. Bootstrapping Model Estimation Results

Hypothesis Testing

Simultaneous Test (H)

Table 1. Silmutaneous Test

	Sum square	df	Mean square	F	P Value	Ket.
Total	44.235	135	0.000	0.000	0.000	H1 Accepted
Error	32.003	132	0.242	0.000	0.000	
Regreesion	12.232	3	4.077	16.818	0.000	

Based on the results above, the hypothesis testing shows that the variables of infrastructure quality, clinical leadership, and organizational culture have a p-value of 0.000 in relation to organizational readiness for KRIS implementation. This indicates that there is a positive and significant simultaneous influence of infrastructure quality, clinical leadership, and organizational culture on organizational readiness for KRIS implementation (Y).

Hypothesis partial

Table 2. Partial hypothesis testing

	***Original Sample* (O)**	***Sample Mean* (M)**	***Standard Deviation* (STDEV)**	**T *Statistic* (|O/STDEV|)**	**P *Values***	**Ket.**
SP -> BO	0.210	0.208	0.095	2.205	0.028	H2 Accepted
KK ->BO	0.691	0.696	0.094	7.325	0.000	H3 Accepted
SP -> KO	0.269	0.275	0.115	2.344	0.019	H4 Accepted
KK ->KO	0.241	0.235	0.153	1.572	0.116	H5 Rejected
BO -> KO	0.319	0.319	0.145	2.197	0.028	H6 accepted

Source: Processed Data, Amos, 2025

Based on the statistical results, all tested paths show T-statistics values equal to or greater than 1.96 and p-values below 0.05, indicating that all direct hypotheses are supported. The only exception is the hypothesis assessing the direct effect of clinical leadership on organizational readiness for KRIS implementation. This hypothesis is not supported, as evidenced by a T-statistic value below 1.96 and a p-value exceeding 0.05.

This finding implies that, unlike infrastructure quality and organizational culture, clinical leadership does not exert a direct and statistically significant influence on organizational readiness. Instead, its contribution to readiness is likely indirect, operating through its positive impact on organizational culture. Thus, the results highlight the importance of strengthening cultural mechanisms within the organization, as clinical leadership alone is insufficient to enhance readiness without the presence of a supportive organizational culture.

Intervening Hypothesis

Table 3. *Indirect Effect* Hipothesis

	***Original Sample* (O)**	***Sample Mean* (M)**	***Standard Deviation* (STDEV)**	**T *Statistic* (|O/STDEV|)**	**P *Values***	**Ket**
SP->BO ->KO	0.067	0.065	0.042	1.608	0.108	H7 Rejected
KK->BO ->KO	0.220	0.224	0.112	1.970	0.049	H8 Accepted

Source: Processed Data, Amos, 2025

Based on the table above, the results indicate that organizational culture plays a significant intervening role in mediating the relationship between clinical leadership and organizational readiness for KRIS implementation. This suggests that clinical leadership enhances readiness not through direct influence, but through its capacity to shape shared values, norms, and collaborative behaviors within the organization. In other words, clinical leaders contribute to readiness by strengthening cultural factors that promote openness to change, teamwork, and a collective commitment to implementing KRIS.

Conversely, the findings show that organizational culture does not significantly mediate the relationship between infrastructure quality and organizational readiness. This implies that improvements in physical facilities alone do not necessarily translate into cultural changes that enhance readiness. Infrastructure may directly influence readiness by providing adequate physical support for KRIS standards, but such improvements are not sufficient to shift collective beliefs, behaviors, or organizational norms. Consequently, infrastructure upgrades

must be accompanied by cultural and behavioral interventions if they are intended to drive deeper organizational transformation.

5. Discution

This study aims to analyze the influence of infrastructure quality and clinical leadership on organizational readiness for the implementation of the Standard Inpatient Class (KRIS), with organizational culture functioning as an intervening variable at RS Bhakti Mulia. The findings provide an important contribution to understanding the determinants of organizational readiness in KRIS implementation as part of the government's effort to improve hospital service quality and ensure equitable access for all patient groups. The results indicate that infrastructure quality, clinical leadership, and organizational culture simultaneously have a significant influence on organizational readiness for KRIS implementation. This means that these three variables collectively contribute to strengthening the hospital's readiness to adopt the KRIS policy. The motivation of healthcare workers and medical staff to support KRIS implementation grows from a conducive work environment supported by adequate facilities, modern medical equipment, and recognition of individual and collective contributions. These conditions foster mutual respect, trust, and organizational stability. The availability of facilities, collaborative clinical leadership, and a culture emphasizing stability, efficiency, and operational control form the perception of readiness among hospital personnel. This strengthens the belief of all organizational elements to support KRIS implementation optimally in accordance with service standards. These findings are consistent with Sari (2023), who showed that readiness to implement digital medical records is influenced by organizational factors such as leadership, culture, human resource readiness, and technological infrastructure.

The analysis further shows that infrastructure quality has a significant positive effect on organizational culture. This indicates that improvements in infrastructure quality correspond with stronger organizational culture. Adequate medical facilities and equipment enhance the comfort and sense of safety among healthcare workers, creating a conducive and well-organized work environment. These conditions promote resource efficiency, strengthen internal control, and ensure optimal operational performance in responding to evolving service demands. Eisenberger et al. (1986) state that the provision of adequate facilities such as ergonomic equipment, modern technology, and safe work environments fosters a sense of appreciation among employees, which in turn strengthens loyalty, engagement, and a positive organizational culture. Similarly, Barney (1991) explains that valuable, rare, inimitable, and non-substitutable physical and technological resources play a strategic role in shaping professional, productive, and adaptive work behaviors. Trist and Bamforth (2015), through sociotechnical systems theory, also argue that infrastructure quality, as part of the technical subsystem, supports comfort, healthy social interaction, and a collaborative culture oriented toward continuous improvement. In this study, these findings indicate that infrastructure improvements do not merely fulfill technical standards but also form the foundation for cultivating positive cultural values that strengthen RS Bhakti Mulia's readiness to implement KRIS effectively.

The findings also show that clinical leadership has a significant positive effect on organizational culture. This means that improvements in clinical leadership lead to an enhanced organizational culture. Appreciation for each member's role—both in daily tasks and decision-making builds a sense of ownership and responsibility toward the organization. Such conditions enhance work motivation, team collaboration, and systemic stability, while improving resource efficiency through clarity of roles, trust, and effective communication. An open work culture supports stronger internal control, enabling hospital operations to run optimally and respond to service dynamics efficiently. These results support Niki et al. (2021), who demonstrated that effective clinical leadership plays a central role in shaping and reinforcing organizational culture in healthcare settings.

Infrastructure quality is also found to have a significant positive effect on organizational readiness for KRIS implementation. This means that higher infrastructure quality increases organizational readiness. The motivation of health and medical personnel to support KRIS implementation emerges from a supportive work environment. Adequate medical facilities

and equipment foster comfort and security, thus enhancing readiness, confidence, and active participation in the implementation process. This finding aligns with Akande et al. (2019), who found that resource availability is crucial in encouraging organizational commitment to change. Sitepu et al. (2023) also reported that physical conditions—such as building structure, air circulation, and bed facility completeness—play a significant role in hospital readiness to implement KRIS. Similarly, Christian Myers Laugen (2022) emphasized that adequate resources are key factors in shaping organizational readiness for change.

The study further reveals that clinical leadership does not have a significant direct effect on organizational readiness for KRIS implementation. This means that no strong or statistically meaningful relationship exists between clinical leadership and readiness. Organizational readiness may remain high even when clinical leadership is not dominant, provided that procedures, human resources, and infrastructure already meet required standards. This suggests that the effectiveness of clinical leadership is contextual and may be replaced by strong structural mechanisms and a solid organizational culture. This finding is consistent with Siswaty & Meilani (2023), who found that clinical leadership does not directly relate to organizational readiness, and with Al-Hussami et al. (2018), who identified a significant negative relationship between leadership and organizational readiness for change ($\beta = -0.19$; $p = 0.03$). Kerr & Jermier's (1978) Substitutes for Leadership Theory explains that leadership influence can be replaced by factors such as employee competence and motivation, routine tasks that naturally provide feedback, and cohesive organizational structures, all of which reduce or eliminate the direct role of leaders in shaping organizational readiness.

Organizational culture is found to have a significant positive effect on organizational readiness for KRIS implementation. This means that stronger organizational culture enhances readiness for change. The motivation of healthcare personnel is a key factor in supporting KRIS implementation at RS Bhakti Mulia, driving organizational stability, efficient resource utilization, and stronger internal control systems. These conditions ensure optimal operations and readiness to respond to KRIS implementation challenges. This finding aligns with Anwar (2021), who emphasized that organizational culture significantly affects readiness for change. It is also reinforced by Haffar et al. (2023), who found that organizational culture plays a crucial role in shaping employees' emotional readiness for change, and by Metwally et al. (2019), who demonstrated the role of organizational culture in shaping both individual and collective readiness for change. Cultures that support innovation, collaboration, and continuous learning foster a sense of belonging and motivation to adapt. These findings are further consistent with Tiu and Picardo (2025), who reported that organizational readiness for evidence-based practice implementation is influenced by culture and collective beliefs about the benefits of change, and with Ratna Wardani et al. (2024), who found that positive organizational culture increases individual readiness to implement electronic medical records (EMR) in hospitals.

The results indicate that organizational culture does not mediate the relationship between infrastructure quality and organizational readiness for KRIS implementation. This means that infrastructure quality does not influence readiness when mediated through culture. Although RS Bhakti Mulia has adequate facilities, these improvements do not automatically translate into a supportive organizational culture for change. The main challenge lies in the uneven internalization of cultural values—such as collective responsibility, active participation, and sense of ownership—across work units. This weakens the mediating role of culture between physical readiness and institutional readiness. This finding aligns with Leslie et al. (2020), who concluded that infrastructure availability does not guarantee organizational readiness if the internal culture does not support change, especially when staff participation is low, internal communication is weak, and managerial engagement is minimal. According to Barney's (1991) Resource-Based View (RBV), organizational resources can only provide sustainable competitive advantage when they meet the criteria of being valuable, rare, inimitable, and non-substitutable (VRIN). In this context, hospital infrastructure is valuable but not rare or inimitable, limiting its influence on shaping a unique organizational culture. Culture is largely shaped by intangible factors such as values, norms, leadership, and communication—rather than physical assets. Therefore, even if infrastructure is adequate, it does not automatically create an adaptive and collaborative culture needed for change. This highlights the importance

of pairing physical investment with cultural strengthening to ensure that infrastructure improvements translate into enhanced organizational readiness for KRIS implementation.

Finally, the study shows that organizational culture successfully mediates the relationship between clinical leadership and organizational readiness for KRIS implementation. This means that clinical leadership influences readiness only when transmitted through a strong and supportive organizational culture. Effective clinical leadership—through encouraging individual contributions and collaborative decision-making—builds a respectful and trust-based culture. This culture strengthens the impact of clinical leadership on readiness, enabling RS Bhakti Mulia to create a participative, collaborative, and adaptive work environment to support KRIS implementation. This finding aligns with Nieuwboer et al. (2019), who reported that clinical leadership plays a key role in implementing integrated primary care through interprofessional collaboration, evidence-based decision-making, and cross-sector coordination.

6. Conlucsion

This study confirms that organizational readiness for KRIS implementation at RS Bhakti Mulia is simultaneously influenced by infrastructure quality, clinical leadership, and organizational culture. Infrastructure quality directly contributes positively to organizational readiness while also shaping a conducive organizational culture. Similarly, clinical leadership has a positive effect on organizational culture, although it does not exert a significant direct influence on organizational readiness without the mediating role of organizational culture. Organizational culture itself plays a crucial role in strengthening institutional readiness for service transformation. However, the indirect effect of infrastructure quality on organizational readiness through organizational culture is not significant, indicating that physical aspects have not been fully internalized into the collective values and norms of the organization. In contrast, organizational culture effectively mediates the relationship between clinical leadership and organizational readiness. Thus, this study highlights the importance of transformative leadership and adaptive organizational culture as foundational elements for the successful implementation of KRIS, alongside improvements in infrastructure and operational systems.

The findings also demonstrate that RS Bhakti Mulia exhibits a high level of readiness for KRIS implementation, with key strengths in its commitment to change, adequate infrastructure, and strong clinical leadership. Nevertheless, several weaknesses remain, particularly in progress monitoring, inpatient room layout and privacy, the "providing direction" dimension of clinical leadership, and team participation in decision-making. Therefore, efforts to enhance organizational readiness should focus on strengthening change monitoring systems, improving inpatient room design in accordance with KRIS standards, developing visionary leadership capacity, and cultivating a collaborative work culture that encourages active staff involvement. These efforts are essential to ensure comprehensive and sustainable KRIS implementation

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