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Organizational Culture with Individual Readiness as a Mediator for *Championing Behavior* Electronic Medical Record Implementation

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ABSTRACT

Background: The dynamism of the application information technology in the health sector, especially in hospitals, which is currently being developed is the electronic medical record (EMR). Global competition in the era of industrial revolution 4.0 makes all hospitals must be ready for the changes that will occur in the management of medical record management.

Purpose: This study aims to analyze the influence of organizational culture with individual readiness as a mediator on championing behavior in the implementation of electronic medical records (EMR) at Muhammadiyah Hospital.

Method: The respondents were 133 health professionals who will be involved in the implementation of the EMR. The research instrument was in the form of a questionnaire via google form link. The analysis was done using SEM (Structural Equation Model) with Lisrel.

Results: The results showed that organizational culture significantly affected individual readiness (β=0.67, t-value=7.40). Organizational culture has a significant effect on championing behavior (β=0.42, t-value=4.10). Individual readiness significantly affects championing behavior (β=0.48, t-value = 4.56). Individual readiness is also a significant mediator of the relationship between organizational culture and championing behavior (complementary mediation type).

Conclusion: A strong organizational culture will support the organization's readiness for planned change. A strong organizational culture also influences behavior to fight for the success of the change plan. Through individual readiness, organizational culture influences behavior to fight for the successful implementation of EMR. Therefore, organizations need to prepare individuals well for the success of the change plan.

Keywords: championing behavior, emr, organizational culture, readiness for change

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BACKGROUND

The development of information technology and information digitalization is growing rapidly. The most dynamic application of information technology in the healthcare sector, especially in hospitals, is EMR. Global competition in the era of the industrial revolution 4.0 makes all hospitals must be prepared for changes that may occur in the management of medical record management. The Ministry of Health, in its strategic plan contained in the Minister of Health Regulation Number. 21/2020, states that it aims for all hospitals in Indonesia to have an integrated electronic EMR by 2024. (Permenkes, 2020).

Medical records can be paper or electronic (Permenkes, 2008). Medical record documents in *paper form (paper-based*) so called manual medical records, while electronic medical record documents (*paperless*) are the use of information technology devices for collecting, storing, processing and accessing data stored in patient medical records in hospitals within database management system that collects various sources of medical datas (Handiwidjojo, 2009). Mentioned in (KEMKOMINFO, 2016) electronic document is any electronic information created, transmitted, received, or stored in analog, digital, electromagnetic, optical, or similar form that can be seen, displayed, and/or heard through a computer or electronic system yet not limited to writing, sound, images, maps, designs, photographs or the like, letters, signs, numbers, access codes, symbols or perforations that have meaning or meaning or can be understood by people who are able to understand it.

The development of manual medical records into electronic is also a discourse at Muhammadiyah Hospital (MH) which is using hospital management information system (HMIS) named Khanza. The electronic medical record feature on HMIS Khanza will be introduced to employees at MH who will be involved in the use of electronic medical records at the introduction of the HMIS at the end of 2019. Until now, medical records at MH are still using *paper* form, but the discourse on implementing manual medical records into electronic has been conveyed in several unit meetings. The plan to convert the manual medical record system to electronic in terms of infrastructure facilities has been pursued by increasing the server capacity to back up data in the EDP (Electronic Development Program Software Department) Information Technology Section, as well as adapting several features in HMIS Khanza to comply with hospital accreditation standards and laws and regulations. Arrangements relating to the plan to convert the manual medical record system at MH to an electronic system are still under discussion before its implementation is finalized for subsequent socialization and training on the use of electronic medical records. The existence of the covid-19 pandemic in 2020 made discussions and preparations related to the plan to implement manual medical records into electronic at MH temporarily stopped due to the centralized concentration for handling covid-19 in hospitals.

The discourse on implementing manual medical records into electronic using HMIS Khanza became a strategic plan at MH in 2022-2023 due to the lack of capacity for medical record files storage space caused by the increasing number of patients visits and patients medical record files.

Based on the strategic plan of the MH, all components of the MH, especially human resources or employees involved in using medical records, must be ready to accept changes in the system of managing medical records from manual to electronic, according to the regulations that will later be determined to be enforced in hospitals. After being ready to accept the change of the system, the employees are expected to fight for or promote the change of the manual medical record system to electronic so that the implementation is successful as planned. Against this background, researchers conducted this research to analyze the factors that affect individual readiness for behavior that supports the plan to

change the implementation of manual medical records to electronic at Muhammadiyah Hospital.

Change is something that will always happen to an organization. The key success factor in organizational change is the readiness of individuals to change (Anggraini & Fajrianthi, 2019). The readiness of individuals (employees) to change has very important role in the sustainability of the organization to change because of some inevitable resistance from human resources, especially when there is a lot of risk and uncertainty in change (Wardani et al., 2020).

Readiness to change human resources in the organization to accept a change in management requires an organizational culture that supports readiness to change (Carlstorm & Ekman, 2012). Organizational culture is the social glue that exists in the organization, containing values, habits, beliefs, which characterize the characteristics of the organization and all members of the organization (Megawati & Nashri, 2015). The stronger the organizational culture, the more positive the attitude of employees in facing change (Astari & Zahreni, 2018). Organizational culture includes 4 dimensions: engagement, consistency, adaptability and organizational mission (Denison et al., 2015).

Based on previous research related to the analysis of readiness for the implementation of electronic medical records in a hospital can be influenced by: organizational culture, governance and leadership, human resources and infrastructure (Maha Wirajaya & Made Umi Kartika Dewi, 2020). Other research states that human resource readiness, organizational work culture and hospital governance and leadership have an important influence on the implementation of electronic medical records (Sudirahayu & Harjoko, 2017). Organizational culture also has strong influence on the behavior of its members (Mauliana & Padjadjaran, 2016).

Change readiness is a comprehensive attitude that is simultaneously influenced by the content or substance being changed, the process by which the change is being implemented, the context in which the change is taking place, and the characteristics of the individuals involved in the change. (Holt & Vardaman, 2013). Change readiness according to (Rafferty & Minbashian, 2019) can mediate the relationship between changes in beliefs and positive emotions about change, as well as behaviors that are supportive of change. Rafferty & Minbashian (2019) have identified a positive influence of readiness to change on behavior that supports change including compliance, cooperation, and *championing*, with the strongest influence being championing behavior and followed by *cooperation* then *compliance*. Among different typologies of employee behavior, *championing* behavior was identified as the most effective behavior for employees to successfully implement change in the organization, also can encourage the participation of other employees in change (Faupel & Süß, 2018). According to Herscovitch and Meyer (2002) in (Bouckenooghe et al., 2014) there are differences from the three support of change behavior including passive and active behavioral support for change (*compliance, cooperation, championing behavior*). *Compliance* behavior is a passive form of change behavior in which an individual exerts minimum effort and is reluctant to engage the behavior that directly support change. *Cooperative* behavior and *championing behavior* are active forms of behavior change (Bouckenooghe et al., 2014). *Championing behavior* is indispensable in organizational change (Islam et al., 2020). In this study, researchers took the variable *of championing* behavior because it is the most effective behavior for employees to implement changes in the organization. Therefore only *the variable of championing behavior* will be examined in this study.

OBJECTIVE

The purpose of this study is to analyze the influence of organizational culture with the willingness of human resources (employees) as mediators for behavior that supports changes (championing behavior) implementation of manual medical records to electronic at MH. The framework of the research design is illustrated in Figure 1.

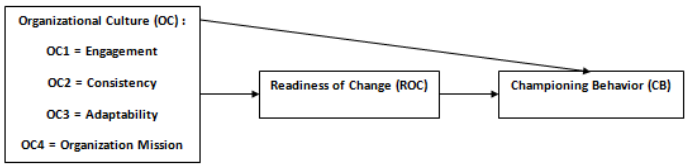

Figure 1, Research Concept

METHODS

This research is a quantitative research with the aim of thoroughly explaining the relationship between the variables in the study and confirming the research model. The independent variable is organizational culture, the dependent variable is change behavior, and change readiness as an intervening variable (as a mediator). The design in the following research plan is *a cross-sectional* analytical study to see the relationship of independent variables to dependent variables in the same time period.

The population in the following research plan is all employees as human resources at MH which is 189 people who use HIMS Khanza. The sampling technique used is a *probability sampling* technique with *a simple random sampling* method. *Probability sampling* technique is a technique for selecting samples from a population using probability rules. *Simple random* sampling is the sampling of elements in a defined population. The sampling units are the units listed in the sample frame itself (Siyoto & Sari, 2016).

The samples to be taken are employees who will be involved in the use of electronic medical records using HIMS Khanza. The number of samples to be taken based on Krejcie and Morgan's table for populations between 180-190 is at least 123-127. Based on personnel data and the database of the information technology system at MH, there are 133 employees who will be involved in the use of electronic medical records. Thus the number of samples to be taken is 133 people, consisting of: physicians (specialists, general practitioners, dentists, registrars), nurses and midwives, other health professionals (medical records, pharmacists, pharmaceutical technicians, medical laboratory technicians, radiographers, radiology staff, dieticians, physiotherapists), information technology (IT), finance, registration, public relations/legal hospital.

The following research plan uses *structural equation model* (SEM) analysis. The minimum sample size according to Hair et.al (Hair et al., 2014) in SEM analysis is in the range of 100-400, taking into account several considerations. The consideration for a sample of at least 100-150 is used for SEM models containing five or fewer constructs (the following study plan consists of three constructs), each with more than three *items* (*observed variable/manifest variable*) and with high *item* community/variable (0.5 or higher). The research instrument used was questionnaires. The questionnaire consists of 16 statement items for organizational culture (OC) variables covering four dimensions, 16 individual readiness statement items for change (ROC) and 4 *championing behavior* (CB) statement

items. The questionnaire used a Likert scale of 1-7. Data analysis using *structural equation model* (SEM) with Lisrel *software*.

According to Hair et.al (Hair et al., 2014), the evaluation of the level of data match with the model in SEM analysis is carried out through several stages, namely the compatibility of all models (overall model fit), the suitability of measurement models (measurement model fit), and the compatibility of structural *models (structural model fit*).

RESULTS

Responses were obtained from respondents totaling 133 answers. The characteristics of the study respondents appear in table 1.

Table 1. Characteristics of Research Respondents

Information	Sum	Percentage
Total Respondents	133	100%
Gender		
Man	32	24%
Woman	101	76%
Age (Years)		
20-24	9	8%
25-29	45	34%
30-34	40	30%
35-39	18	13%
40-44	13	10%
45-49	5	3%
50-54	2	1%
55-59	1	1%
Profession/Work Unit		
Specialist	12	9%
General practitioner	8	6%
Dentist	2	2%
Internsip Doctor	7	5%
Nurse	47	35%
Midwife	14	11%
Other Health Workers	22	17%
Registration	9	7%
Medical Records Staff	4	3%
Finance Department	3	2%
Information Technology Section	2	1%
Cashier	3	2%
Education Level		
Postgraduade	12	9%
Bachelor	56	42%
Diploma	51	38%
High School / Vocational School	14	11%
Period of Service		
< 1 Year	17	13%
1-5 Years	50	38%
6-10 Years	36	27%
> 10 Years	30	22%

The statistical test in this study uses *the Structural Equation Model* (SEM), by processing data using *Linear Structural Relationship* (LISREL) software version 8.8 *for windows* and using SPSS version 26. SPSS is used for frequency analysis and descriptive analysis as well as calculating *Cronbach alpha* and correlation on discriminant validity tests.

Evaluation of the level of data match with the model in SEM analysis is carried out through several stages, namely the compatibility of all models (*overall model* fit), measurement model fit, and *structural model fit*. Data normality tests were performed prior to analysis, but ROC1, ROC2, ROC3 and ROC14 indicators obtained p-values for kurtosis and skewness < 0.05 in univariate normality tests. Furthermore, data analysis was continued after the analysis stage with SEM with *maximum likelihood* and modification to obtain a good *goodness of fit* as the normality test value was not met.

Stages of Fit of All Models (*overall model fit*)

This stage is the stage of testing the suitability of the model through a review of various *goodness of fit criteria,* which is a measure that shows how well a particular model reproduces the covariance matrix among variable indicators (Hair et al., 2014). This model fit test stage is intended to test whether the proposed model has a *fit* with the sample data or not. For the measurement of *goodness of fit.* Hair et al. (2014) suggest looking at chi-square/df (χ^2/df), RMSEA, GFI, CFI, TLI (NNFI), NFI, IFI, AGFI.

Before obtaining a good enough model, the results of statistical tests using SEM with Lisrel in this study have been made several modifications to obtain fit model. OC variable because it uses dimensions, then measurement through *second order* CFA.

From the first CFA results, half of the 10 *goodness of fit index* values were still not good. RMSEA values of 0.13 > 0.08 (not good) and GFI 0.54 (not good) and AGFI values of 0.47 (not good). Modifications where then made to the model by eliminating ROC indicators that have a loading factor value of ≤ 0.5 and or indicators with loading *factors* < *errors* including ROC4, ROC7, ROC9, ROC11, ROC12, ROC13, ROC16 and ROC10, ROC14, ROC 15 (*loading factor* < *error* values). However, GFI values of 0.65 (not good) and RMSEA 0.11 > 0.08 (not good) were still obtained. Next, modifications are made again with *modification indices* according to *the suggestions* that appear in the Lisrel *output.* As a result, RMSEA value 0.05 (*good* fit) and GFI value 0.81 (*marginal fit*) were obtained. The GFI value has increased compared to before but when the *modification indices* run again, the RMSEA and GFI values and other *goodness of fit* values remain. So no modification is done again.

The following table 2 presents the *value of goodness of fit.*

Table 2. Goodness of Fit Value

Goodness of fit* (GoF) *index	***Cut of value***	**Value in Research Model**	**Information**
χ^2/df	χ^2/df ≤ 2	417.01/287=1.45	Good (*Good fit*)
RMSEA	0.03-0.08	0.05	Good (*Good fit*)
RMR	≤ 0.05	0.05	Good (*Good fit*)
GFI	≥ 0.90	0.81	Good enough (*Marginal fit*)
CFI	> 0.90	0.99	*Good* fit
TLI (NNFI)	≥ 0.95	0.98	*Good* fit
NFI	≥ 0.90	0.96	*Good* fit
IFI	≥ 0.90	0.99	*Good* fit
RFI	≥ 0.90	0.95	*Good* fit
AGFI	≥ 0.90	0.77	*Poor fit*

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Based on table 2 above, out of 10 *goodness of* fit parameters, 8 good parameters, 1 *marginal fit parameter*, and 1 poor parameter were obtained. So it can be said that the model is still quite good.

Measurement Model

The stage of measurement model fit is to conduct validity and reliability tests. Validity is the ability of observational variables to describe their constructs, including: convergent validity and discriminant validity. Convergent validity expresses the *commonality* of observational variables. Discriminant validity describes the difference between constructs, discriminant validity determines whether observational variables explain their own constructs or explain other constructs. The criteria for testing convergent validity in this study is whether the Standard Loading Factor (SLF) value ≥ 0.5 or T-value >1.96 then it is declared valid. For reliability tests, measurements were made against CR and VE. Reliable means dependable. Reliability is assessed based on *Cronbach Alpha by processing Cronbach alpha* values using SPSS *software*. *Cronbach alpha* values ≥ 0.7 indicate high variable reliability (7). CR values ≥ 0.7 and VE values ≥ 0.5 indicate the fulfillment of construct reliability tests (25). Table 3 shows all criteria of convergent validity and construct reliability met.

Table 3. Convergent Validity Test Results

Construct	**Dimension**	**Statement (*Item*)**	**Loading Factor**	**T-Value**	**α-Cronbach**	**VE**	**CR**	**Decision**
Organizational Culture (OC)	Involvement (OC1)		0.79	7.32	0.83	0.56	0.83	Valid and Reliable
		OC11	0.72	**				
		OC12	0.72	7.58				
		OC13	0.81	8.45				
		OC14	0.74	7.89				
	Consistency (OC2)		0.84	7.35	0.76	0.50	0.74	Valid and Reliable
		OC21	0.54	3.59				
		OC22	0.71	**				
		OC23	0.80	7.74				
	Adaptability (OC3)		0.94	9.34	0.81	0.53	0.82	Valid and Reliable
		OC31	0.77	**				
		OC32	0.79	9.22				
		OC33	0.67	7.76				
		OC34	0.69	7.94				
	Mission (OC4)		0.83	9.61	0.91	0.70	0.92	Valid and Reliable
		OC41	0.88	**				
		OC42	0.88	14.10				
		OC43	0.87	13.71				
		OC44	0.77	11.08				
		OC45	0.57	6.14				
Readiness of Change		ROC1	0.85	**	0.93	0.71	0.93	Valid and Reliable
		ROC2	0.91	14.27				
		ROC3	0.98	10.92				

	ROC5	0.80	11.48			
	ROC6	0.81	11.52			
	ROC8	0.47	4.91			
Championing Behavior	CB1	0.64	**	0.86	0.63	0.87	Valid and Reliable
	CB2	0.72	7.10			
	CB3	0.89	8.32			
	CB4	0.92	8.49			

From the tabel above shows that the results of the discriminant validity test in table 4 show that all correlation values between constructs are not greater than the square root of AVE shown in the diagonal column of green. Thus, the discriminant validity test has been fulfilled after *modification indices*.

Table 4. Discriminant Validity Test Results

	OC	ROC	CB
OC	0.808		
ROC	0.619	0.880	
CB	0.681	0.733	0.764

Structural *Model*

The stage of fit of the structural model is carried out to test the Hypothesis. Figure 2 shows the structural model of this study.

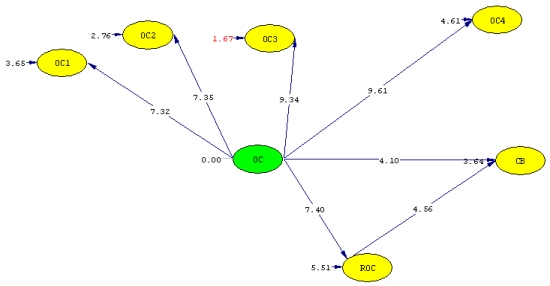

Figure 2. Structural Model (T-value)

Hypothesis Significance Test Results

ROC = 0.67*OC, Errorvar.= 0.55 , R^2 = 0.45
(0.090) (0.10)
7.40 5.51

CB = 0.48*ROC + 0.42*OC, Errorvar.= 0.32 , R^2 = 0.68
(0.10) (0.10) (0.089)
4.56 4.10 3.64

It is known that the value of the OC path coefficient against ROC is 0.67 and the statistical value t = 7.40 > 1.64, so the conclusion is that OC has a significant effect on ROC with a value of R^2 = 0.45. The R^2 value serves to indicate how far each independent (exogenous) variable is able to explain the dependent (endogenous) variable (25). So it can be concluded that 45% of the variation of the change readiness variable (ROC) can be

influenced by organizational culture (OC) and 55% of the variation of the change readiness variable is influenced by other variables that are not observed. These results support the first hypothesis that there is a direct influence of organizational culture on individual readiness for change.

It is known that the value of the OC path coefficient against CB is 0.42 and the statistical value t = 4.10 > 1.64, so the conclusion is that organizational culture (OC) is significant to change behavior (CB). The results of the current study support the second hypothesis, namely the direct influence of organizational culture on *championing behavior*.

It is known that the value of the ROC path coefficient against CB (*Championing Behavior*) is 0.48 and the statistical value is t = 4.56 > 1.64, so the conclusion is that ROC has a significant effect on CB with a value of R^2 = 0.68. This supports the third hypothesis, namely the direct influence of individual readiness for change on *championing behavior*. OC and ROC significantly affect CB with R^2 = 0.68 meaning that 68% of the variation of CB variables together is influenced by OC and ROC.

Mediation Test Results

Furthermore, testing the mediation hypothesis using the theory proposed by Zhao et al. (2010) that the determination of whether a variable is a mediator or not is summarized in Figures 3 and 4 on the classification and type of mediation.

It is known that the standard coefficient OC to ROC a=0.67 is significant and the coefficient of the ROC to CB path b=0.48 is also significant, so that if a multiplied by b or axb = 0.32 the value is significant. Furthermore, it is known that the value of the standard coefficient OC to CB, which is c = 0.42, the value is significant. So, if we look at the concept of determining the significance of mediation in figure 4 above, it is found that axb is significant and c is also significant, so the type of mediation is *complementary mediation*. The current research supports hypothesis 4, namely the indirect influence of organizational culture on change behavior (*championing behavior*) with individual readiness for change as a mediator.

DISCUSSION

Analyze the direct influence of organizational culture on individual readiness for the change in the implementation of manual medical records to electronic at MH.

The results of the current study showed that organizational culture has a direct and significant effect on individual readiness for change with a coefficient value of 0.41. This means that for every 1 increase in the organizational culture variable, individual readiness for change increases by 0.41. This is in line with the theory proposed by Carlstorm & Ekman (2012) that the willingness of human resources in organizations to accept a change in management requires an organizational culture that supports the willingness to change. Likewise, according to the results of research by Astari & Zahreni (2018) showed that the stronger the organizational culture, the more positive the attitude of employees in facing change. The results of the current research are new, namely the known direct influence of organizational culture on individual readiness for change, as well as the similarity of results that organizational culture has a significant effect on individual readiness for change based on previous research Sudirahayu & Harjoko (2017), Astari & Zahreni (2018), Karma & Made (2020).

MH has a strong organizational culture, thus supporting individual readiness for change. The organizational culture adopted today is the beliefs and assumptions that underlie the Islamic values and norms / rules that have been in force at MH in term of involving employees in hospital activities, obeying leaders, obeying regulations, respecting and

working together, adapting to change, overcoming organizational problems, and having an organizational vision and mission. With the values that have been adopted, including adapting to change as a dimension of organizational culture, making human resources at MH will be ready with the change plan that will be set by the organization in this case the plan to change the implementation of manual medical records to electronic. Based on current research, the organizational culture adopted at MH has a significant effect on individual readiness for change, so organizations need to prepare their human resources to ensure that the implementation of manual medical records to electronic can be successful as planned. According to the results of the questionnaire on the statement that changing medical records from manual to electronic is very necessary, the average respondent answered in agree to strongly agree, then the organization can start the implementation of electronic medical records as planned.

Analyzing the direct influence of organizational culture on the behavior of changing the implementation of manual medical records to electronic at MH.

The results of analysis of the direct influence of *organizational culture* on *championing behavior*, the implementation of manual to electronic medical records at MH obtained results that support this hypothesis with a coefficient value of 0.42. This means that for every 1 increase in the organizational culture variable, there is an increase in the behavior that supports the change. (*championing behavior*) by 0.42.

Organizational culture has a strong influence on the behavior of its members (Mauliana & Padjadjaran, 2016). The members of the organization are bound by the norms and rules set by the organization in behavior. Research specifically examining the influence of organizational culture on championing behaviour has not been widely conducted, but according to research Mauliana & Padjadjaran (2016) the researchers assume that according to the results of current research, organizational culture also has a direct effect on behavior that supports *change (championing behavior*) implementation of manual medical records into electronic at MH. Futhermore the implementation of electronic medical records is mandatory for those who involved in it, with a strong organizational culture employees will fight for the success of EMR implementation.

Analyzing the direct influence of human resource readiness on the behavior of changing the implementation of manual medical records to electronic at MH.

The results of research on the direct influence of human resources readiness on *the behavior of change (championing behavior*) implementation from manual medical records to electronic at MH obtained results that support this hypothesis with a coefficient value of 0.48. It is mean in every increase in the change readiness variable by 1 will increase *championing behavior* by 0.48.

Current research is in line with the research from Islam et al. (2020) who conducted a study in Bangladesh that showed the c*hampioning behavior* is closely related to individual readiness for change. Islam et al. (2020). Its also has the same result with the study by Rafferty & Minbashian (2019) which states that readiness *of* change has a significant effect on *supportive change* behavior with dimensions including *championing behavior. Championing* behavior is an active form of behavior that supports change so that it requires individual readiness for change. *Championing behavior* is positively correlated with employee readiness to change, employee desire to change, and vice versa correlated with employee difficulty to change as well as cynicism toward change behavior.

Analyzing the indirect influence of organizational culture with the readiness of human resources as mediators on the behavior of changing the implementation of manual medical records to electronic at MH.

Analysis of the indirect influence of organizational culture with human resources readiness as a mediator on *championing behavior*, the implementation of manual medical records to electronic at MH obtained results that support this hypothesis.

The current study demonstrates that the willingness to make significant changes is a mediator for *championing behavior* with the type of mediation according to Zhao et al. (2010) *complementary mediation*. That is, the type of mediation when direct influence and indirect influence are significant. According to the concept presented by Zhao et al. (2010) in understanding the implications of mediation to build a theory, the identified mediators are consistent with the hypothesized theoretical framework, but the theoretical framework is incomplete and can be considered the possibility of mediators being eliminated in the direct path.

The result of this study is in line with the research that has been conducted by Rafferty & Minbashian (2019). The research showed that individual readiness to change can be a mediator of behavior that supports change, but it used different independent variables from this research. In this study, researchers tried to link the influence of organizational culture to *championing behavior* mediated by change readiness. While research by Rafferty & Minbashian (2019) states that change readiness can be mediate the relationship between changing beliefs and positive emotions about change to behaviors that support change. *Championing* behavior is an active form of behavior that supports change (Bouckenooghe et al., 2014). So that when employees are ready for the change determined by the organization, they will actively participate in the change and ensure the success of the change plan.

Based on the results of this research, organizational culture variables require individual readiness for change in order to be able to influence *employee championing behavior* in the implementation of manual medical records into EMR at MH. Thus, organizations need to prepare individuals (employees) who will be involved in the implementation of electronic medical records. If individuals have been prepared with norms or values that are believed in the organizational culture related to the implementation of EMR, then employees will be able to strive for success or promote the success of EMR implementation as planned by the organization.

CONCLUSION

This research found that organizational culture factors significantly affect individual readiness for change. Organizational culture has a significant direct effect on an individual's readiness for change and a significant direct and indirect effect on *championing behavior*. Individual readiness for change is proven to be a mediator of organizational culture towards *championing behavior*).

A strong organizational culture will directly affect individual readiness and behavior to fight for the success of the change plan that has been planned by the organization. MH has a strong organizational culture that supports individual readiness for change and will champion and promote the organization's planned change plan. The implementation of this EMR will be *mandatory*. Therefore, organizations need to prepare the employees well to ensure the success of the change plan can run as planned. When the employees are ready for the change planned by the organization they will fight for the success of the change plan, try to overcome the resistance of colleagues, talk positively about the change, be very enthusiastic about the change plan and ensure the success of the change plan.

Subsequent studies can be conducted with larger samples. Research needs to be further developed to complement the theoretical conceptual framework and the conceptual framework of mediation pathways.

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