CHAPTER 1

The Need for Change and Why It Isn't Happening

There is nothing permanent except change.
—Heraclitus (540–475 B.C.)

CHANGE IS ONE of the few constants in our existence, permeating every element of our daily experience. The world around us is changing at an ever-increasing pace. We live in "exponential times."

Contrast yesterday to a day in your life a decade ago. Yesterday, you began your day receiving news that streamed in real time across your personal digital assistant. You listened to your MP3 player while you made breakfast and placed a few phone calls from your car using your hands-free Bluetooth device. None of these technologies existed ten years ago. Your car contains more computational power and information technology than NASA's most advanced spacecraft of the 1970s, and the number of communications you will receive today probably will exceed all the communication you received in an entire week only a few years ago.

The information age has brought us unprecedented access to information and exponential growth in computing speed and data storage. Experts predict that each of these factors will continue to double every 18 months. Our ability to connect to the Internet is becoming ubiquitous, creating expectations that information should

be instantly accessible from any point on Earth. The Internet is rapidly transforming the way people learn, interact, and conduct daily business, and undoubtedly it will continue to play an increasingly critical role in all aspects of our lives, including healthcare.

Change has affected the workforce as well. One out of four employees has been employed with his or her company for less than one year, and employment experts estimate that today's careerist will work for 10 to 14 employers in his or her lifetime. U.S. Secretary of Education Richard Riley stated in a recent speech "that the top 10 jobs of 2010 are jobs that didn't even exist in 2004" (Fisch and McLeod 2007). The implications of these facts are profound. Current students are preparing to work for companies that do not exist today, to use technologies that have yet to be created, and to solve issues we have not yet identified as problems.

WHY CHANGE IS NECESSARY IN HEALTHCARE

Healthcare is not immune to the current velocity of change and the mega-trends shaping our society. In addition, healthcare faces its own unique issues. Today's senior healthcare executives must contend with an endless parade of challenges that keep their organizations in a constant state of flux. The following issues are a few of the major forces affecting healthcare.

- *Mounting pressures to reduce healthcare spending.* Any set of statistics clearly shows that the growth trends in U.S. healthcare expenditures are not sustainable. Currently, the United States spends significantly more on healthcare in total dollars and as a percentage of the gross domestic product (GDP) than does any other industrialized nation (Anderson 2000). According to the Centers for Medicare & Medicaid Services (CMS), healthcare has become the largest segment of the U.S. economy, representing approximately $2.2 trillion dollars, or 16.5 percent of the GDP (Baker 2007). Estimates from CMS

(Baker 2007) and the World Health Organization (2000) project that U.S. national healthcare spending will reach 20 percent of the GDP by 2015 without significant changes to the healthcare system.

- *Evolving consumer attitudes and expectations*. A quick scan of any newspaper confirms that consumers' attitudes and views about healthcare are changing rapidly. Unfortunately, most opinion polls indicate that this change is not for the better. The public is fed a steady diet of negative stories reinforcing the notion that healthcare is, at best, bureaucratic, bloated, unsafe, and inefficient and, at worst, greedy, corrupt, and run for the sole benefit of providers and payers.

  At the same time, today's consumers have come to expect more from their healthcare. They are better informed and no longer rely on their physicians as their sole source of information. Extensive information on diseases and treatment options is instantly available over the Internet, and the web can quickly link people with similar health interests around the globe. For example, a patient in Idaho can complete an online assessment that a physician in Alabama will review for a prescription that will be shipped from Canada. Someone with a rare medical condition can instantly contact thousands of patients suffering the same affliction. In addition, an abundance of information on alternatives to traditional medicine is available, and information on new medical procedures and breakthroughs flows directly to healthcare consumers, unfiltered by traditional medical review.
- *Transparency of quality outcomes*. Recent advances in Internet-based communications, new public accountability agencies, and current political agendas have raised the bar on availability of consumer-based healthcare quality indicators. Many organizations, such as Erlanger Health System in Chattanooga, Tennessee, have begun posting quality indicators on their websites for public review, allowing patients to compare and contrast the quality of different healthcare

organizations. This transparency of quality outcomes may be problematic for academic medical centers that traditionally have based their reputations for quality on the "teaching" halo. Although important, teaching status may affect quality indicators negatively because some staff members are still learning how to provide effective healthcare. Unfortunately, consumer-accepted quality metrics will dwarf the benefits of a teaching hospital before the end of this decade.

- *Changing demographics and an aging population*. The world's population is growing at an unprecedented rate. Although the planet's population did not reach 1 billion until the 1850s, the U.S. Census Bureau (2000) is projecting the worldwide population to exceed 10 billion by 2040. The population of the United States alone has increased threefold between 1900 and 2000.

  The droves of baby boomer retirees headed for Medicare are just beginning. By 2020, the number of seniors in the United States is expected to exceed 55 million. It will reach 80 million by 2040. In contrast, birthrates in Western industrialized countries, including the United States, continue to fall, whereas birthrates in other parts of the world continue to grow.

  These demographic shifts will have a profound effect on healthcare. They will alter the clinical case mix of every hospital and the available talent pool from which healthcare providers recruit staff. Seismic shifts in immigration and ethnic backgrounds will alter the mix of services required by the communities that healthcare organizations serve and will result in significant changes ranging from the type of facilities built to the methods of delivering care.
- *Expanding treatment options*. Hospitals are not the sole providers of healthcare anymore. In recent years, technology growth and consumer demand have spawned a host of standalone surgical centers, specialty hospitals, and imaging centers all vying to take advantage of current trends. The industry has witnessed double-digit growth in the number of outpatient

surgeries over the past decade. On a parallel track, diagnostic imaging has exploded, enabling earlier diagnosis and intervention. Procedures that generated significant revenue a decade ago now incur revenue loss. Former allies and partners have become competitors.

- *Increased competition for a shrinking pool of skilled labor*. There appears to be no relief in sight for the shrinking pool of skilled healthcare labor. Shortages are expected to intensify further as baby boomers retire. The U.S. Department of Labor (2004–2005) projects that registered nurses hold 2.3 million jobs, and through 2012, more jobs will be created for nurses than for any other occupation (American Hospital Association 2004). Because of a lack of nursing talent, position vacancy rates in many areas of the United States are already into double digits. The same is true for physicians. Despite increased demand, medical school admission and graduation rates have not increased since 1981.
- *Globalization of healthcare and medical tourism*. Global competition has had a profound effect on most industries, and healthcare is no different. You may have heard one of your healthcare colleagues say "all healthcare is local." This statement is based on a belief that each healthcare market is self-contained and immune to external market forces outside a limited geographic radius. In other words, what occurs in Chicago has little bearing on what happens in Atlanta. This disconnect may have existed ten years ago, but it does not today.

  Nothing illustrates the changes awaiting healthcare as profoundly as the story on medical tourism aired by CBS on *60 Minutes*. Bob Simon's (2005) report described how U.S.-trained physicians and surgeons are providing world-class care in foreign countries at a fraction of the cost of the same care in the United States. The story documented the dramatic growth of medical tourism and state-of-the-art medical centers offering the most advanced medical treatments in a vacation resort environment. These facilities offer quality of care

and financial incentives sufficient to induce patients to travel 12,000 miles to receive treatment. The report indicates that for a growing number of people, medical tourism has become a viable path to affordable elective and cosmetic surgery. Others see it as their best opportunity to receive expensive life-saving procedures. One of the most moving stories in the program was of a man who could not afford to pay for his heart bypass surgery. He would have incurred an estimated $100,000 out-of-pocket expense in the U.S. system. Instead, he elected to have the surgery performed overseas for $12,000.

This list of healthcare challenges is daunting, and these challenges are not going away; they are just a warm-up for tomorrow's even more complex world. With a list like this one, why are healthcare leaders surprised when there are disruptions and challenges in hospitals? Change is part of healthcare management, and senior executives must be prepared to harness that change and transform it into improved performance. Change is not something we cope with until we can get back to our regular job; leading change successfully *is* our job.

Most senior healthcare leaders know their organization's future viability and success correlate directly with the organization's ability to anticipate and respond to changes in its environment. Intellectually, leaders, managers, and staff know that those who cannot adapt and reinvent themselves are condemned to fail. Realistically, they know that maintaining the status quo is not an option. Continuing on the path of "business as usual" may delay change, but ultimately, change will catch up. Postponing change or even attempting to avoid it will make the change even more difficult to achieve.

Despite this fact, most healthcare organizations protect the status quo. They resist change even when faced with inscrutable evidence that their current care delivery processes are far from optimal, or even broken. Resistance to change has the unintended consequence of creating a widening gap between the organization's need to change and the speed at which transformational efforts occur.

HUMAN NATURE AND THE BARRIERS TO CHANGE

If change is inevitable, why do most people instinctively resist it? The simple answer is that it is against human nature. An effective change agent anticipates barriers to change and organizes efforts to surmount people's natural tendency to resist it.

To create initiatives that flow against human nature is to plan for failure. The following factors may present obstacles to achieving transformational change and must be considered when designing a new program.

- *Acceptance of the need to change is an admission of guilt.* Before change can occur, managers must acknowledge that change is needed and that their current performance and work processes are not optimal. Some perceive this acknowledgment as an admission of failure or incompetence on the manager's part. This perception may have a paralyzing effect on improvement.
- *Fear of failure and rejection trumps the desire for change.* For many individuals, the personal risk involved in change outweighs its potential rewards. Nowhere is this fear more apparent than in healthcare. Fear of failure appears to be part of healthcare's DNA. For example, clinicians are trained first to do no harm. They are taught to follow proven pathways and protocols or treatments that have been proven effective by their own experience. There is a natural bias to resist changing what works, even if there is substantial evidence supporting the use of something new. To deviate from the proven or established clinical protocols is considered acceptable only after extensive studies have demonstrated the effectiveness of a new treatment. Healthcare is a risk-averse culture. It fosters an environment that demands error-free performance and does not reward risk taking.

  Real improvements in healthcare organization processes do not come without risk. Change may incur failure. In an industry

where failure is unacceptable and viewed as final or absolute, the only perceived safe and rational course of action is to maintain the status quo.

- *Comfort with the familiar leads to avoidance of change*. Fear of the unknown can stop change in its tracks. Human nature's first response to a change is to evaluate the risk and run through endless scenarios of possible negative outcomes. This type of threat assessment is a natural and organic response to a change in the environment. Regardless of how bad a current situation or process is, department managers and hospital staff are usually comfortable with it. They may acknowledge that their work processes leave much to be desired, but they fear that change to their current routines could produce an unexpected outcome that they would be unable to handle.
- *Complicated projects create the Mt. Everest syndrome*. When considering a complex task in totality, people become overwhelmed. Imagine yourself as a mountain climber facing a difficult slope. If you sit at the base of the mountain and contemplate the climb, trying to envision every step of the journey to the summit, you will become overwhelmed with the magnitude of what you must accomplish. This view has a paralyzing effect on your psyche. If you break the climb into achievable phases, your outlook changes. It becomes a series of small climbs rather than an insurmountable challenge. In a similar sense, healthcare consists of a series of complex care and work processes. When confronted with the prospect of reengineering complex work processes, managers and staff may perceive their challenges as Herculean. The size and complexity of the task may immobilize even the strongest leaders. They may perceive goals as unattainable and inadvertently diminish staff's motivation to try. As with the mountain example, breaking a complex process into several sub-processes and focusing efforts on one sub-process at a time may make the reengineering effort more manageable.
- *Discomfort with ambiguity leads to avoidance*. Most human beings are uncomfortable with even small amounts of ambiguity

and uncertainty. They seek a proven map before they take the first step of a journey. Ambiguity is the root cause of many anxieties. This desire for certainty can prevent progress. Fear and protection of the status quo can masquerade as due diligence. Ambiguity can invoke a perpetual call for more data, more analysis, and examination of more alternative solutions. A guiding vision is important, but seldom does one have the luxury of knowing all the answers and details before starting a transformational initiative.

ORGANIZATIONAL BARRIERS TO CHANGE

In addition to human nature, organizational factors may present barriers to change. These barriers may prevent even the most dedicated and committed healthcare organizations from achieving desired goals. Although organizational factors that prohibit success vary from organization to organization, recurring themes tend to appear as hospitals implement new work processes. An organization can improve its probability of success by understanding and addressing these major barriers.

- *Competing priorities and lack of clear organizational focus.* Performance improvement activities require time and resources. Healthcare organizations are notorious for adding one improvement initiative on top of another. Senior leaders decide to change the current strategy and charter new taskforces and work teams without disbanding the former ones. At some point, the organization passes the tipping point and change grinds to a halt. Managers are frustrated because they spend all their time in meetings and have minimal time to implement needed improvements. Focus remains on the urgent rather than on strategically important issues. These symptoms signal that the hospital has no systematic and

strategic way of assigning priorities or ensuring that the resources for change are sufficient and focused on improving important core processes.

Perpetual priority shifts cause managers and staff to develop a resistance to the directions of leadership. Even well-meaning managers may be slow to act because of confusion about organizational priorities. Other managers may adopt a strategy of keeping a low profile because they know the next "daily crisis" will postpone the need for them to act today. In the *Harvard Business Review* article "Change Through Persuasion," Garvin and Roberto (2005) claim that "Where leaders repeatedly proclaimed a state of crisis but made few substantive changes, employees became jaded. They developed a bunker mentality. The wisest course of action is to ignore new initiatives."

- *Misaligned incentives*. Changes in work processes and department interactions may create misaligned incentives—formal or informal rewards that put individual interests at odds with organizational interests. For example, managers may resist using staff more efficiently if they perceive that doing so will reduce their number of direct reports and thus diminish their standing in the organization. Likewise, a laboratory manager may seek to optimize personal performance by batching lab results to improve the efficiency and costs of producing a diagnostic result. Batching would allow the lab director to minimize reagent utilization, labor, and other costs per test result, thus achieving financial targets. However, excessive batching of test results typically delays the release of patient data, thereby hindering the physician's ability to write timely discharge orders for patients. Although the lab is meeting its cost goals per test result, the hospital is incurring excess labor costs and losing revenue while it cares for patients who should have been discharged. This project-by-project approach often creates misaligned incentives that cost the hospital millions in lost revenue and expenses related to poor patient flow. When senior leaders

delegate project selection and performance improvement down to the manager level, the result is a project-by-project approach that focuses efforts on insignificant tactical issues and proliferates misaligned incentives.

- *Benchmarking's potential to paralyze*. The concept of comparative data swept across healthcare approximately 20 years ago. Today, data comparison, or benchmarking, is a multibillion-dollar industry. On the surface, the concept of benchmarking is straightforward and logical. You compare your performance to others, which helps you to find opportunity for improvement. Unfortunately, benchmarking has paralyzed more healthcare organizations than it has helped. Healthcare institutions spend excessive amounts of time, money, and human capital arguing about the accuracy of data instead of using this time to implement needed changes. Benchmarking data are valuable, but the way most healthcare organizations use these data slows progress and creates barriers to action. Benchmarking can be a useful exercise if it incites a hospital to act, but not if it causes further delays and protects the status quo.
- *Ineffectiveness of external standards and best practices*. As with benchmarking, organizations have expended tremendous resources to identify healthcare best practices. Some of the industry's greatest minds have focused on isolating the clinical practices of top-performing hospitals and departments across the country. This research is based on a prevalent belief that if organizations can identify the nation's top-performing emergency room, surgery department, or nursing model, they can emulate its care processes in their facilities.

  Unfortunately, direct import of best practices seldom produces success or lasting change. The concept of best practices assumes that each emergency department is operating in the same environment and is experiencing the same constraints and bottlenecks. Healthcare is too complex for hospitals to be identical. Therefore, the premise on which the best practice model is based is inherently flawed.

The best practice approach also assumes that best practices can be imposed on staff without cultivating belief in the proposed change. Consultants often issue reports containing manifold well-vetted best practices only to have staff reject them. The hospital staff even may agree to implement the proposed changes in a half-hearted fashion to prove the consultant's recommendations were wrong. Even when the recommendations show promise, gains dissipate once the consultant leaves and hospital staff members drift back to their old work patterns. Without taking the necessary steps to foster belief in the change and to hardwire improved work processes, lasting results will not ensue.

Identifying best practices is a valuable step in designing new work processes, and much can be learned from examining the practices of other providers, but senior leaders must recognize that every hospital has its own complex interconnected work processes and culture.

- *Overreliance on monitoring systems*. Hospitals are striving to catch up with other industries in their use of information technology. Senior leaders are staking their careers and futures on multimillion-dollar investments in monitoring systems. The prevalent belief in healthcare is that if we only had a way to monitor the problem, we would know what to do and the problem would correct itself. Research indicates that hospitals that see monitoring systems as the prime solution to driving improvement are headed for disappointment.
- *Inadequate accountability*. Hospitals have moved toward a more collaborative environment in the past few decades, using multidisciplinary teams, creating task forces, and developing a number of shared governance structures. This team approach provides staff with the opportunity to express viewpoints on critical issues. Unfortunately, these collaborative efforts have not produced the level of change and transformation their creators had anticipated. Objective observation of many of these teams in action reveals that they have

degenerated into gripe sessions, social clubs, and monitoring organizations. Teams spend a minimal amount of time, if any, implementing and pursuing solutions. They spend most of their time discussing issues or monitoring clinical metrics rather than singling out one issue to improve before the next meeting. Senior leaders frequently express concern about this lack of accountability for producing tangible results. When everyone is responsible for a result, nobody appears responsible. In many cases, these multidisciplinary teams mask inaction and protect the status quo.

A CALL TO ACTION

The quickening pace of change has heightened the importance of leading transformational efforts and made such leadership a highly valued executive core competency. The current healthcare environment demands that senior executives develop specific leadership skills to guide their organization through transformational efforts and coach managers in the methods of change.

Change is unavoidable. The logical response is to develop a deliberate strategy for embracing it and harnessing its energy. The following chapters discuss how senior leaders can embrace their role as change leaders and develop accountability for change, create an environment conducive to change, and link strategies to quality outcomes.

REFERENCES

American Hospital Association. 2004. *Stat: Tackling Today's Challenges, Addressing Workforce Shortages*. Annual Meeting Paper, July 28.

Anderson, G. 2000. "Quality and Innovation: Issues, Strategies, and Implications for Policy." Commonwealth Fund International Symposium on Health Care Policy, Washington, DC, October 11–13. [Online information; retrieved 6/20/08.] http://content.healthaffairs.org/cgi/content/full/20/3/219#T5.

Baker, S. L. 2007. "U.S. National Health Spending, 2005." [Online information; retrieved 6/27/08.] http://hadm.sph.sc.edu/COURSES/Econ/Classes/nhe00.

Fisch, K., and S. McLeod. 2007. "Did You Know 2.0." Washington, DC: U.S. Chamber of Commerce, June 22. [Online information; retrieved 6/27/08.] www.youtube.com/watch?v=pMcfrLYDm2U.

Garvin, D., and M. Roberto. 2005. "Change Through Persuasion." *Harvard Business Review* 83 (2): 104.

Simon, B. 2005. "Vacation, Adventure and Surgery." *60 Minutes*, CBS, September 4.

U.S. Census Bureau. 2000. "Census 2000." [Online information; retrieved 6/20/08.] www.census.gov.

U.S. Department of Labor, Bureau of Labor Statistics, Office of Occupational Statistics and Employment Projections. 2004–2005. "Occupational Outlook Handbook." [Online information; retrieved 12/19/07.] www.bls.gov/oco/home.htm.

World Health Organization. 2000. *The World Health Report 2000—Health Systems: Improving Performance*. Geneva, Switzerland, June 1.