

Accelerating Change and Changing Behaviors

WHY FOCUS ON CHANGE?

Here is a straightforward reality: A hospital or healthcare system that aspires to transform its patient safety performance from harmful to zero patient harm *must change*. It must stimulate adjustments in behaviors and practices, and this requires individual caregivers who *want* to change the way they do things. It must redesign patient care processes and modify embedded defenses, and this requires the active participation of frontline staff in developing and implementing the changes necessary to minimize error traps and improve safety. It must strengthen existing structures and systems to support the consistent delivery of safe care, and this requires active leadership and adequate resources to sustain the benefits derived from the change. Transforming behaviors, processes, and practices and the resultant difference in attitudes, values, and beliefs require a mastery of change facilitation methods and skills. Healthcare leaders must become master change agents if they want to motivate and lead their organization in pursuing transformational improvements in patient safety that will result in zero patient harm.

Which came first—the chicken or the egg? This timeless riddle and folk paradox describes a causality dilemma or the problem of origin and first cause. It raises the question, “What needs to happen first?” Did the chicken come first, or was it necessary to have an egg for the first chicken to hatch? This riddle is a metaphoric expression used when it is not clear which of two factors is the cause and which is the effect. The causality dilemma for hospitals that aspire to ascend to the high-reliability level, in which zero patient harm is the norm, is whether safe practices or safe thoughts come first. Does a change in thoughts (beliefs and attitudes) cause a change in practices and behaviors? Or does a change in practices and behaviors cause a change in thoughts? Does it matter?

Based on the high-reliability organization research of Karl Weick and Kathleen Sutcliffe (2007) and the study of human factors and safety culture by James Reason (Reason and Hobbs 2003), the following discussion suggests that changing practices and behaviors is a far more direct and effective way to achieve the zero harm goal than first trying to modify attitudes, beliefs, and values throughout the organization. A change in behaviors and practices comes first, resulting in improved attitudes, beliefs, and values that, in turn, cause a transformation in the organizational culture.

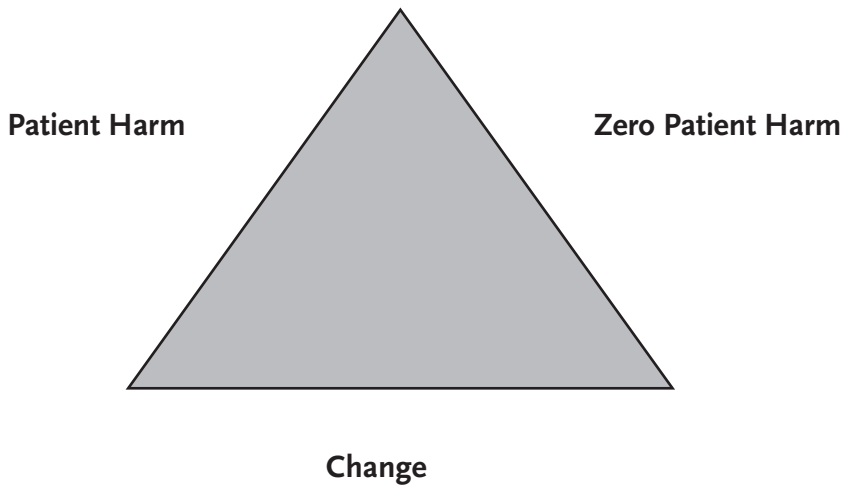
Hospitals and healthcare systems that aspire to put in place a consistently safe, highly reliable patient care environment must have a competency in effecting change in practices and behaviors. Facilitating this change and adopting the safe practices of high-reliability organizations is the most effective and direct route to eliminating preventable patient harm. Visioning is important; as Douglas Smith (1996, 230) has said, “Visionless people do not change.” But visioning or thinking about and believing in a goal alone is not sufficient for goal realization. Changing practices and behaviors is the critical delta necessary to achieve and sustain zero patient harm (see exhibit 1.1).¹

This is why chapter 1 is devoted to change. Change facilitates the achievement of zero patient harm, which requires the acquisition of knowledge, skills, and abilities (KSAs) necessary for becoming an excellent agent of change. Job number one for leaders of organizational efforts to eliminate all patient harm is to learn how to create a sense of urgency for change, clearly communicate the vision of a more successful future, gain staff’s commitment to and engagement in the change effort, reduce complacency and resistance to change, and provide ongoing support and resources to ensure the successful implementation of the change.

WHY IS CHANGING PRACTICES AND BEHAVIORS CRITICAL TO ACHIEVING A CULTURE OF SAFETY AND CONSISTENTLY SAFE PATIENT CARE?

How often do we think about doing something, create a mental plan for accomplishing it, and dream about the potential results, but then procrastinate and fail to take the action necessary to realize the goal? Getting from A (the current state) to B (the desired future state) requires change. Most people are fearful of change and the uncertainty it represents. But as our experience with making changes in either our personal or professional life grows, we learn that change often provides new opportunities for both personal and professional success. It is an unassailable fact that people need to take action to actualize their thoughts and aspirations. To change the outcomes of something, people need to change their practices and behaviors.

Exhibit 1.1: Effects of Change



The same is true for an organizational change effort. Actualizing the aspiration of zero patient harm can only occur through action or doing—specifically, following the Five Disciplines of Performance Excellence: (1) preparing (through simulation, practice, and training) to deliver safe care, (2) applying proven safe care or offensive strategies, (3) minimizing errors and mistakes, (4) maximizing the controls or defensive strategies, and (5) routinely receiving guidance and feedback from patient safety coaches.

In the pursuit of a culture of safety, organizations may find it harder to change attitudes and beliefs than practices and behaviors. “Effective practices . . . will eventually bring attitudes and beliefs into line with them” (Reason and Hobbs 2003, 156). Although action is the key determinant of goal achievement, action is only possible if the people affected are convinced of its merits and are motivated to take or support it. In other words, action is dependent on effective change facilitation and competent agents of change. “No matter how well a system or solution is conceived, designed, and executed, if people do not like it, it will fail. The goal of the change leader is to . . . create well-designed solutions that will gain wide acceptance” (Bulger and Weber 2005, 372). In addition to being a visionary and charismatic champion for patient safety, today’s healthcare leaders must have a mastery of the KSAs of change facilitation to be able to define, reward, and expect the practice of safe behaviors by all staff. According to John Kotter (1996, 151):

Organizations act their way into what they become.

—Karl Weick and Kathleen Sutcliffe (2007)

Culture changes only after you have successfully altered people's actions, after the new behavior produces some group benefit for a period of time, and after people see the connection between the new actions and the performance improvement. Changing the culture should never be the first step in a major change effort.

According to Jeffrey Hiatt and Timothy Creasey (2012, 1), change management provides the bridge between solutions and results: "The bridge between a quality solution and benefit realization is individuals embracing and adopting change." Organizational transformation occurs because the people in the organization are convinced that, after the change, they will be better off and the organization will be in a better position to meet its objectives. People change the organization, what it does, and what it is able to accomplish. Healthcare leaders must become compe-

Change is part of organizational life and essential for progress. Those who know how to anticipate it, catalyze it, and manage it will find their careers, and their companies, more satisfying and successful.
—Richard Luecke (2003)

tent agents of change to facilitate the changes in staff practices and behaviors and the adoption of safe care practices.

Change involves patient care teams doing their jobs differently. "A perfectly designed process that no one follows produces no improvement in performance" (Hiatt and Creasey 2012, 1). Therefore, leaders who want to achieve a level of performance excellence must use effective change facilitation tools, including being a champion for change; creating a shared need for change; explaining how the change will benefit both staff and the organization; building a coalition

of support for the change; mobilizing the commitment for change; and motivating, monitoring, and rewarding action.

CHANGE TO IMPROVE PERFORMANCE

The four major targets and resulting benefits of organizational change initiatives are as follows:

1. *Structural.* These changes are focused on reorganizing the organization's operating units or parts to improve efficiency and performance. Such change efforts might include acquiring new parts through acquisition or shedding some operating units through divestiture.
2. *Efficiency.* These changes are focused on cost reduction, elimination of nonessential activities, and identification and elimination of waste.

3. *Process.* These changes alter how things get done in the organization. The objective is to make processes more reliable, safer, less costly, more effective, and faster.
4. *Cultural.* These changes focus on modifying the norms, attitudes, beliefs, and behaviors of the organization to support a new vision.

All four of these targets facilitate the organizational changes necessary for a hospital to become highly reliable, to eliminate all preventable patient harm, and to achieve a level of consistent performance excellence. Given that changes in staff behaviors (setting clear behavior-based expectations) and the adoption and consistent application of safe care practices are a top priority in delivering safe care, making *process changes* should be the first order of change in the organization. Along the way, hospitals should make *efficiency changes*, applying Lean Six Sigma tools and techniques to root out waste and inefficiencies in care processes and design, to ensure that only the critical and high-quality characteristics remain.

Effective change management requires leaders to introduce *structural changes* to structures and systems that will support the hospital's evolution to an environment of high reliability and zero patient harm. Visioning, revising or creating policies, providing training, and providing positive reinforcement are examples of the type of structures needed to support the practical changes in patient care practices and behaviors. Leaders must avoid the appearance of change for change's sake and clearly and regularly communicate the desired harm-free healthcare objective. As a result of the changes in priorities, processes, and practices, *cultural changes* occur in the form of new norms, attitudes, and beliefs. As Smith (1996, 98) says, "A performance focus forces everyone to consider the consequences and benefits of changing or not changing." Managing and facilitating change in the hospital setting is "the ultimate human challenge" in that the leaders, functioning as change agents, transform organizational performance and practices of a large group of people by learning new skills, behaviors, and working relationships.

The primary objective of change is performance, not change.
—Douglas Smith (1996)

ASPIRING TO CHANGE

The management of *organizational change*—change that is meaningful and enduring—will be carried out in three stages. Phase 1 establishes the shared aspiration for improvement through change. Phase 2 involves making the change happen through those most affected by the change. Phase 3 entails assimilating

the change and related new behaviors and habits throughout the affected parts of the organization.

An aspiration is an ardent desire to accomplish something new. The safety-related aspiration for hospitals is a culture in which every patient receives harm-free health-care. Leading change, creating a shared need, and shaping the vision for change are the first three pillars of the Change Acceleration Process model (Six Sigma Institute 2019). In this model, the leader's role is to articulate the reason for change as well as explain why the change is important, how it will help them, and how it will benefit the organization. The CEO and senior leadership must be champions for the change initiative and, as such, must demonstrate public commitment to and support for the change. Visioning spotlights the desired outcomes of the intended change and defines the adjustments in behaviors needed to realize the benefits of the change. Creating a shared need for the change happens when the perceived need for change exceeds the resistance to change.

Following are the five determinants of the rate of change adoption that leaders must proactively address to enable the change initiative to succeed (Bulger and Weber 2005):

1. *Relative advantage.* If those affected by the change perceive it as relatively better than the current situation, the change is more rapidly adopted.
2. *Compatibility.* Change adoption is faster when staff perceive the change to be consistent with their values, past experiences, and needs.
3. *Complexity.* The simpler the change, the more likely it is to be adopted.
4. *Trialability.* The perception of risk is lowered if the change can first be implemented on a trial basis before it is adopted.
5. *Observability.* The adoption of the change is enhanced if the affected staff can observe others who are trying the change first.

Facilitating the change initiative will require leaders to create a sense of urgency about the need for change, to overcome the organizational tendency toward homeostasis. *Homeostasis* is the ability to maintain a relatively stable internal state through feedback mechanisms despite the influence of external changes. As Esther Cameron and Mike Green (2012, 140) note, "The forces of homeostasis act to preserve the status quo in any organization." Leaders have to assess the organization's propensity for change before announcing a change initiative. This assessment should include a review of the following (Cameron and Green 2012):

- *Nature of the change.* Five types of change can each provoke a different response from those potentially affected by the change: evolutionary

or revolutionary, externally driven or internally motivated, one time or routine, minor or transformative, and contraction or expansion.

- *Consequences of the change.* Those affected by the change will want to know who the potential winners and losers will be; who will benefit; who will be “hurt”; and what the specific consequences will be for employees, customers, and the organization.
- *Past experience with change.* How the organization has handled change initiatives in the past, how it has resourced changes, and what its capacity is to support change should be considered when launching a new change initiative.
- *Individual change factors.* Change is accomplished through the individuals in the organization; therefore, it is important to understand what values motivate them (e.g., money, power, status, inclusion), what personality types may be affected by the change, and what their past experience has been with organizational change initiatives and their *adaptive resilience* to handle change.

“We aspire to be a hospital that consistently provides excellent patient care that is safe and free from harm” is an example of a patient safety vision. Setting such a vision must be based on a clearly defined business problem (eliminating preventable patient harm), must describe an altered and improved future (delivering harm-free healthcare), and must inspire the commitment and energy of all of the staff affected by the change (adopting the safe care practices of high-reliability organizations) (Luecke 2003). Turning the aspirational change objective into action requires change in behavior or practice; leaders need to decide and announce what they specifically want people in the organization to become continually better at doing. Then, they need to provide the support and facilitation that will enable people to learn and adopt the expected and desired change (Smith 1996, 261–67).

In preparing to implement a change initiative, the organization should determine its readiness with the following tasks (Smith 1996, 259):

1. Identify the people who will be affected by the change, and determine how their behaviors and activities will need to shift.
2. Articulate the from/to aspect of the changes in job functions (e.g., ensure peer checking for high-alert medication administration) and individual behaviors (e.g., consistently ensure that all aspects of the fall prevention policy are enforced, including installing bed alarms for at-risk patients and answering the call for ambulation assistance quickly).
3. Assess the sources of readiness.

4. Assess the sources of reluctance.
5. Create the inspirational vision and purpose of the change and effectively communicate them.
6. Describe the “how” of making the change happen.
7. Describe the expected or desired behavior or practice during the change initiative.

ACTUALIZING THE CHANGE

The goal of this book, which should be the principal goal of every hospital or healthcare system, is to facilitate the adoption of best practices, including the Five Disciplines of Performance Excellence (each of which is discussed in its own chapter), that if consistently followed or incorporated into day-to-day performance will lead to excellence and the elimination of preventable patient harm. These practices demand a commitment to changing behaviors and adopting new safe care practices. This commitment, in turn, requires leaders to be smart about initiating and executing change as well as convincing the staff that change is critical to protecting patients from harm. This commitment enables the gains in improved patient safety to be sustained for a long time.

Actualizing the change—to make it a reality—takes a skilled approach. Several effective models for actualizing the change are available, including John Kotter’s Eight Accelerators, Edgar Schein’s Model of Transformative Change, Cameron and Green’s Seven Stages of Change, Smith’s Ten Management of Change Principles, the Prosci ADKAR Model of Individual Change, Hiatt and Creasey’s Foundational Tenets for Change Management, and Beer’s Eight Steps to Create Real Change. Leaders will want to become familiar with the advantages of each model. Kotter’s and Schein’s change models are discussed here.

Kotter’s Eight Accelerators

Kotter’s Eight Accelerators model, published in 2012, expands on the Eight-Step Process of Creating Major Change introduced in his 1996 book *Leading Change*. The change accelerators are intended to help organizations “stay competitive amid constant turbulence and disruption” and make significant operational changes that enable the constant adjustment to an ever-changing environment (Kotter 2012). According to Kotter (1996, 30), organizations need to respond to mounting complexity and rapid change with greater agility, speed, and creativity by accelerating strategic change:

Managing change is important. Without competent management, the transformation process can get out of control. But for most organizations, the much bigger challenge is leading change. Only leadership can blast through the many sources of corporate inertia. Only leadership can motivate the actions needed to alter behavior in any significant way. Only leadership can get change to stick by anchoring it in the very culture of an organization.

The accelerators are different from the original eight steps in that the accelerators (1) are concurrent and always at work, (2) involve as many people in the organization as possible as a “volunteer army,” and (3) require the flexibility and agility of a network. The accelerators “serve as a continuous and holistic strategic change function” that jump-starts the organization’s momentum to improve and become more agile. Recruiting and training many volunteers as change agents who are personally inspired and motivated to participate is a key success factor in bringing about meaningful change. Leaders need to appeal to the individual’s emotions and genuine desire to contribute. The leader’s role in the change “game is all about vision, opportunity, agility, inspired action, and celebration” (Kotter 2012). The following is a summary of the eight accelerators:

1. *Create a sense of urgency around a single big opportunity.* This urgency to realize a strategically rational and emotionally exciting opportunity is the bedrock on which a change initiative is built.
2. *Build and maintain a guiding coalition.* A broad range of skills, departments, and levels of staff must be represented on the coalition. Coalition members should be knowledgeable about both external influences and internal operations as they are charged with making good enterprisewide decisions about which strategic change initiatives to pursue and how to implement the change.
3. *Formulate a strategic vision and develop change initiatives designed to capitalize on the big opportunity.* The right vision provides a “picture of success” and is feasible, emotionally appealing, and focused on taking advantage of a big opportunity.
4. *Communicate the vision and the strategy to create buy-in and attract a growing volunteer army.* The communication should be memorable and authentic. Its goal is to attract staff to join the volunteer army and support (or not resist) the change initiative.
5. *Accelerate movement toward the vision and the opportunity by ensuring that the network removes barriers.* When barriers to change are identified, a member of the coalition volunteers to be the leader and

- recruit others to help. Together, they develop a practical solution to remove the barriers quickly.
6. *Celebrate visible, significant short-term wins.* To silence the skeptics, leaders find evidence that the change benefits the organization or results in short-term success. This proof must be presented immediately, because success breeds success. Celebrating short-term wins helps buoy the volunteer army and prompts more staff to buy in. The description of the win should be unambiguous, obvious, and clearly related to the change vision.
 7. *Never let up. Keep learning from experience. Don't declare victory too soon.* The organization must carry the strategic initiatives through to the end. Along the way, it should adapt to shifting environments, enhance its competitive position, and continue to control the rise of cultural or political resistance.
 8. *Institutionalize strategic changes in the culture.* Strategic change initiatives will sink or be embedded into the organizational culture when they are incorporated into day-to-day activities. For this to happen, the change initiative must produce visible and positive results and provide a strategically better future for the organization.

In *Leading Change*, Kotter (1996, 4–12) identifies several change management errors that leaders should be aware of and avoid: (1) allowing complacency, (2) failing to create a powerful guiding coalition, (3) lacking a sensible vision, (4) undercommunicating the vision, (5) allowing obstacles to block the new vision, (6) failing to create short-term wins, (7) declaring victory too soon, and (8) neglecting to anchor changes in the corporate culture.

Edgar Schein's Model of Transformative Change

Schein's Model of Transformative Change describes the change process in three steps, as follows (Cameron and Green 2012):

1. *Unfreezing.* Leaders and change agents must engender a feeling of psychological safety for individuals. In this way, people are able to overcome their learning anxiety, and leaders can create the motivation to change.
2. *Learning.* Individuals learn new concepts and new meanings from old concepts through trial and error, scanning for solutions, and role models.

3. *Refreezing.* This step involves internalizing the new concepts and new meanings, incorporating them into self-concept, and employing them in ongoing relationships.

Schein suggests that leaders and change agents must address the learning and survival anxiety of people who are affected by change initiatives. When employees are anxious about learning new behaviors or practices, they fear failing, being temporarily incompetent, and being punished for being incompetent. Employees suffering through survival anxiety are worried they may lose their job, be left behind, or lose their membership in their work group. Sometimes, these characteristics may look like reluctance or resistance to change, but they require interventions to help the affected employee regain confidence and competence.

In preparing for change, leaders should assess staff readiness, acquire project resources, assemble the change management team, and identify the champions and sponsors of the initiative. In managing change, leaders should communicate the plan for change, develop coaching and training plans, and establish strategies to address resistance. In reinforcing change, leaders should implement corrective actions in response to performance feedback, manage the remaining resistance to the change effort, celebrate success, and reward performance (Hiatt and Creasey 2012).

Today's most urgent performance challenges demand that you learn how to manage people through a period of change. You already know you must have a vision for what the organization will be like after change has been mastered. But such visions are not enough. People facing change need more than an understanding of the end of their journey. They need guidance about how to make the journey itself.
—Douglas Smith (1996)

ASSIMILATING THE CHANGE

To assimilate a change means to incorporate it into the organizational culture—that is, to conform with the existing customs, norms, attitudes, and values shared by staff. This third phase of change management is important in sustaining the positive outcomes or gains from the change and protecting against recidivism.

Kotter refers to the assimilation stage (the fifth step in the Change Acceleration Process) as either *institutionalizing* or *anchoring* the strategic changes in

Change management is about engaging the passion and energy of employees around a common and shared vision so that the change becomes an integral part of their work and behavior.
—Jeffrey Hiatt and Timothy Creasey (2012)

the culture. Leaders can sustain the change by ensuring that the new practices become common or “the way we do things around here.” New practices and behaviors “help produce better products and services. . . . But only at the end of the change cycle does most of this become anchored in the culture” (Kotter 1996, 156–57).

To test the level of assimilation, leaders may analyze the “From/To” aspect, or the skill and behavior shifts among the staff affected by the change. Has the knowledge transfer occurred? Have the new KSAs been effectively adopted and ingrained in the way things are done in the organization?

Motivations

Getting more and more people onto the change wagon or to be actively involved requires an understanding of the different approaches to motivating individuals to change or accept change: behavioral, cognitive, psychodynamic, and humanistic (Cameron and Green 2012). These four approaches are described as follows, along with the related interventions to facilitate change:

1. *Behavioral.* This approach uses positive and negative stimuli or rewards and punishment to encourage people to adopt the preferred practices or to discourage them from unwanted behaviors. Interventions needed: performance coaching, rewards, 360-degree feedback, skills training, and values translated into behaviors.
2. *Cognitive.* This approach gets people to realize that their old way of thinking is limiting them from experiencing new things or new ways of being. Interventions needed: results-based coaching, visioning, goal setting, and performance framework (e.g., behavior-based expectations).
3. *Psychodynamic.* This approach helps leaders better understand the reactions of their staff during a change process and develop better ways to deal with them. When individuals go through change, they experience a variety of psychological states, including the Kübler-Ross stages of grief or response to profound change (denial, anger, bargaining, depression, and acceptance). Interventions needed: counseling, surfacing hidden issues, and addressing emotions.
4. *Humanistic.* This approach is based on the understanding that individuals have a choice in how they think, feel, and act and are ultimately responsible for their own situation. Interventions needed: emphasizing healthy development and growth, living the values, addressing emotions, fostering communications, and consultation.

Understanding what motivates the employees affected by the change initiative will help leaders prepare them “to get invested and involved in the design and execution of change processes and to facilitate [change] implementation so that there is sufficient buy-in to make change sustainable” (Porter-O’Grady and Wilson 1995, 20–21). Leaders must provide the training and resources necessary for staff to assimilate the change into daily practice. Such support, along with ensuring the person’s capacity for change, can protect against staff burnout, work overload, and frustration.

Resistance and Complacency

The goal of assimilating change is to sustain the resulting improvements into the future. Major threats to sustaining the gains are employee resistance and complacency. “This, too, shall pass” may be heard at the water cooler among the resisters. Assessing whether staff are ready, reluctant, or actively or passively resistant will help determine whether the change will stick. In *Taking Charge of Change*, Smith (1996) says that most people are neither resistant to nor ready for change. Faced with the reality of impending change, individuals become anxious and reluctant about what is to come. The leader’s role as master change agent is to convert this reluctance into readiness, not resistance, by getting staff involved in the practical performance of change. Smith proposes seven tactics for leaders to use when responding to a reluctant employee:

1. Explain the need for change and how the new skills and behaviors will benefit both the person and the organization.
2. Clarify the specific skills and behaviors required by the change.
3. Assess if the person has the minimum capabilities required by the change.
4. Make sure the person is emotionally invested in the change and feels the change is essential.
5. Check that the person has a plan of action and personal commitment to specific performance goals.
6. Assess if the person has taken action to achieve her specific goals.
7. Provide support and reinforcement when the person takes action.

Complacency can cancel the positive effects of change. Complacent staff may feel that everything is going just fine and that change is not needed, wanted, or valued. Complacency may be caused by (1) low individual performance standards, (2) lack of external performance feedback, (3) absence of a major and visible crisis,

If you continue to carry on doing what you are doing, you will continue to get what you are getting.

—Esther Cameron and Mike Green (2012)

(4) focus on functional goals, and (5) too much “happy talk” by senior leaders who believe that “the company is doing great” (Kotter 1996, 40).

Leaders need to involve complacent and reluctant staff in the design and discussion of change, sharing information about the real challenges the organization faces. Leaders must create opportunities for staff to educate management about their frontline perspectives and experiences. The goal of staff engagement is to develop a mutual understanding of organizational problems, challenges, threats, and opportunities for improvement—that is, the reasons that change is needed.

ROLE OF THE CHANGE AGENT

Change agents are a volunteer corps of staff from various departments. They receive specialized training in change management or change acceleration tools and techniques, and they facilitate change initiatives. Change agents are a critical part of any serious change efforts.

The responsibilities of change agents include providing structured guidance and advice, facilitating meetings of the change implementation team (CIT), resolving conflicts, and educating the CIT on the proper use of change facilitation tools (exhibit 1.2). Although they have no direct-line authority over the members of the CIT, they lead the discussion as they have a thorough understanding of the change process. They provide support to leaders and the sponsors of the change initiative by clarifying the general direction of the change and guiding the implementation of the change, mobilization of key stakeholder groups to work through the transition, and integration of the change (Cameron and Green 2012).

Exhibit 1.2: Change Facilitation Tools (CFTs)

CFT 1: Bounding

When to use: At the beginning of the change initiative

Why: To determine the scope and focus of change

How: Create an “Includes–Excludes” list to help narrow the scope of the change initiative by defining the Fives Ws (What, Why, When, Where, and Who) to be included or excluded from the initiative. Alternatively, draw a picture frame on a flip chart and have the change facilitation team use Post-it notes to identify

(continued)

Exhibit 1.2: Change Facilitation Tools (CFTs) (continued)

issues to be included in the scope (place the note inside the picture frame) or to be excluded (place the note outside the picture frame).

CFT 2: SIPOC Diagram

When to use: At the beginning of the change initiative

Why: To identify all the relevant elements of the process to be changed or improved

How: The change facilitation team uses flip charts with the headings S-I-P-O-C. Then, the following are defined or identified: four to five high-level steps in the Process (P) to be changed/improved, then the Outputs (O) of the process, then the Customers (C) who will receive the outputs of the process, then the Inputs (I) required for the process to function, and then the Suppliers (S) of the inputs that are required by the process. The resulting SIPOC diagram helps clarify who the suppliers of the inputs are, what specifications are placed on the inputs, who the true customers are of the process, and what the customers' requirements are. Working through the SIPOC discovery helps the team to clearly understand the elements of a process that is the subject of the change initiative and to narrow the scope to be manageable.

CFT 3: Team Charter

When to use: At the beginning of the change initiative

Why: To develop the team charter, probably the most important activity in the change process

How: The team charter defines all of the critical elements of the planned change initiative, including a clear and concise mission statement of the goal (40 words or fewer), the specific issue or problem that will be addressed, and a list of what is included or excluded from the scope of the initiative. The charter also must include SMART (Specific, Measurable, Achievable, Relevant, and Time-oriented) goals, a list of the change facilitation team members, and key milestones and dates. The charter sponsor, champion of the change initiative, the process owner, finance representative, and change agent must all be specifically identified.

CFT 4: ARMI Analysis

When to use: At the beginning of the change initiative

Why: To identify the key staff in the organization that will be Approvers, Resources, Members of the team, or an Interested party

(continued)

Exhibit 1.2: Change Facilitation Tools (CFTs) (continued)

How: List the names of all key members of the staff who might have an important and influential role in the change initiative:

- A—Approvers of the scope, resources, and change recommendations
- R—Resource staff who may provide expertise, skills, or influence
- M—Members of the team with working knowledge of the process and related issues or problems
- I—Interested party who should be kept informed about the progress and conclusions of the change initiative

The ARMI assessment should be completed at the start of the change initiative, updated as the initiative unfolds, and reviewed at the conclusion of the initiative.

CFT 5: GRPI Team Effectiveness Assessment

When to use: If/when the change facilitation team is experiencing interpersonal challenges or conflicts

Why: To build team trust, clarity of roles, and collegiality

How: Using a low to high 5-point rating scale (1 to 5), each team member assesses the team's effectiveness in GRPI (Goals, Roles, Processes, and Interpersonal):

Goals—How clear is our agreement on the team's mission and goals for this change initiative?

Roles—How well do we understand, agree on, and fulfill the roles and responsibilities for our team?

Processes—To what extent do we understand and agree on the way in which we approach our change initiative?

Interpersonal—Are the relationships, including the level of openness, trust, and acceptance, on our team working well so far?

CFT 6: More/Less of Project Shaping

When to use: After the original vision and project mission have been chartered

Why: To shape and narrow the focus of the change initiative

How: As a team/group exercise, individual change facilitation team members contribute suggestions about what they expect to see more of and less of when

(continued)

Exhibit 1.2: Change Facilitation Tools (CFTs) (continued)

the change initiative has been completed. By identifying both the favorable and unfavorable attributes to be either enhanced or eliminated through changing behaviors, the team paints a picture of the desired future state of the process undergoing change.

CFT 7: The Elevator Speech

When to use: During the introduction of the change initiative to gain acceptance

Why: To convince others of the merits of the change initiative; may include a request for support (the *ask*)

How: The elevator speech is a short and simple statement that has four parts: intent; importance; impact; and an invitation to support, be involved in, or contribute to the initiative. For example: “The zero harm change initiative is about changing behaviors and processes to eliminate all preventable patient harm. It is important because all too often patients are harmed by the very care that was intended to make them better. Your help is needed to encourage your staff to be active and supportive participants in the change effort.”

CFT 8: TPC Analysis

When to use: To identify the root cause of resistance to mitigate it

Why: To help encourage staff commitment to the change initiative, identify the sources of resistance, and better understand the reasons certain staff are resisting the potential change

How: The three main sources of resistance to change are technical, political, and cultural. Staff resistance can be categorized into one or more of these sources, which will help change agents and sponsors design interventions targeted at the source(s) of the resistance. Identify what is important to key stakeholders, their reasons for resisting change, the level of resistance, and the strategic action to counter the resistance.

CFT 9: Force Field Analysis

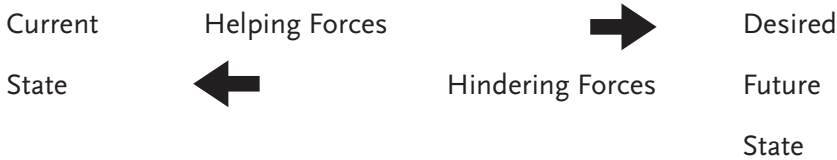
When to use: Early in the design phase of the change initiative

Why: To understand the forces or influences that will either help or hinder the implementation of the change initiative, and to formulate plans to close the gap between where you are and where you want to be

(continued)

Exhibit 1.2: Change Facilitation Tools (CFTs) (continued)

How: Hindering forces (restrainers) create barriers and obstacles against the change to a desired future state. Helping forces (enablers) facilitate the change.

**CFT 10: WWW Action Plan**

When to use: After every change facilitation team meeting

Why: To make sure that intended actions and assigned responsibilities are completed as planned

How: A team member should be asked to maintain the WWW (Who, What, and When) plan during each team meeting, follow up with the stakeholders who have been assigned responsibilities, and report at subsequent team meetings the progress on implementing the WWW plan.

CFT 11: Plus/Delta Assessment

When to use: At the completion of every change initiative

Why: To assess what went well (plus) and what the team would do differently the next time (delta, which is used in mathematics to signify change)

How: As the change facilitation team debriefs at the conclusion of the change initiative, each team member should write on Post-it notes their assessment of what worked well during the change initiative and their suggestions for changing the process for the next initiative. Next, these notes are posted on one of two flip charts labeled “Plus” and “Delta” and then summarized by the change agent for group discussion.

CFT 12: Changing Systems and Structures

When to use: Any time during the change initiative

Why: To assess the need for changing the supporting systems and structures integral to the successful implementation of change

How: The change facilitation team conducts a review of the current systems and structures and determines if a modification is needed to better facilitate the change. The team considers staffing issues, measures and metrics, rewards, communication, organizational design, information systems, and resource allocation.

Cameron and Green (2012) identify the five stages of the consulting process used by change agents and the specific KSAs needed to effectively manage the organization through a change initiative:

1. *Entry*. This stage requires knowledge of project planning; knowledge of appropriate application of relevant tools and models; effective communication, sincere inquiry, and deep listening skills; strategic and analytical skills; ability to cope with mixed emotions; ability to conduct a change readiness assessment; ability to build relationships, build trust, and gain commitment; and political savvy.
2. *Contracting*. This stage requires knowledge of the charter process; knowledge of establishing accountabilities and measures of success; project management skills; ability to use interventions in the discovery process; ability to generate achievable objectives and metrics; ability to develop effective proposals with specific goals, actions, expectations, and responsibilities; ability to manage resources; and ability to develop mutual contracts that define expectations and the way of working.
3. *Diagnosis*. This stage requires knowledge of the operating environment in which the change initiative is needed; diagnostic and data-interpretation skills, and ability to resist the urge for complete data; ability to coach, discuss, and tutor others in the diagnostic methods of change management; ability to provide meaningful feedback to the CIT, leaders, and sponsor; ability to facilitate stakeholder understanding of data, option generation, and securing agreement for action; ability to gather *sensing data* through interviews and conversations; ability to assess the organization's readiness for change; ability to identify specific interventions and viable options for action; and ability to share feedback and relevant, descriptive, and understandable information for sponsor and team consideration.
4. *Intervening*. This stage requires the ability to discern when engagement rather than a mandate for change is appropriate; design sessions that are participative rather than merely presentations; apply methodological leadership to change management interventions; balance theoretical insights and designed methods; design interventions informed by identified change challenges; develop creative and innovative interventions; encourage difficult public exchanges; and put real choices on the table.
5. *Evaluating*. This stage requires knowledge of designing, implementing, and monitoring evaluation methods and metrics; intervention cost-benefit analysis skills; ability to assess the success of the interventions;

ability to explain to all stakeholders whether the objectives have been achieved; and ability to train the staff and units affected so they can manage the change going forward.

In *Diffusion of Innovations*, Everett Rogers (1983) defines the change agent as one who (1) works through others to translate intent into action, (2) motivates people to change, (3) stabilizes the adoption of innovation, (4) is accepted as trustworthy and competent, and (5) fosters self-renewing behaviors in others to minimize the need for the change agent in the future. Change agents should have the ability to ask *catalytic questions* throughout the stages of the change process and thereby help others through the learning cycle (Cameron and Green 2012). These questions may include the following: What could we have done differently? How did that work out? And what are the implications of not changing?

CONCLUSION

Creating a culture of safety in a hospital or healthcare system in which harm-free healthcare is not just wishful thinking but a daily reality is largely dependent on the organization's ability to change. More precisely, achieving the high-reliability goal of zero patient harm is dependent on leaders' ability to convince their staff of the need for change so they will willingly change their behaviors and specific patient care practices. Changing behaviors and practices will lead to a change in attitudes, values, and beliefs, which in turn will transform the organizational culture into a culture of safety. Healthcare leaders must first be masters of change facilitation so they are able to fully engage staff in this behavioral transformation, the antecedent of consistently safe, highly reliable healthcare.

CHAPTER 1 SAFE CARE PRACTICES

1. Aspire to achieve a healthcare environment in which zero patient harm is the norm. Effect change in practices and behaviors first, and change in organizational beliefs, values, and attitudes will follow. These changes are the foundation of a cultural transformation.
2. Improve performance by making structural, efficiency, process, and cultural changes. These organizational changes are necessary for becoming highly reliable and eliminating all preventable patient harm.



3. Assess the organization's readiness for change using Douglas Smith's seven-item checklist. Among these seven tasks are identifying the people who will be affected by the change, and determining how their behaviors and activities will need to shift.
4. Make the change a reality with guidance from existing models, including John Kotter's Eight Accelerators and Edgar Schein's Model of Transformative Change. Kotter's accelerators provide a methodology for making significant operational changes to constantly adjust to an ever-changing environment. Schein's model suggests that leaders and change agents must address the learning and survival anxiety among the people affected by the change effort.
5. Assimilate the change into the organizational culture. In other words, reinforce and continually support the change initiative until the existing customs, norms, attitudes, and values reflect the desired change.
6. Convert employee reluctance into readiness by involving them in the practical performance of change. As a master change agent, the leader should apply proven tactics to address reluctance and resistance.
7. Ensure that change agents are part of the change effort. Change agents provide critical support by clarifying the general direction of the change and guiding the implementation of the change, mobilization of key stakeholders, and integration of the change.
8. Sustain the change by ensuring the new practices become common practices and "the way we do things around here."

NOTE

1. The uppercase delta, the fourth letter of the Greek alphabet, is used as a symbol of change in mathematics and science.

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