1

How Organizations Can *Really* Change

Leon C. Megginson (inspired by Charles Darwin) said that it is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.[1]

General Erik Shinseki, who was U.S. Army chief of staff from 1999 to 2003, said, "If you don't like change, you will like irrelevance even less."[2]

The quality guru W. Edwards Deming put the matter even more starkly: "It is not necessary to change. Survival is not mandatory."[3]

Though health care offers few guarantees, there may be one simple truth that everyone in the field can agree on. Organizations that embrace change will stand the best chance of surviving, prospering, and delivering better care. Those that shrink from change are likely to be put out of business, or else be swallowed up by more nimble competitors.

Change, of course, is a loaded word, fraught with emotion and associations.

High up in the organization, few question its desirability. Chief executives and their senior management teams typically want to be known as bold, forward looking, visionary. They may assume that the need for change

is equally visible to everyone, from the boardroom to the operating room to the kitchen—or that it soon will be, once the leaders explain it to everybody. Some leaders seem to think that change will happen automatically; all they have to do is announce the goal and the timeline.

This affection for bold reforms and visionary improvements is why "change talk" seems to permeate so many health care organizations. But what is the reaction to all the talk once you leave the C-suites and move out into the finance office or obstetrics ward? In my experience, people welcome change about as enthusiastically as they would welcome a plague of locusts. *Watch out*, the feeling runs. *Here comes another one. Maybe if you keep your head down it will go away*. Buddhists say that we are frightened by new things, and so we experience the suffering of change. The reason for this fear and loathing is that change always involves giving something up. We lose what we know in return for a promise of an uncertain future. People may even greet change with a kind of grief reaction, exhibiting all the familiar stages we have learned from Elisabeth Kübler-Ross.[4] *Denial*: Confronted by change, we confidently assert that it isn't really going to happen. *Anger*: We get mad. ("They can't do this to *me*!") *Depression*: We feel sad, demoralized. *Bargaining*: We negotiate to keep a little of what we had before. Sometimes I think that people faced with change undergo all the stages of grief except the last one, *acceptance*.

Change, in short, makes everybody uncomfortable. Like the body's homeostatic system, the mind naturally reverts to the familiar, the well-worn, the time-tested and trusted patterns of behavior. The mental system returns to its comfort zone. This is why change is so hard, and why so many change events or initiatives peter out, unsuccessful. The all-too-frequent approach from senior management—"Of course you will want to buy into the change I am proposing"—leaves people not only uninspired but anxious as well. It is little wonder that health care organizations, where every employee typically has plenty on his or her mind anyway, find it so difficult to do anything differently. Most stakeholders seem to view a proposed change skeptically, and the proposal stalls before it can get out of the starting gate.

A BETTER APPROACH

But let us imagine that you are a health care leader who actually wants change to *happen*, rather than simply to be announced. Let us imagine you are prepared to follow through, to mount the kind of systematic attack on the status quo that this book will prepare you for. The first thing you will need is a different mind-set, one that in some ways has been alien to health care. You will have to acknowledge difficult truths and use a different vocabulary. You will have to borrow from other industries. You will have to adopt some elements of marketing, often seen as anathema by medical professionals. Action is essential, of course, and the rest of this book will describe the actions necessary to get your change initiatives off to a productive start. But first must come the thoughts, assumptions, and attitudes that will inform your actions. Today's health care leaders must embrace five key changes in their attitudes.

1. Acknowledge How Hard Change Can Be

Nobody should ever assume that change will come easily. We all know from experience how difficult it is for anyone to change even minor aspects of his or her behavior. How many times have we made a New Year's resolution to alter our eating habits or visit the gym regularly, only to find ourselves making the identical resolution the following year? Despite such knowledge, we somehow seem to assume that change will come more readily to organizations. It will not. Organizations, after all, are just collections of individuals pursuing various sets of objectives. Training, expectations, habit, and inertia govern how they go about this pursuit. If people are to behave differently, they will need new training and new sets of expectations, and they will need to develop new habits and a new baseline of action. All of that requires a considerable amount of time and a lot of effort. Progress will be uneven—two steps forward, one step back. Organizations have a built-in resistance to change, and to ignore that fact is to set yourself up for failure.

So don't ignore it. Accompany every change initiative you propose with a deep understanding that this will mean loss for some people. Acknowledge that you will meet resistance, and that resistance is perfectly normal, even healthy. Sit down and assess the risks you face in advance. (The history of your organization's past change efforts is often a good guide to the difficulties you will encounter in the future.) Develop tools for mitigating those risks. Involve the people who will be affected in creating the change you want to see. Adopting this perspective will lend credibility to your efforts, and it will build trust. Nobody believes a leader who says change will be easy.

2. Accept and Communicate the Idea That, Whatever the Difficulties, Change Is Not Optional

It is a funny thing. In nearly every other industry these days, sentiments like those with which I began this chapter adorn the walls. They appear in executives' speeches. They are so common as to be commonplace. *Of course* change is not optional. *Of course* we must adapt or die. Nearly every other industry is littered with the remnants of companies that were once strong competitors but, challenged by their resistance to change, at some point suddenly ceased to exist. Think TWA or Pan Am, Polaroid or RCA, Netscape or Atari. (Some of these brands live on, but the companies themselves are long gone.) However, few health care organizations make the same assumptions. They may talk about reforms and improvements, but they rarely assume that change is an imperative. They may say, "Innovate or die," but they do not act as if they believe it.

A few organizations, however—generally the highest performers—embrace a wholly different way of thinking, known as *permanent beta*.

Beta is a term borrowed from the technology world, where it refers to products that are still in testing and hence not quite finished. Successful organizations realize that they are never perfect, and that virtually everything about them can always be improved. They exist in a state of permanent beta. Not only do they *exist* in a state of permanent beta, but also they regularly *talk* about being in a state of permanent beta. "Words are

like children," said Martin Luther in a 2003 biopic. "The more attention we pay to them, the more demanding they become."[5] When you use words like *permanent beta* regularly, they worm their way into people's consciousness. They become a part of the organizational culture. They encourage the idea that change is never-ending—that it is not an "event" that happens at a single point in time. The expectation of change becomes a part of people's daily work lives.

3. Embrace "From—To"

Every change event attempts to move an organization *from* a current state *to* a future state. That is why so many people greet the effort with skepticism at best and hostility at worst. "You want me to leave my safe, secure, familiar, comfortable world in exchange for—what? A brave new world that you *say* will be better? Are you crazy?" Health care professionals and staff in particular are rarely excited about moving from their present state to some future state. Health care has been a growing industry. Most organizations are doing well enough, and many individuals within those organizations are busy, well paid, and highly satisfied with their respective jobs. The changes mandated by new government policies such as the Patient Protection and Affordable Care Act threaten to upset a lot of these applecarts. So clinicians and others in health care have a strong inclination to leave well enough alone. "If it ain't broke, don't fix it." Even seemingly unexceptionable goals, such as pursuing evidence-based medicine and embracing electronic health records, often run into massive resistance.

But what if today's world is no longer so safe and comfortable? What if people in an organization learn, through constant repetition, that the status quo is unpleasant, unsafe, uncomfortable, and above all unstable? Health care costs have been rising steadily and inexorably. There has been *no* improvement in the rate of amenable mortality. The health care system wastes 30 percent of its resources. "If you think this situation can continue forever," a leader might say, "you are living in a dream world. If we fail to change, one of two things will happen. One possibility is that we will be forced to change, on somebody else's timetable, by government

edict or insurance company policy or in response to the expectations of the marketplace. The other possibility is that we will have no opportunity to change, because we will have been forced out of business."

This kind of thinking—making people uncomfortable with the current state of affairs—alters the terms of the equation. Marketers have known this for centuries, and have used it effectively. "Your clothes are drab, your car is unexciting, your medicine doesn't make you feel better, your cooking is terrible. But all you have to do is buy our product, and that will solve your problem." I am not suggesting that health care leaders turn themselves into full-time marketers. I am suggesting that they learn the basic psychology that underlies marketing: people will not change unless they feel dissatisfied with the current situation. Other businesses talk about creating "burning platforms." People will be receptive to new ideas when they feel that their platform really is burning.

4. Think *Kaizen*

Here is another example of how far health care lags behind most other industries in its approach to change. The Japanese word *kaizen*, which essentially means "change for the better" or "continuous improvement," is now used regularly on factory floors in America. Plant managers and employees have come to understand that it is their responsibility, every day and every week, to call out and address the little things that go wrong, the inefficiencies, the bottlenecks, the ways of operating that might have once made sense but no longer do. Some plants sponsor kaizen events, in which employees take time off from their regular work to identify dozens or hundreds of potential improvements, evaluate them, and implement as many as possible.

Kaizen as a concept has made only limited inroads in health care. But health care as an industry probably has more inefficiencies, bottlenecks, and unnecessary procedures than manufacturing ever did. Kaizen is simply a way of helping people identify those glitches and take steps to eliminate them. In health care organizations, it is often very effective to bring

stakeholders together and solicit suggestions to improve a challenging issue. I refer to this process as a kaizen town hall meeting.

5. Understand the Psychological Factors That Affect People's Perceptions

We human beings are peculiar animals. We have an extremely well-developed cerebral cortex, and we think a great deal of it. We value intelligence, rationality, and deliberation. Yet when we make decisions, we are affected by emotional factors of which we are scarcely aware. Again, marketers understand this phenomenon well. They tell stories as well as make arguments. They present us with appealing images, not just words. They understand that we are hardwired to make decisions with emotions first and thoughts second. They appeal to head and heart simultaneously, but the appeal to the heart usually takes precedence.

This emotions-first approach to decision making has two ramifications. One is that people tend to prefer the specific over the general. We ignore a headline about a devastating earthquake somewhere in the world, but we reach for the telephone when an aid organization shows us some of its suffering victims up close and personal.[6] The other is that we fear loss more than we value an equal gain. This is the cognitive bias known as loss aversion, and it has been demonstrated repeatedly in a series of experiments.[7] Where change is concerned, the uncertainty surrounding the future state of affairs is thus likely to outweigh whatever benefits we think we may get from it. We overestimate the value of what we have and underestimate the value of what may be gained by giving it up.

Health care leaders can put this understanding of human psychology to work in the way they frame proposals for change. To get true buy-in, they can appeal jointly to head and heart: no statistic without a story, no story without a statistic, as the axiom of persuasion has it. They can help people visualize and imagine the future state so that everyone begins to *feel* its desirability. They cannot ignore the necessary losses that always accompany change; attempting to do so costs them their credibility and undermines trust. But they can help people remember the losses, such as a potential

threat to job security, that will inevitably accompany a *failure* to change. Those losses are presumably far more significant than anything the change itself is likely to bring.

Will there be resistance? Of course. Everybody knows that nobody likes change except a wet baby. Resistance is a healthy sign, a sign that people are taking the prospect of change seriously. They will be anxious, uncertain, skeptical. But a positive approach to managing change can help people work through their resistance and come out on the other side.

FROM "PROJECTS" TO CHANGE EVENTS

These five changes in the leader's attitudes are essential. They can help people in an organization overcome their natural uncertainty about doing things differently. But by themselves they are insufficient. Leaders also need to create a new way of thinking about the process of change. If there were a mantra for this part of the book, it would be, "Don't leave change to chance."

To begin, it is worth remembering that change itself can be systematically analyzed and codified, and many leading thinkers have done so. The classic 1951 book by the social psychologist Kurt Lewin described the three phases of change as "unfreeze," "transition," and "refreeze."[8] This cycle can be repeated as necessary. Lewin's phases are intuitive to most and serve as a basic foundation for conceptualizing change in an organization. Harvard Business School professor John Kotter has outlined an eight-stage process for creating major change:[9]

1. Establishing a sense of urgency
2. Creating the guiding coalition
3. Developing a vision and strategy
4. Communicating the change vision
5. Empowering broad-based action
6. Generating short-term wins
7. Consolidating gains and producing more change
8. Anchoring new approaches in the culture

Note that some of Kotter's stages involve the kind of marketing mind-set we have just been discussing—establishing a sense of urgency, communicating the change vision, and so on. But others have to do with the mechanics of actually creating change and embedding it in the way the organization goes about its business—such as empowering broad-based action and anchoring new approaches in the culture.

Change can even be encapsulated in equations, which help us remember the key variables and the interactions between them. For example, a well-known formulation by organizational development specialists Richard Beckhard and Reuben Harris (refined by Kathie Dannemiller) looks like this:[10]

$$D \times V \times F > R$$

where
D = Dissatisfaction
V = Vision
F = First steps
R = Resistance to change

The formula can be used as a diagnostic aid to determine whether an organization is ready for change. All three components—dissatisfaction with the current situation, a vision of what is possible in the future, and achievable first steps toward reaching this vision—must be present if the organization is to overcome its resistance to change. The formula helps answer the question, "Can we successfully undertake change? Are our people and our organization prepared?"

Another useful equation is this one, used by the company GE Healthcare:[11]

$$E = Q \times A^3$$

where
E = Effective results
Q = Quality of the solution
A = Acceptance of the idea
A = Alignment with organizational goals
A = Accountability for the implementation

Some 62 percent of change efforts fail, says the company, due to lack of attention to the "A"—really, the multiple "A's"—in the equation. You don't get good results unless the change effort fits the organization and people are held accountable for implementing it successfully.

Many large organizations, including some in health care, have attempted to systematize their approach to change by creating a project management office (PMO). The office is responsible for overseeing, managing, and evaluating the initiatives through which the organization hopes to change and improve. This is a step in the right direction, and later chapters will discuss some of the functions such an office can perform as well as variations on the theme.

But for now, let's just look at the language. The word *project* suggests a nuts-and-bolts engineering enterprise. The phrase *project management* conjures up visions of workers in hard hats on a construction site. Make no mistake: projects are worthy endeavors, and I will sometimes use that language in this book just because it is so common. But *change* is broader, more inspiring, and ultimately more accurate in describing what needs to happen in health care. Suppose we thought of every project as a change event, every project manager as an agent of change, and the PMO as a change office. Change is scary, to be sure. But properly managed—with the mind-set I have outlined in this chapter—it can be inspiring, exciting, even thrilling. A project operates in a business-as-usual context, and is content to make a small improvement in everyday operations. A change event is part of a movement toward a goal, a step toward realizing the organization's mission. It can be approached every bit as systematically as a project, and managed just as intensively. But it is a goal that is worth the effort, a journey that can get people fired up and wanting to climb on board.

Indeed, project-based work is steadily growing. It is becoming more common for colleagues to band together as a change initiative team to undertake a prescribed piece of work. Once the task is completed, the team disbands, only to be reorganized into new teams for new change events.

I don't mean to load too much onto the backs of mere words. You will read about managing projects as well as about managing change in this book. If you modify the language you use to describe change without

modifying the reality, you will not be making much of a difference. But words do matter, as does context. Right now, health care needs a mind-set that welcomes change; that acknowledges its difficulties; and that embraces the paths leading to real, sustainable change. That is an enterprise worthy of a true leader, and one that I believe will be the hallmark of higher-performing organizations.

SUMMARY

- "Change talk" permeates most health care organizations, but real change is seldom welcomed at all levels of an organization.
- Leaders need to adopt a different mind-set—acknowledging how hard change is, understanding that it is not optional, and making people uncomfortable with the current state of affairs.
- Leaders also need to borrow from other industries, drawing on the concept of *kaizen* (continuous improvement) and the tools of marketing, which appeal to people's emotions as well as their intellect.
- Don't leave change to chance. Look at it systematically, and build enthusiasm for change events.

NOTES

1. Leon C. Megginson, "Lessons from Europe for American Business," *Southwestern Social Science Quarterly* 44, no. 1 (1963): 4.
2. Fast Company, *The Rules of Business: 55 Essential Ideas to Help Smart People (and Organizations) Perform at Their Best* (New York: Crown Business, 2005), 7.
3. Attributed to W. Edwards Deming at "W. Edwards Deming quotes," accessed April 29, 2013, http://en.thinkexist.com/quotes/w._edwards_deming/2.html.
4. Elisabeth Kübler-Ross, *On Death and Dying* (New York: Macmillan, 1969).
5. "Luther Script—Dialogue Transcript," accessed April 29, 2013, http://www.script-o-rama.com/movie_scripts/l/luther-script-transcript-joseph-fiennes.html.
6. See, for example, Deborah A. Small, George Loewenstein, and Paul Slovic, "Sympathy and Callousness: The Impact of Deliberative Thought on Donations to Identifiable and Statistical Victims," *Organizational Behavior and Human Decision Processes* 102, no. 2 (March 2007): 143–153.
7. Daniel Kahneman, Jack Knetsch, and Richard Thaler, "Experimental Test of the Endowment Effect and the Coase Theorem," *Journal of Political Economy* 98, no. 6 (1990): 1325–1348; Amos Tversky and Daniel Kahneman, "Loss Aversion in

Riskless Choice: A Reference Dependent Model," *Quarterly Journal of Economics* 106 (1991): 1039–1061; Daniel Kahneman, Jack Knetsch, and Richard Thaler, "Anomalies: The Endowment Effect, Loss Aversion, and Status Quo Bias," *Journal of Economic Perspectives* 5, no. 1 (Winter 1991): 193–206.

8. Kurt Lewin, *Field Theory in Social Science* (New York: Harper & Row, 1951).
9. Adapted from John P. Kotter, "Why Transformation Efforts Fail," *Harvard Business Review* 73, no. 2 (March–April 1995): 59–67.
10. Cited in Dannemiller Tyson Associates, *Whole-Scale Change: Unleashing the Magic in Organizations* (San Francisco: Berrett-Koehler, 2000), 16.
11. Justin Holland, *Prescription for Effective Change* (Waukesha, WI: GE Healthcare, 2011), 7, http://nextlevel.gehealthcare.com/Prescription_For_Effective_Change-WP-0811.pdf.