CHAPTER 2

The Challenge of Change

CHAPTER OBJECTIVES

- Identify the impact of change on organizational life.
- Identify the manager's role as change agent.
- Review examples of successful change.
- Examine a major change having ongoing impact.
- Describe the organizational change process.
- Identify specific strategies for dealing with resistance to change.

THE IMPACT OF CHANGE

Change in the healthcare environment is continuous and challenging; the trends and issues in the healthcare setting reflect the reality in every stage of the life cycle of the organization, as well as in its attendant survival strategies. Trends and issues intensify, becoming mandates for change in patient care, setting, and administrative support. This affects workers at all levels. Such changes consume financial and administrative resources; they have the potential of draining emotional and physical energy away from primary goals. Thus, the managers accept the role of change agent, seeking to stabilize the organization in the face of change.

THE MANAGER AS CHANGE AGENT

Managers, as the visible leaders of their units, assume the function of change agents. This change agent role involves moving the trend or issue from challenge to stable and routine. This is accomplished in several ways:

- Mediating imposed change through adjusting patterns of practice, staffing, and administrative routines

- Monitoring horizon events through active assessment of trends and issues
- Creating a change-ready environment
- Taking the lead in accepting change

REVIEW OF SUCCESSFUL CHANGE

Managers foster a change-ready environment by reminding the work group of successful changes. This raises the comfort level of the group and provides insight into strategies for achieving desired outcomes. Six examples are provided here to illustrate the process of successful change:

- Year 2000 (Y2K): change as opportunity
- Patient Self-Determination Act (PSDA): routinization of change
- Health Insurance Portability and Accountability Act (HIPAA): extensive change via legislation
- Electronic health records: proactive change
- Economic and market forces: anticipatory readiness through organizational restructuring
- Disruption in personal circumstances: revitalization through career development

Change as Opportunity: Y2K

Recall the transition to the new century: Y2K. The phrase alone reminds us of successful responses to an inevitable change. It also reminds us of the pre-Y2K concerns about technology-dependent systems: would they work? Faced with the possibility of massive systems failure, managers carefully defined the characteristics of this anticipated change:

1. A definitive event with an exact timetable
2. Well known ahead of time (3- or 4-year run-up)
3. Unknowns or uncertainty mixed with known technical aspects: which systems might fail, what would the resulting impact be (e.g., failure of power grids, communication disruption, financial infrastructure chaos)

During the run-up to Y2K, managers assessed the potential impact and planned accordingly. Furthermore, many managers seized the opportunity to make even bigger changes. When the cost of upgrading some existing systems was compared with adopting new systems, managers chose to spend the money and time on a comprehensive overhaul.

Funding such a major project became part of the challenge. Many chose a combination of borrowing, along with "bare bones" budgets, with deferred maintenance and elimination of discretionary projects (e.g., refurbishing) to meet this need. The end result in many organizations was the adoption of new, well-integrated computerized systems. This overall plan of upgrading was

supplemented with contingency planning closer to the December 31, 1999, deadline. Managers took such practical steps as:

- Eliminating all backlogs (e.g., coding, billing, transcription)
- Preregistering selected patient groups (e.g., prenatal care patients)
- Obtaining and warehousing extra supplies
- Adjusting staffing patterns for the eve of Y2K and the days immediately following it, with workers available and trained to carry out manual backup for critical functions

Managers also took the opportunity to review and update the emergency preparedness and disaster plans for the healthcare organization. Again, the anticipated Y2K change was the catalytic agent for renewed efforts in these areas. Y2K came and ran its course; the change was absorbed with relative ease because of careful planning.

The Routinization of Change: The Patient Self-Determination Act of 1990

End-of-life care and related decisions have always been a part of the healthcare environment. However, technological change (e.g., advances in life support systems) along with definitive court cases (e.g., *Quinlan, Cruzan*, *Conroy*) led to a renewed interest in these issues. This interest, in turn, resulted in the passage of the PSDA, which had implications for patient care as well as the administrative support systems.

The response to this change was orderly and timely because the healthcare providers and the administrative teams assessed the change in a systematic manner. This strategy of absorbing change through rapid routinization into existing modes of practice included the following:

1. Outreach to clients or patients and their families, along with the public at large, to provide information and guidance about healthcare proxies, advance directives, and living wills. Information about support services such as social service, chaplaincy, and hospice care was included as part of the regular client/patient education programs.
2. Review and update of do not resuscitate (DNR) orders and related protocols for full or selected therapeutic efforts.
3. Review of plan of care protocols for "balance of life" admissions.
4. Increased emphasis on spiritual and psychological considerations of patients and families, with documentation through values history or similar assessments.
5. Renewed involvement of the ethics committee of the medical staff to provide the healthcare practitioner, patient, and family with guidance. The committee also adopted review protocols to assess patterns of compliance with advance directives and end-of-life care.
6. Documentation and related administrative processes augmented to reflect the details of this sequence of care (e.g., documentation that an advance directive was made, movement of the document with the patient as he or she changed location, flagging the chart to indicate the presence of the directive). Existing policies and procedures were updated to reflect these additional practices.

The changes stemming from the PSDA were easily managed through systematic review and adjustment of existing, well-established routines. However, there is a potential downside to routinizing change: the changes might become so well accepted that they are more or less ignored. For example, the living will becomes just another piece of paper or data entry, checked off as being available but not truly part of the care plan.

Because response to legislated change is often required, it is useful to examine yet another such mandate. A consideration of HIPAA reflects a different dynamic in the organizational process of responding to new requirements.

Extensive Change via Legislation: Health Insurance Portability and Accountability Act of 1996

This act, known commonly by the acronym HIPAA, crept inconspicuously on the scene as Public Law Number 104 of the 191st Congress (PL 104-191). When it was a newly passed law, its most visible portion was broadly described by the name of the law, addressing primarily "portability" of employee health insurance.

The intent of HIPAA was to enable workers to change jobs without fear of losing healthcare coverage. It enabled workers to move from one employer's plan to another's without gaps in coverage and without encountering restrictions based on preexisting conditions. It proclaimed that a worker could move from plan to plan without disruption of coverage.

In 1996, a great many healthcare managers did not concern themselves with HIPAA. Human resources managers became most aware of the new law because it concerned their benefits plans, but the burden of notification was borne mostly by the employers' health insurance carriers, so there was little to do other than answering employees' questions. For many managers, the employer had no concerns about HIPAA beyond ensuring health insurance portability. But HIPAA's major impact was to come later, and its arrival was a genuine eye-opener for many. This law consists of five sections: titles I, II, III, IV, and V.

Title II in the Spotlight

Titles I, III, IV, and V of HIPAA deal with employee health insurance, promoting medical savings accounts, and setting standards for covering long-term care. Title II is the section driving most HIPAA-related change. This section is called "Preventing Health Care Fraud and Abuse, Administrative Simplification, and Medical Liability Reform." It is referred to as just *Administrative Simplification*, a term that is misleading at best; for many of the organizations that have had to comply with it, the effects have been anything but simple.

Administrative Simplification includes several requirements designated for implementation at differing times. Compliance with the Privacy Rule, the most contentious part of HIPAA, was required by April 14, 2003. Compliance with the Transactions and Code Sets (TCS) Rule was

required by October 16, 2003, and the Security Rule was set for implementation in April 2005. The Centers for Medicare and Medicaid Services have issued, and continue to issue, a wide variety of rules and guidelines, with managers implementing these routinely. HIPAA has become a fixed feature in healthcare systems.

Nearly all of the controversy over the intent versus the reality of HIPAA involves the Privacy Rule. In trying to strike a balance between the accessibility of personal health information by those who truly need it and matters of patient privacy, portions of HIPAA have created considerable work and expense for healthcare providers and organizations that do business with them, not to mention creating inconvenience and frustration for patients and others.

The Continuing Privacy Controversy

Reactions to the Privacy Rule have been numerous. Patients and their advocates claimed that these new requirements were forcing a choice between access to medical care and control of their personal medical information. Government, however, claimed that the rules would successfully balance patient privacy against the needs of the healthcare industry for information for research promoting public health objectives and improving the quality of care.

When HIPAA's privacy regulations first received widespread exposure, hospitals, insurers, health maintenance organizations, and others claimed that the Privacy Rule would impose costly new burdens on the industry. At the same time, Congress was claiming that HIPAA's protections were immensely popular with consumers. Consumer advocates hailed the Privacy Rule as a major step toward comprehensive standards for medical privacy while suggesting that it did not go far enough.

To comply with the Privacy Rule, affected organizations were required to

- Publish policies and procedures addressing the handling of patient medical information
- Train employees in the proper handling of protected health information
- Monitor compliance with all requirements for handling protected health information
- Maintain documented proof that all pertinent requirements for information handling requirements are fulfilled

In many instances, the HIPAA privacy requirements are causing frustration for patients and others. For example, a spouse who has to help obtain a referral or follow up on a test result cannot do so without the signed authorization of the patient (unless the patient is a minor). Anyone other than a minor or a legally incapable or incapacitated individual must give written permission for anyone else to receive any of his or her personal medical information.

There are a number of instances in which personal medical information can be used without patient consent. These instances, along with all patients' rights concerning personal medical information, must be delineated in the Privacy Notice that every provider organization must provide to every patient.

Effects on an Organization

All healthcare plans and providers must comply with HIPAA. Provider organizations include physicians' and dentists' offices; hospitals, nursing homes, and hospices; home health providers; clinical laboratories; imaging services; pharmacies, clinics, and freestanding surgical centers and urgent care centers. In addition, such organizations include any other entities that provide health-related services to individuals. Also required to comply are other organizations that serve the direct providers of health care (e.g., billing services and medical equipment dealers). All affected organizations must

- Protect patient information from unauthorized use or distribution and from malfeasance and misuse
- Implement specific data formats and code sets for consistency of information processing and preservation
- Set up audit mechanisms to safeguard against fraud and abuse

All subcontractors, suppliers, or others coming into contact with protected patient information are also required to comply with the HIPAA Privacy Rule. In addition, all arrangements with such entities must define the acceptable uses of patient information.

Depending on organization size and structure, compliance with the HIPAA Privacy Rule could involve several departments (as in a mid-size to large hospital), a few people (as in a small hospital or nursing home), or a single person (as in a small medical office). Overall, whether compliance is accomplished by separate departments or just a person or two, compliance can involve a number of activities, including information technology, health information management, social services, finance, administration, and ancillary or supporting services.

The necessary changes have been numerous and have added to the workload in every affected area. Providers routinely obtain written consent from patients or their legal representatives for the use or disclosure of information in their medical records, as had been the standard practice. However, renewed attention has been focused on release of information practices. Also, providers are now legally required to disclose when patient information has been improperly accessed or disclosed.

The Privacy Rule created a widespread need for healthcare providers to revise their systems to protect patient information and combat misuse and abuse. Providers now must protect patient information in all forms, implement specific data formats and code sets, monitor compliance within their organizations, implement appropriate policies and procedures, provide training all in HIPAA's privacy requirements, and require the organization's outside business partners to return or destroy protected information once it is no longer needed. Also, it is not enough simply to do everything that is supposed to be done: there are also a number of documentation requirements as well. Even a provider organization's telecommuting or home-based program must be HIPAA compliant.

Physical Layout Considerations

The HIPAA Privacy Rule has necessitated changes in physical arrangements to ensure that no one other than the patient and caregiver or other legitimately involved person knows the nature of the patient's problem—or even, for that matter, that the specific individual is a patient. Medical orders or information about an individual's condition must be conveyed with a guarantee of privacy. Numerous organizations had to move desks or workstations, erect privacy partitions, provide soundproofing, and make other alterations so that no one other than those who are legally entitled to hear may overhear what passes between patient or representative and a legitimately concerned party.

The Privacy Official

Every healthcare provider organization must have a person designated to oversee HIPAA compliance. In a large organization, this position could be filled by a full-time HIPAA coordinator. In a small organization, such as a medical office, the task might be an additional responsibility of the office manager. This person must monitor all aspects of compliance and ensure that appropriate policies and procedures are maintained and kept current. Professional associations, including the American Health Information Management Association (AHIMA), have developed detailed position descriptions and guidelines for privacy officers.

The Department Manager and HIPAA

Depending on the nature of a department's activity, HIPAA's requirements could significantly affect the manager's role. For example, in addition to most managers' involvement with the Privacy Rule, some person working in health information management must be concerned with the TCS rule. A manager within information technology or information systems will be significantly concerned with the Security Rule because of its relevance for information stored or transmitted electronically.

As with other laws affecting the workplace, there is much more to compliance with HIPAA than simply putting policies, procedures, and systems in place. Some HIPAA regulations are complex, and in the most heavily affected areas of an organization, considerable training can be required. Also, HIPAA necessitates some training for most staff regardless of department; any person who comes into contact with protected patient information must receive privacy training. As a consequence, most managers will be both trainees and trainers, learning HIPAA's privacy requirements and communicating them to employees.

Not Going Away

Some HIPAA requirements continue to be amplified, and it is clear that the law's basic privacy requirements are here to stay in one form or another. Privacy rules will continue to affect every physician, patient, hospital, pharmacy, healthcare provider, and all other entities having contact with

patient medical information in any form. The American Recovery and Reinvestment Act of 2009 and the related Health Information Technology for Economic and Clinical Health Act amplify privacy practices, with particular emphasis on breach notification. The breach notification provisions include detailed regulations touching on the following issues:

- Notification of individuals if there is significant risk of financial, reputational, or other harm
- Time frames and manner of notification
- Tracking and reporting
- Internal compliance monitoring systems

HIPAA has brought with it a considerable amount of unwelcome, unwanted, and frequently burdensome change affecting the jobs of many healthcare managers. Because the requirements of HIPAA are government mandates, the individual manager has no option but to comply. The manager's challenge, then, is to conscientiously approach the necessary changes in the role and incorporate them so that they are addressed as efficiently and effectively as possible.

As an unexpected positive outcome of HIPAA-related actions, the health information management environment has been primed to undertake major efforts in expanding electronic health records.

A Study in Proactive Change: Electronic Health Records

Implementation of electronic health records reflects a proactive approach to change. The application of technology to enhance the creation and use of healthcare information has been a welcome advance. The migration from hard copy records and systems to automated ones represents change, both incremental and rapid. Data gathering and analysis via punched cards in the early 1960s was a precursor of advances to come. As the country became accustomed to electronic capture, exchange, and use of information as a result of the new technology (the credit card—easy to use, easy to carry), smart cards with embedded personal health information were a highlight in the early 1970s. Why not apply the same idea to one's personal information? Applications of smart cards in the late 1980s included patient's use of interactive behavioral healthcare protocols. Throughout this period, automated and outsourced administrative processes were adopted readily. The Y2K events occasioned a thorough review of systems. Advances in technology, plus related legislation in favor of electronic health records, have resulted in rapid change and a cascade of changes. Note, by way of example, the adoption of Health Level-7 standards, the creation of a national health information technology coordinator and the national health information technology plan, and such specific legislation as the Medical Modernization Act and its mandates concerning electronic prescription systems.

The electronic health record incentive program provided an additional catalyst for the adoption of this massive system change. Yes, the technology is continually evolving, but the underlying principle is enduring: quality health information for use in patient care, research, and administrative

support. Legislative mandates requiring universal adoption of electronic health records further reinforce this ongoing professional mission.

Health information practitioners have taken leadership roles in their workplaces and through their national association, AHIMA, along with its state component organizations. A strategy for proactive engagement with these changes was developed and continues to be applied as the migration from hard copy to electronic information systems unfolds. The overall strategy has six features:

1. Individual initiative within the workplace
2. Advocacy in the public arena
3. Partnership with key stakeholders
4. Outreach to clients and patients
5. Continual adjustments to information systems
6. Reassessment of health information management job roles and credentialing

Individual Initiative

Within the workplace, individual health information managers have steadily adopted computer technology to support basic operations. Workflow and processes have been gradually converted over time, including automated master patient indexes, coding and reimbursement processes, digital imaging, and speech recognition dictation. Internal administrative systems have served as building blocks for the expansion of computerized systems to include electronic health records. Although individual initiative continues to be an important facet of this transition, fostering change through advocacy has been primarily an organized group effort through the national association, AHIMA.

Advocacy in the Public Arena

External forces, particularly law and regulation, are affecting the process of developing electronic health records. It is essential, then, that professional practitioners help shape the debate, contributing their knowledge and expertise through organized efforts. Regular interaction with lawmakers and regulatory agency officials has been central to this process. Participation in work groups, task forces, and special initiatives has been steady. Landmark events bear the imprint of such involvement, including the Centers for Disease Control and Prevention's Public Health Information Network to implement the Consolidated Health Informatics standards, the Public Health Data Standards Consortium, the Department of Health and Human Services (DHHS), the American Health Information Community and its initiatives toward creating a national health information network, and the Certification Commission for Healthcare Information Technology.

Partnerships with Key Stakeholders

The health information profession has long been the authoritative source of practice standards. With the advent of electronic health records, many of the questions that have arisen are variations

of issues with which health information management practitioners have successfully dealt. Those experiences have prepared these practitioners to offer guidance in such areas as documentation content and standardization, authentication of documentation, informed consent, accuracy of patient information, access and authorized use of data, and data security.

AHIMA has developed a series of position papers, statements of best practices, and guidelines for these and related topics. This organization has strengthened its efforts through partnership with key stakeholders, as the following examples demonstrate

- American Health Information Community (DHHS): standards for electronic health data
- American Medical Informatics Association: data standards
- Medical Group Management Association: performance improvements and need for consistent data standards
- National Library of Medicine: data mapping (e.g., Systematized Nomenclature of Medicine and International Classification of Disease interface)
- American Society for Testing and Materials and its committee on health informatics: core data elements and definitions
- Corporate partner industry briefings: cosponsored exchange sessions

Through these and similar outreach efforts, AHIMA makes available valuable guidance to those involved in adopting electronic health records.

Another major initiative by AHIMA has been the move toward open membership. In recognition of the important partnership with information technology specialists, clinicians, and others with a shared interest in health information, as well as to foster even greater teamwork, the AHIMA members voted to eliminate associate membership, moving this group into the active membership category. An open, inclusive membership provides additional strength to the association in its efforts to support the electronic health record initiative.

Outreach to Clients and Patients

Consumers are an important partner in the effective use of electronic health records. AHIMA has developed an initiative to raise public awareness of these personal health records. As part of this initiative, individual health information practitioners, using AHIMA-created presentations, interact at local and regional levels with consumer groups such as local chambers of commerce, health fair coordinators, and specialty support groups (e.g., cancer support groups). Participation in the Blue Button initiative (begun by the Department of Veterans Affairs) has provided another opportunity to educate the public about electronic health records. Presentations and articles by health information management professionals concerning the health information exchange or "how to" explanations about accessing an electronic health record for one's personal use have fostered patient engagement in this unfolding endeavor.

An important adjunct to this outreach is advocacy. Clients and patients must continue to have trust in the process of revealing their personal information fully and truthfully during healthcare

interactions. AHIMA continues to press for specific protective legislation with a nondiscrimination focus: protect the patient from any discriminatory action stemming from documented information about patient care encounters.

Continual Adjustments to Information Systems

In summary, electronic health record initiatives reflect the best in proactive involvement by managers in facing major change. As the transition from paper to electronic records continues, AHIMA has provided position papers, best practices guidelines, and training materials including document imaging to link paper documents to electronic health records, along with retention guidelines for postscanning management of data; "copy and paste" guidelines; making corrections, amendments, and deletions to ensure record integrity; the definition of the legal record; and e-discovery rules under federal rules of civil procedures.

Reassessing Health Information Management Job Roles and Credentialing

The changing landscape of health information management job roles and functions has produced associations that periodically review this work. Such evaluation has become a more urgent priority as attention to the need to reassess both traditional jobs as well as emerging ones. Logical steps have included identifying the new configuration of jobs and role sets, identifying the associated knowledge and competencies, and developing and expanding the educational preparatory levels (associate, bachelor's, and master's degrees, as well as graduate certificate in healthcare informatics). The credentialing process has also been expanded to include new categories of specialization (e.g., Certified Documentation Improvement Practitioner, Certification in Healthcare Privacy and Security).

Economic and Market Forces: Anticipatory Readiness Through Organizational Restructuring

Sometimes an organization as a whole faces severe circumstances caused by economic and market forces. Consider the situation of a facility offering two levels of care for frail, elderly people: personal care and assisted living. This facility opened 40 years ago and has been in the same physical building since then. It has had a history of modest but steady success. An analysis of the balance sheet reflected breakeven points for 11 of the 40 years and 14 years of modest profit. Only the first few years showed yearly losses, primarily because of startup costs. Then, most recently, there was a 5-year run of steady loss and increased debt, due to increased competition in local market and to the need for expensive renovations to the 40-year old physical facility. Decreasing reimbursement rates from third-party payers added to this erosion of revenue.

To reverse this trend, the management team undertook the process of preparing the organization to survive and thrive in a new era. The team restructured the organization. It also anticipated probable changes in state law, including those leading to a decrease in skilled care beds through a

buy-back provision. Decreased reimbursement for this level of care gave the organization an additional reason to convert some units to increase the size of its dementia care service. Assisted living care was discontinued. The assisted living building was converted to additional personal care and respite care, plus an adult day care center. Comprehensive home care services, using a contractual provider, rounded out the reconfigured services. Through all of these efforts, the organization emerged from its threatened state and became a leading provider in its geographic region.

Disruption in Personal Circumstances: Revitalization Through Career Development

The individual is certainly not immune to the pressure of change. Consider the situation of the health information professional whose family circumstances require increased income over the next several years. This credentialed practitioner had been working part-time as a coding specialist in a community hospital. There were no anticipated resignations in the department management team, and internal advancement was unlikely. Furthermore, this woman needed to remain in the region for family reasons. Recognizing the constraints in her situation, she made and implemented a plan for advancement. First, she utilized the AHIMA career development and self-assessment program to identify competencies needing upgrading. While continuing to work, she undertook master's degree studies in health informatics and participated in several projects. These projects included research in correctional facilities, juvenile detention centers, and protective service agencies. Through this health information professional's involvement in local civic activity, an opportunity developed for her to work in first local, and then regional, correctional facilities. She worked first as a part-time consultant and then as the full-time director of the health information department. Both her personal and professional goals were met.

Using the foregoing examples as background, let us now consider the theoretical aspects of organizational change.

CHANGE AND RESISTANCE TO CHANGE

Change is inevitable, but change can also be chaotic and painful. Alfred North Whitehead once said, "The art of progress is to preserve order amid change and to preserve change amid order." That statement captures the essence of change and its effects on all of life. Much change is beneficial, even necessary, but change is often upsetting and unsettling and thus must be controlled. For good or ill, change is inevitable. So, too, is resistance to change inevitable.

This section addresses the inevitability of change, including how, as individuals, we tend to deal with change and how, as managers, we can deal with employee resistance to change. In discussing this topic, it is necessary to look at individual attitudes toward change, those of both managers and employees alike, because resistance is a human reaction that can arise in anyone regardless of organizational position. In other words, the manager who is expected to be a change agent and

supportive of inevitable change may initially experience feelings of resistance equivalent to those of the employee. It is also necessary to consider how to meet change when it occurs and how to make change work.

Significant change—change that has the power to confuse, frustrate, and very nearly overwhelm—is a frequent modern concern. Broadscale change has been a phenomenon affecting only the recent few generations, and for the most part people remain unable to shake off centuries of programming that causes them to dig in their heels and resist when change that they neither want nor welcome threatens to pull them down.

The Collision of Constancy and Change

Humans have been thoroughly conditioned by many centuries of little or no change to expect constancy. Up until a few decades ago, an individual could adopt a career and with few exceptions expect to remain in that career for a lifetime. The effects of the knowledge explosion and the Industrial Revolution that preceded it, however, included changes that rendered some occupations obsolete or changed them dramatically. Occupations that had existed for several generations all but vanished as machines took over work that had long been done by hand. Entire industries disappeared. For example, whaling, once an economic mainstay of the northeastern United States, shriveled and died as petroleum products replaced whale oil. Many individuals have seen their jobs and careers disappear as a consequence of change that continues to accelerate to this day.

Those working in the delivery of health care have seen and are seeing new medical technologies arise to either replace or augment existing technologies, in some instances making it necessary for workers to learn new skills or seek new occupations. Some individuals still working in diagnostic imaging were first employed when imaging was entirely X-ray; these people have seen the addition of the computerized axial tomography (CAT) scan, magnetic resonance imaging (MRI), positron emission tomography (PET) scan, and other technologies. One technologist who had been employed in a hospital laboratory for 30 years observed that more than 80% of the tests she performed on a routine basis did not exist when she first entered the field. A professional in another field, comparing the changes in college course curricula in his field over a period of 30 years, observed that he would have to take one or two new courses each semester for the rest of his life to remain completely current with the pace of change in his field.

On a simpler level, for the conduct of routine business functions, whether in health care or elsewhere, where have all the typewriters (and typewriter makers) gone? And considering the rapid advances in electronics that are seeing devices becoming both smaller and more powerful, one might soon be inspired to ask, where have the personal computers gone?

People have been conditioned by centuries of little change to expect constancy or near-constancy. That, plus a natural tendency to seek equilibrium with the surroundings, conditions many people to be automatic resisters of change. They are continually attempting to preserve equilibrium with the environment, and whenever it is disturbed they tend to take steps to reestablish

that equilibrium—to return to a "comfort zone." Certainly not all people behave in the same manner, but it is likely that most people seek equilibrium with their surroundings and tend to equate security with constancy. Indeed, security was once likely to be found in adopting an occupation and doing it well for life or in remaining a loyal employee of one organization for life. No longer, however, is there security in constancy; rather, today's security, to the extent that it may exist, lies in flexibility and adaptability.

The Roots of Resistance

The principal cause of most resistance to change is the disturbance of the previously mentioned equilibrium. Resistance will, of course, be influenced considerably by one's knowledge of where a given change is coming from. It is unlikely that a person will resist a change with which he or she wholeheartedly agrees or one that is his or her own idea to begin with. The person does not resist such a change because it is welcome and, therefore, does not threaten one's equilibrium. Thus it is not change itself that people resist but rather *being changed*—being made to change by forces or circumstances outside of themselves.

A secondary major cause of resistance lies in the inability of people to mentally conceive of certain possibilities or think beyond the boundaries of what they presently know or believe. The limitations imposed by what people know and what they believe can provide significant barriers to creativity and progress. Ideas that are today deemed revolutionary were not originally welcomed with open minds. Many people we have come to think of as innovators and visionaries were, in their day, regarded as dreamers, charlatans, or crackpots. Here are four examples.

1. Barely 2 months before the Wright brothers flew, a noted scientist publicly explained why a heavier-than-air flying machine could never work. However, the brothers went ahead and flew anyway; they had an advantage in not knowing "it couldn't be done."
2. A device called a "telephone" was branded a fraud, with an "expert" proclaiming that even if it were possible to transmit human voice over wires, the device would have no practical value.
3. When television was new, the head of a major Hollywood studio proclaimed that people would soon get tired of staring at a plywood box every night.
4. Even in the field of medicine, change has often been thought impossible: in 1837, leading British surgeon Sir John Erichson stated that the abdomen, the chest, and the brain would "forever be shut from the intrusion of the wise and humane surgeon." Note as well that many people alive today once thought that surgery on a living heart would never be possible.

To a considerable extent, then, the roots of resistance to change are within human beings themselves.

Primary Causes of Resistance

Concerning change that occurs in the workplace, people tend to be thrown off balance by changes that are thrust on them and especially by the way in which many of these changes are introduced. Common sources of change in the work organization occur in many areas:

- Organizational structure, when departments are altered or interdepartmental relationships or management reporting relationships are changed, including the changes that result from merger, affiliation, or system formation
- Management, whether in a department, a division, or an entire organization
- Product or service lines, as services are added, dropped, or altered significantly
- Introduction of new technology, bringing with it new equipment that employees must learn to use
- Job restructuring, altering the duties of particular jobs, such as combining jobs that were formerly separate
- Methods and procedures, requiring workers to learn new ways of doing their jobs
- The organization's policies, especially personnel policies affecting terms and conditions of employment

Consider how much—or perhaps how little—control the average rank-and-file employee or the typical department manager can exert over the foregoing changes. In most instances, the individual is essentially powerless. Managers and some employees might perhaps have a voice in restructuring jobs and altering methods and procedures, and perhaps they might be involved in selecting or recommending new equipment, but chances are they have little or no voice in the decisions necessitating such changes. It is doubtful that many employees or managers below the level of executive management have any influence on changes in products or services. And concerning the remainder of the major sources of change described—significant sources of stress and resistance for managers and employees alike—rank-and-file employees and their department managers are powerless.

Organizational Changes

Depending on the extent of reorganization, structural changes within a healthcare organization, such as combining departments or groups or realigning departments under different executives, can engender ill feelings and generate considerable resistance. Most department managers and their employees are well aware that reorganizing under any name—reengineering, downsizing, whatever—often means that some people will lose their jobs, so fear and insecurity and thus resistance increase while productivity inevitably decreases. Even more likely to upset employees are the changes accompanying merger or other form of affiliation, acquisition by a larger organization, or health system formation.

Management Changes

Changes in management are among the most potentially upsetting changes employees can experience. The stress of a management change, and thus the resistance to it, is concentrated within the hierarchy beneath the management position that is turning over; therefore, a change in department manager will affect primarily that department, whereas a change in chief executive officer will affect the entire organization. A change in management almost always involves exchanging a known quantity for a complete or partial unknown, and it is fear and apprehension concerning the unknown that causes most initial resistance to management changes.

Policy Changes

Major changes in the policies of the organization, especially personnel policies affecting terms and conditions of employment, are likely to spark a certain amount of employee resistance, especially if employees perceive they are losing something. In these years of fiscal belt-tightening, it is not uncommon to see, for example, employers in health care and elsewhere shifting an increasing portion of ever-growing health insurance costs to employees, or reducing the corporate contribution to defined-contribution retirement plans or other investment plans, or reducing the sick-time benefit and combining the remainder with vacation and personal time in "paid time off" plans. Such policy changes have inspired so much resistance for some employers that they have become major issues in union organizing campaigns and labor contract negotiations.

Many Causes

Resistance can occur anywhere, resulting from almost any change within an organization, often arising in situations that no one had thought would prompt any objections. Times of relative turmoil in health care, with all of the fallout of "merger mania" and all of the cost-reducing and cost-saving pressures brought to bear on the healthcare delivery system, finds the healthcare worker—and the healthcare manager as well—working in an environment of intensifying change and an eroding sense of security.

Meeting Change Head-On

The healthcare department manager is in a uniquely difficult position relative to change that has an impact on the healthcare organization. As an employee, the manager is just as affected by change as the rank-and-file employees and is just as likely to feel helpless, demoralized, and resistant. Yet it is up to the manager to try to minimize the negative reactions of the work group and attempt to raise employee morale and ensure continued productivity. If the manager openly projects doom, gloom, and resistance, the staff will be all the more likely to become more deeply mired in doom, gloom, and resistance themselves, ensuring that morale and productivity both suffer. It can be a most difficult role for the manager to function as "cheerleader" when there seems to be nothing to

cheer about. Yet the manager must make a conscious effort to rise above all the negative thinking. Succeeding at doing so is largely a matter of attitude, including the willingness to take a moderate amount of risk.

Flexibility and Adaptability

As noted, people can no longer find security in constancy, maintaining loyalty to the same ideas, concepts, and institutions for life. Rather, security, to whatever extent it exists today, is more likely found in flexibility and adaptability. The manager who remains rooted in place, with a fixed set of ideas and an unchanging concept of the job, will not be particularly successful; however, the manager who can move about, who can flex and adapt as circumstances change, stands a much greater chance of success. Also, to enhance the department's chances of success in adjusting to changing circumstances, the manager must be a role model for flexibility and adaptability.

A department manager may be able to help some employees increase their flexibility by instituting cross-training wherever possible. For cross-training to be effective, it is necessary that there be a number of employees distributed across multiple jobs of approximately the same skill or grade level; thus, it is not possible in every department. When cross-training is possible, however, there are benefits for employee, department, and organization alike. With people trained in multiple activities, coverage for vacations and other absences is more readily accomplished, employees get the advantages of task variety, and employees may become more secure during times of readjustment by being capable of moving into certain other jobs, already trained and competent.

A Matter of Control

The department manager who becomes caught up in a sea of change should immediately learn the difference between what can be controlled and what cannot be controlled. Much energy is wasted in trying to control that which is uncontrollable. For example, a manager may be greatly stressed about an impending merger and subsequent combination of departments, but there is nothing that the manager can do about it; it will happen whether he or she wishes it or not.

Stress as a response to change, both real and impending, is an emotional reaction. An important early step in gaining a measure of control over one's circumstances is learning to control one's emotions. A person may have little or no control over the changes themselves; however, he or she has complete control over how one's *response* to the changes.

Fortunately, there are usually a few factors that the individual department manager can control to some extent. Reorganizing or reengineering frequently results in the need to combine positions and restructure a number of jobs—that is, change job descriptions, assignments, crew or team sizes, equipment, or later services. These actions usually entail changes in methods and procedures, changes that can be determined in detail within the department by the manager, often with the participation of the employees.

Addressing Resistance with Employees

A manager responsible for implementing change has three available avenues along which to approach employees regarding a specific change. The manager can (1) simply tell them what to do, (2) convince them of the necessity for doing it, or (3) involve them in planning for the change.

Tell Them

The use of specific orders or commands is one of the hallmarks of the autocratic or authoritarian leader. The boss is the boss, a giver of orders who either makes a decision and orders its implementation or relays without expansion or clarification the mandate from above.

The authoritarian approach is sometimes necessary; occasionally, it is the only option available under urgent or completely unanticipated circumstances. However, in most situations the "tell-them" approach is the approach most likely to generate resistance, so it should be used in only those rare instances when it is the only means available.

Convince Them

In most instances, including those in which the change in question is an absolute mandate from top management, the individual manager has room for explanation and persuasion. At the very least, there is the opportunity to try making each employee aware of the reasons for the change and the necessity for its implementation. It may be necessary for the manager to champion the cause of something clearly distasteful to all concerned (except, most likely, to those mandating compliance) because it may be good for the institution overall or good for patients, or even perhaps because it is mandated by new government regulations. The employees may not like what they are called on to do, but they are more likely to respond as needed if they know and understand why the change must be implemented.

The employees deserve all the information available, and this information often serves the manager well because it can remove the shadow of the unknown from the employees and thus lessen their resistance. Few, if any, changes cannot be approached by this means. The authoritarian "tell-them" approach should be reserved as a last resort to be used on those occasions when employees clearly cannot be "sold" on the change.

Involve Them

Whenever possible, and especially if it affects the way they do their assigned jobs, employees should become involved in shaping the details of any particular change. It has been repeatedly demonstrated that employees are far more likely to understand and comply when they have a voice in determining the form and substance of the change. For example, if new equipment is under consideration and there is sufficient lead time, it is helpful to obtain the input of the people who will have to work with the equipment once it is in place. This sort of involvement not only enhances

employee cooperation but often leads to a better decision because of the perspective of the people doing the hands-on work. When expansion or remodeling will change the characteristics of the department, employee input in the planning stages will bring the workers' perspective into determining optimal layout and work flow. Through involvement, change can become a positive force. Employees will be more likely to comply because they own part of the change; in effect, a piece of it is their idea.

There is another potential benefit to involvement as well: employee knowledge of the details of the work in ways the manager may never have. The manager supervises a number of tasks, some of which he or she may have once done personally. However, the employees regularly perform in hands-on fashion the tasks the manager only oversees. Thus, the employees usually know the details of the work far better than the manager and are in a better position to provide the basis for positive change in task performance.

The numerous sources of management advice that promote the value of employee involvement are correct. The participative and consultative approaches to management are the best ways of getting things done through employees. The most effective ways of reducing or removing the fear of the unknown make full use of communication and involvement.

Guidelines for Effective Management of Change

To secure employee cooperation and participation and successfully manage change in the workplace, it is necessary for the manager to take the following steps:

- *Plan thoroughly*. Fully evaluate the potential change and examine all implications of its potential impact on the department and the total organization.
- *Communicate fully*. Completely communicate the change, starting early, ensuring that the employees are not taken by surprise. This should ideally be two-way communication, preparing the way for employees' involvement by soliciting their comments or suggestions.
- *Convince employees*. As necessary, take steps to sell employees on the value and benefits of the proposed change. When possible, appeal to employees' self-interest, letting them know how they stand to benefit from the change and how it might make their work easier.
- *Involve employees when possible.* It is not possible to completely involve employees in all matters, but involvement is nevertheless possible on many occasions. Be especially aware of the value of employees as a source of job knowledge, and tap this source not only for the acceptance of change but also for the development of improvements.
- *Monitor implementation*. As with the implementation of any decision, monitor the implementation of any change until the new way is established as part of the accepted work pattern. A new work method, dependent for its success on willing adoption by individual employees, can be introduced in a burst of enthusiasm. Do not let it die of its own weight as the novelty wears off and old habits return. New habits are not easily formed, and the employees need all the help the manager can furnish through conscientious follow-up.

True Resistance

Resistance to change will never be completely eliminated. People possess differing degrees of flexibility and exhibit varying degrees of acceptance of ideas that are not purely their own. However, involvement helps, and the manager will eventually discover, if not already having done so, that most employees are willing to cooperate and genuinely want to contribute. Beyond involvement, however, continuing communication is the key. Full knowledge and understanding of what is happening and why it is happening are the strongest forces the manager can bring to bear on the problems of resistance to change. Ultimately, one will discover that it is not change that people resist so much as they resist *being changed*.

In addition to applying the foregoing strategies, managers facilitate their response to change by

1. Recommitting to the full spectrum of their role through a review of the enduring functions of the manager
2. Remaining attentive to
   - Developments in the history of management and the ways in which managers adjusted their focus from time to time
   - Shifts in organizational life from informal to formal, stable organizational patterns
   - Opportunities for building a strong network of internal and external relationships

ONE MORE CHALLENGE: THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The major legislation known as the Patient Protection and Affordable Care Act of 2010, more commonly referred to as the Affordable Care Act, affects the healthcare system at all levels. Middle managers need to use all of the strategies described in this chapter to deal with the massive changes associated with this legislation focusing on the provision of affordable care and healthcare reform. They need to take into account the political aspects of the legislation's passage, which are likely to lead to further amendments, deletions, and changes in its implementation time frame. The federal mandates, in turn, will generate companion state-level legislation. More than 100 regulatory agencies, boards, and councils are empowered to issue guidelines and mandatory regulations. The designated time frame for the implementation of the federal law is from 2010 to 2018. Thus, many people face an almost decade-long period of sustained change.

The manager who has a positive attitude will more easily respond to these challenges than one who is resistant. Flexibility, creativity, and attentiveness to the unfolding mandates—these traits will serve the manager well. A commitment to factual analysis will lead the manager to develop a system for monitoring the details of this law. For guidance, the manager should turn to trusted

sources, such as professional associations—especially these organizations' legislative divisions, which monitor primary documents such as federal and state regulation publications. The manager might partner with several peers in the work setting to study the unfolding mandates and share insight about their impact.

Following is a suggested template for use in tracking these changes. A few examples are included under the headings as a starter.

- Impact on the organizational setting
  - Increase in community health centers
  - Development of independence-at-home programs
  - Creation of community-based transition programs for Medicare patients at high risk for readmission to acute care
  - Phasing out of physician-owned specialty hospitals
  - Increase in use of observation units as a bridge between emergency care and admission/readmission to inpatient care
- Patterns of care
  - Increase in use of outcome measurement for clinical effectiveness research
  - Implementation of wellness programs and preventive care (e.g., smoking cessation counseling)
  - Wellness care incentives
  - Increased emphasis on coordination of care for all stages of care, with particular attention to discharge planning and reduction of preventable readmission within 30 days
  - Creation of medical homes or health homes programs (i.e., a decentralized coordinator of care) for chronic illness care. (*Note:* The term *homes* is not used to denote a place to live; in this context, it means the primary caregiver who coordinates various aspects of care including referrals to specialists.)
- Practitioners
  - Increased funding for training
  - Increased utilization of physician assistants and nurse practitioners
  - Increased roles for pharmacists in direct counseling of patients concerning medication management
- Clients
  - Increased numbers as individuals come under new health insurance coverage
  - Surge in demand for specific services as coverage for these services unfolds (e.g., free annual physical examination)
  - Increased need for client education about the details of coverage and the time frames associated with various benefits (e.g., preexisting conditions coverage starts in 2010 for children but does not begin for adults until 2014)

  - Increased need to capture eligibility data (e.g., income levels, prescription medication expenses for the benefit period, Medicare or Medicaid coverage)
  - Increased sensitivity to patients' concerns about their coverage and their continued access to care. This involves the development of trusted adviser contacts who assist clients with their understanding of their eligibility for, and coverage options, with regard to health-care insurance plans
- Employees
  - Need for timely information about changes in health insurance coverage, copayments, and deductibles
  - Need for annual information (on W-2 forms) about the dollar value of the health insurance fringe benefit
  - Concern for job security when the organizational setting changes
  - Questions about job rotation (e.g., if mergers occur or if community-based programs are developed, will the employee be obliged to rotate among various geographic locations?)
  - Need for more frequent continuing education (e.g., intake processing and health insurance questions)
- Specific systems impact
  - Budget adjustments to include resources for more frequent continuing education
  - Increase in fraud detection processes
  - Increase in patient-centered outcomes standards research and studies
  - Increase in monitoring of discharge planning, coordination of care, readmission rates, and supportive rationale

The manager constantly attends to change, meets it through managing the organization through its life cycle, uses strategies for organizational adaptation and survival, and strengthens the organization's relationships with key constituents and stakeholders. These concepts are discussed in subsequent chapters.

CASE: IN NEED OF IMPROVEMENT?

You are an administrative staff specialist newly employed by the hospital to act as a management engineer and address a number of issues relating to operating efficiency. Your first assignment is to analyze work methods and staffing in the central sterile supply division of materials management. The department was singled out for study for the following reasons:

- The manager—a registered nurse who has held the job for more than 25 years—has requested two more processing aides, although her staff is already one person larger than that of another area hospital of equivalent size.
- There has been a recent, seemingly unexplainable, upturn in the consumption of disposables.

- A number of storage shelves appear to be stocked to overflowing with infrequently used items.
- The department issues frequent rush orders to obtain needed items that have completely disappeared.
- Observed conditions in the department include an overcrowded storage area, a seemingly inadequate decontamination area, and a grossly oversized processing area referred to by most employees as "the ballroom."

On your initial visit to the department, the first thing the manager says to you is, "So you're the one who's going to tell us what we're doing wrong?" Her tone is none too friendly.

Instructions

Develop a proposed approach to a complete study of the department, including the "sales pitch" you would use to try to win the manager's cooperation and support. Specify what should be done, why it should be done, and how you propose to address the inevitable resistance of both manager and staff.