

Section 2.7 Plan

CCC Program Change Management

This tool is an overview of change management relating to coordination among health care professionals and community resources within the community-based care coordination (CCC) program. Although change management is very much part of patient communications, patient change management is addressed in other tools in this Toolkit. This tool focuses on the challenges and opportunities for program change, stages and agents of change, and conflict resolution.

Time needed: 3 hours to review tool and reflect upon strategies and tactics suitable for the status of the CCC program.

Suggested other tools: CCC Maturity Assessment; Resource Checklist for CCC; Establishing the Care Team: Roles and Communication; Approaches to Patient Communications; Supportive Communications; Workflow and Process Analysis/ Redesign/ Optimization for CCC tool suite

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How to Use

1. **Review** the challenges and opportunities for change associated with coordinating patient care among health care professionals and community resources to achieve the triple aim goals of improved quality, cost, and experience of care.
2. **Use** the stages of change tool to assess the CCC program and its participants with respect to making the change toward community-based care coordination.
3. **Identify** potential strategies and tactics for effecting change, as well as agents for change who may assist in carrying out the strategies and tactics within the CCC program.
4. **Anticipate** possible deterrents to the changes brought about by the CCC program and develop strategies to resolve conflicts.

Challenges and Opportunities for Change

Challenges to Change: Change is one of the most challenging behaviors to effect. While few people are willing to articulate why change is so difficult for them on a personal level, change is frequently viewed as shifting the balance of power. Even those who have a high degree of formal power afforded to them, such as physicians, may fear losing that power or may have grave concerns about what impact loss of power may have on their ability to perform their work satisfactorily.

Health care professionals are trained to work autonomously. Although there is a health care team, the team has a very clearly-defined hierarchy. Each class of health care professionals knows precisely where they stand in the hierarchy and takes great care not to overstep the applicable boundaries. Some boundaries are set by professional licensure but many have been set over time by the norms of the profession.

Health care professionals have cultivated norms to deal with stress, fatigue, and errors. Some of these norms include denial, blame, and cover-up. Such norms contribute to making change more difficult. This is especially true for physicians who carry the most authority and responsibility and can include lawsuits, loss of privileges, and loss of licensure in the case of an untoward event. All health care professionals face some of these risks. As a result, an impending change often results in resistance and even sabotage, sometimes subconsciously.

Opportunities for Change: In establishing a CCC program, the underlying principle is that of coordination. Care coordination may be defined as *sharing information and resources so that each party can accomplish his or her part in support of a mutual objective*. Coordination affords the opportunity to ensure that the program's goals can be met for the benefit of all. Coordination does not mean giving up what authority and responsibility a health care professional has, but acknowledging that others can significantly contribute to achievement of the goals by playing important and supportive roles.

An example of coordination is between a physician and a CC. A physician should not have to make arrangements for (or even take the time to determine the need for) transportation of patients for their office visits. However, physicians who do not support the CC in meeting patients and learn of their needs will not achieve the overall benefits of the CCC program. This may be an obvious and simple example, yet some physicians choose to ignore the CC or brush off their assistance as unnecessary.

Another example of coordination is between a physician and pharmacist. The physician should be willing to consult with a pharmacist about medication therapy management (MTM) strategies for a patient with polypharmacy who is becoming increasingly forgetful, complains of dizziness, and displays signs of confusion. While a pharmacist may not have the same authority as a physician to write a prescription, pharmacists have specialized training that not only can be helpful to the MTM discussion but can save the physician time in researching new drugs, contraindications, and other related information. The coordination between the physician and pharmacist contributes to the overall triple aim goals of CCC: improved quality, cost, and experience of care.

Clinical Transformation

Clinical transformation is a concept that describes the scope of change needed to effect true health reform. Regulations, staffing, reimbursement, cost, malpractice, report cards, and other issues have catapulted organizations to seek a significant revamping of their workflows and processes to meet new requirements, recruit and retain good providers and staff, optimize reimbursement, reduce waste and errors, and address public concerns. Clinical quality is now at the forefront of all health care organizations' concerns. Clinical transformation suggests some hallmarks that are different from previous approaches to change in health care organizations. These include:

- **Clinically-focused**

Many changes in health care have largely been financial and administrative. New payment models, new organizational structures for delivering care, workflow changes, and even adoption of health information technology have largely been on the periphery of the core business of health care: taking care of patients to improve their health and well-being, and ultimately improving overall population health. However, changes in clinical processes need to be made by health care professionals in order to have an impact upon the effectiveness and efficiency of patient care delivery and population health improvement.

- **Integrated**

As noted, the health care team is largely comprised of individuals working autonomously within a scope of practice. Physicians may rely on nurses to perform specific nursing functions but, in many cases, do not appreciate reminders or even alerts which nurses may convey to a physician about a patient. The team often does not work in a coordinated or integrated manner. To transform clinical processes, all health care professionals need to work together, not only to improve patient outcomes, but to ease the burden on each professional who is part of the team. Clinical transformation also requires that the patient and/or patient's family/caregivers be considered part of the team, with authority to make decisions and responsibility for carrying out agreed-upon treatment regimens.

- **Comprehensive**

Clinical transformation relies on having a comprehensive picture of the patient. This requires access to information that can have an impact upon clinical decision making. Information held by any one provider needs to be shared with a given patient's other providers. Sharing of information needs to be done in a timely and succinct manner. For example, it is critical that a primary care provider knows that a patient has been admitted to a hospital so that pertinent information can be provided to the hospital when needed. (This process can actually be fully automated, but a trigger must be built into information systems to do so.) If there are specialists also treating the patient, either the primary care provider should receive relevant data from them in order to compile complete information about the patient, or those providers must make such information accessible directly to the hospital. The result must be a comprehensive set of information about the patient. Being able to provide comprehensive patient information in a timely and usable manner generally requires that providers have electronic health records (EHR). Ideally there is a health information exchange (HIE) infrastructure in place that can facilitate sharing of the information.

- **Knowledge-based**

Clinicians are knowledge workers and need to have all those who are a part of the health care team be knowledgeable in their specialty area and be able to work to the level of their

credential. Physicians routinely refer patients to other physicians when specialty needs arise. However, the level of coordination in terms of information sharing (by both parties) is often lacking when such referrals are made. Furthermore, physicians are less inclined to consult with pharmacists, therapists, social workers, and other non-physicians even though coordination with them may result in improved outcomes. Finally, physicians sometimes demonstrate tolerance of staff members who are less qualified than the job calls for or who do not work to the level of their credential. Physicians tend to compensate for these deficiencies rather than take direct action, such as providing training, re-training, further education, performance reviews, or making necessary decisions about retention of such staff. The health care professional team must be fully qualified, and trust must be established among the team members.

- **Outcome-oriented**

Clinical transformation is about achieving better outcomes. There are many factors that need to change fully to realize the benefits that result from positive outcomes for patients. While no provider would state that their goal is to keep their patients sick, the traditional reimbursement structure has only rewarded providers based on volume and level of disease complexity of people treated. Health reform movements have only recently begun to address value-based purchasing so that the current payment model can be turned around to where providers are rewarded for keeping patients well. Clinical transformation depends on understanding what the outcomes are and how outcomes can be improved, and then rewarding health care professionals for improved outcomes. Such an outcome orientation requires comprehensive information and coordination among those caring for patients.

Stages of Change

Unfortunately, no magic wand is available to effect change without effort. Some studies suggest that change requires progression through stages, such as the five stages of the grieving process (denial, anger, bargaining, depression, and acceptance). Several studies support the work of Prochaska and others that indicate change requires pre-contemplation, contemplation, preparation, action and maintenance over a fairly significant amount of time, or at least more time than is often devoted to acclimation to new initiatives such as the CCC program.

Other change management experts describe a process that entails unfreezing old habits by pointing out deficiencies in the current approach and the value of new approaches, and then making the change through engagement, education and training, and freezing the change into new habits through continual reminders and reinforcement as well as commitment to enforcing, supporting and celebrating the results of the change. All of these models suggest one commonality—that change is complex, and that people must progress through multiple stages before real change occurs.

Assessing Stages of Change

McDonough and Doucette¹ have suggested a staged approach to developing a pharmacist-physician collaborative working relationship. Their approach can be applied to coordination among other health care professionals and patients to assess the current status of coordination and to identify strategies to move to a level of coordination that fully supports a CCC program. (Note: some suggest there is a distinct difference between coordination and collaboration.

Coordination is sharing information and resources so that each party can accomplish their part in support of a mutual goal. It is about teamwork and getting the job done so the goal is met.

Collaboration is working together to create something new in support of a shared vision. This is not an individual effort focused on an established goal, but a process where stakeholders work directly together to create something new. In the case of the CCC program, the goal is generally set by the program, and coordination is needed to achieve that goal.)

To use this tool (outlined below), identify the key stakeholders in the CCC program who should be developing a coordinated working relationship. Based on observation of the CC and/or using a virtual group process, identify where each stakeholder is on the coordination scale (explained further below).

It may also be appropriate to use this same tool within a given organization to determine if there are any differences between members of the organization in relationship to other stakeholders. Expand the list of stakeholders by copying this table to a spreadsheet.

Stages of Coordinated Working Relationship	Stakeholder Group 1 <i>Example: Primary Care Providers</i>	Stakeholder Group 2 <i>Example: CCC Program CC</i>	Stakeholder Group N <i>Example: Clinical Social Worker</i>
Commitment to the coordinated working relationship			
Professional relationship expansion		X	
Exploration and trial			X
Professional recognition	X		
Professional awareness			

In the example above (denoted by italics), primary care providers are rated as generally having “professional recognition” of others, the CCC program’s care coordinator (CC) is rated as being at the stage of “promoting professional relationship expansion,” and the clinical social worker is in the stage of “exploration and trial” with respect to care coordination.

An alternative approach to assessing the degree of coordination is to consider just two types of stakeholders at a time and rate each on the scale in relationship to one another. For example, the primary care providers in the example above are believed to be at the “professional recognition” stage overall, but when assessed against the CCC Program CC, they may be at the lower “professional awareness” level. The CCC Program CC may be only at the “exploration and trial” level with this stakeholder group. If the CCC Program CC is compared against a pharmacist stakeholder group, the CC may be at the “commitment to coordinated working relationship” stage and the pharmacist stakeholder group may be at same level with the CCC Program CC, even though the pharmacist stakeholder group may be at a different level as compared with primary care providers, clinical social workers, etc.

Stages of Coordinated Working Relationship	Stakeholder Group 1 <i>Example: Primary Care Providers</i>	Stakeholder Group 2 <i>Example: CCC Program CC</i>
Commitment to the coordinated working relationship		
Professional relationship expansion		
Exploration and trial		X
Professional recognition		
Professional awareness	X	

- **Professional awareness** exists when one stakeholder knows that another stakeholder exists within the health care domain and has general familiarity with that stakeholder’s roles and functions, but does not interact directly with that stakeholder or beyond the stakeholder’s basic functions.
- **Professional recognition** exists when one stakeholder acknowledges the value of another stakeholder’s roles and functions within the domain, but only interacts with that stakeholder when called upon to do so by that stakeholder or other professional. Positive exchanges, however, begin with a foundation of trust and a growing commitment to coordination.
- **Exploration and trial** is the stage where a resistant stakeholder up to this time believes there may be value interacting with another stakeholder and begins to appreciate the coordination, but needs to test the potential for an ongoing relationship.
- **Professional relationship expansion** is the stage where the stakeholder who has engaged in exploration and trial develops sufficient trust in the other stakeholder as to slowly initiate coordination activities.
- **Commitment to the coordinated working relationship** is the stage at which two stakeholders fully coordinate when appropriate, with one seeking out the other.

Effecting Change—Strategy vs. Tactics

The Web-Strategist blog² distinguishes between strategies and tactics, observing that one does not substitute for the other. Both are needed in effecting change of any kind, including organizational and stakeholder change. **Strategy** refers to the broad picture of how to accomplish something, generally over a fairly long duration of time. In effecting change, strategy helps set overall goals, identifies the nature of resources needed to achieve those goals, and provides accountability for achievement of the goals. **Tactics** break down the broad picture into manageable tasks that can be performed in the short term. Tactics provide clear deliverables and outputs. Accountability for achievement of tactics is held at the level of those tasked to carry out specific sub-goals.

Organizational Strategies and Tactics

Strategies to effect change to achieve the nation's health goals are generally set by government and other key stakeholders. Strategies for any given health care community to achieve the goals of a CCC program focus on both organizational and stakeholder elements – offering a vision of the desired end state, identifying all stakeholders in the community that can provide resources, providing the context for the desired change, and holding accountability for achievement of the goals.

At the strategic level, executives of the CCC program:

- *Create a vision* for the CCC program that supports goal achievement.
- *Identify resources* needed, including attracting or helping to create in existing health care professionals the knowledge, attitudes and beliefs necessary for openness, transparency, multi-directional communications and exchange of information.
- *Establish norms of behavior*, including developing outcome expectations, assessing performance and identifying potential conflicts and resolutions in the CCC program.

At the tactical level, each CCC program will establish their own tasks, but in general, the tactics tend to follow the overall structure of this CCC Program Toolkit:

- *Assessing needs* that help define goals, and assessing readiness to achieve goals.
- *Planning the design and development* of the program (e.g., is the CCC program part of a bigger initiative, such as a patient-centered medical home, an accountable care organization, or an insurer-based value-based purchasing program?)
- *Selecting needed resources* such as:
 - Staff (e.g., community-based care coordinator(s), patient recruitment specialists, administrative aides, actuarial assistance, data analytics specialists, IT staff)
 - Stakeholder education (for individual providers and provider organizations, community resources and patients/families) on the goals of the CCC program, benefits for each stakeholder group, etc.
 - Information technology (e.g., EHR, HIE, remote patient monitoring, telehealth, registries, clinical data repository, clinical data warehouse, analytics tools)
 - Other resources (e.g., funds to address special needs, consultative services to help implement the program)
- *Implementing the program*, including establishing expectations for success, writing policies and procedures, acquiring necessary resources, making workflow changes, installing and gaining adoption of information technology, developing educational materials, creating applicable forms, providing training, conducting applicable testing, rolling out the program (potentially in stages) and identifying and addressing issues and conflicts as they arise.

- *Maintaining the program*, including ensuring continued success through continual process improvement, monitoring goal achievement (including quality scores monitoring for any oversight body) and root cause analysis to support corrective action.
- *Optimizing the program* through applying a systems lifecycle feedback mechanism and continual enhancements.

Stakeholder Strategies and Tactics

Although it can be difficult to think of an organization separate from its stakeholders (and there certainly are dependencies), strategies and tactics that effect change in an *organization* may actually be more straightforward and easier to achieve than the changes in the *stakeholders* themselves. In fact, it is often the difficulty in effecting changes in stakeholders that leads to organizational change failures.

One element of a change management strategy that impacts the organization's stakeholders is to understand the organization's innate change management style. (This discussion generally does not apply to customer (patient/family) stakeholders.)

Every organization has some way of introducing and requiring even moderate amounts of change in its staff and others who provide services. Most effective change managers recognize the corporate culture of the organization and either work within that culture or attempt to move the organization to a more positive culture.

One or more of the following types of change management strategies is typically found in every organization. Although each can be effective given the characteristics of the organization, in general, the most effective and longest-lasting change is achieved through a behavioral norm-based strategy, with effectiveness decreasing with incentive-based, sanction-based and adoption-based strategies.

Consider your organization's approach:

- **Behavioral norm-based strategy** is one in which behavioral norms or expectations are changed by organizational leadership and/or external factors. For a given stakeholder group, the best way to achieve a behavioral norm-based strategy is to provide continuous education and feedback (especially on "what's in it for me"), engaging as many stakeholders as possible in dialogue about the change and celebrating examples of successful care coordination so that there is evidence of what works. Continuous feedback, including celebration and corrective action where results are not being met, is essential. Corrective action should avoid blame and focus on identifying and overcoming systemic root cause(s) for lack of success. Leadership tools that inspire change in stakeholders include visioning, storytelling, role modeling, holding conversations and persuasion.
- **Incentive-based strategy** is one in which conformance is rewarded. This is becoming more popular as payers (especially the federal government) has announced incentives, especially for adoption of EHR. These incentives include different forms for different types of organizations or professionals, including grants, loans and payments. However, some experts fear that once the incentive is removed stakeholders will slip back into "old ways."
- **Sanction-based strategy** may be viewed as the opposite of the incentive-based strategy where nonconformance is penalized. In this case, payers may introduce disincentives,

such as Medicare adding time to pay on claims if not filed using the HIPAA-required electronic transactions, withholding a percentage of payment from hospitals that do not participate in voluntary quality reporting, or reducing reimbursement for providers who do not adopt EHR by a specified date. Although for an individual organization where it is not legal to withhold pay from employees, requirements for adopting organizational changes can be included in job descriptions and part of staff performance reviews. For providers, profit or savings can be shared in a pre-determined way as an incentive, and withheld as a sanction.

- **Adoption-based strategy** is one in which stakeholders are transferred from the old way to the new way over time, such as giving clinicians the option of whether they will adopt a change or not. This strategy may be useful in some instances, but with today's focus on clinical transformation, most organizations find they do not have the time or resources to accommodate such a strategy. This strategy is also often accompanied by "power tools," such as coercion, threats, operating procedures, and other punishments or intimidation to bring stakeholders in line.

Agents of Change

Another key strategy in managing change is to recognize that no single person (administrator, CC, or physician champion) is the sole change agent. In fact, everyone involved in the process of implementing change needs to be a change agent, including stakeholders who help each other. Individuals involved specifically in the change project, as well as supervisory staff, may need to reflect upon the following skill requirements and take steps to hone them for the good of the organization:

- **People skills** are essential to understand the diversity among all individuals, skill sets and positions that are impacted by change. People who can effect change are able to listen, restate, reflect, clarify without interrogating, draw out the quiet, quiet the verbose, channel discussion, plant ideas and develop trust and confidence in stakeholders with the change.
- **Political skills** are needed to understand the various viewpoints and counter viewpoints that may arise during discussion about a change.
- **System skills** help organize and manage the technical aspects of a change while translating this into language that each stakeholder group will understand and respect.
- **Analytical skills** ensure that workflow and processes are not only understood and appropriately improved upon, but are also used to assess and manage the financial impact of the change.
- **Business skills** are needed to understand the underlying manner in which the health care organization works, including the underlying clinical processes. Change agents need be able to "talk the talk" and "walk the walk" related to their roles.

Recognizing and Responding to Resistance to Change

Reading people and preparing to respond to their concerns about change is an important task for the change agents. In addition to the pace at which individuals adopt change, people react to change in different ways, which may vary from actively supporting the change to not participate in a new program to threatening to leave. Reading reactions and responding appropriately is very

important. This is especially true for those known to be “informal leaders” or “opinion leaders” who you will want on the side of change. Common reactions to change and how to respond include:

- **Leaving**

Some clinicians may indicate that they will leave or retire before adopting a change. Some may be convinced to stay and can serve the organization well if their active resistance can be channeled into representing a resister’s viewpoint for the good of the change program. However, if this is not possible, it may be necessary to simply acknowledge the person’s accomplishments and let them make their own decision. Shortages of physicians and nurses may be a stumbling block to this approach, but even one or two highly disgruntled staff or providers can sabotage a change program. Such an environment calls for a significant level of education and one-on-one support for the change.
- **Active resistance**

In active resistance, the organization has an advantage because the individuals are clear about how they feel. Such individuals can be a benefit to a change project if, as described above, the active resistance can be channeled into representing a resister’s viewpoint for the good of the project. Once active resisters are turned around, they can be equally active in their support. Active resisters often do not threaten to leave. As a result, they are easier to turn around than those threatening to leave. Active resisters must be turned around because their resistance can be infectious and derail the entire change program.
- **Opposition**

A person who opposes change but is not an active resister can be the most difficult to identify and turn around. Often this is a person who is generally negative about everything and, potentially, may be depressed. Offering life/career counseling to such individuals is often necessary. If this is done, however, the benefits can be great, not only for the change but for the individual.
- **Acquiescence**

An individual who grudgingly accepts a change is someone who needs to be monitored closely. This individual could swing to either opposition or fuller acceptance. Involving this individual with specific tasks and recognition for work well done will help ensure movement toward acceptance.
- **Acceptance/modification**

An individual who reacts by always claiming to accept the change, but who continuously offers modifications to the program, can put change at risk. Often a person with such a reaction is actually one who opposes the change and is trying to avoid the change. This exuberance for modification needs to be carefully managed – often by piloting change, reporting on successes, acknowledging weaknesses, seeking help and generally continuing course.
- **Acceptance**

A person who quietly accepts the change is certainly one to be appreciated. However, such persons could contribute more to the process of turning others around if they were more actively supportive of the change, and they should be encouraged (if not called upon) to express their interest.

- **Active support**

Some people will be genuinely active supporters of a change, and should be greatly appreciated and acknowledged. Their energy and enthusiasm should be channeled into constructive help.

Deterrents to Change and Conflict Resolution

A number of deterrents to change, especially with respect to a CCC program, have been identified throughout this tool. Perhaps the most difficult deterrent to overcome in health care professionals is the ingrained norms that they hold, manifested largely by a lack of trust in anyone but themselves. This lack of trust is so strong that care coordination can feel to the health care professional like giving up total control even when it is actually gaining them time and resources that enable them to take more control of their personal responsibilities. To overcome such concerns by health care professionals there must be clearly established roles and responsibilities for all stakeholders involved in care coordination.

As much as some stakeholders should reach out to tap the resources of specialists in other fields, they must also not overstep their boundaries. Those stakeholders will largely have to take the lead in engaging the coordination, which can be a burden for them and may even seem somewhat demeaning. Change agents who are involved moving to a CCC program should work hard to keep all stakeholders working at a level of mutual respect, bolstering egos when necessary. Continuous demonstration of real results from the change, even if they start very small, is essential.

In this environment of change, it is very likely that there will be conflicts among stakeholders, which may be very subtle and difficult to spot. Reading not only resistance, but that a conflict has arisen, is important for all agents helping effect the change. Such change agents should approach the parties to the conflict in a non-confrontational manner. It must be acknowledged that a conflict has occurred and that the change agent wants to help resolve the conflict. The change agent should be prepared for the stakeholders to deny there is a conflict; often in their minds, there is no conflict.

The change agent may want to use a form of supportive communications, as recommended for use with patients (see *Supportive Communications*), to help the stakeholders understand the conflict and solicit recommendations for resolution. The change agent may also need to be prepared with examples of successful care coordination, recommendations for others to speak about their experiences, and assume responsibility for taking the root cause of the conflict to a higher authority to seek resolution, if necessary.

References

¹ McDonough, RP and WR Doucette. Collaborations Between Pharmacists and Physicians: Steps for Building More Effective Working Relationships, A continuing education program sponsored by an educational grant from MERCK and the American Pharmaceutical Association. Available at: <http://courses.washington.edu/pharm445/collaborations.pdf>

² Owyang, J (Jan. 14, 2013). The Difference between Strategy and Tactics, The Web-Strategist Blog. Available at: <http://www.web-strategist.com/blog/2013/01/14/the-difference-between-strategy-and-tactics/>

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