Introduction

A Common Scenario

Dr. Bud Jones sits down at the long table in the small and darkly paneled conference room. The practice administrator who is seated and looking grim-faced gets up and closes the door before clearing his throat and carefully choosing his words. "Bud, this isn't going to be easy to hear, but the report I've got here says that the productivity of the group has slipped far behind where we should be. I thought you, as managing partner, should know this before tonight's meeting." He pushes a stack of papers across the table.

"That certainly isn't what I expected to hear from you, Jon. What do you mean by 'way behind,' and what report is this? Where did you get these data? I feel that I'm as busy as I've ever been. There's been no slacking off in this group as far as I can tell."

"I've compared our total patient visits for the past half year with some national and regional data. And, for a group our size, we should be fifteen to twenty percent more productive."

"Jon, I hate to interrupt, but that might be the problem right there. These data you're talking about probably have nothing to do with us. Our practice is different. You can't compare us to physicians in other parts of the country or even to others in town. I would have to see other figures before I conclude we've got a problem. What did our collections run this past year? Besides, none of us joined this group to run patients through like it was some sort of mill. If you're a doctor in the practice across town, you see four patients an hour. You tell me how you can give decent care when you're under the gun like that."

"Bud, you can pick this apart if you want. Overhead has gone up and reimbursement's gone down. Those are facts. I want to put this on tonight's agenda so we can begin to figure out what to do."

"Can't you take something out of overhead? I told you I thought we signed some bad contracts. When they come up again, you'll have to negotiate harder."

"I'd be happy to drive down some overhead costs. The main problem is the doctors so far haven't been willing to standardize anything—not what supplies they order, not how the front desk schedules appointments."

Bud rolls his eyes. "Jon, bring it up this evening if you want, but I would guess the doctors aren't going to be in a mood to have the conversation until they see you take a bite out of overhead."

On his way to his office, Bud asks a receptionist to look up the booking schedules for the four physicians who practice on his unit. All four are booked four or five weeks out for routine care. She reports that this is the way it's always been as far as she could recall. When he walks past an office, Bud sees Ann, one of his partners, eating lunch at her desk and asks for a few minutes of her time.

"Ann, I need your help. Any difference in the past few months in the number of patients you see? Jon and I were talking, and he says we're not being as productive as we should be, given the decline in reimbursements that we've seen."

"Management. It's always the same story. 'You're not good enough. Other doctors in town are going to eat your lunch.' When hasn't he been concerned? About my patients, it feels to me as if I'm working as hard as ever. I'm seeing more seniors maybe, and they take more of my time. But I can't say there's been any appreciable difference in my practice. There's a board meeting tonight, right? I suggest you ask Jon what administration is doing to cut costs. If we're seeing all the patients we can, and there's still a revenue problem, tell him to do his job—get us good contracts and figure out how to make the practice work with less overhead."

That night's board meeting lasts until nearly midnight. Despite Jon's detailed report regarding revenue and expenses, the physicians have difficulty agreeing that they need to change. Jon acknowledges some administrative costs could be trimmed, but he insists that is not where the leverage lies. Without agreement to uniform processes and some standardization, the reductions he can make will have a minor impact on the bottom line. The conversation goes in circles. At one point, the internist on the board becomes exasperated. "I will not go back to my colleagues and tell them they need to work harder. Agreeing to do that would be a betrayal of the trust they've put in me." Jon reminds the group they sat together over a year ago to draft a document of purpose and values to guide the group's future. That triggers a conversation about who did and did not vote in favor of that document and questions about whether all the physicians, in the end, agreed to what was in it. The meeting breaks up without consensus about whether a problem exists and, if it does, what should be done about it. They agree to meet again the following week.

Unfortunately, this frustration-filled scenario is not uncommon. Like most physicians we know, these doctors work hard and pride themselves on giving patients good care. They are committed to what they are doing and do not intend to be obstructionists. When they resist hearing that they need to change, they are acting like normal human beings. Of course they do not want the distraction change involves; they want to focus on what they know best—practicing medicine.

But this group's prognosis may well depend on how quickly it can implement change and turn around performance. Although the administrator is convinced that change is needed, the physicians do not see the situation in the same way. There is not a deep commitment to a shared vision for the practice. Physician leaders are concerned about the backlash from their decisions, are skeptical of data, and believe that it is management's job to identify and fix problems.

Although this scenario might not capture the dynamics around change you experience in physician organizations, we have seen elements of this scenario in most of the physician organizations with which we have worked. Some of what impedes change responsiveness and success appears to occur regardless of organizational size, structure, ownership, or governance. To be effective, any management approach must take into account these dynamics when they are present. The framework presented in this book is based on the commonly occurring determinants of success or failure.

The Amicus change management framework shown in figure I-1, page xvii, consists of:

- Three issues (referred to as the change foundation) that build the capacity for implementation of all organizational changes.
- Five levers that leaders can apply to enhance implementation of any specific change.

What follows is a high-level orientation to the components of the framework. Each foundational issue and lever is explored in subsequent chapters.

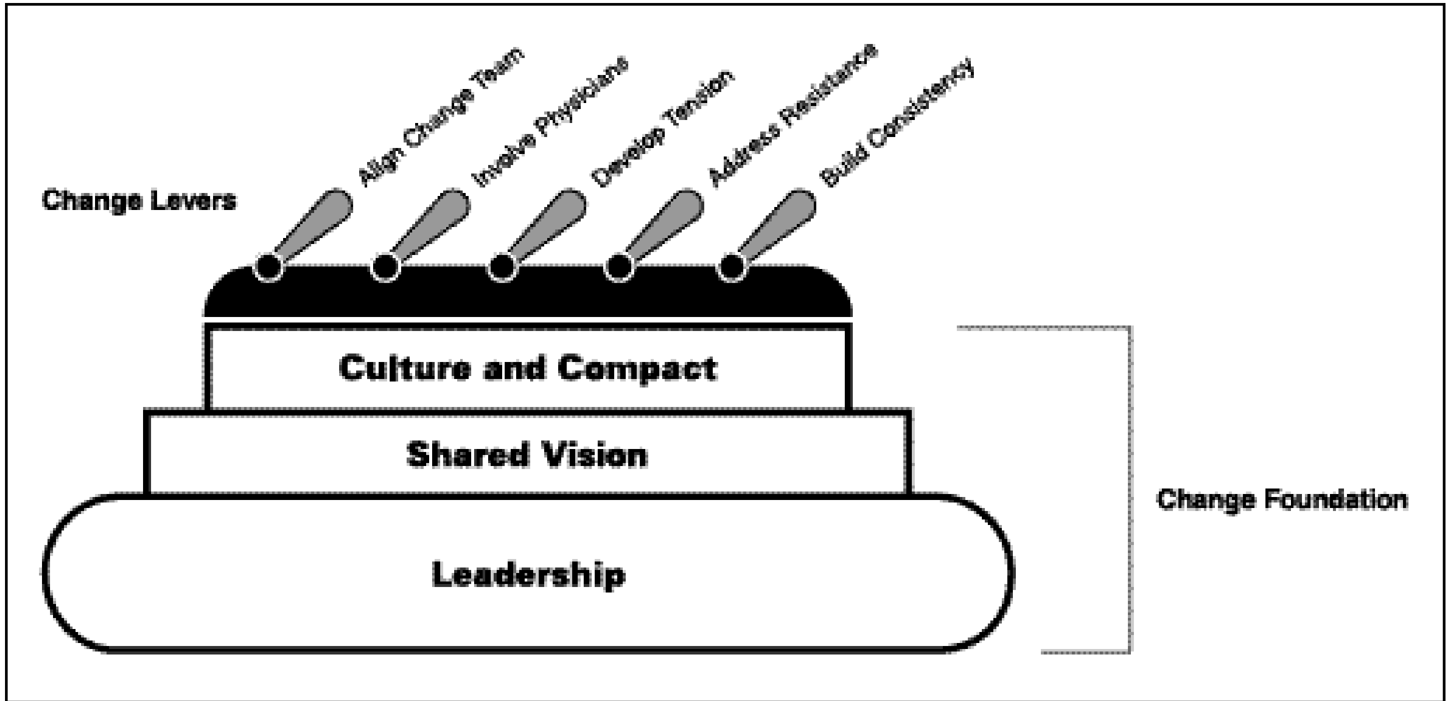
Foundational Issues

Leadership, shared vision, and culture and compact are the foundation of the framework. In our experience, these foundational elements represent the most common reasons large- and small-scale changes are not successfully implemented in a timely way in physician organizations. Leadership is ineffective, doctors are not in agreement around a vision for the organization, and physicians' expectations of their practice life are incompatible with what change requires of them. When a physician organization invests in building a foundation for change by addressing these issues, it benefits enormously. There are many ways that leadership, shared vision, and a realistic compact strengthen an organization; the chief benefit is increased ability to move quickly to implement change as market forces shift.

Leadership

Given the traditions in medicine and the history of most physician organizations, leadership is often weak. Physicians do not typically see themselves as followers; therefore, they do not readily acknowledge leaders to have any more authority than that required to call meetings or to represent physicians' interests. Effective leadership among physicians calls for more than a skill

FIGURE I-1. Amicus Change Management Framework



set; it takes a mindset on leaders' part that they are responsible for the whole enterprise, and it takes recognition on physicians' part of leaders' authority. Effective leadership almost always calls for a new dynamic between leaders and others in the organization.

Shared Vision

Consultants and academics have used the term vision to mean different things; in our change management framework, vision describes where the organization is headed. A useful vision paints a clear picture of where the organization will be at a future point and speaks to those elements that distinguish it from competitors. To serve as a foundation for successful change, a vision has to be inspirational yet reality-based.

The power of vision to support organizational change is ultimately not a function of the particular words chosen to describe it. Its potency depends on the extent to which it is meaningful to and widely shared by all members of the organization. It is useful as the context for implementing change only if there is shared agreement that it represents a future state that is desirable for both individuals and the enterprise.

Culture and Compact

The other foundational issue that significantly affects a physician organization's ability to implement change is its culture. The culture defines normative behavior and typically is a barrier to physicians' embracing changes that call for new behaviors. Physician organizations tend not to consciously create their culture so that it can support their vision and business plan. Instead it is allowed to evolve from the compact that exists between the organization and its physicians.

The physician compact is the *quid pro quo* or "deal" between the physicians and their medical group, IPA, hospital, or strategic partner. It defines what physicians expect to give and what they expect to get in the relationship. Typically these expectations are not written down and formalized, but they do shape physician behavior and in turn the organization's culture.

Culture and compact potentially affect the implementation of every change involving physicians. Many of the demands for new physician behaviors—for example, to add hours to their schedules, share staff, or follow practice guidelines—are not consistent with the practice life they believe they were promised. This makes changes that require different expectations on physicians' part particularly challenging to implement.

The Five Change Levers

Once leaders have established the change foundation, those responsible for supporting and implementing change can most effectively employ the change levers

The Framework Applied to a Change

BY PAUL HACKMEYER, MD

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As Vice Chief of Staff, I was in charge of Cedars-Sinai's Quality Improvement Committee (QIC).The monthly reports to the QIC from 14 subcommittees varied widely in their quality focus and format. The reports were supposed to summarize ongoing quality improvement activities.However, the quality of the reports was an impediment to QIC's fulfilling its mission and being able to monitor improvement within the institution. I undertook an effort to get all subcommittees to establish indicators that could be tracked, recorded,and presented in dashboard format. I had learned the Amicus change model in a workshop, and I used it to guide my efforts at changing the reporting process.The project was to change the reporting structure in the QIC first and then export the model if successful. By the end of one year, we achieved almost 100 percent compliance, with 12 out of the 14 committees presenting in the desired format.

One benefit of the model was being able to understand what the change process would require of me even before I began. If I had gone about this change as I had others, I would have tried to effect change on my own and not figure out who I needed to involve up front in the process.I would not have anticipated resistance and adequately prepared for it. Last, I would not have kept the goal for the project in front of everyone, constantly and consistently.

I began by getting clear on what I wanted the reports to accomplish and by sharing this goal with others. Making the picture of what would be different after the change a shared goal was an important step.

Identifying key players in the change process is critical. I knew I couldn't do this alone, so I identified key support people from quality improvement and key physician leaders to share what the change would look like and what it would accomplish. I wanted these people to all communicate about the change in the same way. Many projects fail because those trying to promote it are inconsistent and send mixed messages to the physicians.

to move any specific change forward. Each addresses a vital aspect of the change management process. Even though change is impeded when foundation issues are not addressed, the levers can still help in the design and execution of a change process that gets results.

Align a Change Team

This lever addresses the kind of leadership any specific change requires and describes three distinct change roles that need to be played: sponsor, agent, and champion. It focuses not just on development of a leadership team but also on the process that leads to alignment among team members. Alignment is a key issue, because it results in consistency that minimizes back-door politicking and mixed messages.

Involve Physicians to Enhance Change Design and Implementation

In the experience of many physician leaders, involving physicians does not always produce better results. Ineffective involvement does not just complicate change efforts; it also frustrates those who were asked to offer input as well as those who say they want it. Yet, the participation of those who will ultimately have to change is essential. This lever uses physician participation to design and implement change. When used properly, this lever enhances physician commitment to a proposed change and makes it more workable, without bogging down the overall change process.

Develop Tension for Change

To leave the comfort of the status quo, most individuals need to believe that change is truly imperative and that there is a more attractive alternative. This is the lever leaders use to energize change. It involves addressing complacency, where it exists, and communicating urgency for and the benefits of change. Leaders get physicians ready to change by helping them understand the price of not changing (what we call "pain" strategies) and by creating a picture of a future state that attracts and energizes them toward it and away from the status quo ("pull" strategies).

Address Resistance

In our experience, leaders who seek to help change happen in physician organizations often give short shrift to the affective component of the process. In addressing resistance, leaders help those involved in a change let go of what is familiar and predictable,

express their concerns or ambivalence, and commit to new behaviors and perspectives. Being able to apply this lever requires leaders themselves to make an emotional transition and commit to the new way. It also means leaders have to be proficient in surfacing others' emotions and then in responding appropriately.

Build Consistency

Willingness to stick with a change fades quickly if the environment sends inconsistent messages or provides inconsistent support. This lever identifies how leaders can build a consistent context for change by providing physicians and team members with the capacity to follow through with implementation. Capacity includes resources, time, staffing, and appropriate work design. Consistency is also built through financial and nonfinancial rewards and through the way in which feedback is designed and delivered. Building the consistency to support change is often critical for success; a change effort can flounder in an inconsistent environment, even when leaders and implementers are deeply committed to its success.

In our experience, no magic bullet exists for accelerating organizational change. For example, only modifying the physician compensation formula to provide an incentive for a change rarely results in sustained change. Sharing data in the absence of perceived urgency also will not motivate anyone to adopt a change. Inviting physician participation in designing the change does not lead to sustained implementation if physicians do not have adequate resources and other supports that contribute to a consistent environment. Those who seek to influence physicians need to acknowledge the complexity and challenge involved in successfully integrating change in a physician organization. The challenge is best met by applying a system-

In this case, I wasn't looking to other physicians to come up with the new way—I had a protocol I wanted them to buy in to. However, as the project took on a life of its own, contributions from the participants emerged. I also understood that consensus might not be possible and that moving forward is the responsibility of leadership, despite lack of unanimity.

I used our upcoming JCAHO survey to create tension to get people to make the change. I also positioned as an "attractor" the ease of reporting the information required. This stage did involve a lot of hands-on communicating on a personal level with the doctors involved. Without this effort, the change would have failed.

The model reinforces that resistance is natural. Understanding that resistance will occur helped me prepare to hear it and respond. I found I was able to validate the resistance some doctors had to changing the reporting system without allowing the project to be abandoned because of some opposition.

I was pleased with how this change unfolded and the results achieved. Within a year, all but two reports were coming to QIC with exactly the information that the committee needed. It made the committee more functional, and, by using the reporting protocol, the quality of the subcommittees' work has been improved.

Any new behavior needs to be reinforced to keep it from reverting back to what it used to be. Constant feedback from the Medical Executive Committee and other committees and task forces to QIC and its subcommittees has communicated that what they do makes a difference.

I have shared the Amicus model with other physician leaders in my organization, and they have responded well. It helps identify who will be most important to the change and helps organize an approach to "get things done." Those who use it find the model makes the process of change much more manageable.

FIGURE I-2. Types of Individuals Seeking to Influence Physicians

RELATIONSHIP TO THE ORGANIZATION		PHYSICIAN: YES	PHYSICIAN: NO
	INSIDE	Medical director, department heads, site leaders	COO, administrator, department manager
	OUTSIDE	System or insurance company medical director	System CEO or CFO, insurance company executive

The Framework in Daily Life

LOIE LENARZ, MD

Loie Lenarz is Senior Medical Director for Fairview Clinics and is responsible for 22 primary care clinics in the Twin Cities of Minneapolis and St Paul. Fairview Clinics is part of Fairview Health Services, a large health care system of clinics, hospitals, pharmacies, home health,long-term care, and other related services.

With such complex changes in health care, many issues need to be addressed. By being deliberate about a change foundation, and by thinking through the levers in a systematic and thoughtful way, the change happens much more readily and effectively. If leaders say, "Such and such has to change," without detailing how to make it happen, the change is much less likely to be successful. With the time pressures we are all under, it makes more sense to take an organized and thoughtful approach to change so you can get it right the first time.

The Amicus change framework is most useful when it's in the hands of the whole team responsible for leading the change. Having it in front of you and talking through each lever leads you to a plan. It helps bring clarity about who needs to be involved and how. This conversation also starts to build the team, and helps people get clear on the work involved and how, collectively, the team is going to get it done.

When approaching change, a very important consideration is culture and compact. Change that involves a shift in culture is by far the most difficult to achieve, and when culture is the root cause of not being able to make change, it is essential to apply a remedy that addresses this issue. Superficial solutions won't suffice, although it's tempting to try this first.

I have become convinced of the need for effective individuals to fill all of the change leadership roles—sponsor, agent, and champion. One of my responsibilities is interfacing with other leaders in our large system. When progress in making a change is slow, it's often because we, as leaders,don't have clarity about who the sponsors are, who the agents are, and who the formal and informal champions are. Perhaps we haven't tapped into these potentially important catalysts,or, worse yet, we may have agents or champions who are actually preventing the change.

Another way I've used the change role descriptions is to fill open medical director positions. Ideally, the new leader would be someone who could listen to doctors,

atic and comprehensive approach to leading change. In the sidebar on pages xviii-xix, a medical center chief of staff explains how he used this model for a specific change, and in the sidebar left and on page xxi, a medical director in a physician organization shares how she draws on various parts of the model in daily life.

Physicians, Insiders, and Outsiders

The framework can be used to guide change efforts with any group of staff in health care organizations. However, the intent of the book is to apply the framework to supporting change among physicians. This is not meant to imply that physicians are the only ones who matter or that they single-handedly achieve results. In our experience, physicians have the most influence on the implementation of most operational changes that aim to improve organizational performance. Whether it is improving clinical quality, access, service, or coding and collections, physicians are critical. Physicians also have a powerful influence on staff's receptivity to change. Physician and administrative leaders deeply believe that, if they can only get the doctors "on board," everyone else will follow. When Willie Sutton, notorious for robbing banks, was asked to explain his actions, he allegedly responded, "Because that's where the money is." We believe focusing on physicians when it comes to implementing change is critical, because that is where the greatest opportunity lies.

We have found it helpful to categorize those trying to influence physicians to change from two perspectives:

- Is the individual a physician?
- What is the individual's relationship to the organization?

Figure I-2, page xix, gives examples of roles that illustrate the various possibilities. In the upper left quadrant are the leaders who themselves are physicians and members of the organization. Of all four categories, these individuals, in our experience, have the greatest leverage with physicians involved in change efforts. However, even these individuals are seen as "not-exactly-like-us" by other physicians, a label that has implications discussed in more detail in Chapter 1.

Individuals in the other three quadrants are typically seen by physicians as "not-at-all-like-us" from one or

both perspectives. Like many professions, medicine can be described as a guild or lodge. The connotation is that, beyond a specialized body of knowledge, insiders share traditions and a special degree of loyalty to one another. The profession was set up to protect the economic interests of members, and the alliance among members is typically strong. Health care administrators, managers, and executives, regardless of their skill set and the bonds they establish with the physicians with whom they work, are not treated the way fellow physicians are. Those who work for other organizations—health plans, insurance companies, PPMs—tend to be viewed by physicians as outsiders, with motives not necessarily in physicians' best interests.

We use the term "outsiders" to refer to all those who are not inside both the profession and the organization. We are not making any judgments in this terminology. In our experience, it aptly describes physicians' views. The better those outside the profession or organization understand how they are seen, the more effective they can be. Being mindful of physicians' perceptions can help them interpret behavior appropriately. It also points out that some paths are more fruitful than others.

We wrote this book for all who are responsible for supporting and leading physicians through change to improve the value of the care they provide—for physician leaders such as Bud Jones and for administrators who, like Jon, are accountable for overall organizational performance. It is our goal to provide readers, regardless of where in the matrix they fall, with information that is useful and actionable. We believe the framework and guidance we offer can help accelerate positive improvements that make care better for patients and work life better for physicians and the staff who work with and support them.

work with them so they can be professionally satisfied and productive, and get the group to function together as a team. In these situations, I evaluate each doctor who is or could be a candidate in terms of his or her ability to be a sponsor for change. The doctor needs to be able to "straddle" the worlds of clinical medicine and administrative medicine and to have a commitment to each. Using the change role descriptions also helps me sort out the doctors who function best as informal leaders or champions and those who could be effective as formal leaders.

Involving physicians in a change has so many pluses you can't skip over this step. Physicians are independent thinkers, and effective group participation can be hard to come by without facilitation. Most of what we do in clinical practice reinforces our sense that when we're with the patient, we're on our own. On our own we need to gather data, assess what's important and what's not, and make a decision. When physicians collaborate or solve problems together, an entirely different skill set is called for. When working together, physicians can bring their own agendas to the table and won't even be aware they're doing it. Our inclination toward independent thinking can pervade group work. I find there are times I need to consciously remind myself what skills I need in such situations. Having someone facilitate these groups can help physicians shift into this other skill set.

I believe that many of the operational changes that could strengthen our business or make life better are resisted because of the deep unhappiness in our profession. Most doctors I know didn't go into medicine to practice the way we do today. The biggest disappointment is the changed relationships we have with patients. We simply cannot spend the time with each patient we think would be best and still get out of the office at a reasonable hour. The insurance forms, regulations, and productivity demands all mean doctors have to be very creative about how they parse out their time. For some physicians, being asked to change is the straw that breaks the camel's back. So, as the framework points out, leaders have to be sensitive to doctors' emotions and be prepared to deal with resistance that change so often provokes.