



# IMPLEMENTING CHANGE: FROM IDEAS TO REALITY

*How do you get your group to defy the status quo and act on good ideas? It starts with vision, teamwork and some fire in the belly.*

Jack Silversin, DMD, PhD,  
and Mary Jane Kornacki, MSPH

If you've ever tried to implement a good idea in your practice only to watch it be squashed by your colleagues' resistance or the daily grind, the following scenario may sound all too familiar:

Dr. Anne Davidson is passionate about implementing changes that would make her five-doctor group more efficient in delivering patient care. She's keenly aware of the precious time wasted every day on cumbersome processes and is adamant about eliminating waste and redundancy so she can spend more time delivering direct patient care.

At a partners' meeting one evening, she makes an appeal for change and suggests several ideas the group might try. Her colleagues don't disagree that some change is needed. They're open to considering her proposals, but not at this meeting, which they feel should be devoted to sorting out some IPA issues. "After all," one partner

sighs, "each of us wants to do better, but there just aren't enough hours in the day to tackle what needs to get done."

In the following weeks, Dr. Davidson's enthusiasm wanes as she falls into familiar routines and is sapped by the crises and ongoing battles that have become a daily part of practice life.

## The 10,000-foot view

If it were possible for Dr. Davidson and her colleagues to view their practice from several thousand feet above where they live daily life, they might gain some needed perspective and understand why good ideas aren't being successfully implemented in their group – even when stakeholders have a deep commitment to change. Common barriers to change include the following:

**The vice-like grip of the status quo.** Inertia, like gravity, is a powerful force. Even when current routines are frustrating,

*Dr. Silversin and Ms. Kornacki are founders of Amicus, [www.consultamicus.com](http://www.consultamicus.com), a physician consulting firm based in Cambridge, Mass., and coauthors of *Leading Physicians Through Change: How to Achieve and Sustain Results* (American College of Physician Executives; 2000). Conflicts of interest: none reported.*



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Ideas for change are easier to implement and sustain if they further a vision the entire group shares.

annoying or time wasting, their familiarity and predictability make them difficult to put aside. Making a change – even a relatively simple one – takes time, involves a learning curve and might require new skills or alter a relationship. For doctors, change might mean letting go and delegating responsibility, or it might mean stretching yourself in an area of weakness. Change is often viewed as risky; business as usual seems the safer bet.

**No perceived need for a change.** Given the inertia associated with the status quo, a group's physicians must have conviction that the change is needed or that it offers an advantage to the status quo, or they will not bother with it. In practices that don't have an urgency to change – when the “fire in the belly” is weak or doesn't exist – change is going to be difficult.

**Lack of a shared vision.** A vision – or picture of the future – that all doctors and staff share is the cornerstone of your practice's change capability. When individuals have different visions that they don't discuss and work through, the group compromises its ability to change. A practice can accommodate a good many differences among its physicians, but at the core, individuals who work together must have a shared sense of where they're headed. Without a clear direction in mind, a suggestion for change has no context. The answer to the question, “Why should we bother with this change?” must be “Because it helps take us where we all said we want to go.” If that's not the answer, then change is likely to be a slow and difficult process.

**The corrosive effect of cynicism and pessimism.** Failed efforts at change con-

tribute to a “why bother” mind-set. Regardless of why previous change efforts were unsuccessful (e.g., bad ideas or poor planning), it is hard to overcome the skepticism and cynicism they leave in their wake. In addition, many physicians may feel cynical due to the tumultuous health care environment, in which they feel powerless to effect change. Whatever the cause of their cynicism, physicians should not allow it to derail legitimate and promising ideas for change. To do so would be obstructionistic – and to their own detriment.

## Foundation for change

Despite these common barriers, family physicians can successfully implement change in their organizations, provided they have built a strong foundation. Here's how:

**1. Find your North Star.** In other words, determine where you are headed as a group and articulate your shared vision. Vision is not ephemeral, touchy-feely or psychobabble. It is the crux of successful change implementation. The “V word,” as cynics might call it, is simply a statement that captures what the doctors and other key members of the group want for their practice and what it will take to be successful given industry trends and local conditions. A useful vision statement highlights what makes the practice unique or special and should be inspirational and compelling. For example, “Family Practice Associates provides high-quality yet cost-efficient care by balancing old-fashioned doctor-patient relationships with the latest medical evidence and technology.”

Ideas for change are easier to implement and sustain if they further a vision the entire group shares. In the case of Dr. Davidson, becoming more efficient may be her personal goal, but how does it fit with what her colleagues want? Does she even know what's most meaningful to them? Have they ever invested in conversation to clarify the goals they're all working toward?

Here's how to develop a shared vision:

- Set aside time to have quality conversation with your colleagues about the direction of your group. Don't schedule this for a time immediately after you've been seeing patients for 10 hours. Find a block of time when the daily routine, phones and beepers won't intrude.

- Come prepared. Ahead of time, physicians and other practice leaders should clari-

## KEY POINTS

- The vice-like grip of the status quo makes it difficult to change processes even when they are frustrating, annoying or time wasting.
- Ideas for change are easier to implement and sustain if they move the group closer to where the members have said they want to go.
- Without a sense of urgency, visible sponsorship from a respected leader, alignment with resources and processes, and credible feedback, change will be too difficult to sustain.

fy their own aspirations for the practice. (Putting your thoughts on paper helps the process.) Data about industry trends and local market conditions that may be relevant to your discussion should also be collected and reviewed.

- At the meeting, put all perspectives and practical realities on the table. Let each person share how he or she wants the practice to be known by patients, staff and other medical colleagues. Get beyond aspirations, and consider what will contribute to a successful business going forward, keeping in mind demographic, health care and technology trends; current strengths and weaknesses; local competition; etc.

- Listen to and respect divergent points of view, and encourage openness. If someone's picture of the future doesn't mesh with the future others want, it's better to surface and address those differences now than to allow unstated differences to block needed change in the future.

- Don't get hung up on wordsmithing. Strive to uncover a vision that captures the essence of what's most meaningful to the group and that is aligned with what it will take to compete and thrive in your market.

- Don't frame and hang your vision statement and think the job is done. You've only just started. If the vision isn't challenged, refined and put to use to guide your strategy and decisions, it will become a lifeless document.

**2. Clarify "give and get" deals.** A compact, or "give and get" deal, is the unspoken but commonly understood obligations and privileges of being part of your practice. It is the quid pro quo summed up as "what I give" and "what I am entitled to in return."

A "give and get" deal is implied in every business relationship. For example, loyalty in exchange for job security is, in some companies, part of the compact. When a company breaks that compact, its employees feel betrayed and angry.

A similar compact exists between doctors and their practices. As the number of doctors practicing together increases, the compact's significance as a support for, or barrier to, change also increases. In many group practices, physicians' traditional professional values shape the compact. What they expect

to "give" may include taking care of patients and delivering the best care possible. What they may expect to "get" includes autonomy and some protection from market forces. When the requirements of a change overstep what physicians expect to give, the change is often resisted. Physicians might respond with "I didn't sign up for this."

To ensure a compact works for, not against, change, your group must be willing to articulate current expectations and discuss how well they fit with what the practice

needs to succeed – what's required to achieve the vision.

To create a compact that supports flexibility and change, consider the following:

- Review the practice vision. What do physicians need to "give" – not at the level of specific behaviors but philosophically – in order to achieve the vision? What should every doctor in the practice be able to count on his or her colleagues for? What is the appropriate balance between individual autonomy and doing what is in the group's best interest (when it means adopting change, standardizing work, etc.)?

- Make sure your practice offers something significant to its physicians as part of the compact. What will doctors get that is meaningful to them? What level of control, influence or communication can the practice promise and sustain? What privileges can doctors count on?

**3. Don't depreciate your human capital.** The change-readiness of a practice has a good deal to do with its culture, and positive doctor-staff relationships are key. Staff play a central role in many changes. When their morale or commitment to the practice is low, their willingness to be flexible and open to new ideas suffers. The difficulties associated with a change are magnified when staff feel alienated, don't share the doctors' vision for the practice or feel unappreciated. If staff are so frustrated that they "quit but stay," change will be nearly impossible.

Doctors set the tone in a practice. By what they say and do, they either build positive esprit and teamwork or erode it. When doctors work consciously to develop trust, respect and teamwork, they help build the foundation for change. If the practice has an

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When your staff's morale or commitment to the practice is low, their willingness to be flexible and open to new ideas suffers.



To build up your team, leave pessimism and negativity at the door, and sincerely and frequently acknowledge your staff's contributions.



If pessimism or complacency outweigh the urgency to change among your colleagues, you must first build your case for change.



Facts alone are not the most effective means for engaging others in your change efforts.



The more powerful way to get busy physicians' attention is to couple information with an experience that has visceral impact – a “see, feel, change” approach.

administrator or management staff, teamwork between the doctor and these individuals is also extremely important. A gap in their communication or lack of shared vision and urgency will impede the practice's ability to incorporate new ideas.

Specific team-building actions doctors can take include the following:

- Treat all staff with courtesy and respect,
- Ensure that managers are skilled, treat all staff fairly and are responsive to concerns,
- Ensure that staff input is included when decisions affect them,
- Leave pessimism, negativity and any other morale-sapping emotions at the door,
- Set clear expectations for staff, and ensure that poor performance is dealt with directly and in a timely manner,
- Help every staff member see his or her role in achieving the practice vision,
- Sincerely and frequently acknowledge your staff's contributions to the practice's success.

**When no one in charge says, “Here's where we're going,” change agents can't develop needed momentum.**

### Change-management guidelines

Having a foundation for change is a critical first step, but it isn't enough to make change happen and endure. You also need to apply some change-management skills. While it's not rocket science, change management is a learned skill. The following four guidelines can help you implement a change and make it stick.

**1. Increase the sense of urgency.** Start planning for change implementation by assessing your group's perceived urgency to break away from the status quo. A high comfort level with current practices won't bode well for a change.

There are two components to urgency that you should consider:

1. The extent of dissatisfaction with the status quo (that is, the degree to which individuals acknowledge that current processes or behaviors cannot or should not continue),
2. The belief that something can be done to remedy the situation (that is, the degree to which hope, optimism or openness to possibility exists within your group).

Urgency is a state well beyond mere interest. Dr. Davidson's partners might be interested in her ideas for change, but unless they

share her sense of urgency, her plans aren't likely to get far. If pessimism or complacency outweigh urgency, she must first build her case for change.

“People change what they do less because they are given analysis that shifts their thinking than because they are shown a truth that influences their feelings.”<sup>1</sup> This finding from change-management experts John Kotter

and Dan Cohen suggests that a report or verbal presentation that relies purely on data isn't the most effective way to engage most people. The more powerful way to get busy physicians' attention is

to couple information with an experience that has visceral impact, what Kotter and Cohen call a “see, feel, change” approach. The purpose of any “see, feel, change” experience is to motivate action. It means finding a way to have others connect with the need to change at an emotional level.

To accomplish this, you might ask one or more patients to come in and candidly discuss their experiences with your practice. Hearing in the patient's own words what it is like to interact with the practice can do more to catalyze change than any memo. Also, learn to tell compelling stories that rally people around your idea for change. Or, follow the example of one multispecialty group that was losing money on prescribing costs (under a full-risk capitation contract). To get physicians engaged in an intervention to change the group's culture around prescription writing, the leadership circulated a memo about cost-effective prescribing along with a copy of the \$400,000 check the group had to pay the health plan to cover losses. “The big-check memo got a lot of attention, made the follow-up education much easier and had a substantial impact upon physicians.”<sup>2</sup>

**2. Ensure visible sponsorship.** All changes need a sponsor – someone with the authority to say, “This is important.” Others – managers or quality-improvement staff, for example – can help plan and execute a change, but when no one in charge says, “Here's where we're going,” change agents can't develop needed momentum. The change seems optional. Those who want to get on board do; others wait on the sidelines

to see how events unfold.

In large and complex health care organizations, a common reason for slow change adoption is lack of sponsorship. Internal consultants and human resources staff who have no authority relative to physicians are put in charge of making change happen. While they play an invaluable role in implementing change, they are generally more successful as part of a team that includes someone in the chain of command who demonstrates personal commitment to the change.

The chain-of-command concept is difficult in a physician practice where doctors view colleagues as equals, but sponsorship is still important. If Dr. Davidson, for instance, asks a medical assistant to organize a reminder system to boost preventive care in the practice and does not step into the sponsor role with her physician colleagues, change is likely to be seen as elective. The MA may not have any sway with the doctors. She can do the work to organize the project, but change involving doctors is likely to be implemented more smoothly if a doctor is the prime mover.

To sponsor new methods to improve office efficiency, Dr. Davidson would need to take responsibility for engaging her colleagues. She would be the first to adopt changes, answer questions and, when necessary, address concerns or resistance. While counting on a staff person to carry out certain tasks associated with the change, she would demonstrate, in actions and words, her personal commitment to implementing the change practice-wide.

**3. Align resources, structure and processes to support the change.** Inconsistency sabotages change efforts. To keep your change on track, you must make sure it is supported by your practice vision, policies, resources and, often, your compensation system. (While money isn't the only meaningful incentive for new behavior, no change will be long-lived if physicians suffer economically by implementing it.)

In the planning stage, identify all the current practices that run counter to the change you want to make or would make it difficult to incorporate the change into daily life. Then, decide whether the current practice

can be realigned to support your change or whether your change must be altered to accommodate current practice.

One large institution invested in a sophisticated software program that allowed its physicians to access critical information for management of their patients with diabetes from their desktop computers. The program allowed the physicians to see which of their patients did not have their diabetes under control, and they could then generate contact lists for follow-up. They could also see how their management of diabetes compared to the performance of their peers. The disease-management program had the potential to significantly impact patients' health with just a couple of mouse clicks. But because the information was accessible only when the physicians exited the electronic medical record program they used when seeing patients, the disease-management program was sub-optimized. The innovation's usefulness was compromised because its creators did not align it with the physicians' work routine.

**4. Use feedback to keep the change on track.** Reinforcement is important as doctors and others try on new behaviors. During the transition zone – when new routines are not completely established and the old way still beckons – feedback and acknowledgment can make a critical difference. When individuals stretch beyond their comfort zone, they want to know whether their actions are making a difference.

Credible information and feedback helps keep a change on track. In planning for a change, ask, "How will we know whether this change is working?" Then, identify the measures that will provide the best feedback about the effectiveness of the change. For example, if you are implementing changes to make your office more efficient,

one of the things you might measure is patients' cycle time (that is, the number of minutes from check-in to check-out). It can be helpful to solicit input about measures from those who will be receiving the feedback. Physicians are more likely to accept a plan for measurement, even if it has limitations, if they have had a chance to react and provide feedback. ►

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To keep your change on track, make sure it is supported by your practice vision, policies, resources and compensation system.



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Internal data drawn from small sample sizes can provide you with credible and timely feedback about the effectiveness of your change.



Implementing meaningful change takes more than good intentions.

When testing the effectiveness of a change in order to provide feedback, most practices will be relying on small-scale tests. While physicians generally trust the statistics used in large, well-funded clinical trials, they can be suspicious of data involving a small sample and may need to be convinced that such data are reliable. Through the last decade of the quality-improvement movement, practical methods have been developed to assess whether a change has really made a difference.<sup>3</sup> These methods include using small, local tests (or Plan-Do-Study-Act cycles) in which you learn what works by planning a change, taking action on small scale, studying the results and adapting your ideas as needed. These small tests of change are guided by simple measurements tracked regularly over time, which reveal important patterns in performance. Sharing knowledge of the power of these methods can minimize doctors' tendency to dismiss internal feedback as not rigorous enough to be credible.

### Beyond resolutions

New Year's resolutions are the oft-cited example of good intentions falling short of



meaningful change. Change does take more than a wish, hope or prayer. In a medical practice, shared vision, dialogue about individuals' expectations and teamwork lay the groundwork for successful change. When there is urgency for change, a respected leader sponsoring the effort, a consistent environment to reinforce the new way and credible feedback about progress, good ideas can be transformed into results. **FPM**

Send comments to [fpmedit@aafp.org](mailto:fpmedit@aafp.org).

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