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Facilitating Change in Health Organizations

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Abstract

Purpose:

Significant time and effort are needed to facilitate organizational change; thus a well-constructed conceptual model may help health professionals identify and overcome the barriers impeding this process.

Design / methodology / approach:

Currently, there is no single framework for organizational change that has gained widespread acceptance. However, two well-validated organizational models are the Prochaska and DiClemente transtheoretical model and Green et al. al.'s health promotion model. In this paper we synthesize these models in the context of organizational change for a physician audience.

Findings:

We created a new model of organizational change that keeps the best elements of both the Prochaska and DiClemente transtheoretical model and Green et al. al.'s health promotion model. Furthermore, an example is illustrated using this approach.

Originality / value:

Most health organizations lack a consistent approach to managing change. As a result they have not been as effective in this area as they could be. Most previous organization change theorists have attempted to solve this dilemma by constructing new models of organizational change, which they hope will eventually become the dominant model. Our approach is original in that we have incorporated the best features of two pre-existing models. The value of this approach is that improving these existing models has a much greater potential for widespread acceptance than developing yet another new model.

Key words: Leadership; Models; Organizational innovation; Organizational objectives; Personnel management

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INTRODUCTION

Since the 1990's evidence-based institutional medicine has, in theory, become central to Canadian health care system (Sackett, Rosenberg, *et al*, 2007); however, in practice this has proven to be a challenge. Although evidence-based methods do exist to ensure patient safety and effective treatments for Canadians, there are often significant barriers that prevent medical institutions and organizations from implementing and practicing these effective, evidence-based methods (Cabana et al., 1999). In general, most physicians are aware that evidence-based improvements often require considerable effort. Furthermore, those championing change within their organization will likely be disappointed when searching for guidance on 'best-practices' in terms facilitating organizational change. In comparison with the robust data on behavior change at an individual level, the data in the field of organizational change is just beginning to surface (Castaneda et al., 2012; Helfrich et al., 2011; Prochaska, Prochaska, & Levesque, 2001; Weiner, Amick, & Lee, 2008). Castaneda et al., Weiner et al., and Helfrich et al., have recently reviewed the literature on models in organizational change and concluded that there are no consistently used models to date but instead many different models being used. We argue that the underdeveloped state of organizational change theory is in large measure a result of the fact that the field lacks a

single widely accepted model (Prochaska et al., 2001). While a wide variety of models have been developed to help facilitate innovation and change within health organizations (HOs), none has achieved wide acceptance (Castaneda et al., 2012; Helfrich et al., 2011; Prochaska et al., 2001; Weiner et al., 2008). Herein, we explore pre-existing models as potential practical and user-friendly approaches to facilitate organizational change.

1. THEORY/CONCEPTUAL FRAMEWORK

The Transtheoretical Model (TTM) of Prochaska and DiClemente, a model developed to facilitate lifestyle change in individual patients, is one model that has potential to gain wide acceptance in the field of HO change (Prochaska et al., 2001). Indeed there are striking similarities between the TTM, and many of those trialed in HOs.

Health Care Workers (HCWs) who are called upon to make changes within an HO will likely find these similarities reassuring. Many HCWs, particularly those with a professional background in mental health, are already quite familiar with using the TTM for lifestyle change. Therefore, HCWs need not learn an entirely new model when faced with HO change; they can simply apply a model they already comfortable with in a new context. HCWs may also find it comforting to know that their expertise in encouraging behavioral change in patients will also help them when they are called upon to implement improvements in health care provision. By basing planning and implementation of HO change on a model that is generally known and accepted by HCWs, HO administrators may find this model most useful.

The TTM model was developed in the early 1980s in an effort to create more effective methods of identifying and motivating individuals to adopt healthier lifestyles. The model has undergone several minor modifications since that time. The 6 stages of change generally identified in this model are: 1) Pre-contemplation; 2) Contemplation; 3) Preparation; 4) Action, 5) Maintenance; 6) Relapse. This model has also been evaluated in a wide variety of behavioral settings including smoking (Andersen, Keller, & McGowan, 1999), substance use disorders (DiClemente & Hughes, 1990; Rabkin, 1998), domestic violence (Scott & Wolfe, 2003), unhealthy eating (Kasila, Poskiparta, Karhila, & Kettunen, 2003), lack of exercise (Dannecker, Hausenblas, Connaughton, & Lovins, 2003), and STD protection (McGrath et al., 2002).

Over much the same period (1980-1990), the field of academic medicine was developing remarkably similar tools to help identify the stages of change within HOs such as medical practices and health-care institutions (Kaluzny AD, 1988). In their 1988 review of organizational change models, Kaluzny and Hernandez note that these models generally identify four primary stages in the organizational change process (Kaluzny AD, 1988). The four stages in this model are: 1) Recognition that providing a change in practice behavior is required, 2) Identification of the practice policies and systematic approaches necessary to make this change, 3) Implementation of these practice policies and systematic approaches and 4) Institutionalization of this new system.

In other words, the 1980's saw the development of two strikingly similar change models: the Prochaska/DiClemente model for individual change and the Kaluzny/Hernandez model for organizational change. Interestingly, the review by Kaluzny and Hernandez (Kaluzny AD, 1988) makes no reference to the individual change work of Prochaska and Diclemente. Similarly a recent article by Prochaska (Prochaska et al., 2001) on the use of the TTM model for organizational change makes no reference to the work of Kaluzny on this subject. There is one striking difference between these models: while the TTM model for individual change has gained wide acceptance, little has been done to analyze or validate a stage of change model for HOs as a whole (Prochaska et al., 2001).

The Prochaska and DiClemente's and Kaluzny's models use similar terminology and were designed for a similar purpose. They both identify readiness to change, not how to create change. Through another point-of-view, these models focus on the individual or organization being targeted for change. A complementary model is needed that focuses on the effector arm (i.e. the individual or organization who is trying to motivate their target audience to change).

One of the earliest and most well validated models looking at how to motivate HOs to change is the health promotion model by Green et al. (Green LW, Kreuter M, Deeds S, Partridge K, 1980). In this model, motivational interventions are categorized into four basic types: 1) Predisposing Strategies- The basic act of supplying knowledge (i.e. passive information-lectures, journals, newsletters, media campaigns etc.); 2) Enabling Strategies- Providing the skills, approaches and strategies necessary to successfully implement the change (i.e. some level of interactivity- academic detail visits, workshops, seminars, problem based learning sessions, clinical flowcharts etc.); 3) Reinforcing Strategies- Refers to the factors necessary to maintain a change in behavior (i.e. includes elements such as feedback, audits, reminder systems etc.); 4) Mixed Strategies- This approach incorporates the strategies of 1, 2 and 3.

The work of Davis et al. has served to further clarify and validate Green's original model (Davis D, 2001; Davis et al., 2003). Davis et al. has reviewed 50 studies looking at 74 types of interventions designed to change physician behavior and health outcomes. In this review of the literature, Davis notes that the Mixed Strategy approach showed the best improvement in both physician performance and patient health care (Davis D, 2001). This is not surprising. TTM research has consistently demonstrated that stage matched interventions generally have a much greater impact than "action-oriented, one-size fits-all programs" (Prochaska et al., 2001).

2. METHODS

Combining the ideas and concepts presented in these various models gives us a framework within which organizational change can be better understood and more easily facilitated. For easy reference, this framework is presented in figure 1. In designing this framework, the terminology used by the TTM model was chosen over that of the Kaluzny and Hernandez model out of recognition of the TTM model's familiarity and influence (Pendlebury DA).

3. FINDINGS

Application of the Organizational Change Model through an Example:

We highlight through example the application of our presented framework to the implementation of TB screening in a HO. TB screening methods are well-evidenced (Canadian tuberculosis standards.2007). The advantages of early detection TB (screening) as opposed to TB detection in patients with late disease manifestations are two fold: 1) the patient has safer and more effective options for treatment and, 2) the public is exposed to far less active TB. Unfortunately, the implementation of a TB screening program into a HO still proves to be difficult and thus is used as an example for readers.

Case- Part 1: You are trying to implement a TB screening protocol for inpatients at your institution. The staff you work with question the benefit of this intervention, and are expressing reluctance to move forward with screening. They are concerned that TB screening will increase their workload and they point out that there has never been a significant TB outbreak at this institution.

Commentary (Case- Part 1): This institution is pre-contemplative in terms of its readiness to change its current TB screening practice. Therefore, predisposing strategies would be the most appropriate choice of intervention. An important first step in facilitating change is creating an organizational environment that is more willing (or predisposed) to change. One could consider various predisposing strategies designed to assist with disseminating information and knowledge about the pros and cons of TB screening (lectures, handouts, etc.).

Case- Part 2: You begin by initiating several predisposing strategies. You arrange to present a literature review of the benefits of TB screening at the next staff meeting and also provide staff with several original articles on this subject. At this point, many of the staff agree that this is worthwhile, but still question the feasibility of implementing this change within the organization.

Commentary (Case- Part 2): This is an institution that is contemplative in terms of its readiness to change its current TB screening practice. Further predisposing strategies (discussed above) and or enabling strategies would be appropriate at this phase. Enabling strategies that might be helpful include workshops, seminars, or a pilot/ feasibility study on the issue.

Case- Part 3: You consider a variety of enabling strategies and decide that at your next staff meeting, you will arrange to have a guest speaker from an institution that already does routine TB screening. The guest speaker helps reassure staff at your institution that this change is feasible, and overall the staff is in agreement with the guest speaker's assessment. Staff remains concerned about how to implement screening in the most effective and least disruptive way.

Commentary (Case- Part 3): This organization is now in preparation phase. More advanced enabling strategies are likely to be effective at this stage.

Case- Part 4: You decide the best enabling strategy at this point is to propose that the institution try assessing the feasibility of TB screening by piloting the screening with elective admissions only, and phasing in full screening if this seems realistic. The staff agree to this plan. After several months, routine TB screening becomes the norm at this institution.

Commentary (Case- Part 4): This organization is now in maintenance phase regarding TB screening, and may require a variety of reinforcing strategies to maintain this change.

Case- Part 5: As a reinforcing strategy you implement an audit system to randomly check charts to see if TB screening is being done. A year later, after a period of large staff turnover, you discover TB screening is often not being done.

Commentary (Case- Part 5): This represents a relapse to a previous pattern of behavior. At this stage, the organization's readiness to reinstitute a change in practice must be reassessed. Once again, the strategies chosen will be determined by the organization's readiness to change.

Final Commentary: As this case has hopefully demonstrated, when faced the need for organizational change, a variety of interventions may appropriate. Of course, the choice of interventions depend not only the readiness of the institution to change, but also on variety of other factors (such as what the proposed change is and who the audience will be that is making the change).

4. PRACTICE IMPLICATIONS

Significant amounts of time, effort and funds are involved in attempts at organizational change. Despite these efforts, attempts at organizational change all too often end in failure. Because of this, a simplified, user-friendly framework to help identify and overcome barriers to organizational change is presented (figure 1) as well as a summary of key lessons for practice:

Lessons for Practice:

• There are numerous competing conceptual models of organizational change

• A single, well-validated conceptual model of organizational change would allow a focused approach towards the research, development and practice of knowledge transfer strategies.
• To be effective, such a model must do two things:
• Identify barriers to change
• Provide strategies to help overcome these barriers

Establishing a conceptual framework for organizational change is merely an essential first step in a longer process that includes rigorous assessment and evaluation of the model's validity

However, establishing a conceptual framework for organizational change is merely an essential first step in a longer process, as has already been highlighted by the aforementioned publications (Castaneda et al., 2012; Helfrich et al., 2011; Prochaska et al., 2001; Weiner et al., 2008). Rigorous assessment and evaluation of the model's validity is the next step to practical implementation into organizational change.

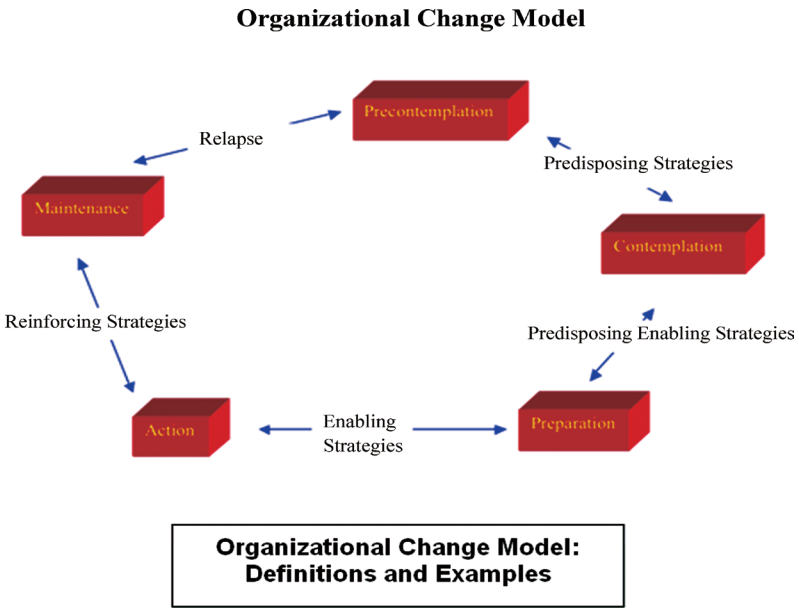

Figure 1
Organizational Change Model

Health Organization (HO): For the purposes of this article, an HO is any group of health professionals that are being targeted to change the way they practice. The target audience may be small and local (i.e. working with office, lab and pharmacy staff to set up a methadone program in your clinic) to large and international (i.e. targeting health care workers world-wide to deliver more effective HIV prevention counseling).

Precontemplation: The targeted individuals within the health organization (HO) are not yet contemplating change. For example, they may not yet be aware of the need to change, they may feel change is unnecessary, they may feel threatened by change, etc.

Predisposing Strategies: Refers to the basic act of supplying knowledge. These strategies are best used when individuals within the HO are not yet fully ready to change. Generally, predisposing strategies rely on supplying passive information to recipients. Interaction between those providing the information and those receiving it are usually minimal. Examples include lectures, newsletters, websites, etc.

Contemplation: The individuals within the HO are considering the proposed change, but are not yet ready to initiate it. HOs at this stage are characterized by ambivalence. For example, individuals may be only partially aware of the need to change, they may feel change is unfeasible, they may continue to feel threatened by change, etc.

Enabling Strategies: Refers to the provision of skills, approaches and strategies that are necessary to successfully implement the change. Enabling strategies generally require some level of interactivity between those providing the information and those receiving it. Examples include academic detail visits, workshops, seminars, problem-based learning sessions, etc.

Preparation: The individuals within the HO are convinced of the need to make the proposed change, but may be uncertain how to make this change most effectively. At this stage, there is much less conflict about the need to change, and much more about how to change. Typical concerns would be around disruption of services, economic impact, feasibility, etc.

Action: The individuals within the HO are convinced of the need to make the proposed change, they have planned how to implement that change and are prepared to act on that plan.

Reinforcing Strategies: Refers to the factors necessary to maintain a change in behavior. Examples include constructive feedback, audits, reminder systems, incentives, etc.

Maintenance: The individuals within the HO remain convinced of the need to continue with the change they have made.

Relapse: The individuals within the HO revert to their previous pattern of behavior.

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