CHANGE MANAGEMENT IN HEALTH CARE – OVERCOMING MENTAL AND ORGANISATIONAL BARRIERS

ZARZĄDZANIE ZMIANĄ W PLACÓWKACH MEDYCZNYCH – POKONYWANIE BARIER MENTALNYCH I ORGANIZACYJNYCH

Eliza Dąbrowska, Jolanta Sielska, Joanna Zdanowska

Department of Organization and Management in Health Care
Poznan University of Medical Sciences

ABSTRACT

The need for drawing up a change management model which takes into account the specificity of medical facilities and makes it possible to overcome mental and organizational barriers is beyond doubt. The legislative dynamics, multiplicity, diversity and sometimes contradictory requirements imposed on medical institutions (on the part of: patients, competitors, suppliers, the government, the payer, insurers, etc.) constitute a vital incentive to standardise the change management process. A lack of well-thought-out mechanisms of implementing changes results in the creation of bogus solutions damming bureaucratic absurdities. Maintaining elementary rules of change management logic, a sequence of actions supported by the right motivation as well as communicating benefits significantly increase the likelihood of a successful implementation, thereby building an atmosphere of openness and communication.
The change management model proposed to medical facilities is universal. However, in the case of medical facilities, due to their specificity, the mentality of the personnel, repeated organizational failures, specific steps as part of the process are of fundamental importance. They determine the success of the implementation of changes. In order not to commit elementary errors while creating the model, it is necessary to obtain the answer to the question what the basic mental and organizational barriers accompanying the change management process are. The knowledge ought to be transformed into systemic solutions, which should then be skillfully weaved in the model and applied with unrelenting consistency.

KEYWORDS: change management, mental barriers, organizational barriers.

STRESZCZENIE

Potrzeba opracowania modelu zarządzania zmianą, uwzględniającego specyfikę placówek medycznych, pozwalającego pokonywać bariery mentalne i organizacyjne jest niekwestionowana. Dynamika legislacyjna, wielość, różnorodność, a czasem i sprzeczność wymagań nakładanych na placówki medyczne (ze strony: pacjentów, konkurencji, dostawców, rządu, płatnika, ubezpieczycieli etc.) stanowi istotny bodziec do standaryzacji procesu zarządzania zmianą. Brak przemyślanych mechanizmów wdrażania zmian skutkuje tworzeniem fikcyjnych rozwiązań piętrzących biurokratyczne absurdy. Zachowanie elementarnych zasad logiki zarzadzania zmianą, sekwencja działań wspartych odpowiednim umotywowaniem, zakomunikowanie korzyści, istotnie zwiększają prawdopodobieństwo sukcesu wdrożenia, budując tym samym atmosferę otwartości i komunikacji.
Proponowany placówkom medycznym model zarządzania zmianą ma charakter uniwersalny. Jednakże w przypadku podmiotów leczniczych, ze względu na ich specyfikę, mentalność personelu, powielane błędy organizacyjne, określone działania w ramach procesu, mają znaczenie zasadnicze. Decydują o powodzeniu implementacji zmian. Aby uchronić się przed popełnieniem elementarnych błędów przy tworzeniu modelu, niezbędne jest uzyskanie odpowiedzi na pytanie, jakie są podstawowe bariery mentalne i organizacyjne towarzyszące procesowi zarządzania zmianą? Wiedza winna przekształcić się w systemowe rozwiązania, które następnie należy umiejętnie wpleść w model i stosować z żelazną konsekwencją.

SŁOWA KLUCZOWE: zarządzanie zmianą, bariery mentalne, bariery organizacyjne.

What is held responsible for creating ossified structures, building an organizational fiction supported by ungrounded bureaucratization of actions is in a substantial majority the ill-considered, improperly planned change implementation system. Omitting elementary rules in the process of change management almost always ends in an organizational paralysis. Disorganization and chaos translate into a lack of cohesion of action and an inability to perform tasks in an organized and predictable way. It results in an increase of the level of frustration among the employees and a decrease of the level of the employees' trust in the organization. Although the decision-makers know the rules and perceive their sense, it happens that in practice there is no common-sense approach. The problem of difficulty in implementing changes concerns especially large or-

ganizations with a high degree of complication of actions. An example of such organizations are hospitals, especially clinical hospitals which accomplish medical and didactic aims, not infrequently aims that remain in strongly antagonistic relationships with one another. The hospitals which have been subsidized by the State for years, have not managed to develop effective organizational-managing mechanisms. And probably the organizational powerlessness would still remain an immanent trait of medical facilities if it were not for the changes which have taken place in the recent years as well as the announcement of changes which in the following years are to be introduced. Those changes and restrictions will force medical institutions to take radical actions in the reengineering dimension. The institutions which will find determination and strength in themselves as well as draw up a proper key to implementing systemic changes and maintaining a new status quo will succeed in this process.

The process of transforming hospitals in subjects acting according to the market rights began on April 15th 2011 when the new act of medical activity was implemented (Journal of Laws from June 1st 2011). The regulations significantly limit the State's interventionism in maintaining hospitals in good financial condition at all costs. The institutions were coerced into financial balancing under penalty of the necessity of transformations into corporations (art. 6 sec. 1) in a situation in which the founding body (for clinical hospitals these are medical universities) will not demonstrate willingness or will not have a possibility to cover the hospital's financial losses [1]*.

The National Health Service is announcing further changes, for example implementing new legal solutions which concern contracting the services. For the first time points for treatment quality will be granted. The hospitals which possess the Accreditation of the Quality Monitoring Centre will be appreciated. The value of the Accreditation Certificate will be priced at a few per cent of the value of the contract (3–5%).

Moreover, the facilities which will decide to implement systems in conformity with the following norms: ISO 9001, 14001, PN-N 18001 and ISO 27001 will obtain additional sums to their contracts. What is important, the institutions possessing the above-mentioned systems already at the stage of competition will be assessed more favourably. The financial incentive will most certainly motivate medical facilities to implement the systems and apply for appropriate certificates. However, maintaining and implementing the systems entails a skillfully applied systemic approach inseparably connected with change management. This is the basis for creating a comprehensive and complementary management system which takes into account the requirements of the aforementioned accreditation standards and norms. A lack of a well thought-out plan of change implementation will result in creating autonomous systemic entities functioning in isolation from the organizational prevalence. This will lead to introducing irrational solutions which will not be able to defend themselves for a long time.

The purpose of a change is to order and/or improve. It is definitely easier to implement improving changes in an ordered system than changes the aim of which is to impose a new order. Thinking about complex change management one should first of all undertake these actions which aim at regulating the system. Otherwise there is a substantial likelihood that we will encounter organizational mines which, unless they are effectively annihilated, will constitute a persistent obstacle for all the systemic movements. Moving on the paved paths will definitely facilitate the implementation of further changes.

While making an attempt at building an effective change management model, one should search for the hints in the literature on the subject.

What is of key importance in the process of change management is to determine subsequent, logical, consecutive stages; in other words – setting the methodology of proceedings. The literature on the subject shows that a correct approach to change management occurs when the change is preceded by the following actions [2]:

- defining the aims of the organization, both the main ones and the secondary ones;
- analyzing the network of the interaction of mutual influence in the present situation of the organization;
- making an analysis of the strong and weak points of the organization;
- analyzing the possible scenarios of changes;
- drawing up the strategy of action;
- implementing the solution chosen.

Complying with the above-mentioned hints constitutes an expression of a holistic approach to change management, thanks to which the organization significantly increases its chances of succeeding in obtaining desirable results of the changes implemented.

While reviewing the knowledge connected with the subject matter presented, one may not forget to mention the most popular model of planning and implementing changes, perceived as a flagship model. The model in question was designed by K. Lewin and it consists of three stages of a crucial importance to the success of the undertaking planned [3]:

* The act of medical activity (Journal of Laws, June 1st 2011).

- 1st stage defrosting – leading to a situation in which the need for a change becomes obvious for the organization, and first of all for their members. It is based on creating a need for changes in people. It may be achieved either as a result of increasing the driving force or by reducing the hindering force as well as by applying a combination of the aforementioned ways;
- 2nd stage change (transformation) – it means a transition from the present state to the new, desirable one. This stage encompasses the following actions: communicating the vision, obtaining the support for the changes, planning the changes, implementing specific projects, eliminating opposition towards the changes;
- 3rd stage re-defrosting – it encompasses stabilization and integration of the transformations as well as institutionalization of these changes and their assessment. The organization must develop new action practices, a policy of proceedings and new attitudes among its members.

The effectiveness of implementing the change depends largely on the unity of vision, aims and synchronization of actions as well as a division of roles. The importance of the above-mentioned elements was perceived by J. Kotter who presented the rules of change management in the following points [4]:

- developing a sense of the necessity for a change;
- creating a coalition directing the change process;
- drawing up the vision and strategy;
- informing the members of the organization about the new vision;
- entitling the members of the organization to take actions in a wide scope of the ability to make decisions;
- developing short-term benefits;
- consolidating the initial benefits with a simultaneous encouragement for further changes;
- reinforcing the new changes in the organizational culture.

The concepts presented have a lot of elements in common; however, each one brings an original look. The decision of applying a particular concept depends on the character of the change implemented and the degree of readiness as well as the level of acceptance in the organization. The model presented at the end of the literature review is the Clark model. What is interesting, an unconventional approach to change management is included in the methodology of seven stages of the change process. Clark puts strong emphasis on the problem of the resistance which occurs with reference to the changes; therefore, the model presented finds application in change management in medical facilities where overcoming barriers constitutes a significant challenge for the managers. The model encompasses the following stages [5]:

- anticipating and overcoming resistance with reference to the changes;
- accomplishing visionary leadership;
- status quo destabilization;
- an intensive and wide process of communication;
- the choice of the right moment and expectation of introducing the change;
- implementation of the change;
- reinforcing the changes implemented.

Thus, in order to use the literature data to create a change management model which becomes part of the specificity and problems of medical facilities, one should begin with the analysis of their problems and then skillfully weave the solution in the model designed. The barriers, which frequently thwart the plans intended, may have both a mental and organizational basis. Most frequently, however, they constitute a compilation of the first and the second one.

Among the barriers of a mental basis the following ones should be indicated:

- **Resistance to ordering.** Standardization of actions gives rise to pejorative associations. Employees equate order with implementing rigorous procedures which do not give them a free hand to decisions, interpretation. Therefore, it is so important to leave a margin of flexibility in the diagnostic interpretation and therapeutic actions. It guarantees a progress in the development of this very important discipline. Order is, nevertheless, an essential condition of treatment security, action schedule, predictability of the results of the actions undertaken. While introducing changes, one should strongly emphasize the fact of constant improvement. Each change, each new / changed standard is subject to assessment and further improvement. Yet exceptions to the rules established cannot be accompanied by chaos or incertitude of results. The fear of ordering may also have a different, less ethical nature. A transparent system generates a risk of a quick and relatively easy identification of errors which surely occur in health care. The reason for the errors is negligence, actions supporting particular interests. All this becomes more visible when an organisational order is imposed.
- **Equating change with a deepening bureaucratization.** Indeed all the steps of the medical

personnel are strongly formalized. Each action needs to be taken note of, each activity must be supported by a standard. The border between logic and absurdity is thin in this case. Such disgraceful bureaucracy is, on the one hand, substantiated in the form of: a concern for security of the patient, employee, hospital, the need for settlements with the payer, judicature which does not leave any doubt that the lack of a regulation is tantamount to the lack of action. Yet on the other hand, this border is often shifted by the employees themselves. Unwilling to obey common-sense rules, they force creating more and more restrictive monitoring mechanisms according to the rule: the less willingness to the proper execution of tasks, the more prescriptive and monitoring mechanisms.

- **Unwillingness to learn and the necessity of adjusting to the changing rules.** In an intelligent organization employees are required to be fully involved in the development of the company as well as their own by participating in trainings, courses and cooperating with others. It means a necessity for a continual improvement of one's own qualifications, which is putting a substantial educational effort on the part of the employees. It happens that the employees, convinced of their own infallibility and omniscience, are not willing to learn, take part in trainings or change their approach. This attitude constitutes a significant barrier in the improvement of the organization.
- **The atmosphere of supervision, fear, tension instead of support and cooperation**. The atmosphere in the institution depends on the people. One wonderful boss will not guarantee a good atmosphere of work in the whole unit. In a situation when plenipotentiaries, directors at different levels will arouse negative emotions, any organizational movements will give rise to anxiety on the part of the employees and provoke sabotage actions. Solely cooperation of the whole managing team, their attitude, creation of an appropriate atmosphere as well as clear formulation of the values of the organization guarantee the achievement of success in implementing changes [6].

Among the barriers of an organizational basis the following ones should be indicated:

- **Failure to impart extensive knowledge of the changes introduced and their functionality by the managers.** Fragmentary knowledge of the actions does not allow the employee to learn the sense and essence of the changes introduced. In this situation it is impossible to expect involvement. The knowledge of the functionality of the change is the fundamental factor conditioning willingness and support on the part of the employees.
- **Introducing useless changes or an inability to show benefits**. Medical facilities are forced to frequent changes. In response to each one of them a useful solution should be drawn up. The objective of the managers is to find these benefits and skillfully weave them in the change designed. While implementing a change where the only incentive is the external pressure, any chances of maintaining it in a longer perspective are lost.
- **Discussing solutions at managerial levels**. Implementing changes pursuant to some notions and not pursuant to a real, objective assessment of the situation. If managers think that they hold a monopoly on knowledge and accuracy of decisions without the necessity of confronting their notions with the employees' opinions, the change introduced may end in a fiasco. In this case the image loss of the decision-makers in the eyes of the employees may turn out to be more acute.
- **The lack of a tested implementation model.** Each change should be introduced in accordance with a common and tested methodology which is known to everyone. When every time the implementation model is different, incomplete and does not take into consideration such important elements as: information and promotional actions, trainings, a pilot study on a small sample and implementation in accordance with the PDCA Deming cycle or the necessity of providing feedback, it is difficult to expect employees to adapt easily to the process of change as the process takes on a different form each time.

The model of a comprehensive approach to change management presented below (**Figure 1**) takes into consideration the answers to the above-mentioned problems which accompany the process of change management in medical facilities.

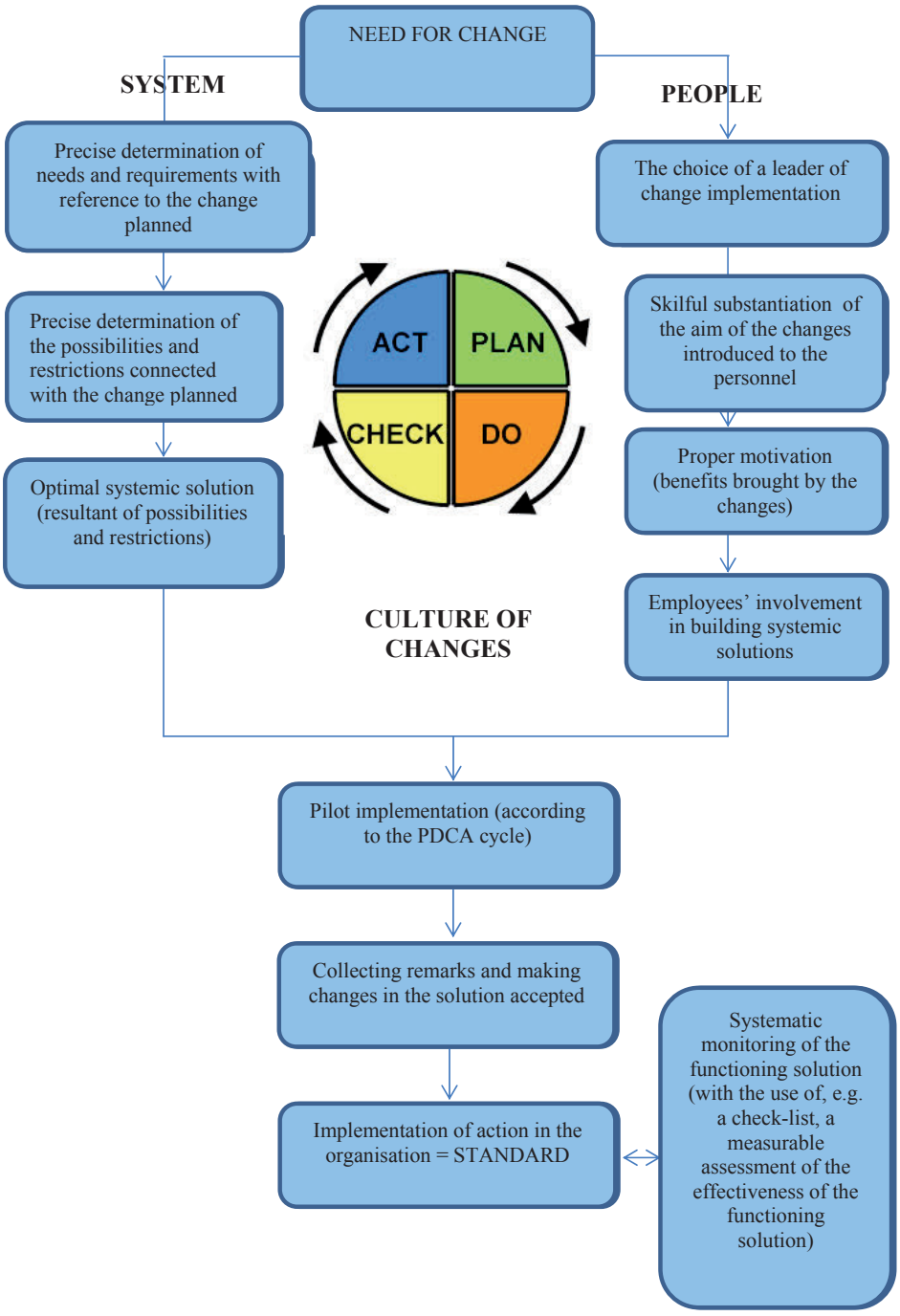

Figure 1. The model of a comprehensive approach to change management
Source: Authors' own study

The improvement of managing Polish hospitals is the condition of the success of inevitable reforms which are going to be implemented soon and the aim of which is to introduce market elements to hospital management. This improvement is possible thanks to, among others, using the knowledge of the people who are employed there: managers, doctors, nurses and midwives [7].

The application of the model presented in practice does not provide a hundred per cent success, yet it significantly increases its probability. Success depends on people. Involving employees in designing changes is characteristic of mature organisations which distinguish themselves by higher awareness culture.

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Corresponding author:
Eliza Dąbrowska
Smoluchowskiego 11
60-179 Poznań, Poland
phone: +48 61 861 22 80
e-mail: emarusz@ump.edu.pl
Department of Organization and Management
in Health Care
Poznan University of Medical Sciences