Change, Change, Change...Leadership and Management in Action

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Disclosure Statement

- No relevant financial relationship exists
Objectives

At the end of this session, you will be able to:

• Describe change management theories addressing the organization, team and individual
• Explain the difference between change management and change leadership
• Utilize readiness assessments in preparation for change
• Identify and manage resistance to change
• Utilizing the example of the relocation of a major service line at UPHS, apply these models and theories to change within your organization
“Who Moved My Cheese?”
The Writing on the Wall

Change Happens
They Keep Moving the Cheese

Anticipate Change
Get Ready for the Cheese to Move

Monitor Change
Smell the Cheese Often So You Know When It is Getting Old

Adapt To Change Quickly
The Quicker You Let Go of Old Cheese, The Sooner You Can Enjoy New Cheese
The Writing on the Wall

Change

Move With the Cheese

Enjoy Change!
Savor the Adventure And Enjoy the Taste of New Cheese!

Be Ready To Change Quickly And Enjoy It Again & Again
They Keep Moving the Cheese
The image presents a matrix with four quadrants. The x-axis represents 'Parts' and 'Faster Pace', while the y-axis represents 'Structured Approach' and 'Unstructured Approach'. The quadrants are labeled as follows:

- **Top Left Quadrant**: Slow Pace, Structured Approach, "Hem the Stabilizer"
- **Top Right Quadrant**: Faster Pace, Unstructured Approach, "Scurry the Producer"
- **Bottom Left Quadrant**: Slow Pace, Unstructured Approach, "Haw the Unifier"
- **Bottom Right Quadrant**: Faster Pace, Structured Approach, "Sniff the Innovator"

The bottom of the image emphasizes a 'Whole' perspective, linking the process-oriented view with results-oriented thinking.
Stabilizer
- Focus on How
- Allow analysis

Producer
- Focus on What
- Allow autonomy

Unifier
- Focus on Who
- Allow processing

Innovator
- Focus on Why Not?
- Allow excitement

Structured Approach
- Short View

Unstructured Approach
- Long View

Slower Pace
- Process Oriented
- Whole

Faster Pace
- Results Oriented
THE KÜBLER-ROSS CHANGE CURVE

Morale and Confidence

Shock
Surprise or shock at the event

Denial
Disbelief; looking for evidence that it isn’t true

Frustration
Recognition that things are different; sometimes angry

Depression
Low mood; lacking in energy

Decision
Learning how to work in the new situation; feeling more positive

Integration
Changes integrated; a renewed individual

Create Alignment
Maximize Communication
Spark Motivation
Develop Capability
Share Knowledge

Time
Barriers to Organizational Change?
Barriers to Organizational Change

- Inwardly focused cultures
- Paralyzing bureaucracy
- Parochial politics
- Low level of trust
- Lack of teamwork
- Arrogant attitudes
- Lack of leadership in middle management
- General human fear of the unknown
Phase I: Preparation or “Unfreeze”  

Lewin,

- **Assessment**
  Organizational Change Readiness Assessment (OCRA); Russell Consulting, 2006
  - As perceived by change leader after gathering data from others (if needed) regarding employee perceptions in 4 components:
    1) Organizational support
    2) Cultural
    3) Change Environment
    4) Employee Attitudes and Behaviors
  - Assists the leader in structuring change accordingly by identifying the red flags

- **Vision and Strategy Development**
Take 10 minutes.....

• Respond to the behavioral statements and calculate your four OCRA dimension scores and overall OCRA score
• Reflect on the results
• Discuss with your neighbor, 3 actions you can take in your role to enhance organizational change readiness
“Those who were seen dancing were thought to be insane by those who could not hear the music.

Friedrick Nietsche, German Philosopher
8 Errors Common to Organizational Change Efforts & Their Consequences, Kotter 1996

- New strategies aren’t implemented well
- Acquisitions don’t achieve expected synergies
- Reengineering takes too long and costs too much
- Downsizing fails to get costs under control
- Quality programs don’t deliver hoped-for results

Allowing too much complacency
Failing to create a sufficiently powerful guiding coalition
Underestimating the power of vision
Undercommunicating the vision by a factor of 10
Permitting obstacles to block the new vision
Failing to create short-term wins
Declaring victory too soon
Neglecting to anchor changes firmly in the organization’s culture

• Kotter, 1996
Process that creates power and motivation sufficient to overwhelm all the sources of inertia

Driven by high-quality leadership, not just excellent management

Successful Change
Management vs Leadership, Kotter 1996

Management: a set of processes that keep a complicated system of people and technology running smoothly
- Planning and budgeting
- Organizing and staffing
- Controlling and problem solving

• Produces a degree of predictability & order.
• Has the potential to consistently produce short-term results expected by stakeholders

Leadership: a set of processes that creates organizations in the first place or adapts them to significantly changing circumstances.
- Establishing direction through vision and strategy
- Aligning people with the vision through effective communication
- Motivating and inspiring to overcome barriers to change

• Produces useful change, often to a dramatic degree
“Our Iceberg Is Melting”
The Eight-Stage Process of Creating Major Change

1. Establish a sense of Urgency
   - Help others see the need for change & the importance of acting immediately
   - Identify and discuss crisis, potential crisis, or major opportunities

2. Create the Guiding Coalition
   - Put together a group with enough power to lead the change and possesses leadership skills, credibility, communications ability, authority, analytical skills and a sense of urgency
   - Get the group to work together like a team

3. Develop a Change Vision and Strategy
   - Clarify how the future will be different from the past, and how you can make that future a reality
The Eight-Stage Process of Creating Major Change

Kotter, 1996

4. Communicate for Understanding & Buy In
   - Use every vehicle possible to constantly communicate the new vision and strategies
   - Have the guiding coalition role model the behavior expected of employees

5. Empower Broad-based Action
   - Remove obstacles including systems or structures that undermine the change vision
   - Encourage risk taking and nontraditional ideas, activities, and actions

6. Generate Short-term Wins
   - Plan for and create visible improvements and successes as soon as possible
   - Visibly recognize and reward people who made the wins possible
7. Consolidate Gains and Produce More Change
- Use increased credibility to change all systems, structures, and policies that don’t fit together and/or the transformation vision
- Hire, promote and develop people who can implement the change vision
- Reinvigorate the process with new projects, themes, and change agents

8. Anchor the change in the culture
- Create better performance through customer- & productivity-oriented behavior, more and better leadership and more effective management
- Hold onto the new ways of behaving until they become strong enough to replace the old traditions
- Articulate the connections between new behaviors and organizational success
Leading the Change Process

Stage 1: UNFREEZE
1. Sense of Urgency
2. Guiding Coalition
3. Creating a Vision
4. Communicating Vision
5. Empowering Others
6. Creating Short-Term Wins
7. Consolidating Improvements
8. Institutionalizing New Approaches

Stage 2: CHANGE
Kotter’s Eight-Step Change Model

Stage 3: REFREEZE

Kübler-Ross Change Curve
Denial → Frustration → Depression → Experiment → Decision

Source: Mapping of Change Management Processes (adapted from Vahs, 2009)
Be Bad First  Andersen 2016

• The ability to learn well and quickly is the most important skill we can have
• Be willing and allow others to be a novice over and over again…. Be willing and allow others to be bad at things on the way to getting good at them
• Capitalize on human nature: We may hate to be bad at things … but we love getting good at things
The Transition of the University of Pennsylvania Level I Trauma Center
Four Domains of the Transition Plan

• Staffing
• Education and Training
• Facilities, Equipment and Supplies
• Communication
The Trauma Center at Penn

HUP (1987 – Feb 2015)  PPMC (Feb 2015 – present)

• Accredited by Pennsylvania Trauma System Foundation in 1987
The Trauma Center at Penn

• Average of 2,350 trauma contacts from 2012-2014
• Mean ISS is 7.6 2012-2014
• 26 bed trauma unit
• Penn STAR Flight Program
Mechanisms of injury

- MVC: 17%
- MCC: 3%
- Pedestrian: 5%
- GSW: 14%
- SW: 8%
- Fall: 31%
- Other: 9%
- Assault: 11%
- Bicycle: 1%
- Burn: 1%

HUP State
- GSW: 13.9% 4.0%
- SW: 8.1% 2.6%
- Penn: 22.0% 6.6%
Stage I: Preparation or Unfreezing

• Identifying the Guiding Coalition
• Education of Stakeholders on background and strategy
  - Sense of urgency
  - Creating the vision
• Readiness Assessments
  - Focus groups at both hospitals
Vision and Strategy: Detailed Planning

✓ Ensure Trauma competency transfer to meet the patient needs and ensure Trauma Foundation compliance

✓ Ensure a smooth integration of combined PPMC teams and job roles.

✓ Retain and expand PMC staff as well as increase skills and competencies as needed to support the trauma patient and new care requirements

✓ Mitigate any Human Resources differences between entities as barriers to transfer and retention. Develop an easy process for job role transfer

• Trauma Foundation Executive Committee accepted education & staffing plan 11/20/14

• 200 FTEs from HUP to transition to PPMC (72% nursing)

• PPMC actively hiring 90 FTEs to support a 24/7 operation and Trauma.

• Base pay/PTO same
• Bonus/Preceptor Pay
• Shift Differential Rate
• RN Professional/Exempt model
Therapy Staffing

- Complement for the program did not change: 1.5 PTs, 1.1 OT, .5 ST and .5 therapy aide
- Mid-year transition of the FTEs from HUP to PPMC therapy budget was incorporated into the 2014-15 budget process
- Only 1 therapist (speech) chose to relocate
- Therefore, 3 experienced staff were designated for the initial trauma team and their positions filled at time of transition
- Weekend staffing for 2015 designed to ensure at least one trauma experienced therapist scheduled
Transition of Expertise

• All departments required to collaboratively develop a Trauma Transition Education Plan and submit frequent updates to ensure compliance with Trauma Foundation

• 2 PTs and 1 OT rotated to HUP for 9 months each to gain competence with the trauma and neurosurgical population

• 8 additional PTs and OTs shadowed for half day in the HUP trauma gym with specific learning objectives
Transition of Expertise

• The lead OT trained with expert CHTs to become competent with splinting and co-splinted patients with complex traumatic injuries at HUP on an on-call basis

• Bi-monthly department inservice series 10/14 to 2/15 with presentations by HUP therapists, physicians and other providers
Facilities, Equipment and Supplies

• A year before, an acute therapy gym was created to ensure smooth operations prior to the transition

• Specialized equipment such as the Moveo was purchased and therapists received training

• Mid-year transition of supplies, including prosthetics and orthotics, was incorporated into the 2014-15 budget process
Communication

• Hospital Wide
  - UPHS Intranet
  - weekly “5 Things You Need to Know” to all PPMC employees
  - monthly PPMC Employee
  - interhospital monthly Trauma Nursing and Allied Health Council meeting
  - PPMC and HUP Department Directors meetings
  - monthly managers Work Group report and meetings

• Department Level
  - bi-monthly department staff and lead meetings
  - quarterly interdepartmental meetings regarding transition of expertise plan
Stage 2: Implementation

Move Day Feb 4, 2015

10 patients (5 ICU/ 5 floor) transitioned from HUP to PPMC in 4 hours and 6 received OT and PT that day
Month One – Trauma Center at PPMC

In the first month of operation 148 trauma contacts treated at PPMC; resulting 100 IP admissions, 24 observation, 26 OP
Stage 3: Reinforce Change or Refreeze

Collect and Analyze Data/Feedback

• PPMC Manager’s “Transition Tool Kit”
  - Managers’ mandatory daily rounding and huddles with staff
  - Weekly staff meetings with documented results submitted to interdisciplinary trauma transition team via the intranet
Just In Time Journals

- **Objectives**
  - Document emerging issues in real time.
  - Serves as a central repository for updates.

- **Benefits**
  - Able to be accessed readily by the clinical staff.
  - Assist those that are not frequently on email.

- **Expectation**
  - Review the journal daily to identify any critical issues and/or wins documented by staff.
  - Post updates in the journal.
Daily Transition Communication is Key

The Shaping the Future of PPMC (mobile friendly) intranet website hosts daily updates on critical issues, success stories, and general updates that can be accessed by all employees.

Daily Updates for 3/4/2015

Critical Issue Updates
- The trauma and ICU teams recognized some challenges with bed management while trauma was on divert status yesterday. The divert status was triggered because of the volume of patients in the trauma bay, not the challenges in bed management. The teams are working to identify efficiencies and improvements to the process to ensure patient transitions are smooth in the future.

Recent Wins
- Security, Registration and Respiratory teams did a great job Monday night when we had 7 admissions come in, and at one point all 5 trauma bays were full. The new process for belongings worked well and Respiratory team was on top of the patients needs. Thanks to those team members.
- John Gallagher’s exceptional leadership throughout this transition is being recognized by the Penn Medicine Nursing Clinical Excellence Award committee. We are proud to announce that he is the recipient of the 2015 Victoria L. Rich Award for Transformational Leadership.

Fixes and General Updates
- All PPMC faculty and staff are invited to join us for fun, food and festivity at the “Salute to Our Superstar Staff” celebration from 2:00 to 5:00 p.m. in the Cafeteria (dayshift) or 7:00 to 9:00 p.m. in the PCC’s office (nightshift).
Stage 3: Reinforce Change or Refreeze

Diagnose Gaps and Manage Resistance

• Trauma patients on observation on trauma floor not observation unit
• Daily interdisciplinary communication
• Neurosurgery patients now placed on primarily orthopedic floor
• Orientation/competency to trauma and neurosurgery to cover time off and weekends
Stage 3: Reinforce Change or Refreeze
Consolidate Gains and Produce More Change

- Trauma Unit Based Clinical Leadership (UBCL) formed and meets bimonthly
- Formal and informal education by PTs and OTs
- PT and OT trauma and neurosurgery resources and orientation/competency tools adapted/created
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<th>Transition Strengths</th>
<th>Details</th>
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| Very Smooth Transition               | • Move was a great success - exceptionally smooth  
                                      • Clinical expertise came with the transition                                  |
| Positive for PPMC                    | • Great positive experience for the campus  
                                      • Receptive and responsive teams to the feedback  
                                      • Enthusiasm and commitment to success of the Trauma program and new services   |
| Beautiful New Facility               | • Facility is beautiful and creates a wonderful work environment  
                                      • Well laid out, great facilities – A positive for everyone                       |
| Strong Support & Communication System| • PPMC administration is accessible and helpful. - fully invested in and committed to ensuring that this endeavor succeeds.  
                                      • Collaborative spirit throughout PPMC – great relationships forming, good buy-in |
| Fully Invested Clinicians            | • Long-standing Neurosurgery and Orthopaedic Surgery excellence and commitment  
                                      • Trauma Program – doing whatever it takes                                         |
Transition Weaknesses

**Census Staffing Variability**
- RN Float pull needs to increase in size, on-call nursing model needs to be formalized
- Historic staffing based on unit census with limited ability to flex up 24/7 or quickly

**Limited “Bench” Depth**
- Very limited in-house surgical MD resources (in-house non-trauma surgery residents or fellows).
- Limited depth of ED tech resources, SICU APP resources
- Residents coming from HUP for a number of services, or moonlighter coverage

**24/7 Stress on Clinical Resources**
- New patient populations has uncovered (not unexpectedly) gaps in knowledge and expertise
- Resources have been scaled up but not commensurately with the demand that has resulted from duplication of services
- Some of the final pieces will not be in place until July necessitating implementation of stop-gap measures in the interim.

**Transportation Between Campuses**
- Traveling between hospitals is time-consuming
- Alternative parking provisions & LUCY are sub-optimal
- Expanding faculty and residents impacted
### Transition Opportunities

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| **Cultural Settling**  | • Identifying the differences in organizational operations, workflows, patient flow, and role responsibilities – with new staff  
• Some cultural push back |
| **New Care Models**    | • Staffing and detailed function of the ICU, ED, and OR has changed a great deal – requiring adjustment – across all levels of the organization |
| **High Census**        | • Trauma Bay on Divert 3 times in first month  
• New patient throughput strategy required  
• Surprises have been the volume in the new TSICU, especially the daily rollover (amounts of admissions and discharges per day is higher than at HUP). |
| **New Possibilities**  | • Collaborative research (e.g. PARC)  
• Closer clinical collaboration between services – eg. (the Trauma and Neurocritical Care Services have a closer collaboration & fellows cross-cover)  
• Improved coordination of complex care, both inpatient and outpatient  
• Increased visibility and referral activity via EMS and Hospital Outreach |
Stage 3: Reinforce Change
Recognition: Celebrate Successes

Salute to the Stars

Friday, March 6, 2015 Pavilion for Advanced Care
First Floor Concourse
Stage 3: Reinforce Change

Recognition: Celebrate Successes

• “Share a Success Story” on the PPMC Intranet
• One of the PT trauma superusers was named May 2015 GSPP Employee of the Month
• Insomnia Cookies!

• Successful Pennsylvania Trauma Systems Foundation survey site visit in September 2015
More Changes...

• Moved to newly designed and constructed acute therapy gym on 10/26/15
• 10 bed Neuro ICU opened Fall 2015 with 2.5 additional therapy FTEs and increased to 20 beds Spring 2016
• Census of entire hospital significantly increased immediately and has continued
Everything will be okay at the end. If it’s not okay, you are not at the end.

Anonymous
References

• Andersen, E. Be Bad First. Brookline, MA: Bibliomotion, Inc; 2016.
References


References