Managing to Change: A Model of Cultural Transformation for the Accountable Care Organization

By James M. Levett, M.D., FACS, Jeff Hannah, ABD, M.A., and Peter W. Roberts, M.H.A., M.H.E.

As pressure on the healthcare industry to maximize quality outcomes and reduce costs continues to mount, the Accountable Care System or Accountable Care Organization (ACO) has emerged as a promising model combining both delivery system reform and payment reform. Regardless of their form, ACOs ultimately provide the healthcare industry with the means to simultaneously improve quality, control costs, and assume accountability for outcomes.[1] Establishing an ACO is not a simple task, however. The transition from the fee-for-service model to a population-based approach to healthcare financing and delivery—placing clinical outcomes and value ahead of transactions and episodic care—will require healthcare stakeholders in a local community (healthcare providers, health insurers, employers and consumers) to make significant changes to their business models, processes and behaviors.

With this in mind, it is useful to evaluate the formation of ACOs from an organizational development perspective, particularly with regard to change management processes. Bringing multiple entities together – e.g., individual and group physician practices, physician-hospital organizations, hospital medical staff, public health agencies, and social service organizations – requires a strong legal and business framework, clear definition and assumption of risk, and solid infrastructure. Equally important to this transformation is the ability to effectively introduce substantive cultural change by integrating multiple clinical and nonclinical environments, each with its own staff and work culture. Cultural transformation can be successful only to the extent that a planned, intentional effort is made to deploy change management behaviors and communication strategies to complete critical process milestones.

The approach to creating an ACO that is advocated here entails a significant cultural change guided by a clear vision, reinforced with consistent communication, and facilitated with effective stakeholder behaviors. This approach proposes a framework comprised of several phases, each with its own requirements for appropriate actions and organizational communication.

Theoretical Foundation

Although change management is often acknowledged to be more art than science, and theory has not consistently informed practice,[2,3] there are predictable phases and important roles that when executed effectively and in a timely manner, increase the likelihood of successful transition and transformation. Seminal work in organizational change management was conducted by Kurt Lewin after the Second World War; Lewin's stages of change—unfreeze, change, refreeze—have been the foundation for research and practice over the last six

Reprinted by permission. From *Group Practice Journal*, Vol. 59(6): June 2010.

group practice journal
PUBLICATION OF THE AMERICAN MEDICAL GROUP ASSOCIATION

decades.[4] Each stage features distinct goals, activities and responsibilities:

- **Unfreeze**. Relating the anticipated change to the organization's mission and values and describing it in terms of new attitudes and desired behaviors aligns the change with familiar values. Unfreezing also emphasizes that the "old" attitudes and behaviors will not allow us to achieve the necessary changes—and may even prevent effective change.
- **Change**. This phase introduces and integrates new attitudes and behaviors through training and development, including management development. Training must provide answers to the following questions: "What new knowledge does management and staff need? What do the desired behaviors look like?"
- **Refreeze**. Implementing systems and tools to support and sustain the change, or "hardwiring," may include adjusting personnel policies and processes, installing new or enhanced IT systems for accessing and exchanging information, and updating orientation so that new employees are assimilated into the "New World."

Lewin's model was enhanced with Weick's and Quinn's analysis of organizational predisposition to change.[3] In this construct, *episodic change* that is discontinuous and intermittent is distinguished from *continuous change* that is evolving and incremental. Weick and Quinn note that Lewin's unfreeze-change-refreeze model supports episodic change, but propose a freeze-rebalance-unfreeze approach to continuous change.

More recently, Harvard Business School Professor of Leadership John Kotter identified eight steps to successful organizational change:[4]

- Create a sense of urgency
- Pull together the guiding team
- Develop the change vision and strategy
- Communicate for understanding and buy-in
- Empower others to act
- Produce short-term wins
- Don't let up
- Create a new culture

Widely regarded as the preeminent authority on organizational change, Kotter suggests that the most important—but commonly underemphasized—step is creating a sense of urgency.[5]

Also fundamental to this discussion is the concept of critical roles and behaviors in organizational change. Several analyses have identified the roles of Sponsor, Agent and Target.[6,7] The Advocate, a fourth role, serves a unique function: while neither in a position to initiate the change nor a target of the change, the Advocate provides support, reinforcement, and perspective to Sponsors, Agents and Targets.[7] Not merely a cheerleader, however, the Advocate is an objective, unbiased consultant regarding the change.

To be most effective, each role contemplates specific accountabilities, responsibilities, and

needs as illustrated in Table 1.

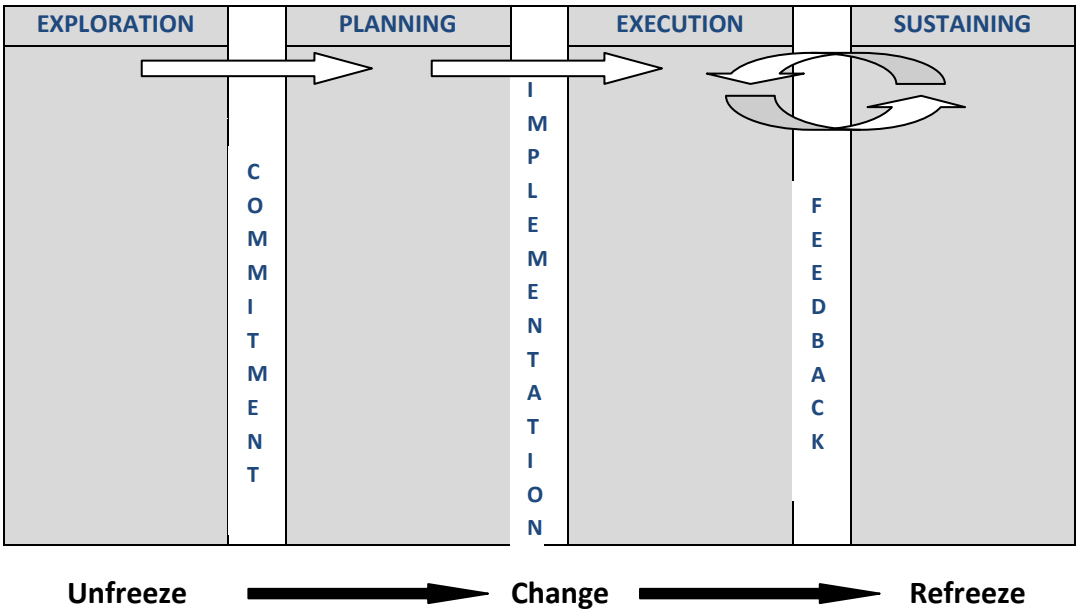
Table 1. Change Management Roles and Key Accountabilities.

SPONSOR	*Role*: Initiate and endorse change efforts, clarify priorities, set time/budget parameters *To be effective* Articulate vision for change; reinforce underlying values Take strong role in initiation and follow-through Create a sense of urgency for the change
AGENT	*Role*: Implement the change; ensure goals are met within time/budget parameters *To be effective* Anticipate and plan to minimize resistance and obstacles Communicate urgency for the change Ensure small, quick successes
TARGETS	*Role*: Utilize new processes, practices, and systems *To be engaged* Understand goals and expectations for the change Become appropriately involved in planning and implementation Monitor the impact of their own behavior on their teams
ADVOCATE	*Role*: Promote and reinforce effective change activities and behaviors *To be effective* Encourage strong sponsorship and change agency Clarify and reinforce roles and specific functions Provide perspective and support

An Approach to Cultural Transformation

Numerous viable ACO models and structures have been identified.[1, 8] Following four distinct phases—Exploration, Planning, Execution, and Sustaining, with an intermediate step between each—is key to cultural transformation in an ACO. Ultimately, as the ACO evolves, the Execution and Sustaining phases become an ongoing loop (Figure 1). It should be noted that transitions between phases and steps are not discrete -- when transitions occur, it may be difficult to discern when one phase has evolved into the next intermediate step, and into the subsequent phase. Similarly, within and between each phase, specific roles and responsibilities evolve, shift, and overlap.

Figure 1. Cultural Transformation Phases and Steps



In the Exploration phase, one or more champions -- innovators from the delivery systems or health plan or an employer -- initiate discussions with stakeholders to "test the waters" and assess interest levels. The authors contend that the success of the ACO transformation process relies on collaboration among local stakeholders, which may include physician practices and groups, hospital medical staff, physician-hospital organizations (PHOs), and employers. In this phase, it is critical to bring together the stakeholders to identify:

- the "burning platform" for change
- mutual interests and aligned visions for improved clinical outcomes and cost containment
- the ability, desire, and willingness to make ACO formation a strategic priority
- the willingness and capacity to assume financial risk for population-based outcomes
- anticipated/potential challenges and roadblocks
- additional groups and individuals to be consulted during the Exploration phase.

It is important to establish a level of trust early in this phase to ensure discussions are open, balanced, and conducted in good faith. There typically is no formal sponsor in the Exploration phase; instead, the champions function as agents of change, while executive leadership from each stakeholder entity assumes the target role.

The intermediate step between the Exploratory and Planning phases is Commitment. This step features an articulated commitment to the vision, shared assumption of risks, and creation of

the ACO, solidified through legal and financial structures. It is during this intermediate step that roles begin to shift and evolve.

Timelines and budget guidelines should also emerge in the Commitment step – these parameters should be clarified and communicated at the outset and rigorously monitored and adjusted throughout.

In the Planning phase, the vision begins to take tangible form, by (1) pinpointing the critical interfaces between the involved practices, groups, and agencies, and (2) formalizing shared processes/practices, systems, and tools. During the Planning phase, an executive steering committee is formed. Under the aegis of the steering committee, cross-functional task forces are commissioned to evaluate and finalize processes and systems. Comprised of practitioners, clinical/agency management, and selected staff, the task forces focus on:

- work flows among practices and agencies
- support systems
- technology tools
- affected clinical processes

It is also useful to designate a team responsible for change communications, which reports directly to the steering committee.

In the Planning phase, the sponsor role is assumed by the executive steering committee, which may include the champion(s). The steering committee simultaneously serves in the agent capacity, providing information, vision, and support to the task forces. The members of the task forces similarly wear two hats: while being directed by the steering committee to alter processes and systems, they are targets of change; as they prepare clinical/stakeholder staff for the changes, they are agents of change.

The intermediate step between Planning and Execution is Implementation. Here, new and enhanced workflows, technologies, support systems, and clinical processes are put in place, and staff members receive appropriate training on the new processes and tools. Beginning in the Implementation step and continuing into the Execution phase, clinical/agency executive leadership serves in the sponsor role, with clinical/agency managers as agents. The targets are clinical/agency staff, who are directed and empowered to utilize the processes, systems, and tools.

The Execution phase is characterized by throughput of patients, clients, and customers utilizing newly implemented processes and systems. Interfaces among practices and agencies and customer service processes are tested. A key component of successful Execution is rigorous collection of feedback from external and internal customers (staff and practitioners). Feedback must be collected and disseminated in a timely manner to enable early course adjustments. Gathering and responding appropriately to feedback comprise the intermediate step—and unifying element—between the Execution and Sustaining phases.

The Sustaining phase is actually a continuous cycle of Execution and Sustaining, motivated and

directed by external and internal customer feedback. Roles similarly evolve and overlap:

- Clinical/agency executive leaders function as sponsors
- Practitioners and clinical/agency management serve as both sponsors and agents, depending upon the type and level of change
- Staff will similarly assume dual roles: incumbent staff act as agents when orienting new staff; as processes are enhanced, incumbent and new staff function as targets.

Notably, as the four phases evolve, the nature and disposition of change will similarly evolve. In the Exploration, Planning, and Execution phases, change is episodic (intentional, discontinuous, and intermittent); in the Sustaining phase, change is continuous, evolving, and incremental. Weick and Quinn note that Lewin's stages of change model supports episodic change, but continuous change requires a freeze-rebalance-unfreeze approach to change.[4]

The Advocate Role in Cultural Transformation

The advocate role is paramount to effective change implementation and can increase the likelihood of successful ACO formation. In the Exploratory phase, the advocate will help to plan meeting agendas, reinforce effective meeting management skills, ensure open and balanced interaction among participants, and foster an environment of trust. Additionally, the advocate will facilitate articulation of a shared vision and overt commitment from interested entities. Although the advocate should care deeply about the success of the initiative and the individuals involved in that success, by definition, he/she is not considered a stakeholder in the change.

In the Planning, Execution, and Sustaining phases, the advocate will encourage sponsor visibility, continually clarify roles and responsibilities, and provide perspective for the individuals and teams impacted. The advocate will work with task force leadership to plan meeting agendas and ensure effective meeting management. This role may also include consultation on updating personnel policies and processes.

The advocate will ultimately work him/herself out of the role -- the goal is to create a self-sustaining culture that is resilient, flexible, and responsive to feedback. It is not inappropriate, however, to re-engage the advocate on a regular basis for feedback.

The ACO continues to draw attention as a model for concurrently improving healthcare outcomes and controlling costs. Solid legal and financial arrangements are critical to the stability and growth of an ACO, but of no less importance is the need to integrate the stakeholders into a culture that is committed to a common vision and goals and bound by a sense of interdependence. To ignore this aspect is to invite dissonance among stakeholders, discontinuity of service, and uneven quality of care. Yet to induce cultural transformation of this scale -- integrating multiple work environments, each with its own leadership, staff and culture – necessitates a conscious, coordinated deployment of change management strategies and tactics. Applying a structured organizational development approach can produce a unified culture that serves as both foundation and framework for the successful ACO.

References

1. Shortell, S.M., Casalino, L.P. 2008. Health Care Reform Requires Accountable Care Systems. *JAMA*, 300(1): 95-97.

2. Poole, M.S., Van de Ven, A.H., eds. 2004. *Handbook of Organizational Change and Innovation*. New York (NY): Oxford University Press.

3. Weick, K. E., Quinn, R.E. 1999. Organizational Change and Development. *Annual Review of Psychology*. 1999(1): 361-386.

4. Kotter, J.P. 1995. Leading Change: Why Transformation Efforts Fail. *Harvard Business Review*. 73(2): 59-67.

5. Kotter, J. P. 2008. *A Sense of Urgency*. Boston (MA): Harvard Business School Publishing.

6. Fossum, L.B. 1989. *Understanding Organizational Change: Converting Theory into Practice*. Menlo Park (CA): Crisp Publications.

7. Conner, D.R. 1993. *Managing at the Speed of Change*. New York (NY): Villard Books.

8. Miller, H.D. 2009. How to Create Accountable Care Organizations. Pittsburgh (PA): Center for Healthcare Quality and Payment Reform.