To: **Community Hospital**

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Subject: Report Based on the initial administration of the Change Diagnostic Index at Community Hospital.

This is a report of the Change Diagnostic Index© data collection at COMMUNITY HOSPITAL from November 10, 2013 until December 20, 2013. It is a composite of the data collected from eleven physician offices and four hospital departments.

Executive Summary:

This Phase 1 report of Change Diagnostic Index© results for Community Hospital is the composite of responses from the participants representing four hospital departments and eleven physicians' offices.

The survey analyzed the collected demographic data by certain groupings:

1. COMMUNITY HOSPITAL organization as a whole,
2. Separation of the hospital employees by position (managers, clinical, etc.),
3. Separation of employees into groups based on their years of service,
4. Separation of the organization into various component parts (hospital departments and physicians' offices).

In the case of COMMUNITY HOSPITAL, the most useful of these grouping proved to be item number 4 above.

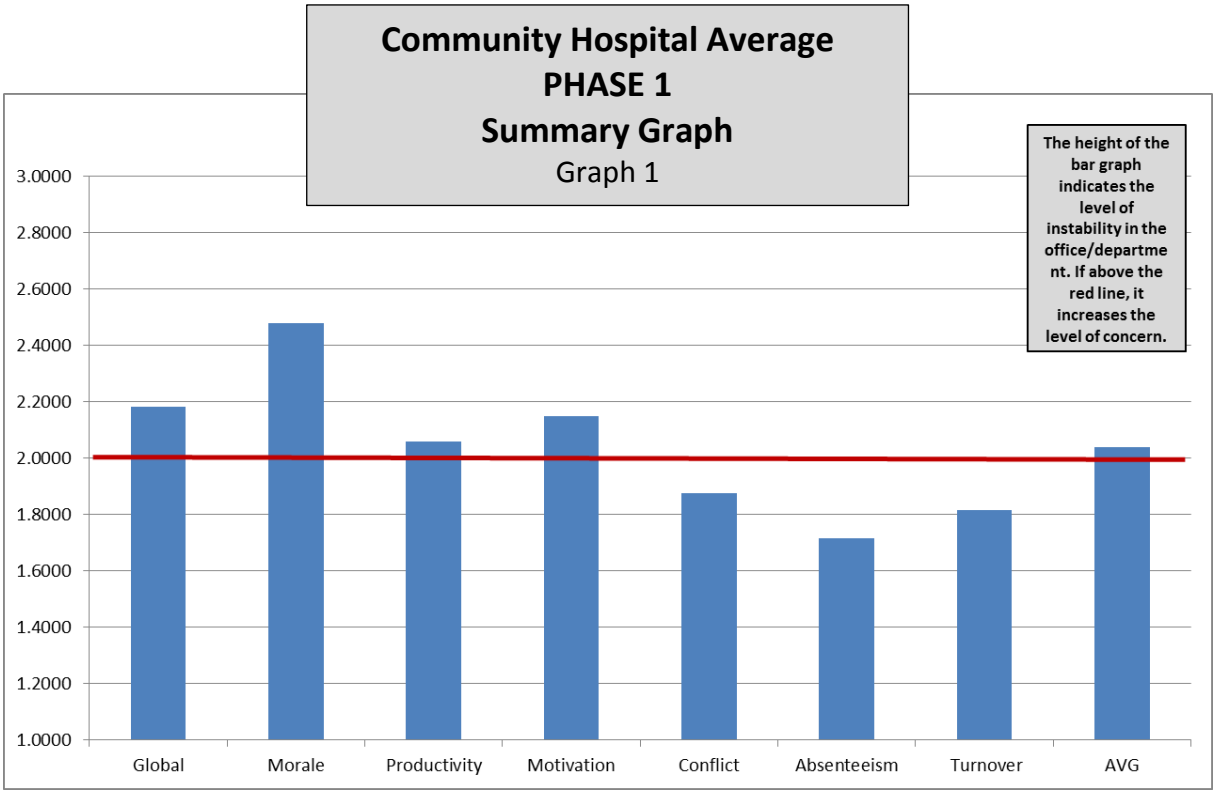
The results of the survey suggest a tendency toward instability for the organization as a whole, and spotlights some departments and offices that are already experiencing symptoms at a higher than preferred level. This was not altogether unexpected due to heighten level of media coverage within the health care industry.

There were 7 offices and 2 hospital departments that exhibited levels of instability that could be interpreted as more potentially troublesome. Within this group, one hospital and 3 offices exhibited elevated signs of conflict and potential turnover which may become disruptive if not quickly curbed. Selective qualitative interviews are often the best method of determining the source of these problems; however during the interviews the other elevated symptoms should also be considered in all the offices or departments.

Based on the trends shown in this report, the Change Diagnostic Index© will provide one aspect of the necessary data on which the consultant can base their change implementation strategy. With this data as a basis for understanding the human nature behind the behaviors, the consultant can better position itself to suppress and proactively eliminate the potential for the disruptive influence of the change.

The graphs that follow present the data collected by the Change Diagnostic Index©:

Graph 1 COMMUNITY HOSPITAL First Phase—Summary Graph
Graph 2 Phase 1 Results—By Position of Responsibility
Graph 3 Phase 1 Results—By Years of Service
Graph 4 Phase 1 Results—Summary Hospital Employee Averages
Graph 5 Phase 1 Results—By Hospital Department
Graph 6 Phase 1 Results—Summary Physician's Office Employee Averages
Graph 7 Phase 1 Results—by more Unstable Physician's Offices
Graph 8 Phase 1 Results—by more Stable Physician's Offices



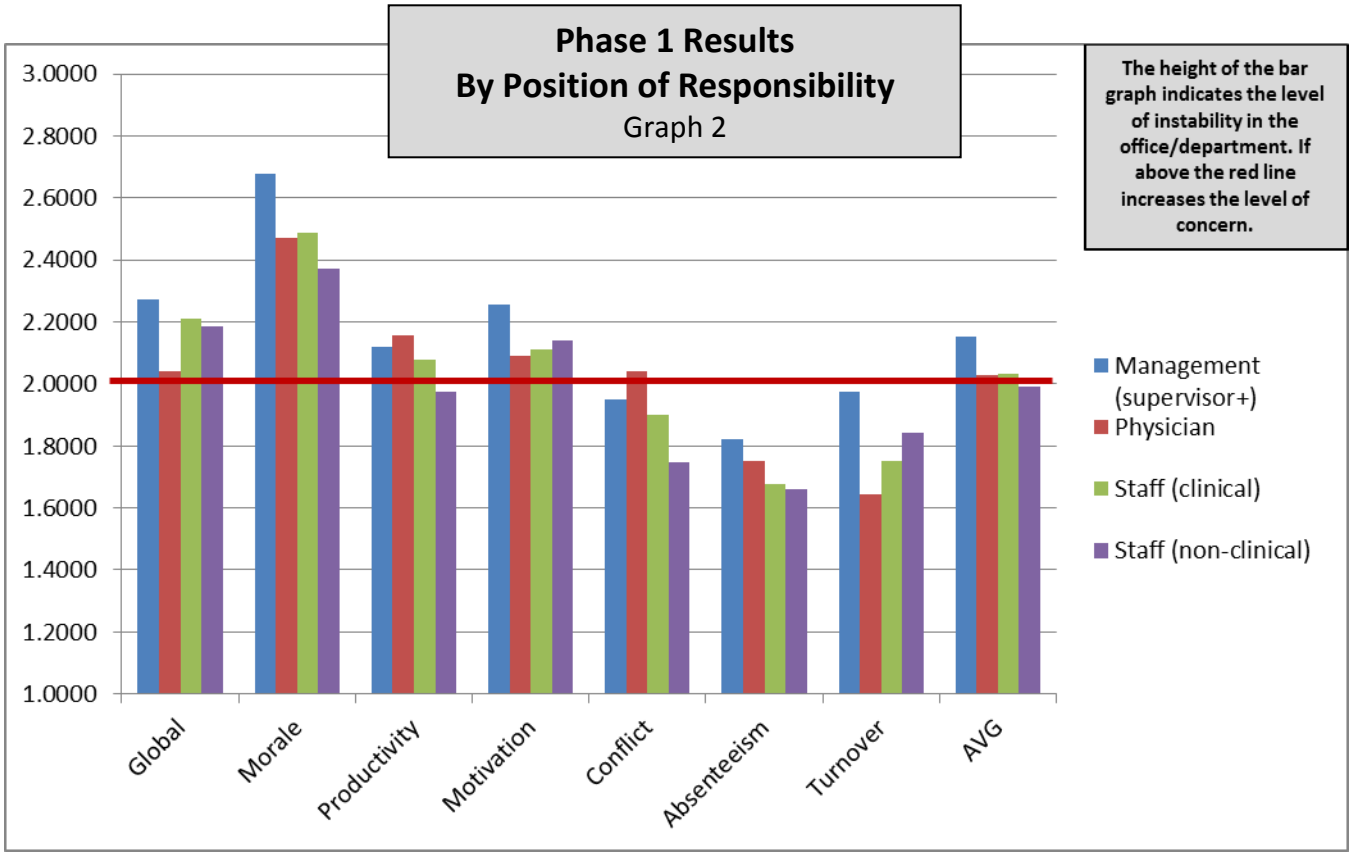
In summary the Change Diagnostic Index© results reveal some persistent elevation of the symptoms of Morale, Productivity, Motivation and overall Average. Elevation of the Global indicator indicates that influences outside COMMUNITY HOSPITAL may also be a factor. The other institutional averages are in the non-critical range. These trends are reflected in the Change Diagnostic Index© results in the demographic breakdowns listed below.

ANALYSIS BY DEMOGRAPHIC DATA

SECTION 1

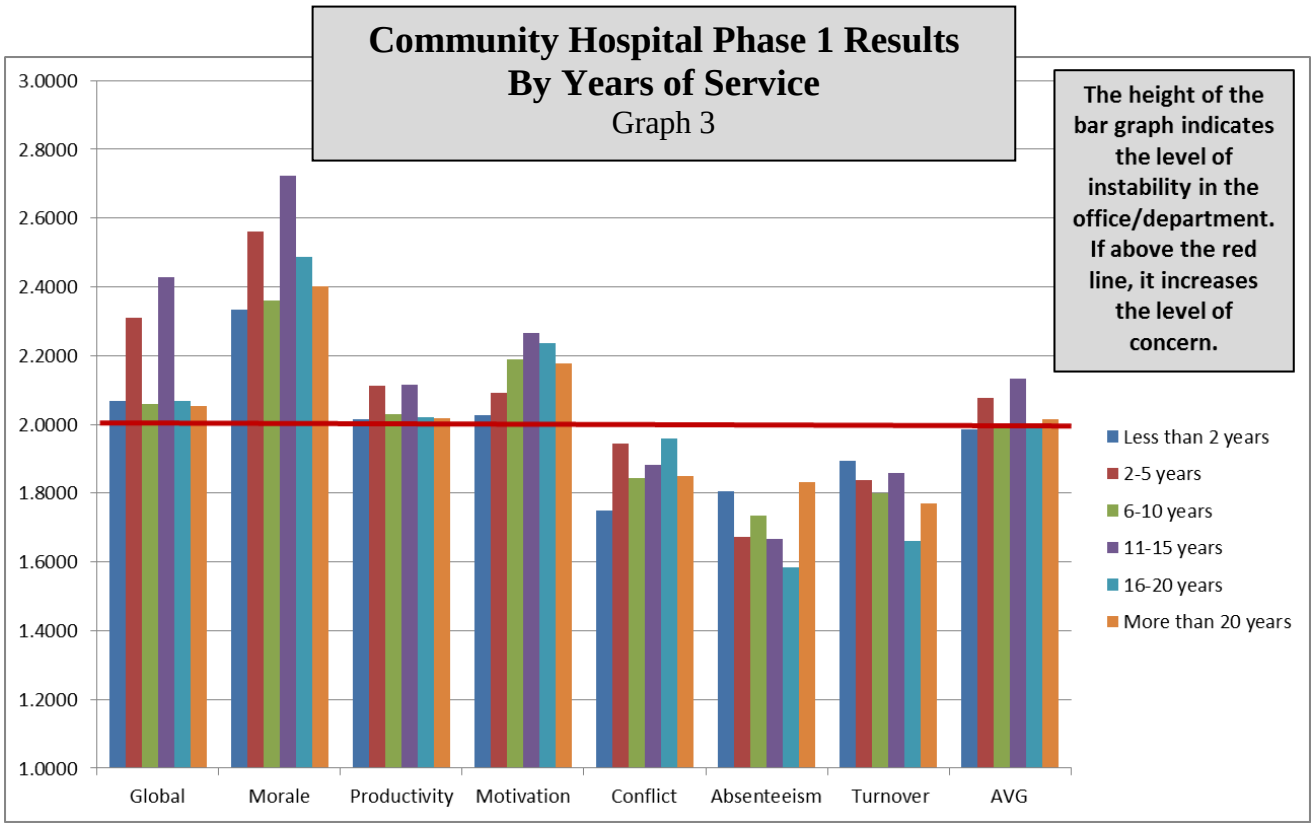
In this first section the Graphs depict the overall average of demographic data collected first by employment position, and then by years of service.

--------- Summary of Results by Position of Responsibility------



Graph 2 shows an equal distribution of scores at or near the result range when sorted by position of responsibility. The higher than preferred overall average for all positions is probably realistic considering the magnitude of the changes that are on the horizon for health care in general, and not just the implications of ICD-10 implementation alone.

--------- Summary of Results by Years of Service------



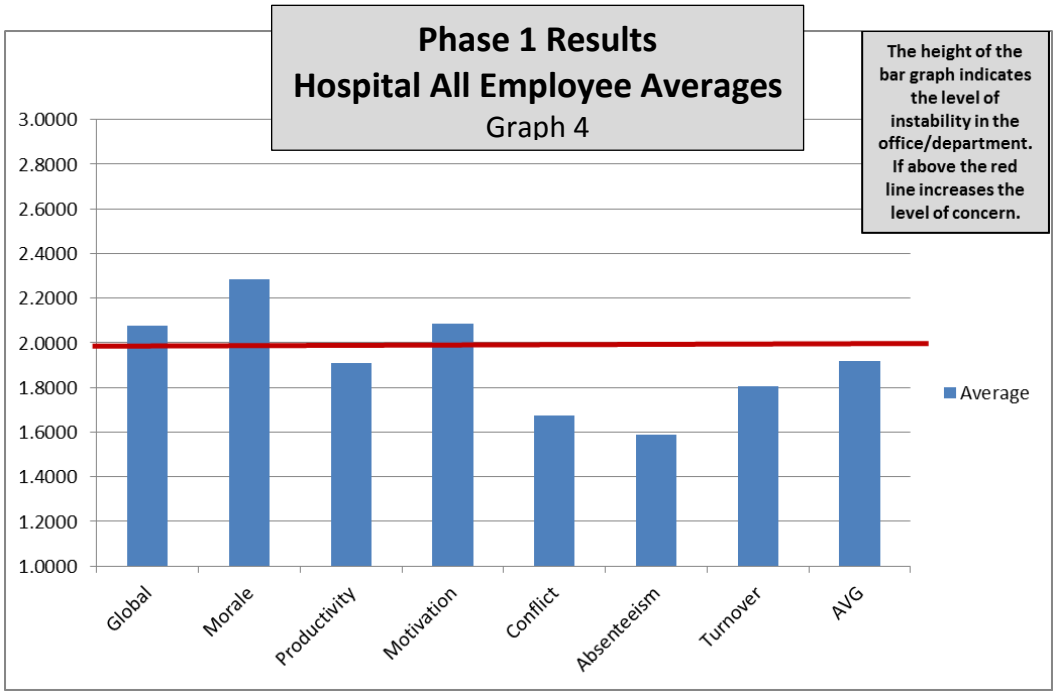
Graph 3 reveals a relatively consistent view across COMMUNITY HOSPITAL with regard to Years of Service. Interestingly, the slight elevation especially in the 11-15 year group is consistent with findings in other health care organizations we have surveyed in the past.

SECTION 2

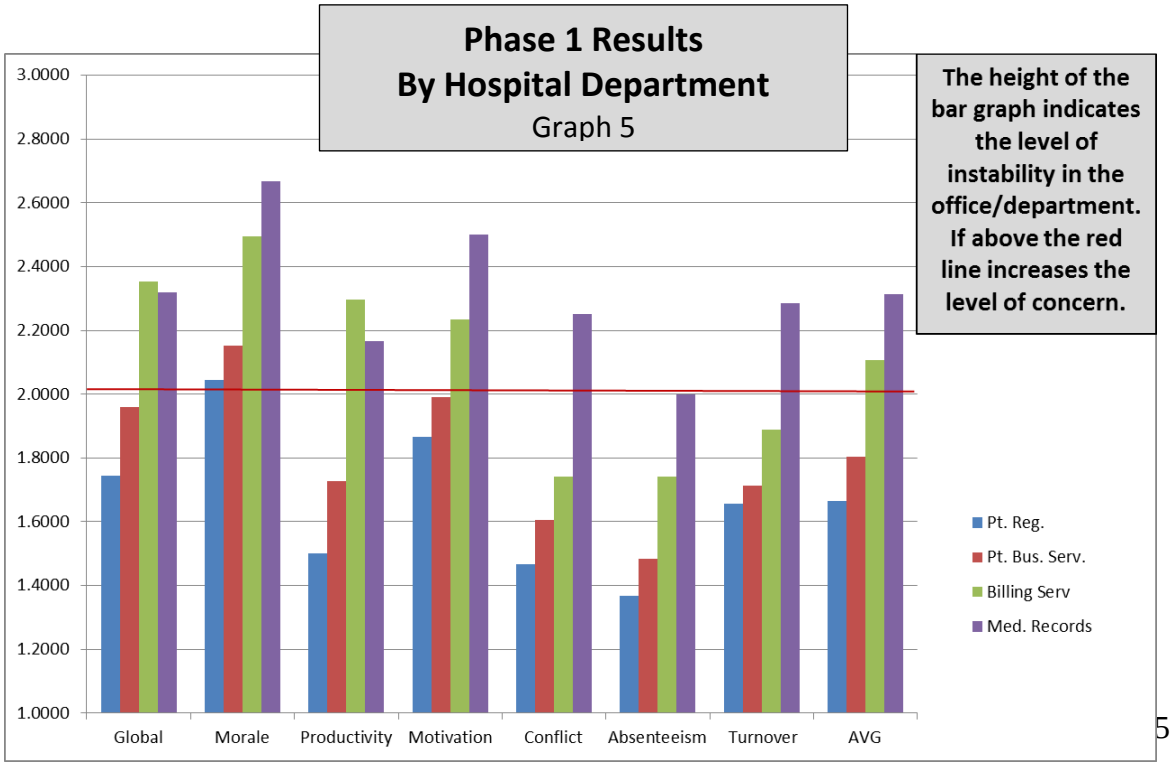
In the second section the demographic data for area of employment is broken down into two divisions—Hospital related data and Physician Office related data. Graph 4 below is a summary of hospital results followed by Graph 5 representing a breakdown of results by individual hospital departments.

A summary of Physicians' Offices results is included in Graph 6. Graph 7 then represents a results for each affiliated physician office.

--- Summary Of Data For Hospital Based Employees----

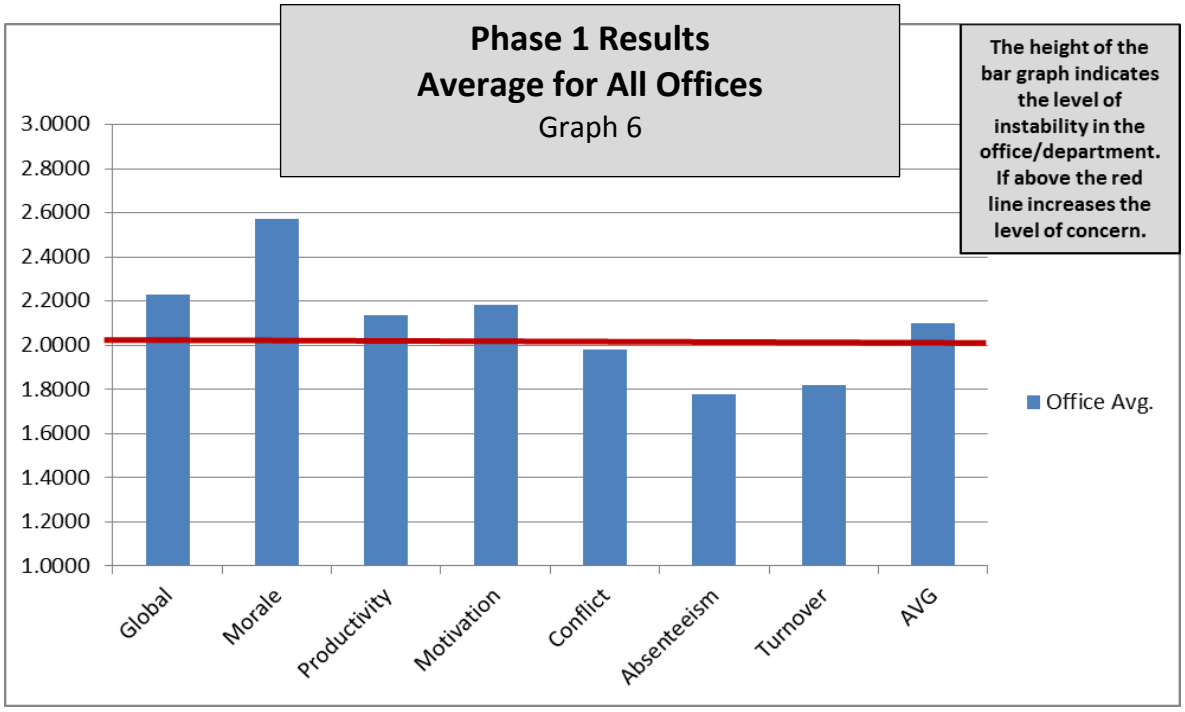


When results from hospital based employees were viewed as an average, the level of instability is less that for the organization as a whole. This suggests that factors influencing the internal aspects of the hospital's operation are providing more support that is available outside the hospital environment. This result might be expected since the resources available to a larger and more formal hospital structure should provide a higher level of security than would be available in the more loosely structured office environment. The results separated by Department are listed below.

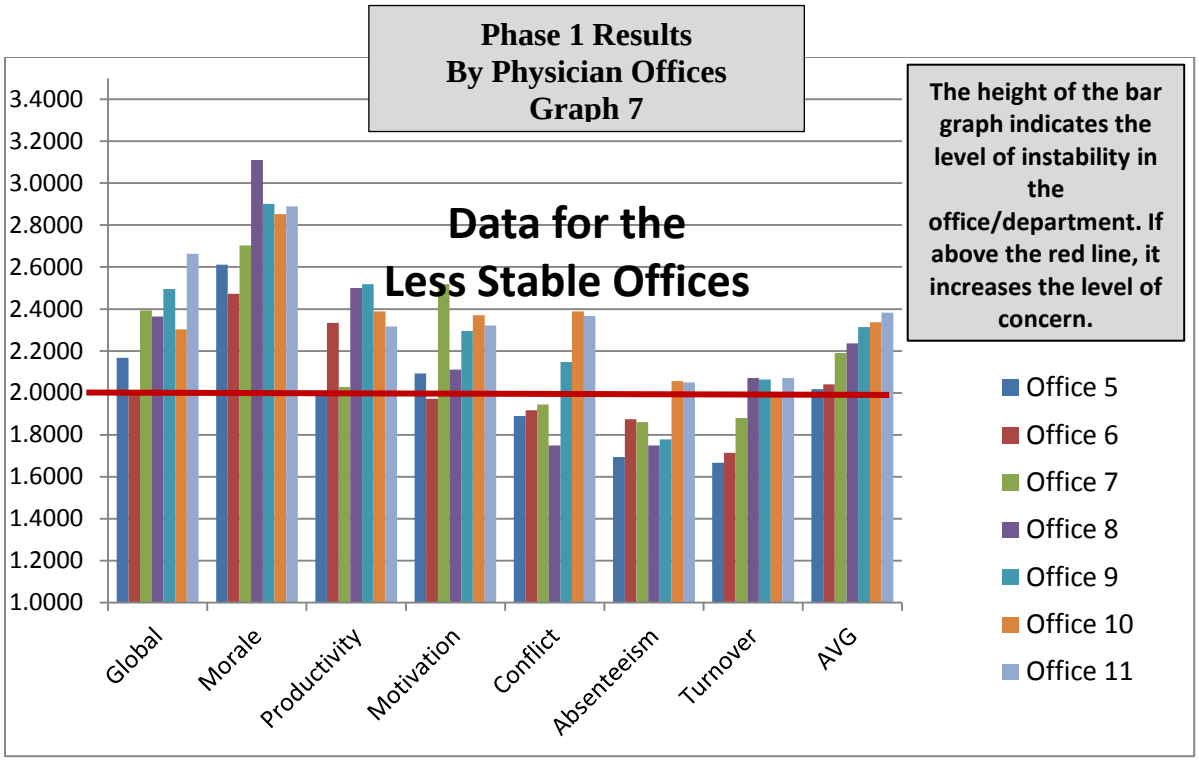


The data shown above reveals that all is not equal in the four departments for which data is available. There is a suggestion of inherent instability in Medical Records and possibly Billing Services. This may be a reflection of justified concern regarding the impact the new coding system on daily operations. Based on the high level of conflict and turnover medical records should be closely monitored, and appropriate training and support provided based on qualitative (observation and interview-based) findings.

-------Summary of Data for Physician Office Based Employees------

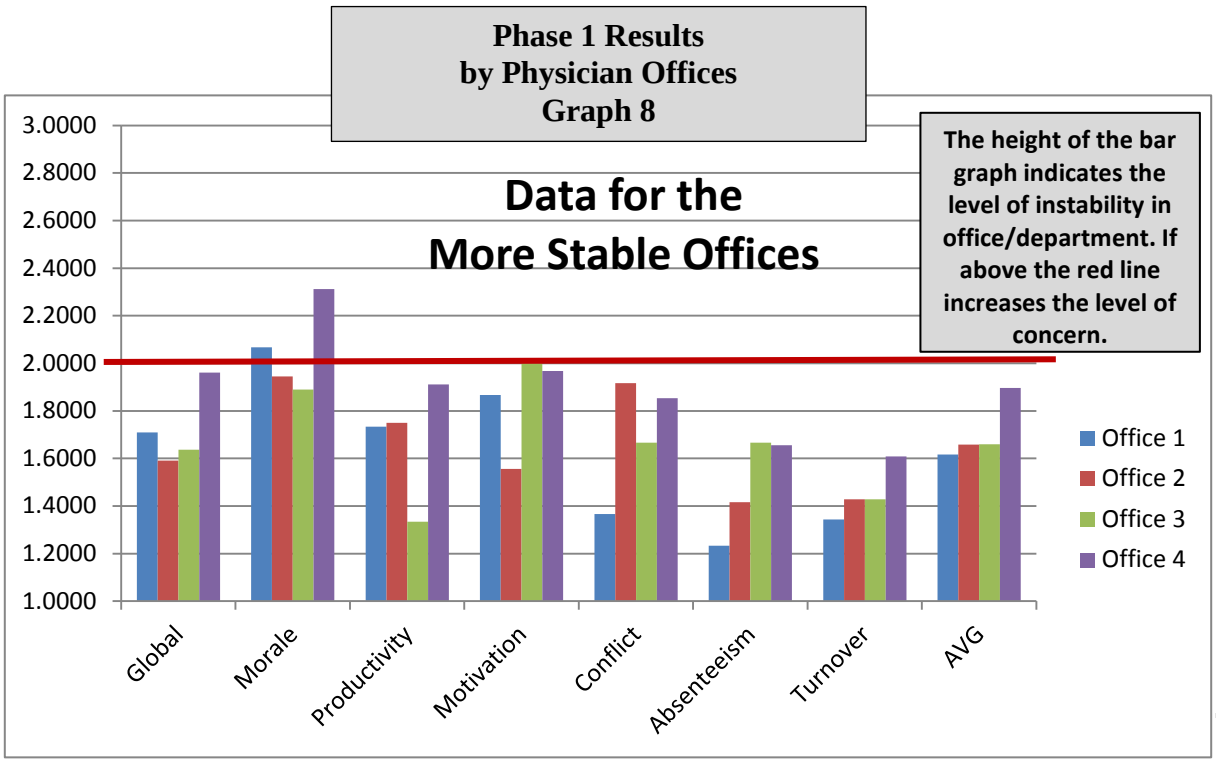


Much of the instability suggested by the COMMUNITY HOSPITAL System averages appears to be present in the office based employees. Graph 6 above reveals an average score that indicates possibility for inherent instability. The significance of these symptoms is more readily observed in Graph 7 and 8 which separates the employee responses into their office of employment.



In Graph 7 we represented the scores of seven offices that suggest a mild to moderate level of instability as they approach the "go live" date for implementation of ICD-10 coding procedures. Of particular concern again was the elevation of conflict, and turnover related behaviors.

Overall the qualitative processes may provide insights regarding the particular source of difficulties, and that some preliminary mitigation plans might be considered to minimize additional reactivity during the early ICD-10 implementation phases.



A total of eleven offices were represented by participants in the survey. The scores in four of these offices suggested a relatively stable and possibly a healthier environment for change. These included: Office 1, Office 2, Office 3, and Office 4 and, and the results are shown above.

COMMENT REPORT:

The findings in the comment section of the survey give the perception that there were problems with communication in the COMMUNITY HOSPITAL system. In Question 1 ("Do you feel COMMUNITY HOSPITAL communicates hospital and physician services goals and activities regularly to its staff?")approximately 34% of respondents felt that communications within the COMMUNITY HOSPITAL system were adequate. The remaining 66% felt that communications within and among the components of the COMMUNITY HOSPITAL system were lacking or needed improvements.

Examples of Positive Comments:
The respondents that answered yes, did so without elaboration.

Examples of Negative Comments:
I feel as though there is a break down between hospital employees and the Physician practices.

I think that the biggest problem at COMMUNITY HOSPITAL is communication. Often information doesn't flow beyond the top level to the employees that need it to correctly perform their jobs. This has been especially true since the implementation of the EMR.

Communication is very poor at COMMUNITY HOSPITAL, needs to be consistent and timely. We all need to hear the same message.

Regarding comment question 2 ("Please discuss your preferred means of receiving information about change initiatives in the hospital and physician practices. (i.e. department/practice meetings, hospital-wide meetings, posted signs, etc.)") there appeared to be universal disagreement with e-mails, meetings, or e-mails and meetings all were well represented in the discussions.

Examples of Comments:
I would prefer to receive information through meetings with department managers and employee forums.

As a satellite office, I feel that communications via email are extremely effective, even if it is simply to announce meeting times and places.

emails, via my manager, hospital wide communications

I'm not sure. It is a very difficult situation. ! if its by e-mail may not get the info for days as there is not always time to check e-mail. Posters in the hall are ok but don't usually have enough info. Maybe direct converation staff to staff example manager to staff members.

OBSERVATIONS AND RECOMMMENDATIONS:

The upgrade from ICD-9 to ICD-10 coding is a long delayed and anticipated adjustment for the health professions. Because of increased anticipation generated by the delays and the significant changes in documentation, it is likely to meet with a great deal of resistance. The prevention or moderation of this resistance should be a goal of all health care administrators, yet the nature and extent of this resistance is not easy to predict.

The implementation of the Index was carried out successfully across an unusually broad range of hospital departments and physicians' offices. Overall 34% of the employees participated in the survey. These participants represented four hospital departments and eleven COMMUNITY HOSPITAL affiliated physician offices. Three physician offices and two hospital departments did not have representatives that participated.

Instability is endemic in change, and in a change of this magnitude and scope, changes in attitudes and behaviors should be expected. The issue is to what extent can they be anticipated, and appropriate strategies implemented to minimize the intensity and disruptive influence so that a return to base line performance can occur as rapidly as possible.

We recommend that the consultant look deeper into the seven offices and two departments that were highlighted in graphs 5 and 7 where conflict and turnover were of concern. In closing, the consultant may find interesting additional information regarding leadership challenges when looking, for example, at the differences in Morale scores between the COMMUNITY HOSPITAL Surgical group and the Orthopedic or Internist groups. This could start with a limited number of qualitative interviews by the consultant staff that is experienced in reading body language and subtle inferences in communications. Many employees in small offices are reluctant to be as forth-coming as they might be in a more anonymous environment. Based on those interviews, and the Index scores, a plan of action should be devised to support the basic concerns of the various offices and departments that show signs of emerging difficulties.

The Change Diagnostic Index© should be repeated approximately two to four weeks after full implementation of ICD-10 and after all training has been completed and trainers have departed. We call this the "Crisis Phase", and it is the optimum time to capture the nature and extent of the instability. The plans can then be readjusted as necessary to meet the emerging difficulties as they arise. We also suggest, using your experience in dealing with issues that arise during change, the consultant consider the intervention chart provided in the Appendix as an additional resource to consider as behaviors arise that must be addressed. A few of these are listed below:

- monitor and encourage, and in some cases supplement the leadership efforts in each division,

- ensure adequacy of communications institution wide,

- plan for individual coaching where indicated,
- provide supplemental education and training opportunities,
- and provide other support and assistance where needed.

APPENDIX:

Table 1 and 2 below contain the Scoring convention and Change Diagnostic Index ©Symptoms to assist in understanding and interpreting the analysis charts:

Table 1: The Change Diagnostic Index© Symptoms and Strategies

Individual Symptoms/Behavior	Organizational Symptom	Suggested Mitigation/Intervention Technique
Anxiety	Morale	Enhance and Increase support from Leadership/Sponsorship
Frustration	Productivity	Increase Education/Training with the identified Change
Rejection of the Environment	Conflict	Improve Communication—subordinate, colleague and supervisor
Retardation of Development	Motivation	Integrate Individual Coaching
Refusal to Participate	Absenteeism	Evaluate Employee Engagement and Support
Withdrawal	Turnover	Monitor Job Satisfaction and Commitment

Table 2: The Change Diagnostic Index© Scoring System

Index Score	Meaning
=1	indicates the organization is functioning in a **stable** environment
1 to 2	indicates the organization is functioning in a **relatively stable** environment, however management should be aware of the potential for volatility
> 2 to 3	indicates that the organization is experiencing **volatility** and management attention is suggested
>3 to 4	indicates that the organization is **relatively unstable**, heightened management intervention is required
>4 to 5	indicates that the organization is very **unstable** and absolute intervention is required

The Change Diagnostic Index© evolved in response to original literature which identified the Organizational Loss of Effectiveness (LOE) and corresponding symptoms. The Organizational LOE is described as follows:

An organizational change causes a loss of stability in the employees who are affected by the change. This loss of stability can result in the development of a predictable and measurable set of symptoms. When a significant number or intensity of these symptoms are present simultaneously, an organizational loss of effectiveness will occur.

(Grady, 2005)

For interpretative purposes, the definitions below provide clarification regarding the origin and use of the word stability as a descriptive factor in Table 2.

Stability- is the quality, state, or degree of being stable, steady, consistent or dependable; as the strength to stand or endure**.**

Loss of Stability (LOS)- is a loss or lessening of the ability to be stable, steady, consistent or dependable. An increasing tendency to become erratic, inconsistent, unpredictable.

(In our work, LOS occurs when there is a change in the availability of an object —such as another person(s), software, location or business process—that is "leaned on" by an individual or group. It is an aspect of our human nature to desire to be attached, or related, to something familiar or secure. LOS occurs as a consequence of a loss or threatened loss of any such object of attachment.)