Change Management in Healthcare

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Hello, welcome to Change Management. I want to start with something that's universally true. Our brains love comfort, and change is the opposite of comfort. Yet here we are in a workplace, a world, a moment in history, where change isn't just constant, it is accelerating constantly. So today isn't about learning to like change.

That's unrealistic right now. It's about understanding change and implementing it within your organization to be a thriving organization. So let's get started.

A little bit about me. Here's our APA disclaimer.

Here are your learning outcomes for today.

So before we dive into models and strategies, I want to start with something really human. When any new change comes our way, whether it's a new workflow, a new leader, a new technology, or a new flavor of chaos, our brains do not immediately jump to fantastic, let's optimize this change. That would be nice if that happened, but it's not going to. They react emotionally first. Our nervous system responds before our logic does.

That's why even positive change can feel complicated. But when change is needed, we have to adapt. And we know in today's world, especially in healthcare, change is coming at us constantly. So let's talk about why change is needed. Change management is needed.

Why in healthcare, change management matters. And statistics say that about 70% of change initiatives fail because they don't do it properly. And it's not because the ideas are bad. It's because the human side of change was not fully addressed along the way. In healthcare especially, we see the same barriers repeat themselves over and over.

And, and all of you who work in organizations in healthcare, I'm sure, can identify with all of these. First is in healthcare, we have a hierarchical culture. Decisions are often made at the top and then they're handed down and there's little room for dialogue. That immediately elevates our threat response and decreases our buy in. Second, in healthcare, we oftentimes have staff shortages.

And when people are already reached, thin. Any new initiative can feel like just one more thing. And even if it's ultimately meant to help us, it feels like, oh, something new to deal with now. Third is poor communication. So this includes unclear messaging, inconsistent messaging or messaging that doesn't address people's worries.

And lastly, the lack of sustainment. We're going to talk a lot about this later on when we launch something new. We push hard for a few weeks, maybe a few months, and then we go back to old habits. And I know from working in many healthcare organizations, staff are frustrated. Here we go again.

Another consultant comes in we're going to change something else, and then it doesn't stick. We're going to work today to figure out how to not let that happen in our organizations. So again, these things are not signs of failure. They're signs that the human brain and the workplace environment were not aligned. That's what effective change management fixes.

It closes the gap between great idea and a successful execution. These realities make it crucial to choose the right change change management framework. So we're going to take a look at some of the models now, going all the way back to 1947, when change management first got its start, really. Lewin proposed that change unfolds in three stages. Unfreeze first, and then we prepared for the system change change.

Then we implement a new process or behavior and then refreeze. Finally, we stabilize it. This model was foundational for change management work, but it's so simplistic, it doesn't work in today's healthcare settings. Then we think about Prochaska and DiClementi. And many of you who work in healthcare might recognize this model because we use it frequently, especially in the addictions areas.

So when we talk about organizational change, it's important to remember that employees aren't just resistant or supportive of change. They're moving through predictable psychological stages. This model shows us those stages. We start in pre contemplation. This is the I don't see a problem here stage.

I don't know why we have to do this. Employees don't believe change is necessary or relevant to them. Then they move into the contemplation stage. Here they're aware something needs to shift, but they haven't committed yet. This is where ambivalence lives.

I can see the benefits, but I'm not sure I'm ready. Then we move to preparation. At this point, people are kind of warming up to the change. They might ask questions about it. They might start gathering information about it or start picturing how it will affect their work.

Then we move into action. This is where behavior actually changes. Trying a new workflow, logging into a new system, learning a new process. And lastly, one of the really important ones is maintenance. So this is the toughest part, and we're going to talk about why later on in this presentation.

This is about sustaining the change, preventing the slide back to the old way, and building confidence through repetition. What's powerful about this model is it reminds us people don't jump from zero to action. And if we expect them to, we will lose them. Effective change management means meeting people where they are and helping them to move one step at a time. The next model is Cotter's eight Steps.

So Cotter provided a roadmap for large scale organizational change. These steps begin with creating the urgency and building coalition and it ends with anchoring new practices in the culture. Hospitals have used this model for major transformations such as when we started rolling out electronic medical records or restructuring the hospital. And it works well.

Another model, the Re AIM framework, asks us to think beyond adoption alone. This emphasizes the reach into the target population, the effectiveness of the intervention, the adoption by the providers, the quality of the implementation in the long term, maintenance. So this is particularly relevant when you're scaling evidence based intervention in health care.

Something we keep in mind when we're doing change management is when we think about change management, especially changes involving new procedures and especially right now, as we're adding more and more AI into healthcare. There's one factor that consistently predicts whether the team adapts well or struggles and that is psychological safety. So Amy Edmondson defies psychological safety as a shared belief that the team is safe for interpersonal risk taking. In other words, people feel like they can speak up, they can ask questions, they can admit they don't know something and they can push back on decisions that are being made. Be part of the change management.

If a team doesn't feel psychologically safe, they won't tell you they're confused, they won't admit they need help, they won't share early warning signs that change is breaking down and they'll quietly struggle. And none of us want to do this personally and we don't want our teams to be doing this. So leaders will play a major role in creating psychological safety. They will invite input. What concerns do you have?

They will respond appreciatively, even if the answer is inconvenient or critical. They'll say thank you for bringing that forward. That reinforces safety. They will normalize learning from mistakes. So change is messy.

People will make errors as they learn. And leaders who say this is all part of the learning curve will reduce fear and increase engagement. So when your team feels psychologically safe, they will move through the phases of change quicker with less errors, and they'll take ownership of it. It's one of the most powerful and underrated tools in change management.

Let's talk about Maria, who works in healthcare. She's a 17 year old veteran healthcare worker who's panicked when the hospital announces a new AI driven procedure. She gets very upset. Fortunately, her supervisor asks her, what's on your mind, Maria? And Instead of shutting down or pretending she feels better about it.

Okay. And when she responds a pre appreciatively, her supervisor says, thank you for letting me know that a lot of people are feeling the same way. Maria will feel less isolated. And when we normalize learning from mistakes and tell Maria lots of people are doing this, she will continue to gain confidence. So if Maria feels psychologically safe, she will move from fear to curiosity, from silence to dialogue, and from avoidance to engagement.

So leaders foster this by doing all of those things. And if they do it correctly, change goes more smoothly. Here's another model, and you'll probably recognize this. Plan, do, study, act. This is the workforce of quality improvement of healthcare.

Teams design small tests. So they plan it, then they try it. They do it, then they analyze what happened. They study it, and then they decide whether to adapt, adopt, or abandon. This iterative process allows rapid learning and risk reduction.

I'm sure you've probably seen it. Here's an example.

So let's say they plan to revise discharge checklist for 10 patients. Okay? So they do a trial on unit A. And then they study the risk of readmission at 30 days. And then they act by adapting the checklist before scaling.

So starting with a small sample lowers the risk and increases buy in. So plan, do, study, act.

The next model is the Consolidated Framework for Implementation, or cfir. It's one of the most widely used frameworks today. It's one of the most recent ones introduced. So it has five domains. So if a hospital is rolling out a falls prevention protocol, this is how it would look.

That's the intervention. The inner setting is the staff and the culture of the staff. The outer setting are the regulatory pressures, the individual involved, thinking about their beliefs and their confidence level, and the implementation process itself. Piloting, training, adjusting. The CFIR simply helps leaders understand why change succeeds or fails.

By analyzing all five of these dorms. I'm going to say that again. Three, two, one. The CFI model simply helps leaders understand why change succeeds or fails by analyzing all five domains. It helps leaders anticipate barriers and facilitators.

Normalization process theory explains how new practices become routine within organizations. So it emphasizes four constructs. Coherence. So this makes sense. Cognitive participation.

People get involved. Collective action. We execute the plan in reflective monitoring. We evaluate the plan. This model helps sustain in complex systems.

So if a large hospital system introduces a new digital sepsis early warning tool, they explain how how the tool becomes routine. The coherence the staff must understand the purpose and value. For

example, nurses and physicians learn to use the tool to detect subtle changes in vitals. And they see why the tool exists and how it is different from what they were doing before. In the participation, people must buy in and commit.

An example is unit champions or what we call super users volunteer to promote the tool. Physicians agree to respond to the alerts and nurses commit to documenting assessments in a way that supports accelerating and alerting. And then the collective action. This is the team coordinates new behaviors and workflows. For example, nurses integrate the tools into their routine vital checks.

Nurses review alerts during huddles and physicians adjust rounding workflow. So so sepsis alerts are discussed in real time and reflexive monitoring teams evaluate and refine the practice. So after three months the data shows that 25% reduction in time to antibiotics. Staff provide feedback and some alerts feel redundant. And it refines the thresholds and improves accuracy.

So as staff see the positive outcomes co confidence and adoption grow, solidifying the tool as a process routine.

Another model is Adkar. So it has five stages. Awareness, why change is needed, Desire, personal motivation, knowledge, skills and training ability demonstrating new behaviors and reinforcement sustaining over time. Again, the psychological safety is important here. And this is where those micro behaviors of leaders come into play.

So inviting dissenting views and appreciating contributions. And frame failure as learning, not as a failure personally, these are all important. So you can see that all these models start to look alike in 2022. The CSIR integrated equity and sustainability in broader healthcare contexts into the previous model. It reflects a modern understanding of how interventions succeed in diverse resource constrained environments, which sometimes we are in healthcare.

It remains the gold standard in implementation research for healthcare. So, so here is your timeline starting in 1947 and coming up to 2022. And these are all models that we can use depending on what exactly we're doing in our change management initiative.

Now I want to move to the personal level. That's your, that's your framework. Those are your models. Let's move to change in yourself and how that is. So what do you feel when you hear the word change?

Why is change so hard? Because it's all about your brain. So as a neuropsychologist, I'm in love with the brain and thinking about how the brain interacts with us all the time. And when most people hear the word change, they pull back. They don't like it.

Brains don't like it. They're emotional. They want us to be calm, cool, collected and staying in what we've already been doing is much better than Adjusting to change and even positive changes are hard. Think about having children, buying a new house, starting a new job. Those are hard.

Your brain reacts with a little bit of, oh, my gosh. Those are all changes we choose, but it's hard. They require adjustment.

Because of that, we have what we call underlying psychological drivers to that change. When we talk about why change feels hard, it's not just the change itself, it's the psychology underneath it. There are some big drivers that shape how we react. One is if you think about, let's say your hospital announces new procedures with AI again, okay? And people are pushing back and not liking it.

They're reacting to what change means to them underneath. So the first thing they're reacting to is identity threat. In healthcare, our identity runs deep. If someone sees themselves as an expert in something, the helper in something, the calm in a storm, in something, new technology can feel like it

challenges who they are. The second is curiosity versus threat.

So am I going to lean into this or am I going to pull back from this? Could this help me or could this replace me? That first split second when you hear change, that's what your brain does. I'm in danger. What's going on?

And then there's loss aversion. Humans hate losing what they already have. Even if AI will save time eventually and make your job easier, the immediate fear is, what will I lose? So when, if we look at it from another perspective, if I said to you, I'm going to make your life very calm all the time from here, moving forward for the whole next week, you're going to feel calm, cool and collected all the time. You probably would feel good about that change.

And then when I say to you to do that, I have to take your cell phone for a whole week. Probably most of you already had a reaction to that. So that I don't want to lose something versus I'm going to feel com, cool and collected. I don't want to lose wins. Loss aversion, cognitive dissonance.

This shows up as, I'm pretty good at my job, so why do I feel confused? The mismatch between how competent somebody usually feels and how unsure they feel about the new tool is completely normal. It's uncomfortable. And lastly, social comparison. So of course, none of us want to feel like we're the last adopters of something new and change.

Okay? We look around, everybody's getting it faster, everybody's buying into it. People are happy about it, and I'm not. What's wrong with me now? I have stress and self doubt.

But keep in mind that all five of these things are absolutely not flaws. They're human. And the more leaders understand these underlying drivers, the better we can guide our teams to change through clarity, compassion, and confidence. So let's go back to Maria in her workplace. Imagine Maria's been

in the hospital for 17 years.

She knows every workflow, every surgeon's preference, and she prides herself in being an on the go person during chaos. Then leadership announces a new set of procedures that will rely heavily on AI and here's what happens internally to Maria. First, she doesn't say, this is fascinating. I can't wait to use this. Instead she says, this is going to make my job harder.

Will it replace what I do?

Then she says, I just mastered the last system. I don't want to lose efficiency. Humans will cling to what's familiar. She identifies as a problem solver. But now she says, what if AI makes me less of the expert in the room?

And her cognitive dissonance is, why is this so confusing? I should be good at this. And then she looks around and she says, oh my gosh, my colleagues love this. Why am I the only one who's stressed? Again, this is all normal.

When her leaders understand this, they can help Maria to reduce all of these variables. Now, also, we need to talk about the fact that the fear of being replaced is different than the fear of being irrelevant. So if we a, AI will do tasks that we do, that's the fear of being replaced. AI will not become who we are, but we worry about that. I don't want to be irrelevant.

When we are overcome by focusing on human skills that AI cannot replicate, like insight, empathy, context connection, we can feel a little bit better. But in reality, the fear of being irrelevant is much greater than the fear of being replaced.

Again, when we normalize this as we do our change management, people can learn ways to feel calm. So I'm going to give you a quick four step process. This process can be used by you. You can use it with your teams, and if you're working with patients, you can use it with patients.

So first we're going to name it I'm feeling anxious. Okay? If you pretend you're not anxious, it will not help. So name it to tame it. Second step, reframe the story you're telling yourself.

Okay? So the real question is, will AI replace us? Let's turn that around a little bit and say, how can AI enhance what makes us human? And then we start feeling better about it. Third step is stay in Learning mode, so I don't have to know everything right now.

I can learn along the way. And lastly, and sometimes this is the hard one, find your irreplaceable value. So technology can automate the tasks. But our irreplaceable value, first and foremost as humans, is our trust, our vision, our wisdom. AI will never have those capabilities compared to humans.

If we go back to Maria and she goes and meets with her supervisor because she's afraid of all of these things. And her supervisor has noticed that. And her supervisor starts by saying, I know this change feels big, Maria. Most people are feeling stress and a little bit of curiosity right now. So they named it stress anxiety.

Maria instantly can drop her shoulders and feel a little bit more relaxed that she's not the only one. Her supervisor continues and says, this is not about replacing your expertise, Maria. We're going to amplify it. You're the one who gives meaning to the AI, the data, data. The data that AI produces.

Maria shifts from I'm being replaced to I'm being supported. Then her supervisor says, you don't have to know this all today, Maria. We have time. Let's just be open and curious. And Maria's anxiety drops again.

And lastly, during a meeting, her supervisor says, maria, AI can process information, but it cannot build relationships. It can't calm a panicked family or navigate a crisis the way you can. You're wonderful at those things. That's why you're essential to us, Maria. And with that, Maria clearly sees they still need her.

She's still relevant in the work environment.

Let me give you a few stress management things to keep in mind. Also, because personally, we all want to continually be looking towards stress management. If we can manage our stress in the midst of any kind of change management initiative that our people are doing, then we can do much better. So these are just an overview of about five things. If you take my course, Getting Calm, I'll give you about 20 or 30 things.

The first is sleep and nutrition. You have to get good rest. Getting a good night's sleep is more important than just about everything you can do for yourself. So if your organization is in the midst of a really big change, I want you to really focus on how much sleep I'm getting and that I'm rested as well as proper nutrition. Sometimes change management makes us nervous and we start to eat things like sugar or caffeine or we want to really be paying attention to our sleep and our nutrition.

Second is develop some breathing techniques. I teach things like box breathing, triangle breathing. You can find those all on the Internet. Breathing techniques are something you can use anywhere you are to calm yourself down.

Exercise. Increase your exercise. During a change management initiative. We all should be exercising a minimum of 30 to 60 minutes, four times a week. I want you to make sure that when you're in the midst of stress, increase that because the stress can, the exercise can lower your stress dramatically.

Next, socialization. Make sure that when you're stressed, you're not checking out. Make sure you're checking in. Be around people, talk with people about what's going on. Continue your socialization.

And lastly, coloring. This is one of my new favorites. So it's one of the many things you can do for stress reduction. It is evidence based to lower your stress levels because it, when you're coloring, it starts the part of the brain that releases what you need for calm. So coloring is a fantastic way.

It's a meditative technique to calm yourself. And it's kind of fun, kind of playful, takes you back to childhood a little bit. So these are just five things and I dropped these in here because stress management is very important for the individual as they're going through any change within their organization.

Now let's switch back to the organization and see what's going on.

So organizations are made of people. You can't change the organization without changing people.

Let's look at how this plays out in perspective from the team. So we're going to talk about a patient named Mr. Jackson. He has been admitted for worsening heart failure. Everyone on the care team is doing their best, but because their work is not aligned, he becomes a perfect example why readmissions are high and why change management is needed here. So the nursing on the day of discharge, the unit is short staffed.

The nurse prints out the whole packet of discharge summary. She doesn't have time to walk through every single point, so she hits a few and then she says, call us if you have questions and moves to the next patient. The hospitalist documents the plan but doesn't realize the discharge instructions conflict with cardiology. And he assumes the outpatient team will clarify anything that he might have missed.

Cardiology wants Mr. Jackson to have a follow up in seven days.

The scheduling team is backed up and he gets booked out three weeks. The care management team now is trying to call Mr. Jackson for a post discharge call, but he misses it and no one calls him back. The patient, Mr. Jackson is at home and he's overwhelmed. He's not sure of the medications they changed. He's afraid to call the hospital.

He doesn't understand when he should go back to the hospital. And by day 10, he's back in the emergency department, not because anybody failed, but because the system was not coordinated. So this is a classic readmission story. Any of you who work in the hospitals probably have seen this, and it's exactly why the kind of challenge that requires very, very careful change management. Not more effort, not more pressure, but alignment, communication and clear implementation.

Now let's say we did it the right way. So now we have a new AI tool that's going to help us. Let's look at the same patient, Mr. Jackson. Okay. Nursing at discharge.

The AI platform flags Mr. Jackson's charts for high risk. Hands the nurse. The hand hands the nurse a simplified patient friendly script. And she says, here are three things you need to watch this week. Mr. Jackson.

She feels confident because she doesn't have to rely on her memory. And the tool did the cognitive lifting. The hospitalist gets an AI generated summary highlighting gaps in discharge medication discrepancies, need for weight monitoring, home with a scale and follow up in seven days, he closes those gaps. And AI didn't make those decisions for him. It simply surfaced what mattered most.

AI automatically searches available clinic slots for the cardiology department and he gets a follow up appointment in five days. So AI did the heavy work. Cardiology gets an alert with Mr. Jackson's risk

profile before he even gets to his appointment. And that helps the appointment go more smoothly. Case management.

AI sends Mr. Jackson a daily text checking in with him about weight, swelling, shortness of breath and medication adherence. Think how much time that saves for all of us. If he reports concerning symptoms, case management gets an immediate notification and they bring him in. And here's the patient, Mr. Jackson. At home.

He got clear personalized instructions, daily prompts and early intervention. When something felt off, he felt supported and connected and he did not readmit to the hospital.

So this is not because AI magically fixed the problem. It worked because the team understood how to use the tool, why it mattered to use the tool, and how it fit into their workflow. So when we combine technology or any kind of change management with psychological safe teams, in a structured change management, you get outcomes and that reduces burnout in your staff.

So when we do change management, one of the first things we have to do is who are the stakeholders? Okay, who's interested in this? In this particular situation, we're in the medical system. Usually the chief medical officer has high power, high interest, and the strategy is for him or her to deeply engage in the change. The Nurses have high power, medium interest, and they must be empowered to take part in the change.

And the patients have lower organizational power but very high interest in their well being. So they need clear communication and support. This is a simplistic model of picking out your stakeholders. So when any kind of change is being implemented, we have to know who the stakeholders are first.

Now let me talk a little bit about change versus transition. And there is a distinction here. So change itself is situational. It might be a new policy we're introducing, a restructuring of a system or a unit that we work in, or the adoption of an entirely new system. It can happen quickly and externally, and leadership often assumes that it's completed once we announce it.

Transition, however, is that whole psychological piece we've been talking about. It's the inner process people move through to let go of an old way and embrace a new way. Transition takes time and it involves emotions, uncertainty, grief and even excitement. In healthcare, we have to recognize that successful change depends not only on somebody telling us what to do, but also how well we're supported through it. Without transition, change does not stick.

So here's a good depiction of this Change is that external event starts on the. Where it says ending. The red box says ending. Okay, so William Bridges described these phases of changes in transition. The ending is every change starts with something ending.

The old process, the old identity, the old comfort zone. When that happens, these are the things people experience. Denial, shock, anger, frustration, stress, ambivalence, not because they're resistant, but because they're grieving. The loss of familiarity and uncertainty. Then there's the neutral zone.

We, we often call this the messy middle. So this is a foggy zone. The old way doesn't count anymore and the new way has not become automatic yet. And people are in the foggy middle. It's uncomfortable.

But it's also where creativity and innovation can live if we support people well in the messy middle. And then last stage is the new beginning. This is where people feel acceptance, skepticism, slows that they know the importance, they have hope about it, and they eventually feel enthusiastic. This is a powerful model to help leaders. So we have to remember change is fast, transition is slow.

So let's go back to Maria, our 17 year veteran in healthcare who initially felt really threatened by AI coming on board. If we look at her in this, these three stages, in the beginning, she's thinking, this is going to complicate my workflow. What if I can't learn it? What if I lose my job? So she moves through.

Then denial. This won't really affect me. Shock. They're changing everything. Anger.

Why can't we stick to what works? Stress and ambivalence. I know we need improvements, but this feels overwhelming. I can't do it. And Maria isn't resisting change.

She's letting go of the familiar. Now she's in the messy middle, the neutral zone. Here's what it looks like. She tries the AI tool. She clicks the wrong thing.

She gets the error message. She worries she's slower than her co workers. She feels unsure, and her confidence is draining. This is the hardest stage because it feels like I am doing everything wrong. But the stage is also where learning, creativity and new habits develop.

So this is where her supervisor normalized it and said, everybody's learning this. This is part of the process. Let's just calm down and get through this. Maria. And then she gets to the new beginning.

She sees that AI catches patient risks where she would have had to scan for them manually. It saves her time. It actually enhances her clinical judgment instead of replacing it. And she moves to, okay, maybe this isn't so terrible. I can do this.

My role here still matters. This tool actually does make things better. What changed? Not the software. What changed was Maria had support through her emotional journey.

So, so important for us to remember. Here's another way to look at it. So if we look at this, we go from our current state to our transition state to our future state, okay? Then the organization does that. The individual goes from current state, how I do my job now, transition state to future state, how I will do my job, hopefully even better.

After we implement the change, we think about it from another perspective. We have project management. This is the solution designed and developed to deliver effectively. This is the technical side. Project management is the technical side of change.

Okay? Change management down below is the solution embraced, adopted, and utilized effectively. This is the people side. This is what we think about with change management. Okay, so project management is the task, the things we're changing.

Change management is the people side of it.

Now when solid, without solid change leadership, we lose people along the way. Look at this. Ultimate ultimately requires individuals to move from their own current to their own future. So they start here in the change. Now they go into the transition.

You see, we've lost a couple people, and then we get to the final stage and we've lost a lot of people. This is what happens if we don't do change management. Well, now sometimes we lose people because we just needed to lose people or they decided to opt out of the change and they Went somewhere else. So keep that in mind. But as leaders in organizations, we really need to be making sure we're doing this change well so we don't lose people because sometimes we lose our best people and we don't want to do that.

And I always tell people when I'm doing change management in organizations that you, everybody are the agents of change. It's not just your leader or the people on the front lines, it's everybody. Okay. All right, Let me give you a model of change management to look at. So These are the ABCs of change and they're adapted from the Adkar methodology in the, in one of those methods I showed you early on.

So we're going to go from awareness, buy in, competence and support. All four of these things are important.

Awareness is what's changing, why is it changing, what is not changing and why now? Buy in is. Know the benefits, Be personally committed, Know how to change. Get enough training and sufficient resources. Support is remedial training.

Celebrate success, rewards and recognition. Let's break these down. Now, here's an example. Let's say you're in an outpatient clinic. It includes physical therapy, occupational therapy, and speech and language pathology.

And they're preparing to launch a new standardized care pathway for post concussion patients. Up to now, each discipline has followed its own flow, documentation style and patient progress measures. Everyone has good intentions. Let's just say that now everyone in healthcare especially has good intentions. But variation in these things leads to inconsistent care plans, duplicated assessments, mixed messaging to patients and frustration among providers.

So leadership says we're going to do a standardized unified model. And here's what it looks like.

We're going to start with building awareness. So when we talk about communication in more detail later on. But right now, everyone needs to be aware of the change. The otpt, slps. What is changing?

A shared coordinated post concussion pathway, which, with consistent evaluation elements, session structure and progress measures. Why is it changing? Because patients have been getting mixed guidance, referring physicians are confused and outcomes vary widely. What is not changing? Each discipline still brings its unique expertise.

No one is losing autonomy. We're aligning, not replacing. Why now? Referrals from neurology have dropped due to inconsistent reports. The system wants a seamless, team based care.

So with this clarity, people don't fill in the blanks with fear. It's important to recognize that research shows people want different communication from different people in the organization. Also, for example, they want the vision given to them by the leaders at the top. Okay. But when they want details, they want their Immediate supervisor who they trust.

So let's keep that in mind. Awareness is the first step of the journey and we can't ignore it. We want to do the executive sponsorship. The top leaders provide the vision you're coaching by managers and supervisors and then ready to access business information. Staff need facts, not rumors, to build trust.

So when awareness is clear, staff are less likely to resist because they see the connection to the organizational goals and to themselves in the picture. Now, in healthcare, I think we're all familiar with the SBAR situation. Background assessment recommendation. It's not just a tool for clinical handoffs, which is what we think about it, for it's really also a leadership tool. So in this example, the chief medical officer says readmissions are high or neurology is not referring to us.

The background is our instructions vary. The assessment is patients are confused and we're not getting the referrals we need anymore. So the recommendation is pilot a structured checklist and structured way to do things. This concise framing in the sbar, which is concise and very effective, makes it easier

for us to act. Now we move to buy in.

This is probably the most difficult to manage because it's very dependent upon an individual's comfort with change. You can make sure that people are aware, but it's harder to influence them. So when we go back to our clinic again, the OTPT SLP buy in grows. If they understand the benefits are reduced, duplication of tests, easier collaboration, clearer roles, better patient outcomes and stronger relationships with referrers, then they have a personal commitment. Each clinician identifies what matters to them.

The OT might say patient safety. The PT says measurable progress. The SLP says consistent communication. Now they're starting to get buy in. We also want to.

We want to say, okay, what is their readiness to change? This very simple readiness pulse tool will help with that. It is a short survey and we can use it. And the scores help predict resistance and tailor interventions. Okay, so we want to give them a one to five scale.

Staff believe change is important, leaders are supportive, resources are available, and I feel I can adapt.

Also, we want to realize. Frances Free and Ann Morris highlight that speed and change is only effective when we have trust. So we want to be really building trust when we're doing the buy in phase. Speed breaks trust, and leaders must communicate clearly, admit their own missteps, and demonstrate reliability to build that trust and speed. Then we're going to move to competence.

So buy in means nothing without competence. People must feel capable. So when we look at competence, we want to make sure that our people have effective training with hands on exercises to ensure staff practice the change, not just hear about it. Job aids to provide reminders, checklists and

help staff apply their new processes. One on one.

Coaching from supervisors to reinforce and access to subject matter experts that allow staff to ask questions and avoid missteps. Competence builds will bridge the gap between understanding and action. So without it, change creates anxiety instead of progress. So we always want to look at competence. What do our people need to feel competent in this change?

And then lastly, support. So feedback from employees surfaces challenges and ideas for improvement. So we always want to be looking for feedback from our employees. Celebrations and recognition will motivate staff and show progress. Aligning incentive programs ensures that what is rewarded matches the new behavior.

And then accountability systems make sure that change is monitored, not forgotten. So when leaders provide consistent support, staff feel validated and adoption becomes embedded in the culture. And that's what we're looking to do. So These are the ABCs of change management. Also, I want to say something about support.

When you give your people the support they need, hidden potential emerges when people receive scaffolding, which is mentoring, coaching and safety nets. Support systems drive growth more than an innate talent. So if you have somebody who doesn't have the innate talent necessarily, but you give them this scaffolding approach to support, they will step up. Leaders who invest in scaffolding multiply their team's capability for change. So we want, we want to look at supporting it.

But also by supporting it, we're unleashing more potential in our people. Okay? So awareness creates clarity, buy in creates motivation. Competence creates confidence, and support creates momentum. That's how change sticks.

Also, and this is a big one for me because I operate from a positive psychology perspective. So positive psychology doesn't mean just stay positive. It means intentionally activating the emotions, mindsets and habits that help us adapt things.

Positive psychology has what they call the perma model. P E R, M A. And this slide will show you some of the things in the perma model. The first is the practice. Positive emotions and humor.

So when we have humor, joy, moments of lightness in our work environment, it counterbalances our brain's negativity response. I always teach the 70% rule. 70% of what you say in your work environment, really in your home environment too. 70% of what you say should be positive, okay? And not fake positive.

Find real positive things. So a leader explaining change with warmth, some humor and empathy helps to calm your nervous system.

Then laughter. Laughter is so important. If you have one good belly laugh. The hormones that released into your body will keep you feeling good forever hours after your big belly laugh. So try to get laughter in your environment.

Next is engagement. This is to be fully into your work. Okay? Positive psychology tells us that engagement grows when people feel invested, included and connected. This is when you get in your flow.

Okay? So you're doing what you love to do and you're in the flow, fully absorbed. Okay? Engagement is also a natural stress reducer. Then we have meaning and purpose.

Remember your why? Why did I become a healthcare provider? Why did I choose this particular system to work in? Why do I continue to do this? Why do I make a change in people's lives?

Reconnecting to your purpose? Why our work matters, who we're serving changes how your brain interprets challenges and keeps you calm during change. Okay? People will will learn faster when they know why it matters to their work and they'll change faster.

Accomplishment and gratitude Support is where positive psychology comes fully alive. Okay. Celebrating small wins we reduce conflicting instructions this week creates momentum to keep going, recognizing effort. Thank you for adapting so quickly everyone. Reinforcement of belonging, gratitude.

Your teamwork is what made this possible. Now we have emotional resilience being created. People feel supported not just structurally but psychologically. And if you go back to your OTPT SLP going through their unified methodology, the leader explained everything and he then got some buy in each discipline gave input and why it mattered to them. Then team members received short hands on trainings and they realized this helps us deliver consistent care.

So competence and meaning and then support weekly check ins and their huddles celebrated the very small wins and thank yous to the team and recognition built momentum and kept morale high. Now let's look specifically at what leadership can do. Because we've looked at individuals, we've looked at the organization. Let's move to leadership.

This graphic describes the three components that are necessary for a successful transition. Leadership seems obvious, but it's amazing how many leaders delegate the change usually to the project management aspect. Who doesn't have any idea how to handle the change management with people or to someone else? Or maybe they give it to a team of people and then they take a hands off approach. This is not uncommon in leadership and that's why change management experts help them

understand you are integral here as well.

Many companies put so much emphasis on this that they forget the change management piece because they went right into that project management. So what we want leaders to do is realize how important they are in the change management. First the leader has to work through their reaction to the change. Maybe they're not happy about what's going on, but they have to do it anyway. Because the board of directors or someone else, joint commission whomever has said you need to change these things.

So the leader works through their reaction to the change management first or they're feeling really good about this change and it makes them not really care what everybody else is thinking. So they have to be aware, self awareness, part of emotional intelligence. Then they have to recognize change is hard and reactions will be different with all parts of the organization. And when they acknowledge that and not see it as a weakness or as somebody resisting for the wrong reasons, they will say I have to get my people through this in a healthy way. Help your staff using the ABCs of change leaders.

And then the leader has to model a change ready attitude no matter what. Sometimes we have to fake this till we make it as leaders. And lastly, communicate, Communicate, communicate. Leaders must communicate. Over communication is much better than under communication.

And the role of communication and change is extremely important. As you can imagine as we've been talking about this, good communication supports each of the ABCs of change.

Everyone has a role in communicating the change. So it's the leader at the top, it's your supervisors and managers, and it's each of us to our peers as well. So change management is not just from the top. Change management is the entire organization. Like I said earlier, we are all the agents of change when we're in the midst of change management.

And again, I've already said it's better to over communicate than to under communicate.

Now this is a model called transformative communication that I'm going to get to. Many large organizations already have communication teams or specialists. Those individuals are familiar with the general concept of building a communication plan. But if you're an organization that doesn't already have this function, it's important to assign someone or a small group of people to oversee building a communication plan. On some level, each of you contribute to this.

To make if we go back to our OTPT SLP clinic, they need a structured communication plan, not just a single announcement. A thoughtful repeated communication strategy aligns with the entire process. So here's how we identify our audiences. So in our case, the audiences are the OTPT SLPs. Also, the front desk can step and and scheduling staff, referring physicians and patients and families.

Each group has different needs, so we don't send the same message to everyone. That's why a communication plan is really important. Next we identify key messages and timing clinicians what's changing, why and what support is available? Front desk health scheduling and check ins processes will shift. Referring physicians.

What's our new standardized report? What does it look like and how will it improve continuity and patients? What can they expect? How will this benefit their care? We also sequence the timing of who gets this communication.

Clinicians should get it first, then support staff, then referring physicians and then the patients. Now we determine the content and the frequency. This is communicate. This can't be just communicated once. But our plan includes.

You have your initial kickoff meeting. Then you might do a one page summary to everyone. You do a weekly fact updates for for the first four weeks. You might even do short training videos, quick huddles to reinforce progress. So frequency prevents assumptions.

Number four determine frequency and senders. And just as important as the message is who delivers the message. So the first person is the clinic director announces the change. That's probably in an all staff meeting. Then each discipline leads.

They reinforce it in team specific huddles. So the OTPT SLP leads reinforce this in their huddles. The front desk supervisor communicates workflow and changes to their staff. And then clinicians explain the change to patients. The messenger matters.

People need to hear from the person they trust the most in their workflow. And I can't say it enough. Without a communication plan, change feels chaotic. With a communication plan, every stakeholder knows what's coming, why it matters and how they fit into the system of change.

Now I mentioned this. The connect model is from my training transformative communication. It's one communication model that if you take transformative communication, we'll go through this in great detail. But just to run through it right now you're going to look at controlling emotions, offering respect, naming facts, name response, explaining your position, common goals and test assumptions. This ensures that resistance can be addressed.

Okay, common communication mistakes that we make. We think telling people means that they are truly listening and understanding. And that is not necessarily true. So communication, while well planned, we make sure we are not just telling people change. Communication requires empathy and timing.

Research in organizational psychology shows us that when we are under stress, our brain is not taking in information like it would if we're not under stress. So if you're announcing things and people have that immediate oh my gosh, what does this mean? All this thoughts running through their head. They're not processing what you're telling them. That's why we have to keep telling them more.

Okay, so in our example I'm going to give you a new one. So imagine a hospital introducing A new electronic medical record. The leadership announces the rollout in one town hall meeting and sends one email summary. Weeks later, they're shocked. Nurses are not using this, and there's confusion.

The problem was not lack of information. It was the communication mistakes. So we stopped at telling people without ensuring comprehension and emotional responses. So we need to make sure that communication is not about volume, but it's about did people hear it? Okay.

We don't move just because we've been informed. We move because we understand why we're moving and we can do everything right. Okay. And still meet resistance. It's not uncommon to have resistance when we're doing change management.

So let's take a look at resistance. One way of looking at resistance is, is the lack of motivation to change. So many things that motivate people are important to look at when it comes to resistance. So let's look at why resistance happens.

Resistance occurs for valid reasons. It may be emotional, such as fear, fatigue, or burnout. It might be cognitive, such as lack of understanding or misinformation. Or it could be structural, such as limited resources or increased workload. We need to look at all three of those.

So when leaders need to diagnose resistance, they can't just do blanket solutions. We have to get to that root cause. Also, keep in mind, resistance can be really subtle. Okay? It could be negativity, like

gossip, complaints, celebrating failure instead of changing.

It could be avoidance, going right back to old habits, ignoring the new systems. It might be the people build barriers so they start recruiting people who don't want to change. And secrecy creates counter initiatives could be being controlling. So using your status to slow change or to defend the current way, when we recognize all of these signals, we can do resistance management also. Now, sometimes I work in organizations where they're like, just ignore it.

The resistance will go away. Everybody will get on board eventually. And I highly recommend you never, ever ignore resistance. And here's why.

When resistance is ignored, adoption rates plummet, staff disengages, turnover rises, and patient safety risks increase. So especially in healthcare, ignoring resistance isn't just costly, it's dangerous. And I want you to keep in mind that resistance signals where your attention is needed. Okay, so resistance prevention. Okay, so we're going to talk about that new.

That hospital rolling out the new AI system, supporting clinical documentation. Instead of surprising the staff, leadership brings in nurses, physicians, occupational therapists, medical assistants, and they all help in the planning phase early. So they're planning for it, they're addressing it. They're eliminating resistance by effectively applying they design workflows, give feedback, and because staff feels included, they want to help do the change management. This will reduce your resistance.

The second is proactive resistance management. So catching barriers early.

During early training sessions, the implementation team notices that the night shift nurses are much more hesitant than the day shift. They worry that the AI tool. The nurses on night shift worry that the AI tool will slow them down during high acuity admissions. Now, rather than waiting for that resistance to

escalate, the leaders run a quick workflow test on the night shift. It identifies specific bottlenecks and then they adjust the prompt tools for the night shift.

Proactively addressing these concerns prevented a much louder wave of resistance from growing.

And number three, resistance response. When resistance becomes persistent, a small group of physicians continues to refuse to use the AI tool after months of the launch. Their concern is accuracy and medical legal exposure. Two totally valid reasons to be resisting. Leadership responds by scheduling peer led demonstrations, sharing updated accuracy and safety data, and offering one on one coaching and allowing a temporary hybrid of the new work over time.

The resistant group starts to adopt the tool because their concerns were acknowledged, not dismissed. Okay, so resistance doesn't mean people are being difficult. Resistance means something important needs our attention.

And here's how we can use the Connect model in the resistance. So here's an example of a nurse being told that she has to use a new checklist. And the nurse says to the leader, this is extra work. At that point the leader can control their emotions. Before reacting, they can offer respect.

I hear your concerns about this. They can name the facts. I know it adds two minutes, but it reduces the errors by 20%. Then they wait and note the nurse's response back. They explain their position if needed.

They emphasize a common goal such as patient safety. And then they test assumptions by asking open ended questions. This Connect model and how we communicate it turns resistance into dialogue and a shared problem solving. And we're going to go back to psychological safety for a minute here because as we know, teams with psychological safety will speak up, share new ideas, admit mistakes

and sustain improvements more effectively and change management. As I said before, psychological safety reduces the fear that fuels resistance.

Here are some micro behaviors of leaders to bring in that psychological safety. Some of them we've talked about, but I'm going to review them again. The leaders can ask what might I be missing? That shows openness to the team. They thank the staff for raising their concerns, sharing their own learning experiences, and they always, always follow up on the input.

These micro behaviors signal that it's safe to speak Up. Okay, so in the hospital that's rolling out the AI enabled system, the change creates anxiety in nurses, who worry that it will override their clinical judgment. Okay, but the leadership says, what am I missing? During the huddle, the emergency department director says, before we finalize this workflow, what might I be missing? From your perspective on the floor?

Which gives the nurse the opportunity to explain that alert timing interrupts medication administration. The leader validates the input and adjusts the schedule. The impact was the nurse felt heard. They recognize the leader as curious and not defensive. Then a physician challenges the accuracy of the AI's risk scores.

Instead of shutting it down, the director says, thank you. That's exactly the kind of critical thinking we need. Let's dig into seeing what you're seeing. The impact was the descent becomes safe, and then they can change things. The director admits, when I first saw the tool, I misunderstood how the risk buckets were calculated, and I had to ask the data team to walk me through it again.

Impact, the leader models humility, which reduces shame and creates psychological safety. And after the rollout, the director emails the staff with updates. You raise concerns about duplicate documentation. We worked with it, and we removed three unnecessary fields. The impact staff see that

feedback doesn't disappear into a void.

And. And when I work in hospital settings in particular, that's one of the things I hear is, yeah, we do change all the time. But you know what? It never lasts because they don't really listen to us. And so, especially in hospital systems, we have to be as leaders, listening and showing them we heard by our change.

Okay, so micro behaviors are small, consistent signals that tell staff it's safe to speak up. And I hear you.

And here's a little bit of data on leadership and resistance that helps us before the change and during the change.

Okay. Evidence supports all of these approaches we talked about.

There's also a tool called a resistance journal. This is a practical tool. Leaders can log the resistance, the type of resistance, the response attempted, and the outcome. They log these four things for a period of time, and then they go back and they analyze them. AI can actually help us do that.

Right. So this allows leaders to move from a reactive response to a proactive response. So I always recommend, if you're really seeing resistance, try using a resistance journal before acting.

And here's your takeaways for resistance. Resistance is data. It is not defiance. And we should never treat our employees like they're being defiant. Leaders should diagnose whether it's an emotional reaction, a cognitive resistance, or a structural Resistance.

Then you apply good communication like the connect model and make sure there's psychological safety strategies in place. And then you get to adoption and engagement. And finally, leaders must model the behaviors they want to see. So they want to be curious, they want to be respectful, they want to be open because culture will always follow your leadership. And so many leaders don't realize that because they go off into their offices and not see it.

But it's very, very important.

Now I want to talk about change fatigue for a minute. So these governing bodies talk about change fatigue and that not all change is good. Okay, so this is the research that you can look to burnout and stress because of change fatigue.

Identify the change fatigue in nursing is that medium to high levels workload, overtime, new tech increases fatigue. And we need to support people to give them buffers. The leadership implication of these things is that we have to sequence how we do change management. When we're introducing changes, we don't want to throw them at people all at one time. We need to say, okay, what do we want to do first?

What do we want to do second? And really sequence all of these things. We want to normalize to our employees that there is a workload trade off to changes that we make because they will feel it. And if we don't normalize that, they just think we don't care. As leaders, we want to embed 30, 60, 90 day reviews that I'll talk about.

We want to treat resistance as data, not defiance. And we want to align our recognition and psychological safety practices. And going back to not all change is good. Ashley Goodall's the Problem with change in 2024 challenges a common belief that more change is always beneficial. He highlights that excessive and poorly justified change creates the fatigue, lower morale and can erode

performance.

And the data we just looked at said absolutely, that's what happens. So leaders have to look to have wisdom to distinguish between change that's essential and change that causes the disruption without a clear benefit. In a health care application, a high stakes environment such as hospitals piling on change initiatives without proper sequencing can lead to burnout and errors and losing people along the way. So protecting stability is just as important as driving innovation.

Now let's assume you've done all your ABCs of change and suddenly it looks like things are not sticking. What do we do now? We have to remember habit formation. So it's not just enough to say let's do this now we have to do repetition. Charles Duig's work on what we call the habit loop Highlights this repetition need.

So we staff need opportunities to practice along the way. They need clear cues, so visual reminders, checklists, automated reinforcement, automated reinforcement. They need reinforcement, positive recognition and feedback that helps secure commitment, motivation. And again, we need leadership modeling. So when leaders consistently model, the new way of working, staff follows.

We've talked about that already, but here's a model from doing that says, this is absolutely what happens when we're forming a habit in our healthcare systems.

The message here is clear. Change doesn't end at implementation. It becomes real when we repeat it, repeat it, reinforce it, reinforcement and model it.

And lastly, why does it fail? Why does sustainment just flat out fail? Because it fades after the pilot. Because competing priorities are there. Because lack of reinforcement and a big one, no accountability.

So we have to make sure we're having an accountability system to keep sustainment.

We want to talk about a scale, a scale up checklist. So a lot of times when we're doing change initiatives, we try to do them system wide. And what we recommend really is that you do a pilot project first and then you scale it up. Okay, so when we talk about successful scaling of a pilot, it's important to realize that not every pilot is ready to scale. Expansion without readiness is one of the most common reasons system wide initiatives fail.

So this checklist will help you ensure that. Are you able to scale deliberately rather than reactively? First, are the pilot results clear? So we're looking for consistent signal, not just one week of data, but ongoing data that shows improvement, stability and alignment with the outcomes we're targeting. Then do we have the resources to scale?

This includes staff time, technology support, funding and the capacity to to manage the rollout. Scaling always adds a load to the system, so we need to confirm that the system can carry the load. Third, is staff trained and comfortable with the change. Scaling doesn't work if a clinic interprets change differently from the pilot project. So standard training, clear workflows and job aids need to be done before scaling a project.

And fourth, is leadership committed at every level, so local leadership buy in is essential, otherwise the initiative will run into individual invisible roadblocks like competing priorities, limited support or passive resistance. And finally, are the measurement systems in place to monitor implementation? So before scaling, we have to make sure we have run charts, dashboards, basic metrics so we can track the fidelity, the adoption and the outcomes across all of the sites. We want to identify early signals that something isn't working. So this checklist will protect your organization from what I call premature scaling and it will increase the Likelihood that a strong pilot project can successfully can successfully evolve into a sustainable system wide improvement.

And then I talked about the 30, 60, 90 day reviews. So at 30 days you want to measure the adoption. So how is it going? So the chief information Officer might say 78% of clinicians have used the AI tool at least once. Only 42% are using them consistently.

So the leadership now knows the adoption is uneven and confidence is an emerging barrier at 60 days. What happened at 60 days? A structured survey. Focus groups identify specific challenges. An example providers report.

I forget to activate the tool training apps. I'm not sure how to customize templates. Lag time in voice to text conversion. If you get all of these things, it can accelerate system optimization and learning and development. Schedules are scheduled for 20 minute refreshers.

And then at 90 days leadership evaluates progress and decides how to strengthen and modify the rollout. Consistent use has increased to 71% and documentation time has decreased system wide. Providers who received coaching showed significantly higher satisfaction. And the new workflow is added to the medical record system. So the outcome is the change is reinforced.

Because adoption is solid, coaching programs become permanent now. So this 30, 60, 90 day review is critical. We want to ask three questions when we're doing changes as well. What are we stopping? So what outdated practices or habits are we going to let go of?

What are we going to start? What new strategies or behaviors should we introduce to align with our goals? And lastly, what are we going to continue? What's already working? What should we maintain?

Too often we focus on what's broken. Let's also remember that we're doing change. We have to also say these are the things we're continuing because they work really well. And this model works well

because it's structured, easy to remember and encourages a balanced reflection. It's not just skepticism, but it also recognizes our success.

So.

So here's our key takeaways from sustainment and scalability.

Change fades without reinforcement. 30, 60, 90 day reviews anchor new practices. Habits and Feedlo feedback loops drive sustainment and scale cautiously only after success and anti fragility for continuous improvement. You want to make sure your system is not fragile. Okay, I'm going to shift now to AI transformation.

So first, human first, tech second. And we don't always do that. Brian Evergreen in 2023 emphasizes that AI transformation is not only about adopting new tools. So just like all the change management we've reviewed up until now, he said that successful implementation requires redesigning structures, workflows and culture to ensure that automation enhances human flourishing. Without this balance, AI adoption risk alienates the workforce and undermines patient care.

So when we talk about integrating AI into healthcare, governance and safety are not optional, they are foundational. Global bodies like the World Health Organization have already issued more than 40 recommendations around ethics, governance and large language models of AI. These emphasize transparency, human oversight and risk management. Professional organizations like the American Medical association, the American Psychological association, ot, pt, slp, all of these professional organizations are now saying that oversight, oversight, liability, clarity and explicit attention to bias mitigation. Because AI can be bias.

Okay, you'll see some of the other agencies. The FDA now provides a lifecycle guidance for AI for enabled medical devices and operationally. The Joint Commission has now rolled out a responsible use of health data certification in partnership with chia, emphasizing trust and accountability. So for leaders, you can't just sit and say these are policies documents alone. These have to be baked into your AI strategy and operationalized through things like the plan, do, study, act cycles.

This is how organizations move from compliance to real world trust. Let's talk about risk that isn't discussed enough in healthcare. De skilling the gradual erosion of clinical skills when we rely on AI. So when we're talking about change and change management, we have to keep this in mind. And some of the things that have been brought forth as ways to prevent this is have what we call AI off intervals.

So these are intentional periods where clinicians practice without AI support so they maintain their sharpness and their independent judgment. So this could be somebody who's reading scans every fifth scan they read without AI assistance. The goal again is not to replace AI or to go backwards. It's to preserve the human experience while benefiting from AI augmentation.

Okay, so let's pull this all together now. So we've talked about the models, the individual, the organization. We added in some AI at the end because that's so important in our world right now. Effective change management is about integrating practices before, during and after the change. So before the change, leaders strengthen trust, build teams and understand both themselves and others.

This reduces resistance during the change, emotional intelligence to anticipate resistance, communicate often and clearly, and reinforce purpose and direction. And after the implementation, sustain momentum by gathering feedback, recognizing contributions, providing ongoing support, and celebrate successes. When leaders view change as a continuous process rather than a one time event, they create a culture where change becomes part of how your organization thrives.

So as we end today, I want to thank you for your commitment to deepening your capacity as a change leader in health care. The work you do is complex. It requires not only clinical excellence, but emotional intelligence, adaptability, and a willingness to guide others through uncertainty. Change management is not a single skill. It's a discipline.

It's a mindset and a practice. And every time you engage in trainings like this, you strengthen your ability to influence culture, support teams, and ultimately improve patient experience. So healthcare will continue to evolve rapidly. Technology, workflows, patient needs. But your ability to lead through those changes remains one of the greatest predictors of the success and well being.

So I invite you to choose one practice you'll implement in the next 30 days. Maybe a new communication habit. Maybe build some psychological safety. Maybe start using the ABCs of change management. Small changes create meaningful momentum.

Thank you for your time and your attention. And most importantly, I want to thank you for being dedicated to the healthcare system and to all of the patients that you serve. Thank you.