# Steps in Leading Change through Process Improvement

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## Introduction

We all agree that change is more likely when organizations are ready for it. Sometimes, and for some organizations, change is in the air. When you want to change things, everything falls into place. Everyone comes on board easily and willingly. Other times, everything is a fight. Change seems impossible. It seems reasonable to think that organizations differ in their readiness for change. But how do we know if an organization is ready? What if it is not; what do we do then? These two questions are the topic of today's lecture.

## Readiness for Change

Often when we face a situation, we think it is unique. We think we are different from others. We think we will work harder and smarter than others. So we go about our business, without imagining what we can learn from others and from their attempts to change. Almost everyone thinks that they are better at changing things than the average person! Here is a contradiction in terms. How is it possible that everyone, or even most people, are better than average. By definition half should be worse than average.

 We tend to think we can beat the odds. We are optimistic and have confidence in ourselves. But no matter how unique the situation, and how experienced we are, there is a lot we can learn about our own chances from experience of others. Researchers have examined and compared organizations and found that certain characteristics of the organization improve the chances for success.

 Understanding the organization's readiness is important because there are situations where we will succeed despite ourselves and situations where we are likely to fail no matter how hard we try. Without learning from the failures and successes of others, we are just as likely to repeat their mistakes. With learning, we can stand on their shoulders and see problems before it is too late.

## Leadership

Leadership is the ability of making organizations change for the better. Much has been written on leadership. We do not wish to replicate many fine books that have already been written on leadership. Drucker, for example, has arrived to the following conclusion about leadership:

* "There may be "born leaders," but there surely are too few to depend on them. Leadership must be learned.
* An effective leader is not someone who is loved or admired. He or she is someone whose followers do the right things. Popularity is not leadership. Results are.
* Leaders are highly visible. They, therefore, set examples.
* Leadership is not rank, privileges, titles or money. It is responsibility.
* Effective leaders do not ask "what do I want?" but "what needs to be done?"
* Effective leaders are not afraid of strengths in their associates.
* Effective leaders submit themselves to the "mirror test" -- that is they made sure that the person they saw in the mirror in the morning was the kind of person they wanted to be, respect, and believe in.
* Effective leaders delegate a good many things."

For another example, Kotter in his book titled "Leading change, Harvard Business Review 1996" lists eight steps in successful efforts to change organizations:

1. Establish a sense of urgency
2. Create the guiding coalition
3. Develop a vision and strategy
4. Communicate the vision
5. Empower employees for broad-based action
6. Generate short term wins
7. Consolidate gains and produce more change
8. Anchor new approaches in the organization culture

One way to look at Total Quality Management is as a set of steps to lead organizational change. In this perspective, leaders create the environment in which others succeed. The following presents the key principles that leaders can take to create an exciting environment for change.

## Does Quality Improvement Work?

This course is about managing change in organizations; and this lecture, in particular, is about preparing organizations for change. The course focuses on quality improvement techniques. Naturally, before we start you want to know what data we have that it works and that you can succeed using this approach. Of course, almost all quality improvement projects lead to some kind of improvement in one corner of the organization, but the real question is whether these individual projects are big enough to leading to lasting improvements in the entire organization. At least 7 studies address this issue:

* Shortell and colleagues in survey of 61 hospitals found that "a participative, flexible, risk-taking organizational culture was significantly related to quality improvement implementation. Quality improvement implementation, in turn, was positively associated with greater perceived patient outcomes and human resource development."
* Curley, McEachern and Speroff randomly assigned patients to a unit where clinicians were trained in quality improvement (interdisciplinary team work) concepts. The unit trained in quality improvement had lower cost of care. In particular, "the mean LOS for interdisciplinary rounds was 5.46 days, compared with 6.06 days for traditional care (P = 0.006), whereas mean total charges were $6,681 and $8,090 (P = 0.002) for the two groups, respectively."
* Goldberg and colleagues conducted a randomized controlled trial of Quality Improvement teams and academic detailing ( a procedure where a clinicians from an academic medical center visits the community clinic and walks through cases together). They examined the relative effectiveness of these two methods in changing care of hypertensive and depressed patients. They found that clinics differed considerably in their implementation of Quality Improvement. Because of this variability in implementation, not all organizations were effective. Quality Improvement was most effective when it was implemented faithfully and when it was combined with detailing.
* Alemi and colleagues study of 92 improvement efforts found that improvement projects self-reported changes in a number of organizational variables. Two percent report reducing cost of services, 8% report increasing market share, 12% report increasing patient satisfaction with care, up to 13% report improved patient care outcomes and up to 30% of projects report improving employee work life.

So what does all this tell us about whether quality improvement works? As Shortell puts it: the glass could be half empty or half full. These data tell us that quality improvement works sometimes but all the time. It tells us that quality improvement can help if:

1. Correctly implemented.
2. Over long time periods.
3. Focused on significant problems.

## 10 Steps to Successful

The first five of these steps are focused on what organizational leaders should do. We address these five steps in this lecture. A later document addresses the steps that improvement teams have to do

## Step 1: Set Mandate

### Start from the top

Change is difficult. Without top management support change is not likely to succeed. Clinicians who want to bring about organizational changes should engage top management and managers who want to change practice patterns should engage clinicians. Both groups need each other.

Gustafson and Hundt reviewed studies examining the role of top management in successful implementation of innovations. Six studies supported the assertion that top management involvement helps. These six findings were:

1. Firms that do not innovate tend to use resources already allocated for other purposes for new changes.
2. Firms that innovate successfully have funds designated for the innovation.
3. Firms that innovate successfully sponsor the innovation throughout the organization.
4. Firms that do not innovate successfully lack a formal commitment from organization.
5. Firms that innovate successfully have sufficient human resources and funds allocated to the innovation.
6. When implementation is sponsored by organizations, innovations are more likely to succeed.

In addition to budgets and human resource allocations, top management also set the environment in which the change will occur. Without a positive change environment change is less likely. The very principles of PROCESS IMPROVEMENT, blaming the system not the people, requires top management initiative and example.

###  What should the top management do?

Cummings TG, and Worley CG (Organization development and change, 1993) suggest the following steps for managing change:

1. Motivate change
* Create readiness for change by highlighting the discrepancies between now and the future.
* Overcome resistance for change by involving people in the change, by dealing with the emotions concerning the change, and by clear communications.
1. Create a vision.
* Statement of the vision. Management gives a picture of the future.
* What are the valued outcomes? Give tangible goals.
* What are the valued conditions? Clarify what are valuable responses to the environment.
* What are the midpoint goals? Show to get there from here.
1. Develop political support.
* Assess the change agent power and acknowledge that the process is sanctioned at the highest level of the organization.
* Identify key stakeholders that may be affected by the change, both inside and outside the organization.
* Influence stakeholders to see in broad terms why change is necessary.
1. Manage the transition
2. Plan for key activities including the specification of sequence of activities to take place, and when will we know if we have succeeded.
3. Plan for commitment. Get the support of key people concerning specific activities.
4. Set management structure and resources. Set up parallel learning structures in order to experiment, to facilitate, or to provide leadership in the change process.
5. Sustain momentum
* Provide resources for change.
* Build a support system for change agents. Without emotional support, change agents may burn out from their early failures.
* Develop new competencies and skills. Allow for acquisition of skills missing.
* Reinforce new behavior. Set clear incentives for implementing the new innovation.

## Step 2. Set Culture

 To set a culture that encourages change, leaders of the organization need to take the following steps:

1. Rely on customer's experiences
2. Avoid Blame
3. Rely on data
4. Rely on teams
5. Involve all

Each of these are discussed below.

### Rely on customers' experiences

Not long ago there was a pervasive feeling among health care managers and clinicians that patients do not know the quality of health care services. In this sense, asking from the patient about quality was considered inappropriate. Instead, judgments of quality were left to the clinicians, hence the creation and promotion of peer review organizations. But process improvement requires a focus on the patient experiences. While the patient may not know the latest medical advances, the patient does know about his/her own experiences. The patient is aware of his life style objectives. The patient is aware of his functional capabilities. In this context, medical services are evaluated by the patient through how they affect his/her day to day life. "Did the operation help me walk easier?" asks a patient undergoing hip fracture operation. A patient undergoing cancer treatment may ask "Does the treatment let me stay with my loved ones longer?" Patients can report their health status in terms of their daily living activities, socialization, ability to keep up with their social roles, and other things. Although they may not understand the medical aspect of the health services, patients can judge the effect of these services on their health status.

Organizations grow through increasing their market share. Process improvement helps organizations increase their market share through improving the quality of services provided to the customers. Larger market share requires organizations to keep their current customers and attract new ones. By focusing on customers, diverse and sometimes conflicting professional agenda can come to address a common perspective: that of the patient. A focus on customers provides a clearer picture of what is wrong with the organization and what needs to be fixed. Customers can tell organizations what is not working without thinking through inter-organizational politics. In the end, patients and their families choose health care services. Despite a growth of contractual arrangements, third party referrals, and other disease management innovations, in the end it is the patient who decide which health plan he/she belongs. A focus on the patient helps the organization sell its product more effectively to other intermediary decision makers who also share the organization's concerns about patient care.

### Avoid Blame

People who apply process improvement believe that problems in delivery of services is not as much a function of the people involved as it is a function of the systems and processes supporting health workers. Thus, process improvement cannot be used to cut people's jobs. It cannot be used to focus training resources on a few individuals. The purpose of process improvement is not to find the bad apples and toss them but to improve every apple in the basket, the good and the bad. This improvement is expected to occur not through changing personnel but through on-the-job training, re-designing delivery systems and improving management. Here is an example that students may readily identify with:

I was teaching a class in Quality Management and a group of students approached me to tell me how frustrated they were that one group member was not contributing as much as they had been. I thought about this complaint and it occurred to me how their reaction was inappropriate. Essentially, they wished to punish a person for poor performance. They were blaming the other group member for being lazy. A manager following process improvement would try to understand the process that prevents the group member from participating and then suggest solutions. He may gather data on the group member's participation before and after implementing the solution. He would see the lack of participation as a function of the communication processes, resource availability, or other functions. So next time you are frustrated by an unhelpful partner, don't ask how you could get rid of him/her. Put yourself in his/her seat and try to understand why. Help him/her do more and that would be in the spirit of process improvement. There are two reasons for following this principle. First, many believe system problems occur more often than people problems. Health workers, given properly working systems, will carry through with their jobs.

The second argument is that a focus on deficient people will force them to become defensive and resistant to change. The atmosphere will worsen. Workers will become angry, defensive, and communication channels will suffer. In this regard, Don Berwick MD writes in New England Journal of medicine [1989, 320 (1): 53]:

"Practically no system of measurement - at least none that measures people's performance, is robust enough to survive fear of those who are measured. Most measurement tools eventually come under the control of those studied, and in their fear such people do not ask what measurement can tell them, but rather how they can make it safe. The inspector says, "I will find out if you are deficient." The subject replies, "I will therefore prove I am not deficient" -- and seeks not understanding, but escape."

Blaming people makes them fear their jobs. In an atmosphere of fear, little constructive and participatory change can occur.

### Rely on Data

There is no guarantee in medicine. Some variations in outcomes occur by chance. Occasionally, even the best clinicians have unexpected adverse outcomes. The focus should not be on these occasional unexpected events but on whether a pattern exists. Data can help us examine patterns of outcomes. Analysis can help us understand whether the observed outcomes are due to our effort or to random chance.

This principle says that our experience, to the extent that it relies on one case study, is not relevant. What matters is observed patterns. This is hard to accept sometimes. After all, if we cannot trust our own judgment, then what can we trust. Process improvement suggests that we should trust observed data. Data across different experiences rather than a single situation.

Within the process improvement approach, it is not enough to haphazardly select a problem to work on. You must have data for the extent of problems and select to work on the most significant problem first. You need to show that the proposed problem is real. You need to point to repeated customers experiences that documents a problem.

In short, when a person using process improvement faces an advertiser's claim that their hamburger is better, he/she will ask "where is the beef?"

When a claim is made that the problem is solved, again you need data. It is not enough to believe that the problem has disappeared. You must give evidence that this is the case. You must observe the process before and after implementing your solution to show that indeed you have solved the problem. You must prove your point. Even if the point is being made just to yourself, you still need data to convince yourself that change has led to improvement. Furthermore, that you need to analyze the data to make sure that it meets your claims. The emphasis of process improvement on statistical quality control distinguishes this approach from many other management approaches.

Data has different meaning to people. Data could be qualitative. Data could be based on experience. Process improvement does not exclude qualitative data. What process improvement analysis insists on is that there should be a pattern. Claims cannot be supported by pointing to one case or one experience. There must be a number of cases or experiences so that we are sure that the observation is not due to random chance events.

Data are needed to distinguish between random variation and variation due to changes in the underlying process. Why is the understanding and control of variation so important? Dr. Donald Berwick writes in Medical Care [1991, 29 (12): 1212-1225.]:

"The answer, simply put, is that variation is a thief. It robs from processes, products and services the qualities that they are intended to have. Variations is in processes what heat is in mechanical systems: evidence of wasted energy. Variation in processes is what entropy is in thermodynamic systems: evidence of the loss of information and of confounding of prediction."

Understanding sources of variation is important so that we are not misled.

### Rely on Interdisciplinary Teams

It takes a village to raise a child. It takes a team to put man on the moon. Team work is necessary for completing complex tasks. Changing organizations, even simple changes, are difficult to accomplish and require team work. Working with teams means that you will take time to socialize with each other, to bring each other up to par concerning the process improvement project, to accept solutions that may not agree with your intuitions. Change by fiat, change because I told you so, will not work. Team work means team members can participate in selecting what to work on, in gathering data and in suggesting solutions.

Teams should be composed of people from different disciplines. Nurses and physicians should talk to each other about how the system should change. For some time now, Clinicians have worked in teams to care for patients.

Clinicians are familiar with team work. What is unusual about process improvement is that for the first time it puts managers and clinicians in the same team: solving patient problems. This gives clinicians a role in management. It also gives managers a role in clinical care. It creates a new environment, where clinicians and managers begin to share a common insight into the life and attitudes of the patient. Instead of divergent and conflicting point of views, the patient experience is the common thread that brings inter-disciplinary teams to common perspectives.

Onetime I was teaching a class on quality management to a group of nurses, physicians and managers. Obviously, I expected that there would be conflict among the nurses and the physicians concerning autonomy and limits of practice. Contrary to my expectations the biggest conflict was between managers and the physicians in the class. The conflict did not center on the typical issues that budgets interfere with patient care. No, the conflict was much deeper. The clinicians felt, and the physicians among them strongly articulated, that good management was not a science. They felt that anyone can become a manager. Good management did not need schooling. They believed what they did was scientific and extensive schooling was necessary to succeed in it. In other words, the clinicians undervalued what it takes to prepare as a manager and overvalued their own professional preparation. We entered into a heated discussion, where each profession argued on his/her own behalf. When managers reviewed their training and reviewed with class the experimental data behind their training, the clinicians came around with more interest. In the end, we came to an interesting compromise. The class accepted that team work did not mean that we should act like each other. Physicians were not managers nor were managers making clinical decisions. But every profession needed to accept the legitimacy of the other professions in helping to solve the problem at hand. In the end, it was the patient experiences that brought the team together. Despite the conflict among them, they agreed that what counts is who can make the patient experience better and healthier. Any profession that can do so is welcomed and appreciated. Managers can take many steps that affects patient clinical experiences. Physicians can take many decisions that affect organization wide management issues. What resolves the conflict and the practice boundaries is the effect of these decisions on the patient experiences. I thought that the class had arrived at a mature decision concerning what really matters. Instead of fighting with each other about turf, they were focused on the customer.

Relying on teams make sense because:

* We all have experiences about how committee meetings, group projects, and team work have been frustrating. Later in this course, I teach about how to avoid pitfalls of group work. But assuming that we can have effective team work, why should we do it. Why should we not rely on individual initiative and effort instead of the much harder group work? Teams are more effective than individuals because:
* The more the number of people involved, the higher the pool of ideas available for decision making. When more ideas are around, the chance of premature closure of problem solving effort is reduced. Team members question each other’s assumptions. They act as a check a balance against each other's idiosyncrasies. Organizations are so large that few individuals have detailed understanding of the entire process. When interdisciplinary teams are involved, more perspectives and experiences are brought to bear on the problem. Interdisciplinary teams are more aware of the nuances of the problem than any one individual in the team. Thus, effective teams may have better judgments than an individual.
* Team work facilitates communication. People in the team need to discuss issues and convince one another. These communications are the prelude of what is going to come when change is implemented throughout the organization. In essence, communication among the team members is a microcosms of what is needed for an organization-wide change. Individuals, in contrast, often know something but do not know how they come to know it. They are not aware of their own reasoning. They just know intuitively that something is right. When it comes to explain their ideas to others and to convince them, they fall short. Because individuals do not need to communicate their ideas to themselves, the communication effort does not start early. And, there is not as much experience with it. As a consequence of poor communication, ideas emerging from individuals may be less likely to be implemented.
* More hands on deck. Teams can do more because they have more people in them. This is an instance that more is better. Tasks can be allocated to more individuals. This is important in accomplishing tasks. It is also important in implementing the team's decision afterwards. Each team member becomes an agent for change. Individual works limits the number of people around to change the rest of the organization.

### Involve All

This principle has several interpretations. First, it means that everyone can help the improvement process. From the CEO to the janitor, all employees can help the process improvement. Quality improvement is not limited to a department. It is what everyone should do every day at their work.

A second interpretation of this principle is that everyone can improve -- even the best among us. Other approaches, like Physicians Review organizations, are focused on finding the "bad apples." Process improvement tries to improve the average employees. The focus is not on a few statistically abnormal cases but the entire group of employees. The intent is to improve the average health worker's job. Involving everyone makes sense because:

* Involving everyone in the change, reduces resistant to change.
* Focusing on the good and the bad apples, helps move the average performance higher.
* Implementation is easier when many organizational members have been involved in the change process.

## Step3: Allocate Funds

### Organize resource center

It is quite possible to conduct an organization-wide improvement without creating a new Department and a new expense for the organization. After all, employee participation in process improvement does not require additional pay. Most employees are asked to volunteer their time. Sometimes, this is time after work. Given process improvement's emphasis on employee participation as part of their current work, why should the organization pay for a process improvement resource center and its staff? In addition, given process improvement's claim that it wants to improve communication across departments and break down barriers, why should the process improvement resource center be organized as a department? Could it not just be part of an existing function?

In process improvement employees are organized in problem solving teams. These are autonomous self-governing teams. These teams design studies, collect information, and report their findings. In order to facilitate the team meetings, the data collection, the data analysis and the preparation of story boards, a facilitator often helps each team. The role of a facilitator is to help the team to achieve its goals, not to actively participate in the team's deliberation. While most employees participate without pay, the facilitator needs to be paid.

Of course, it is possible to conduct meetings without a facilitator. But such meetings inevitably run into problems because of the group skills of the chair of the meeting. Imagine a group of manager and clinicians conducting process improvements. Managers will hesitate taking a leadership role in order not to offend the egos of others present. Clinicians may not wish to facilitate the meeting as they want to actively participate in the meetings and may not have the time in between meetings to collect data and analyze it. A paralysis may emerge. The presence of the facilitator changes the equation. There is no longer a need for a chair and therefore difficulties of establishing who is in charge. There is no longer a need for worries of who will collect data and analyze it. The group can more effectively focus on the job at hand.

Because process improvement team members come from different departments, the budget for the quality resource center needs to be set by the top management. Otherwise, a squabble emerges over which functional unit of the organization should pay for the facilitator? In addition, management must hold the process improvement teams responsible to addressing central organizational issues and not minor issues.

Organizing a quality resource center requires selecting staff. Because these staff are agent of change within the organization it is important that the quality department has appropriate authority and prestige. Diverse experience in implementing various projects is necessary. Success is more likely when the leader of the resource center is respected by the rest of the organization. The staff need group facilitation expertise. They need statistical analysis expertise. They need to know about effective methods for sampling and data collection. Beside an experienced staff, the resource center also needs appropriate equipment and software. More recent group ware (software that helps groups of people work together) may be useful. Gadgets, back drops and flip charts needed for conducting meetings may be necessary. Computers for data analysis may be necessary. Equipment to design and prepare story boards is necessary. Use of technology to tell the story of improvement projects, e.g. video tapes, is also useful and is necessary.

## Step 4: Gather Data and Select Problems

It is best not to identify "the bad apples" among the providers. Any measurement should be used for improving everyone and not for focusing on select few.

Data are needed to track improvement efforts and to verify that implemented changes have adequately addressed the problem at hand. Prior to wide spread use of process improvement, outcomes were measured to identify poor performing providers, usually following these steps:

* Measure outcomes such as mortality, morbidity, patient satisfaction or health status.
* Stratify subgroup data
* Identify individual providers that are organizational outliers.
* Identify poor care provided by outliers.
* Determine corrective action.

When it comes to improvement efforts, this is not a reasonable course of action because it focuses on poor performing providers. Real process improvement should not blame anyone but seek system wide changes. In process improvement data are used in an entirely different way. Data are used to document customer's experience and compare the organization's experience with other organizations. When improvement team implement system wide changes, data is also used to trace whether the change has led to improvement and the problem has been solved.

## Step 5: Assign Teams to Problems

 French WL, and Bell CH write in their book Organization Development (Prentice Hall, Fifth Edition, 1995):

Teams are important for a number of reasons. First, much individual behavior is rooted in socio-cultural norms and values of the work team. If the team, as a team, changes those norms and values, the effects on individual behavior are immediate and lasting. Second many tasks are so complex they cannot be performed by individuals; people must work together to accomplish them. Third, teams create synergy, that is, the sum of the efforts of members of a team are far greater than the sum of the individual efforts of members of the team working alone. Fourth, teams satisfy people's needs for social interaction, status, recognition, and respect -- teams nurture human nature.

For each problem identified by the top management as a significant organization problem, the management should invite a team of individual to address it. A key question is what should be the composition of this team. The composition of the group is an important and generally controllable aspect of problem solving groups. The facilitator could choose group members based on whether they are an expert in the field, an employee intimately familiar with the process, or an employee representing an interest group, profession, or perspective affected by the judgment. The essential requirement is that they be people whose expertise is strong and preferably recognized by people who use the model. Some authors believe that some meetings should be staffed by people from the outside of the organization rather than from the inside. If the co-worker is an expert in the subject and well respected, there is no reason to ignore him/her in favor of an external expert. Representatives of particular perspectives are best used when acceptance of the decision is the prime criterion. Often management does not ask clinicians to participate in process improvement teams. Partially, because many clinicians do not report to the management, are paid on the basis of fee for service and not salary. This is a mistake. Teams should be composed of all relevant professions. If necessary, individuals from outside of the organization should also be asked to participate. The following is a set of principles that we have found useful in assigning employees or outsiders to teams"

* Assign the individuals close to the process to the team. They know more of what is really going on and their cooperation is most needed in carrying out the team's recommendations.
* Assign all relevant professions to the team. The more the pool of knowledge the less likely that relevant information is not considered.
* The number of members of the team should depend on the team's environment. Experiments with groups of various size have shown that if the quality of the group's solution is of considerable importance, it is useful to include a large number of members (e.g., seven to nine) so that many inputs are available to the group in making its decision. If the degree of consensus is of primary importance, it is useful to choose a smaller group (e.g., five to seven) so that members can have their opinions considered and discussed (Cummings, Huber, and Arendt, 1974, and Manners, 1975). It is a general rule of thumb that the group size should not be smaller than five or domination will occur; and it should not be larger than nine when size prevents some group members from participating.
* Heterogeneity of the group's background is closely related to the size of the group and is another important aspect of design of successful groups. A necessary, though not sufficient, requirement for accurate group judgments is to have an appropriate knowledge pool in the group. Since no one person is an expert in all aspects of a problem, diverse backgrounds and expertise are imperative for achieving this heterogeneity. Difference in background and knowledge could, however, accentuate the conflict between the group members and, if neither originality nor quality are criteria for evaluating the team's work, select group members to minimize differences in their backgrounds.
* Getting people to devote their time to a meeting is difficult. Many remember wasted efforts in other meetings and avoid new meetings. Some clinicians are paid per service and see process improvement meetings as not part of their job. There are a number of steps to increase participation. First, examine the purpose of the meeting. If it is difficult to obtain participation, perhaps the problem assigned is not important. Invited group members will participate if the meeting addresses a problem they consider important. Show how the team's recommendations will be followed. An important problem is tied to action. Show what resources are available to the team. Give examples of how clinicians and others have in the past addressed similar problems in other institutions.

## Steps 6-9: Plan, Do, Check & Act Cycles

The quality improvement unit assigns a problem to a cross-functional team. The team meets and through a series of steps solves the problem, improves the organization, and celebrates their success. Details of these steps are explained in a separate paper titled "PDCA Cycles."

## Step 10: Spread Improvement

When an improvement effort has succeeded in one unit of the organization, it is important to spread the improvement to other units.  The key in accomplishing this step is to persuade other units to adopt the change by explaining the benefits of the change.  But sometimes this is not enough.  Some employees may not want to change no matter how much they will benefit from the change.  It is important to work on barriers for widespread implementation of the change.  Many projects make rational arguments, based on self-interest or organization's interest (e.g. if we make this change we can save money).  This is not enough.  Adoption of improvements across organizations are more likely when the self-interest arguments are supplemented with emotional appeals.  Employees are more likely to change when they are reminded about it, feel good about the change, see others that they admire adopting the new ways, and think it will help them do their work with less effort.