COMMENTARY

Is Gaining Affective Commitment the Missing Strategy for Successful Change Management in Healthcare?

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Abstract: Despite the requirement for continual change and development, change failure is omnipresent in health care, ranging from small technical errors within new systems, processes or technologies, through to breakdowns and large-scale disaster. Despite decades of research investment, consultancy and initiatives, creating a healthcare context that promotes clinician engagement with change remains elusive, with limited demonstrated progress. Affective commitment to change refers to commitment that is driven by a desire to support change based on its perceived benefits or value, as opposed to commitment that is based on a sense of obligation or the minimization of costs. Recent evidence from health-care contexts indicates that affective commitment to change drives change readiness more so than the individual's self-efficacy for dealing with the change. Considering evidence regarding the effect of affective commitment to change on individual and collective change readiness among health-care staff, we may need to reorient our current strategies for managing change. We explore the opportunities to enhance affective commitment to change and, in turn, change readiness through adopting values-based approaches to designing and executing change proposals with clinicians and service users.

Keywords: change readiness, commitment to change, affective commitment, implementation, improvement, healthcare change

Introduction

Fundamental to high-performing health systems is the ability of services, and the individuals that drive them, to be responsive to change initiatives that address the emerging needs of service users and the evolving context of healthcare provision.[1] Recent examples include initiatives to adapt services to accommodate virtual care provision, advance integrated and community-based services to attend to population health needs and to integrate electronic health records.[2] These initiatives seek to improve health systems and services by reducing hospitalizations, enhancing patient-centric care and improving patients' and clinicians' experiences.[3] As critical actors within health systems, ensuring clinicians embrace initiatives to bring about these types of system and service-level change is essential.

Despite health systems' requirement for continual change and development, change failure is omnipresent, ranging from small technical errors within new systems, processes or technologies, through to breakdowns and large-scale disaster.[4] As clinicians strive to continually adapt to new models of care and ways of working that do not appear to deliver their promise, change fatigue sets in, with consequences for achieving desired improvements in efficiency, cost, safety, and user experience. Despite decades of research investment, consultancy and initiatives, creating a healthcare context that promotes clinician engagement with change remains elusive, with limited demonstrated progress. Although there is an abiding interest in change, its process, and impact within health systems, change remains poorly managed in healthcare.[5] Recent systematic review evidence of the application of change management models in healthcare shows that few change projects demonstrate the use of evidence-based models and methodologies and that current approaches to managing change neglect sufficient focus on the influence of clinician's emotional appraisal about the need for change

1

and its value.[6] Drawing upon psychological theory, we propose how redirecting focus to emotional investment in change might encourage more successful change management with greater clinician engagement.

Change Management Efforts Often Neglect the Role of Affect

The extent to which individuals accept, embrace and adopt a change initiative is underpinned by their perception that a given change is needed, and that they have the required capability; this is described as *change readiness*.[7] While a multitude of factors determine change readiness, commitment to change and self-efficacy to create change are critical elements. Commitment to change is the "force (mind-set) that binds an individual to a course of action deemed necessary for the successful implementation of a change initiative."[8] Commitment to change is an umbrella concept for three types of commitment: a requirement to support the change due to recognition of cost associated with failure to do so (continuance commitment), a feeling that one ought to support the change due to the sense of obligation (normative commitment), and finally, a want or desire to support the change recognising the benefits associated with it (affective commitment).[8,9] Across 38 identified studies in our systematic review of studies reporting the management of change in healthcare in the past 10 years, the prioritization of messaging about why clinicians ought to or are required to adopt changes towards achieving unit-level or organizational goals is clear.[6] Studies rarely described attempts to gain affective commitment through their change management approaches.[6]

Is Affective Commitment to Change the Missing Strategy?

Affective commitment to change refers to commitment that is driven by a desire to support change based on its perceived benefits or value (as opposed to commitment that is based on a sense of obligation or the minimization of costs).[8] Current evidence suggests that health-care staff dedicate time in the early weeks and months of their initiatives to gain support for the change proposal.[6] There is a lack of evidence about the extent to which health-care organisations focus on affective commitment and specifically the personal value and valence of the change proposal for individuals during this period. The perception of value has long been considered one of the key determinants of worker motivation in the field of organizational psychology. Within the literature on change readiness specifically, beliefs about the personal and organizational valence of change have been identified as critical factors that impact change readiness.[10] Such beliefs (which are at the core off affective commitment to change) are strongly related to positive emotions about change and ratings of overall change readiness.[11] Moreover, meta-analysis of studies in and outside of health-care settings demonstrates that affective commitment to change is strongly predictive of behaviors that support change (to a greater extent than other forms of commitment to change), including compliance, cooperation, and championing behaviors.[9]

In exploring the contribution of self-efficacy to create change and of commitment to change readiness, recent evidence from health-care contexts indicates that affective commitment to change plays an important role. Pilot work findings suggest that affective commitment to change may in fact drive change readiness more so than the individual's self-efficacy for dealing with the change.[6,12] Our regression analysis of four change projects transforming emergency services and outpatient care in metropolitan, rural and remote health services, healthcare staff affective commitment to change was positively and independently associated with the outcome of higher levels of change readiness.[12] Evidence regarding the role of affective commitment to change and its association with change readiness may provide the basis for a strategy to improve the ability of health services to continually adapt and change to meet changing population needs.

Reorienting Change Management Strategies

Considering evidence regarding the strong effect of affective commitment to change on individual and collective change readiness among health-care staff, we may need to reorient our current strategies for managing change. Developing a desire for change to occur on a project-by-project basis lacks efficiency and is unlikely to sufficiently build affective commitment to change. This proposal is not a departure from the range of methodologies used to manage change, but a refocusing of attention to the early components of most contemporary methodologies. It is well established that gaining buy-in and a common purpose underpinned by shared values are critical in bringing about change.[6] Yet applications of change management theories predominantly apply this in the context of individual change projects rather than embedding shared value and purpose at a team or service level. Evidence of the factors that drive affective commitment to change

suggest that we can improve affective commitment to change through leadership approaches that focus to authenticity, open communication, and that foster cultures based on shared values and priorities.[13] We therefore propose that building a core set of shared values and goals within teams and across organizations, by understanding what motivates clinicians, provides a critical basis from which to align proposals for change and their benefits.

Values Alignment Through Co-Designed Change

Legitimising change and its necessity occur through a strong foundation of trust in leadership that is not specific to an individual change project. In health-care settings, this means clinicians believing that there is ongoing alignment of their values with those of senior leadership either at a team or service level, such that decisions about the changes required to a process or service are in the interest of achieving the best possible clinical outcomes. There are potential tensions between creating shared values and ensuring diversity of thinking and ideas in an organization, and in seeking to delineate the changes that offer improvements for patients and staff. Values alignment around the prioritization of patient safety and healthcare quality between clinicians and service-level decision-makers may be apparent, but perspectives regarding the changes necessary to achieve optimal care outcomes often differ, with competing interests for those in hybrid clinician-manager roles cited as an ongoing obstacle.[1,14]

Articulating how the content of change proposals can contribute value to clinicians can be facilitated using co-design, co-production and co-implementation in system and service improvement projects. *Co-design* and the associated terms of *co-creation, experience-based co-design, co-production*, and *public and patient involvement* are methods that facilitate values-based approaches to healthcare improvement.[15] Current efforts to apply co-design and co-production and analysis of the use of these participatory approaches have predominantly focused on the design process and on strategies to enhance the involvement of patients and the public. Lesser attention has been given to the way in which clinicians become engaged in co-design and co-production,[16] how this work can be undertaken in the context of competing clinical commitments and the analysis of whether adopting these participatory approaches routinely can lead to a greater desire to bring about change through promoting a values-based approach; ultimately, can co-design of change projects improve affective commitment and readiness for change?

Conclusion

A dynamic health system and population require clinicians to continually identify, adopt and embrace new processes, systems, and models of care. Affective commitment to change appears to have an important role in creating readiness for change but is not often the focus of change management efforts. Increasing affective commitment to change might be achieved by greater investment to routinely co-design, produce and implement change proposals with clinicians to understand what motivates individuals, the appeal or problems with a change proposal and implementation approach. Co-development of change proposals must be underpinned by a context that espouses consistent shared values and priorities. Consideration of how a diverse range of clinicians can contribute to co-design and development of change proposals, and the provision of the necessary supports for individuals to engage in this process is critical.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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