Change Fatigue in Clinical Practice

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The University of North Carolina is switching electronic health records (EHRs) next year, and the University of Michigan did so last year. Many others already have or will be adopting them for the first time. What is behind these recent efforts? In two words: meaningful use (see Figure 1). The Centers for Medicare and Medicaid Services (CMS) has issued a set of standards that governs the use of EHRs to improve the quality, safety, and efficiency of health care. Attainment of these meaningful use goals is tied to financial incentives, hence the movement by so many health systems and practices to select and implement these systems.

Although this change is long overdue, it is a system-wide organizational change that touches everyone. The amount of work, number of people involved, hours of training required, and hardware and software infrastructure needed to make this happen is nothing short of amazing. In addition, the financial and nonfinancial costs are enormous, although they may be recouped over time with the CMS incentives and improved data capture for billing purposes. But this is not the only change occurring in health care or in nursing. Healthcare providers are being asked to implement distress screening, create survivorship care plans, and focus on palliative care in oncology. With our combined 70 years of nursing, we have not witnessed so many big changes in health care in such a short time.

The second author of this editorial experienced change fatigue firsthand when selecting a setting to implement her doctor of nursing practice capstone project on distress screening. Selecting a site that embodies the positive attributes of change was vital; therefore, a clinical group was sought with a reputation for be-
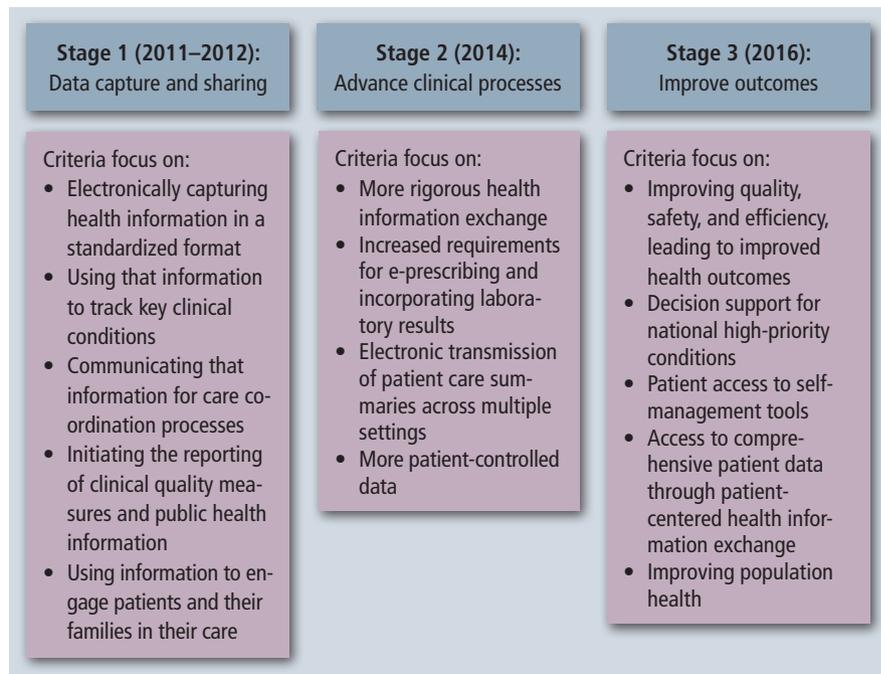

FIGURE 1. Objectives and Measures for Meaningful Use of Electronic Health Records

Note. From "Meaningful Use," by HealthIT.gov, 2013. Retrieved from http://www.healthit.gov/policy-researchers-implementers/meaningful-use.

ing a change agent with a well-established track record of being the first to pilot new processes and innovations for the organization. The leadership was supportive of the screening implementation project and several staff members identified themselves as champions of the innovation. However, an obstacle was encountered—the recent system-wide change to a new EHR. The clinical leadership and champions advised waiting three months after EHR implementation to present the capstone project to the staff. The author did wait and prepared her presentation to be motivating, highlighting the ease of implementation in other cancer centers and the improved patient care that would be realized by implementing distress screening.

The room was filled with nurse practitioners, physician assistants, and physicians who soon became very quiet. Their body language was not that of an engaged audience and efforts to engage them were met with more silence. The group focused on the changes to their work processes and described doubt that the project would improve care, that the innovation would be sustainable and, most surprisingly, they were angry. Statements such as "The EHR isn't even working and now we have to do something else new," "I don't have time for this," "You want us to screen *every* patient and for how long?" "How can you expect us to do this, too?" and "I can't even find my patients' medications and I'm supposed to find where to document this?"

were common. Had the team reached their capacity—were they fatigued with the amount of change?

Change fatigue is different from resistance to change (McMillan & Perron, 2013). With change fatigue, staff can become disengaged and apathetic, often feeling disempowered, burnt out, disillusioned, and passive about changes being introduced. Signs of change fatigue may include questioning the value and objectives of the change, diverting resources to other initiatives, showing impatience with the pace of change, and key leaders no longer being visibly engaged with the change (Reineck, 2007). Reineck (2007) identified structural, behavioral, and technologic change management strategies to facilitate changes and prevent change fatigue, including empowering others to build the change; appealing to logic and rationale; providing information, knowledge, and skills with re-education; altering structures or processes; developing new communication and collaboration patterns; and harnessing the power of computers and automation. Valusek (2007) described the use of a change calendar to help monitor and manage the changes occurring in an organization. Moore and Jones (2010) discussed the complexity of implementing EHRs in a health setting applying Reineck's (2007) strategies. They emphasized creating buddy systems to pair less confident staff with champion users. Other methods identified to reduce change fatigue and improve the potential for success include

- Employing strategies to increase individual and collective adaptive reserve through communication, strong team relationships, and building trust
- Designating time to review change projects and their status, embedding change as a normal process of the group's work
- Bundling the changes whenever possible to reduce their number (e.g., incorporating the imaging of distress screens into the new EHR training).

Some of us embrace change more readily than others, but we all have our limits. We need to realize that change is not linear; there are ups and downs, starts and stops. It can take a long time to perceive benefits from a change, which can lead to frustration. We would like to hear from you as to how you have managed changes in the workplace, particularly with EHRs. What has worked? What hasn't? How have you personally managed these changes without becoming fatigued? We are in the midst of enormous, long-overdue changes in health care. We need to learn from each other on how to survive and thrive amidst them. When in doubt, remember what Frederick Douglass said, "If there is no struggle, there is no progress" (Brainy Quote, n.d.).

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