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How Effective Change Management can be applied to current problems:

Cervical Center Intervention Plan

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INTRODUCTION

During August of 2020, when the world was struggling with COVID19 the World Health Organization (WHO) passed the resolution to eliminate cervical cancer as a public health problem.[1] The target was defined as ≤4/100,000 mortality rate for each country by the year 2030.

They also defined three strategies:

1)90% vaccination rate for HPV for all girls by age 15

2)70% cervical screening for all women by the ages of 35 and 45

3)90% treatment of precancerous cervical disease and also 90% management of invasive cancer.

Currently every nation, even the high resource areas, fall short in some measure. The issue I am facing with this essay is to change the current standard approach to cervical screening to the point that all medical providers can contribute to this WHO

1 Chaib,2021

goal by understanding the overall goals and targets. In addition, I propose to introduce a curriculum that will change the training process to allow a student to approach mastery of cervical screening and treatment of precancerous lesions during a one-month rotation.

CHANGE MANAGEMENT PLATFORMS

Before we get into the weeds of how I plan to accomplish these changes, I feel we should look at several change management platforms. Since change is pivotal to reach goals in all areas of both personal and public life, I shouldn't have been surprised that this is a hot topic and even that people pursue graduate degrees in this area. I confess that I found the text for our course, Switch[2], to be fascinating as well as engaging breaking down the elements of change into directing the rider, motivating the elephant, and shaping the path. These concepts helped to provide a framework for my own understanding of steps to influence change which had previously been located in the realm of interpersonal relationships or personal goals which had only spotty success.

As I looked at other platforms, I discovered that though there are broad areas of overlap there are also significant differences.[3] I focused on three different theories. The oldest was first described by Kurt Lewin who was a German American social psychologist in the early 20th century. Lewin proposes a 3 Stage model to explore how the status-quo can be challenged for effective change. He describes Step 1 as Unfreeze in which the previous equilibrium is disturbed. No one likes to change, so this step

2 Heath ,2010
3 Smith “6 of the Best-”,2021

involves communicating the necessity of change in order to provide the motivation for change. The second step is Change where it is realized that change is possible and when presented in simple, clear terms that show how the new possibilities profit the individual and organization. The last step being Refreeze such that the change is embraced, and the nay-sayers are quietened. When this new sense of stability settles in everyone feels confident with the new process. The controlled crisis motivated a new balance. [4]I find this platform simple but applicable for both the individual as well as organizations. It strikes me as particularly useful if the change process gets stuck at a particular point.

The next platform that I found helpful especially for individual change was the ADKAR framework developed by Jeff Hiatt and first published in 1998.

The acronym stands for:

-A**wareness of** the need for change

-**Desire** to support the change

-Knowledge of how to change

-Ability to demonstrate skills and behavior

-Reinforcement to make it stick

Just like the Unfreeze stage of the Lewin model, so this first step of Awareness requires good communication sufficient to not only describe the reasoning for change but also cause those involved to agree with it. The second step is to foster Desire for

4 -Admin Kurt Lewin, 2021

change. An organization with change leaders can provide specific benefits of the change and spearhead the resistance to change by identifying the core issues brought up by change. Knowledge of the change elements is critical to a successful change and should be specific to the responsibilities of the individual. The fourth element of ADKAR is Ability. Each person must not only know what they should be doing but also be confident in their abilities to accomplish these duties. This phase is where hands-on practice can be valuable. Reinforcement is the last step to making a permanent change. We all know about how easy it is to start a new health habit or train in a new process at work only to find that the old ways are slipping back in place. It is important to set and celebrate small goals and provide a platform where praise and comments are shared. I will show how this model applied to my personal change at little later in the essay.

The last platform I entertained was the Kotter Change Management model. As I reviewed this process it strikes me as much more applicable to institutional change. There are 8 steps to this model:

1. Establish a sense of urgency for change
2. Create the guiding coalition
3. Establish a vision and strategy
4. Enlist a volunteer army
5. Empower (or enable) broad-based action
6. Create short-term wins

7. Sustain acceleration
8. Anchor new approaches

The urgency for change is part of the awareness of the need for change. The guiding coalition is the authoritative body to provide necessary guidance for the change. The vision and strategy are presented as the "big opportunity" that makes others want to join. It provides the "buy-in" to create a movement with a volunteer army. This army is empowered to bring about widespread changes. Celebration of short-term wins helps to sustain acceleration and anchor the new approaches. [5]

MY PATH TO PERSONAL CHANGE

To present this approach and its challenges, I first will delineate the path I took so that I can then "point to the destination" as described in Switch.[6] I have for my whole professional career been involved in women's healthcare. In fact, my Family Medicine residency track included Obstetrics and Colposcopy because I was planning to go to a rural county of eastern NC that had no specialists. My hope with regard to colposcopy was that if I delivered a woman's baby, she would be more likely to come to me for treatment of an abnormal Pap smear. Since these were the very early days of understanding the role of human papilloma virus (HPV) in the development of cervical cancers, and even more cancers as time would tell, the standard of care called for annual screening of all women the year after the debut of sexual activity.

5 Smith "Lewin vs Kotter", 2021
6 Heath, 2010

Needless to say, there was a plethora of women receiving colposcopic evaluations and treatments that we now know were premature and mostly unnecessary. The good news, however, is that none of my patients developed cervical cancer during the twenty-five years I worked in Bladen County. This experience mirrors nicely the statistics in the United States that less than one percent of cancer deaths in women are from cervical cancer.[7]

This medical practice pattern serves as my backdrop for the second act of my career. I am partially retired and working as a family planning provider and medical director at the local county health department, in addition, I run the colposcopy clinic that provides low-cost, high-quality services for women in a two-county area who might otherwise avoid outpatient treatment of asymptomatic precancerous lesions because of cost.

The flexibility of my current schedule has allowed me to pursue training for medical care in Low Middle Income Countries (LMIC). I found such an opportunity through INMED and completed my Diploma in International Medicine and Public Health. The service component of this degree was at La Clinica Esperanza in Roatan, Honduras. This clinic provides excellent care for the residents of the island – far above the national standard. It also has a strong emphasis in women's care to include obstetrics, family planning, and cervical screenings. I was interested that the Paps were the brush-

7 "Cancer of the Cervix Uteri"20211

on-a-glass-slide-with-hairspray methodology from decades ago which is incompatible with concurrent HPV testing. Next surprise was to find a Wallach Zoomscope in the corner of the nurse's lounge in obvious disuse. As I asked about the usual protocol of investigating an abnormal Pap, I found that there is no one on the island qualified to complete the evaluation. As a result, the whole process is shifted to the mainland with at least two trips required for completion of the treatment. The cost of this whole process is equal to a whole month's income for the family! Why would anyone risk their family's survival over an asymptomatic issue? Why even get the Pap to begin with? Why ask the question if the answer does not change your treatment?

As I pondered this situation with the Director of the clinic, Miss Peggy Stranges RN, she challenged me to "Come up with a protocol." Kurt Lewin, one of the first social scientists to describe change theory, would call this my **unfreeze** moment.[8] All I had known to be true was not applicable to this situation. I understood that if adequate cervical screening and treatment was not possible in this exceptional setting under the usual protocol then it was not possible in any LMIC. Upon further investigation, I learned that not only are the specialists for treatment scarce so are the labs and pathologists for reading Paps and even when such a pathology report is generated there can be a lengthy period before the answer is resulted. How do you find the woman needing the treatment? All medical people even in high resource areas know the

8 Admin.Kurt Lewin

frustration of being unable to contact a person with a potentially dangerous condition. This problem of too few medical providers, technicians, and pathologists as well as poor transportation and low personal income plays out all over the LMIC to prevent cervical cancer evaluations.[9]

I find that Jeff Hiatt's ADKAR framework aptly describes my personal journey.[10] My time in Honduras was just the beginning of my **awareness** of the need for change. As I dug further into the plight of LMIC women, I learned that greater than fifty percent of cancer deaths in women in these countries stems from cervical cancer resulting in >270,000 lives lost annually[11]. This compares to less than one percent of cancer deaths in high resource countries.[12] Average age at death in these countries is 40 years old with devastating consequences to their families not to mention the loss of a powerful economic engine.

The **desire** to support the change started with the spark struck by Miss Peggy to help out this excellent clinic. It grew into a bonfire as I became aware of the resolution passed by the WHO calling for the elimination of cervical cancer as a public health problem.

As I dug deeper into the literature regarding the strategies delineated by the WHO for accomplishing this lofty goal (vaccination, screening, treatment), I realized that we

9 Wolford,2015
10 Smith,2021 ADKAR
11 Cheney 2018
12 "Cancer of the Cervix Uteri"2021

already possess the **knowledge** that is the key to an effective model! I discovered that the screening of the cervix by Visual Inspection with Acetic acid (VIA) followed by treatment of abnormal findings with cryotherapy has been described and utilized for at least a decade in many various locations.[13] [14]

Since I have a wealth of experience visualizing the cervix with the assistance of both acetic acid as well as Lugol's iodine, I decided to give it a try to take a woman with suspected abnormality as determined by an abnormal Pap and visualize the cervix without the benefit of excellent lighting and magnification provided by the colposcope. I found the process was not at all straightforward and I had NOT met the **ability** bar! If I had failed in this attempt how could a novice proceed to the point of mastery in this screen and treat model during a relatively brief time frame?

At this point I began my search in earnest for an effective teaching model that would provide the **knowledge and ability** to gain confidence for widespread skills transfer. In addition, this model would need to be simple enough that La Clinica Esperanza and many different organizations could use it in a form that would allow regular **reinforcement** for long term utilization and retention of use.

VIA SCREEN AND TREAT MODEL

The VIA screen and treat model is reasonably easy to learn and apply. The

13 Roger 2014
14 CCAE "Screening and Treatment" 2020

healthcare provider swabs vinegar, 5% acetic acid, on the cervix and looks for areas of change. White coloration can indicate precancerous or cancerous lesions. These abnormal lesions can be ablated if appropriate on the spot without need for further treatment. It can be coordinated with HPV testing to improve sensitivity and decrease false positives and reduce over-treatment.[15] I had found so many Bright Spots as the Heath brothers would call them that I wondered why the light was not already widespread protocol. [16]

This procedure has many similarities to the usual collection of Pap specimens. There are however several barriers to implementation. Most notably, the gaining of adequate experience to be competent with treatment. Even in a country like Haiti which has the highest incidence of cervical cancer in the Western hemisphere at 94/100,000[17] one would still have to screen thousands to catch dozens of positive cases. How does a student overcome this steep learning curve?

Another barrier is that every provider wants to provide research backed and regularly updated standards of care. This was the panic I felt when Miss Peggy challenged me to "Come up with a protocol." I would assume that each provider and each training institution would like to know that the protocols are uniform and not just cobbled together from various resources. I suspect that this lack of certification of

15 Boskey, 2020
16 Heath, 2010
17 Roger, 2014

standards is the weak link to all of those programs that I mentioned who already had experience with VIA.

Enter the World Health Organization with a resolution to eliminate cervical cancer as a public health problem. The WHO has many arms that carry out research and has the strength of widespread authority to set worldwide standards.

In the document that discusses cervical cancer care there is a section of sanctioned reference materials. Of the myriad of documents, I selected four resources which when taken as a whole provided individual as well as institutional support. The first of these is the "Virtual Course on Comprehensive Cervical Cancer Control (2018) "[18] which is available on the Virtual Campus for Public health which is sponsored by the Pan American Health Organization (PAHO) in conjunction with WHO backing. This is a self-learning program that uses a virtual teaching platform that consists of ten modules that progress through basic science of cervical disease through diagnosis, treatment, and palliative care including incorporation of all of the WHO strategies. It is available in both English and Spanish making it especially appropriate for programs based in Honduras and Central America. This course incorporates integral evaluation and just-in-time feedback for each of the ten modules consisting of ten multiple choice questions and a discussion forum as well as a final test consisting of forty questions. A seventy percent pass is required for successful completion of the course as well as being awarded

18 PAHO 2018

a certificate issued by PAHO.

At this point the student is equipped with the foundation to proceed with practical instruction about screen-and-treat. The WHO has an arm, the International Agency for Research on Cancer (IARC) which has organized two web-based atlases both of which are available in many languages.

The first is "Atlas of visual inspection of the cervix with acetic acid for screening, triage, and treatment."[19] It includes the theoretical background of VIA as implied by the self-explanatory title as well as a "large repository" of before and after acetic acid cervical images with interpretation. It demonstrates how this information is used to determine eligibility for ablative treatment. The last of three sections consists of a quiz of cases for the student to interpret followed by the correct results as a self-assessment of competency.

The second web-based atlas is "Atlas of Colposcopy: Principles and Practice"[20]which details many standard treatments for precancerous lesions to include detailed instructions on treatment by cryotherapy.

The fourth component of this learning experience is what I call "the secret sauce." Julia Kramer and Maria Young have developed a simulation model[21] which they used in Ghana to train midwives in VIA. The simulated vaginal cavity and custom tabs

19 Mital 2020
20 Basu 2017
21 Young 2013

reveal before and after cervical images thus allowing students to train at their own pace and get immediate feedback.

These tools allow any student who is **aware of the need for change** and **desiring to support that change** to be able to acquire the **knowledge of how to change, the ability to demonstrate skills and behavior, and reinforcement to make this change stick.** In the platform of Kewin, I have now **changed** and am ready to **refreeze.**[22]

INSTITUTIONAL CHANGE

At this time, I face the challenge of how to bring about change in the world-wide system of training providers for support of the WHO target and strategies. As I review the change management model needed to change an institution, I find the Kotter model [23]most appropriate though there is of course overlap among the various platforms. There are eight steps in this model.

The first step is to establish a sense of **urgency** which correlates to **awareness** and **desire for change** in the ADKAR. The second step is to create the guiding coalition by contacting programs and institutions already involved in women's health initiatives. The third step to **establish a vision and strategy** reflects on the WHO resolution.

The key for me I feel is to **enlist a volunteer army.** These volunteers could come from the workshop I am leading for the AAFP World Health Summit this October- keep

22 -Admin. Kurt Lewin 2021
23 Smith Lewin vs Kotter 2021

me in prayer. They could come from residency programs especially those with International Medicine tracks. They could spring from Non-Government Organizations (NGO's) involved in missions especially those who already support family planning and midwifery. They could be accepted by Ministries of Health in LMIC.

I have purposely designed this program to be easily accessible and nonproprietary with the exception of WHO sanctioning– especially the web-based components- in order to **empower and enable a broad-based action.** I would hope that any of the stake holders listed above feel free to update, adjust, or in any way make this guide to be their own and most appropriate to their given situation.

As a method of **creating short term wins**, I hope to introduce this training program to La Clinica Esperanza as the beta site since it was my experiences there that started me down this path. As my next step, I would consider this endeavor a success if as many as five institutions adopted VIA training by the end of this year.

In order to **sustain acceleration,** I will endeavor to continue to expose other groups to the possibilities of worldwide change by planning more workshops and contacting other stakeholder groups. I am considering a web page as a bright spot site to expose other individuals to the urgent need for change and point to the destination.

CONCLUSION

It is my fervent prayer that as I have experienced an unfreeze and change process

entering the **refreeze**[24] stage that we can "rally the herd"[25]so that more and more individuals, institutions, and lands will **anchor this new approach in culture.**

24 Smith, 6 of the Best 2021
25 Heath, 2010

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