Leading strategic change

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Abstract Most strategic change initiatives are never implemented. While one cannot guarantee a strategic result, two steps are essential for reducing risk and improving outcomes in Leading Strategic Change: firstly, adapting a strategic mindset that is open to more than just incremental change; secondly, execute, execute, execute. In the author's experience, most strategic initiatives fail not for their poor strategic choices but for being unable to expand on prior mental models and for poor execution. This paper examines four common mental model pitfalls and proposes means of overcoming them, from frame narrowness to confirmation bias, groupthink and finally attribution bias. Execution depends on clear priorities; understanding stakeholder needs; and clear, simple, consistent communication.

KEYWORDS: strategic change, strategy, organisational change, strategic execution, healthcare organisational change, healthcare change management, leading change

INTRODUCTION

In these trying times, most healthcare leaders are simply trying to cope. Overwhelmed by rising numbers of COVID-19 patients, staff shortages and provider burnout, a paper on Leading Strategic Change may seem at best superfluous . . . and, at worst, poorly timed.

Still, once some level of normality returns, healthcare institutions will need to plan for their future. *Leading Strategic Change* should be the one time to challenge past actions and assess a range of future investments to establish a path forward into an ever-evolving, ever-receding future. It should be creative, even potentially transformative.

But, as Lou Holtz, the great football coach at Notre Dame, stated, 'When all is said and done, more is said than done' — most strategic efforts in healthcare result in little more than incremental changes to past activities — even as the US healthcare system faces unprecedented challenges. While we celebrate the technological leadership in so many parts of our healthcare enterprises, these same enterprises seem stuck in past models of care, unable to substantially lower the costs of healthcare delivery, dramatically expand access or significantly improve quality. Could it be that 'one of the evolutionary laws of business is that success

breeds failure; the tactics and habits of earlier triumphs so often leave companies — even the biggest, most profitable and most admired companies — unable to adapt'?[1]

In my experience, the most successful strategic change efforts are built on two components that will be explored in this paper:

- *Strategic Mindset*. Approaching strategic change with an unconstrained mindset is critical to identifying and prioritising future opportunities. Otherwise, the resulting initiatives will tend to look to the past . . . incrementally moving the healthcare organisation forward, blind to the opportunities required to lead in future healthcare ecosystems.
- *Strategic Execution*. According to a recent Harvard Business School Online paper, 90 per cent of businesses fail to achieve their strategic goals.[2] Leading strategic change demands clear priorities: building a portfolio of short-, medium- and longer-term initiatives that allow the entity to grow in the current budget cycle *and* build new capabilities to lead no matter how the US healthcare system evolves.

STRATEGIC MINDSET

Professor Robert Schiller, the Yale economist, writes that 'people tend to make judgments in uncertain situations by looking for familiar patterns and *assuming future patterns will resemble past ones*, without sufficient consideration of the reasons for the pattern or the probability of the pattern repeating itself'.[3] Yet in times of uncertainty, as with how the US healthcare system could evolve, the past is *not* prologue. The problem is, as Daniel Kahneman writes, 'In making predictions and judgments under uncertainty, people [. . .] rely on a limited number of heuristics[4] which sometimes yield reasonable judgments and sometimes lead to severe and systemic error'.[5] The good news, Kahneman argues, is that '*executives can't do much about their own biases . . . But given the proper tools, they can recognize and neutralize those of their teams*'.[6]

Thus, before jumping to the specific choices in a strategic change effort — eg *what* needs to change, *what* is going well, *what* we need to do to succeed in the future, etc — teams should step back and discuss '**how**' to overcome four common *decision-traps*:

1. **Frame Bias***:* Leaders, especially those with strong personalities, want to 'get to a solution'. Too little time is spent asking: what problem is being addressed . . . and what are the team's assumptions about this issue(s)? Anthropologists speculate that our primordial ancestors had to decide quickly whether that movement in the bush was a man-eating lion . . . or only the wind; as a result, today we 'frame' problems rapidly, intuitively. Rarely are underlying assumptions made explicit or adequate time spent assessing: *what is the real problem?* What are the major issues the team is trying to resolve, and, more importantly, what are various assumptions about those issues and potential options? For example, if part of the leadership team thinks the way forward is to reduce operating costs, while others believe that only shifting from fee-for-service to 'value-based' operating contracts will drive future success . . . consensus will be hard to achieve when trying to establish future strategic priorities.[7] As a warm-up, ask team members to discuss —
   - Why was our institution/group successful in the *past*?
   - What do we need to do in the *future* to maintain or increase our success?
   - Looking forward, what could derail or impact those assumptions?
2. **Confirmation Bias:** Most individuals, consciously or not, go to data sources that support their *existing* points of view. Even

the Internet, which holds the promise of unlimited information, 'is contributing to the polarisation of America, as people surround themselves with people who think like them and hesitate to say anything different'.[8] The problem is, as Paul Schoemaker writes, 'We are too sure of our single view about the future, and we fail to consider alternative views sufficiently'.[9] As a result, it is often hard to change beliefs; challenges to existing orthodoxy are all too often dismissed as 'not relevant'.[10] Before the strategy team begins to examine the strategic implications of possible healthcare reform and gather relevant data, discuss the following questions:

- Are we too narrowly relying on a single, common view of the future?
- How can we gain a fresh perspective on the data or reports we will be examining to help broaden our perspectives on future strategic options?
- What can we do to surface alternative insights from inside and outside of our institution or group?[11]

3. **Groupthink.** Subconsciously, most individuals want to be part of a group . . . a member of the 'A-Team'. After all, the worst form of punishment is solitary confinement. Once part of a group, it is *emotionally* hard to challenge the prevailing mores or beliefs of that group. Individuals quickly understand what is and is not acceptable in their team . . . what does the boss, or most senior person, 'want to hear' and what is 'out of bounds'?[12] Even when individuals are asked to challenge existing orthodoxies in brainstorming sessions, they rarely do, stifling their innermost thoughts to fit with prevailing team norms. As Adam Grant explains, '*For a culture of originality to flourish, employees must feel free to contribute their wildest ideas. But they are often afraid to speak up, even if they've never seen anything bad happen to those that do.*'[13] What to do? The venture capital firm Kleiner Perkins Caufield & Byers (KPCB) — arguably one of the most successful venture capital firms ever — employs a 'balance sheet' to bring forth different points of view (see Figure 1).

   Whenever the partners at KPCB have a major strategic decision — to buy a company, sell a company, change the management of an acquired firm, for example — each partner must fill in what they label 'their balance sheet': what are the 'pluses' and 'minuses' of this idea or action *from each individual partner's point of view.* Then, *before* discussion begins, each partner reads from his or her 'balance sheet'. Two things happen: first, everyone must prepare ahead of the meeting, and, second, partners report they changed their points of view 'by being forced to listen to the views of others first'.[14] It is important to *delay* discussion. The minute discussion begins, individuals stop listening as they (subconsciously) prepare to explain their own ideas, justifying their own points of view.[15]

4. **Attribution Bias**: Once decisions are made, how easy is it to alter course when

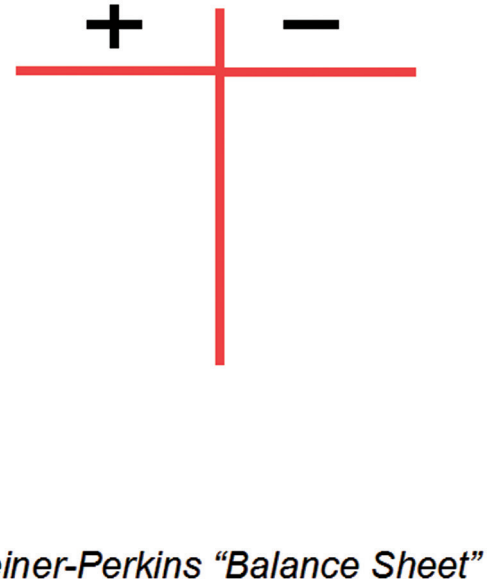

Figure 1: Ideal group process
Source: JH Austin Associates, Inc.

results are suboptimal or environments change? According to a study of nearly 8,000 executives on why execution fails, organisations struggle to move people or resources when environments change (see Figure 2).[16]

Objectivity is too often lacking when assessing progress to goals and what needs to be done to improve future outcomes. When an individual or team is successful, the tendency is to laud one's personal efforts; when things do not go so well, 'external factors' — those pressures that 'no one could control' — are blamed.[17] Worse, the organisational culture unique to healthcare settings can be an impediment to change. As Amy Edmondson found in studying organisational failures at major hospitals,

> The lack of organisational learning from failures can be explained instead by three less obvious, even counterintuitive, reasons: an emphasis on individual vigilance in health care, unit efficiency concerns, and empowerment (or a widely shared goal of developing units that can function without direct managerial assistance). These three factors, while seemingly beneficial for nurses and patients alike, can ironically leave nurses under-supported and overwhelmed in a system bound to have breakdowns because of the need to provide individualised treatments for patients.[18]

In summary, as Warren Buffett opines, *'What the human being is best at doing is interpreting all new information so that their prior conclusions remain intact'*.[19] In creating the Strategic Mindset for Leading Strategic Change when facing the uncertain future of US healthcare, teams should follow the advice of Dr Jerome Groopman:

> Most errors are mistakes in our thinking. I learned from this to always hold back, to make sure that even when I think I have the answer, to generate a short list of alternatives [. . .] this simple strategy is one of the strongest safeguards against cognitive errors.[20]

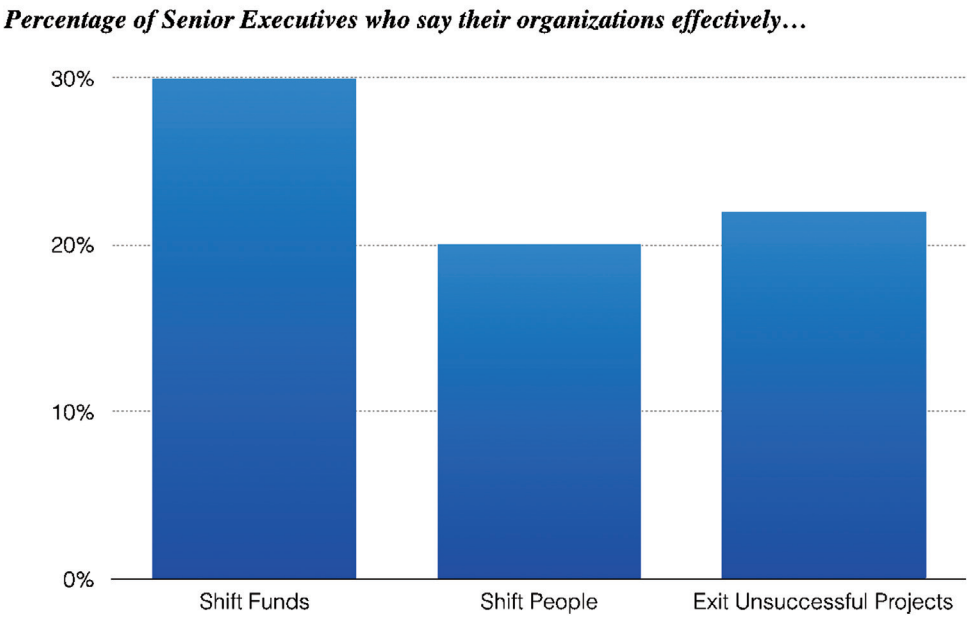

Figure 2: Most organisations do not adapt quickly enough to changing markets
Source: Copyright JH Austin Associates, Inc., 2017.

STRATEGIC EXECUTION

Benjamin Franklin[21] wrote in 1737, 'Well done is better than well said.' Entities typically run into trouble not so much from their strategic choices but from their inability to execute. And while there are many models of strategic execution, from my experience the *best* execution efforts are built on three things —

- clear prioritisation of initiatives
- deep appreciation of stakeholder needs and
- simple yet memorable communication of progress to goals.

Clear priorities

The main **output** from strategic planning efforts should be a portfolio of critical priorities, what I label a 'strategic pyramid', consisting of three types of initiatives: Core, New and Wow (see Figure 3).

- Core initiatives keep current operations running ever more efficiently, such as quality or operational investments essential for meeting current budgetary and payer/patient requirements. Based on examples from different industries, Core strategic priorities represent 70–80 per cent of what existing institutions should focus on.[22] Note: the Core activities 'pay for' those new or transformative initiatives as rarely are the medium-term (New) or longer-term (Wow) efforts accretive in the short term. Thus, if incremental investment resources are not being generated by the Core, organisations will struggle to do more than simple meet short-term financial and operational necessities.
- New. These are medium-term, moderate-risk priorities that can replenish or expand the Core over time. Typical investments here might be developing a risk-sharing relationship with several payers or forming an accountable care Organisation (ACO). Initiatives in the New category should represent 10–20 per cent of a group's strategic investments. This category should also include those investments that an

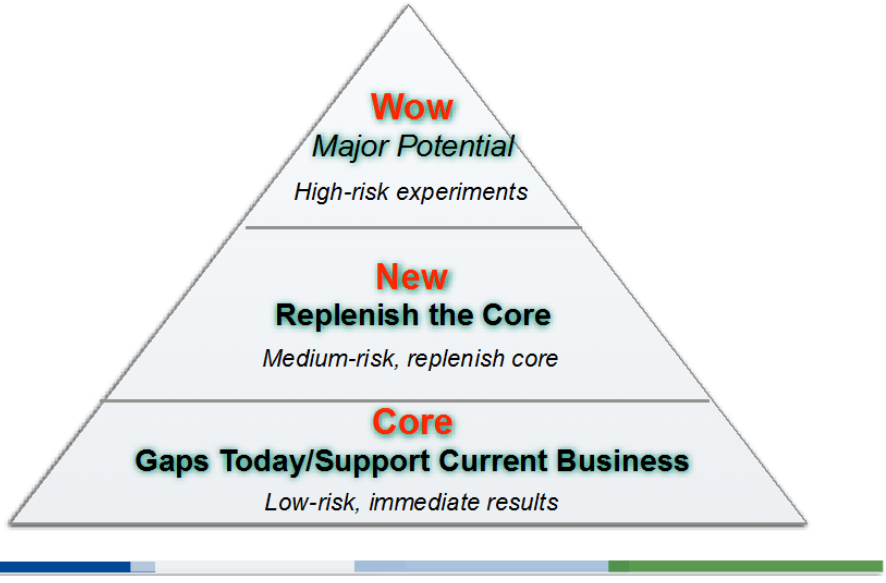

Figure 3: 'Strategic Pyramid': strategic portfolio of initiatives for attaining short-term goal, and longer-term transformation.

Source: JH Austin Associates Inc.

organisation decides to *eliminate or reduce* to redirect resources to more important Core or New growth activities.[23]
- Wow. These are a few experiments or 'pre-pre-feasibility' studies that could reveal transformative growth opportunities. These are classic investment 'options' such as new social media platforms for reaching younger patients or transformative medical tourism offerings with a few high-quality, non-US providers.[24] No matter how seductive such efforts might be, however, beware of focusing more than 5–10 per cent of resources and management time on the ideas in this group *as most of these initiatives will not pass muster.*

Why is a portfolio of options — the strategic pyramid — the critical strategic planning output when facing the uncertain future of US healthcare? Rita McGrath, a professor at Columbia Business School and a leading strategic thinker, writes:

> Few companies manage to prosper over the long term. Those that do are both more stable and more innovative than their competition.[25]

In her study of nearly 4,800 publicly traded large companies (those with a market capitalisation greater than US$1bn) over five years, and slightly less than 2,400 entities over a 10-year period, *less than 10 per cent of those firms grew 5 per cent every year* — which was slightly less than global annual GDP growth during her study period! How did the few 'outliers' outperform their peers? In their Core, these firms:

- promoted from within
- focused management on culture and shared values
- held on to talent
- did not make radical strategic or business/operational shifts
- maintained a reliable customer base.

At the same time, the outlier firms were also 'rapid adaptors':

- making small bets to diversify their existing businesses
- were active acquirers of new talent
- tried to build flexibility into their operating processes so they could respond to unforeseen challenges
- sought to make their current operations ever more efficient and innovative.

As Professor McGrath identified, entities that succeed over time must *both* support their Core and layer on rapid adaptive capabilities to meet changing environments. For example, in its 2020 Strategic Plan the Mayo Clinic articulated a portfolio of initiatives organised into the following three areas:

- **Run** (ie continue to operate existing activities as efficiently and effectively as possible)
- **Grow** (ie expand current activities); or
- **Transform** (ie pursue new products and business models).[26]

Successful strategies also *focus on doing a few things really, really well*. And most strategic investments fail not for being poorly formulated or lacking in feasibility, but *because they are not executed*. According to HH Jorgensen, only 41 per cent of strategic initiatives 'fully met their objectives' (see Figure 4).[27]

Entities get into trouble when they seem to pursue a strategy of 'more is better'; as Jim Collins writes, one of the signs of organisational decline is the 'undisciplined pursuit of more'.[28] With the strategic pyramid, an individual or team should be assigned specific responsibility for each of the major priorities articulated in the plan. Then on a regular basis, the Leadership Team reviews progress to plan, calling on the relevant individual/team for an update; in this way, transformative change is built on the '20% that will drive 80% of results' not

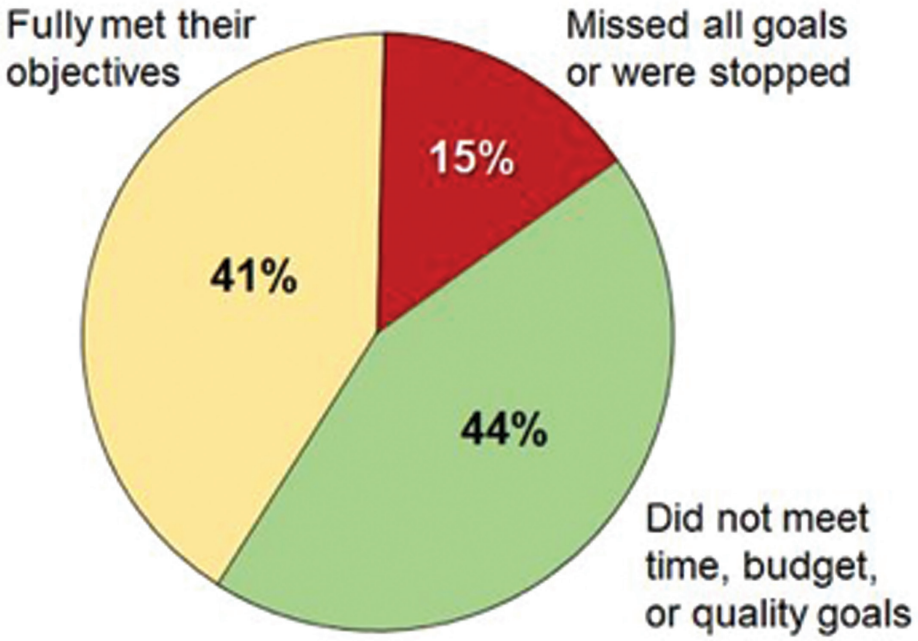

Figure 4: Strategic objectives outcomes

trying to do everything. As Laura Ramos Hegwer explains in 'Leading Change from the C-Suite':

> Many healthcare executives aim to transform how their organisations think about delivering care. However, the most successful leaders recognise that what they choose **not** to do is just as important as what they actually do during times of change.[29]

Stakeholder needs

In the early 1850s, patient survival rates from surgical procedures in the US or Europe were roughly 50/50. Two events happened in the late 1840s that changed medicine. First, Dr William Morton, a dental surgeon in Boston, discovered the amazing properties of ether for reducing the pain of surgery (at least while under the anaesthesia!). Hearing of this advance, Dr Henry Jacob Bigelow, a surgeon at Mass General Hospital, performed the first public display of the use of ether in 1846; within six months, every major hospital in the US and Europe was using ether in the operating room (OR).

At the same time, Louis Pasteur in France and Joseph Lister in the UK were studying germs and their link to infection and patient morbidity/mortality. Lister even created a sterilisation process where carbolic acid was to be sprayed over the OR, instruments boiled between usage and surgeons/attending advised to wear washable gowns.

Below is a painting completed in 1875 by Thomas Eakins entitled 'Dr. Gross' Clinic'.[30] At the head of the OR table is the anaesthesiologist, administering ether through gauze laid over the patient's head (Figure 5).

Yet does this look like a semi-sterile environment? Why was ether embraced so quickly while sterilisation techniques were not? Even though post-surgical survival data proved sterilisation of the OR dramatically improved patient outcomes, carbolic acid *burned the surgeon's hands*. In fact, it was not until the early 1890s, when the chief of surgery at Johns Hopkins Hospital introduced the use of rubber gloves — to

Figure 5: The Gross Clinic by Thomas Eakins, 1875

counter the boils carbolic acid produced on his wife's hands, an attending at the hospital — that sterilisation techniques became standard practice.

The lesson: if you want to lead change, make it easier — *not harder* — for people to support the changes. Make their lives simpler, not more complex. Understand their issues, especially their perceptions, and build changes on those. If you try to alter what people do but in the process make it harder for them to accomplish their ongoing activities — no matter what data you have supporting the changes — it will be an uphill battle.

At a deeper level, not all stakeholders are created equal. In most healthcare organisations, certain subspecialists are typically granted higher status in the provision of care: MDs outrank RNs; RNs lead techs; and so on. Can these hierarchies optimise the transformative changes desired? The Cleveland Clinic's fundamental organisational changes in 2008 — which improved outcomes *and* lowered costs — depended on

- a strong, well-respected leader, Dr Cosgrove, willing to challenge prevailing norms;
- a successful integration pilot run by a creative, independent neuroradiologist — a subspeciality typically lower in status than the surgeons being asked to join the transformational team;
- the board of governors' support for major, not incremental, changes in the pursuit of radically better healthcare delivery;

- emotional appeals, not simply analytical, in uniting the organisation around the various changes; and
- the Cleveland Clinic's history of innovative, team-based care delivery.[31]

While these attributes might be seen as unique to the Cleveland Clinic, transformative change must take account of important stakeholder needs, aligning them in ways tailored to each organisation's history, capabilities and resources. There is no 'one size fits all'. Two points, however, are critical:

- Important Stakeholder Engagement: Stakeholders need to be engaged based on Interest and Power. Beware of those individuals (often staff positions) that have relatively little organisational power but wish to be involved in every meeting, decision.
- Alignment: Most managers believe *their* teams are aligned to the strategy but rarely trust the same for *other functions.* In a study of nearly 8,000 managers, 84 per cent indicated they could rely on their teams to carry out their corporate or divisional strategy. A mere 9 per cent, however, indicated they can rely on other functions to do the same (see Figure 6).[32]

How can organisations break down silos? According to Brigadier Gerhard Wheeler CBE, the British Commander of the Kabul Security Force in Afghanistan — a multinational force of 1,000 soldiers from the US, the UK, Australia, Denmark and Mongolia — to create unity of purpose and action it is important to:

- agree the mission ('Why are we here?')
- understand issues, constraints, perspectives
- play to individual and group strengths
- accept that each group has unique objectives for contributing to the organisation; try to utilise these if they do *not* conflict with overall goals, mission
- avoid creating an 'us versus them' environment
- show respect; seek to learn from others.[33]

As Gillian Tett explains, silos are natural reflections of increasing specialisation, data overload and external complexity. The

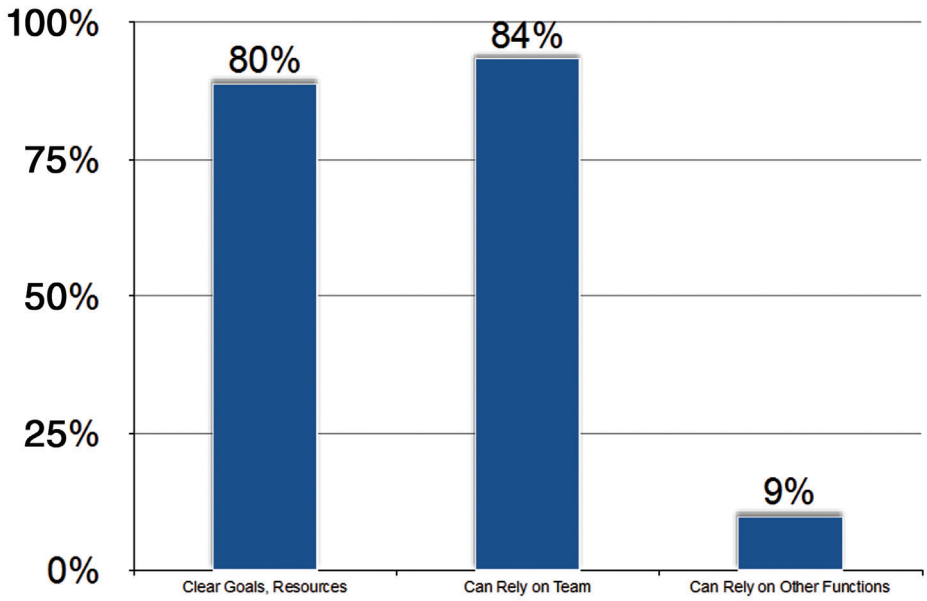

Figure 6: Execution = alignment?
Source: Sull, D., et al. (March 2015) 'Why Strategy Execution Unravels', HBR.

challenge comes when the silos *prevent* information exchange or organisation-wide, transformational initiatives. To gain greater alignment across organisations, Ms. Tett argues for

1. keeping the 'boundaries of teams in big organisations flexible and fluid . . . rotating staff between different departments . . . creating places and programs where people from different teams can collide and bond'
2. reviewing incentives as 'collaborative pay systems, of the sort seen at the Cleveland Clinic . . . are needed — at least in part — if people are going to think as a group'.
3. creating a culture that does not hoard information but freely shares data, enabling 'everyone to interpret information — and let different interpretations be heard'. Where there are specialists — as in medicine — that use highly complex, technical language, there may need to be 'cultural translators' who can 'move between specialist silos and explain to those sitting inside one department what is happening elsewhere'.
4. Challenging existing taxonomies and organisational designs, as Dr Cosgrove did at the Cleveland Clinic, to 'visualise the world around how the patient experiences health, rather than how a doctor is trained'.[34]

Simple, consistent communication

Finally, as John Kotter explains, for change to occur,

> Successful large-scale change is a complex affair. . . . The central challenge . . . is changing people's behavior . . . . Changing behavior is less a matter of giving people analysis to influence their thoughts than helping them to see a truth to influence their feelings. Both thinking and feeling are essential and both are found in successful organizations, but the heart of change is in the emotions. The flow of see-feel-change is more powerful than that of analysis-think-change.[35]

The problem is that most people perceive change as a threat. For example, a change in staff responsibilities — nursing shifted from in-patient care to an ACO — will most likely cause emotional disruption for the individual or group. Vineet Nayar, CEO of HCL Technologies, explains that in any major change initiative approximately

- 10 per cent of the population will support the change ('early adaptors')
- 80 per cent will 'wait and see' ('fence sitters') and
- 10 per cent will never agree.[36]

The critical challenge is to sway the 80 per cent 'fence sitters' to support future change efforts. The following measures that are essential in order to gain engagement are

- clear, consistent explanation of the need for change (the 'why')
- clear, consistent messages about the impact of these changes on individuals and groups ('What is in this for me?') at an emotional level and
- clear, consistent statements explaining the benefits of the changes for important stakeholders, both within and outside the organisation.

In my experience, communication difficulties typically arise from a lack of 'active listening and discussion'. Too many senior leaders — especially strong physician leaders used to life-and-death, time-sensitive clinical decision-making — tend to 'push' their point of view. Successful communication efforts vary from situation to situation but typically include the following:

- Open Door Policies/Walk the Halls — Leaders should be accessible, seeking opportunities informally to answer employee questions about changes as well as seeking their perspectives on progress, barriers.
- Meetings:

  - Staff meetings — The execution plan and its progress should be an agenda item in all staff meetings.
  - Lunch meetings — These offer senior leaders and various stakeholders the opportunity to engage more informally on the transformational plan progress.
  - Town Hall meetings — While too often over-scripted and rigidly formal, Town Hall meetings are critical for broad information exchange. They can also be essential forums for celebrating milestones reached or updating specific groups on progress-to-date.
- Newsletters, Suggestion Boxes (virtual or physical) — When HCL Technologies' CEO Vineet Nayar was transforming the organisation, he instituted a 'smart service desk' with the job of managing an:

> online system that allows anyone in the organisation to lodge a complaint or make a suggestion by opening a ticket. We have a defined process for handling tickets (for instance, a manager has to respond to every ticket), and the employee who opened the ticket determines whether its resolution is satisfactory. Not only does the system help resolve issues, but it effectively puts managers in the service of frontline employees.[37]

  During the Raritan Bay Medical Center merger with Meridian Health — creating one of New Jersey's largest healthcare networks — the Raritan CEO sent letters in English *and* Spanish to all staff homes to 'keep them updated on the merger and the rationale behind it'.[38]
- Surveys — Pre- and post-change employee surveys are helpful in gauging broad employee sentiments as well as soliciting specific ideas or feedback through open-ended queries. Those entities that successfully employ surveys ensure confidentiality and are willing to engage in two-way dialogue, no matter what the surveys reveal. Note: trust in any Leadership Team can erode quickly if survey feedback is requested and then *not* acknowledged or acted on in a timely fashion. Those entities that use survey results to maintain or even increase the level of organisational trust
  - share results widely;
  - discuss outcomes in small groups to ensure understanding; and
  - utilise findings as a basis for future actions.[39]

Throughout, the aim is to foster two-way communication, enabling senior leaders to gain a 'pulse' on progress and employees to be better informed and, ideally, more emotionally engaged in the overall effort. Successful two-way communication is based on trust. The following are essential means of promoting *personal trust*:

- Competency: Do you have the requisite capabilities, brain 'power', to do the job?
- Reliability: Do I 'walk the talk'? If senior leaders say 'we are all equal', but continue to park in their assigned places or attend in-house cafeterias only serving senior executives — personal trust is quickly eroded.
- Emotional Commitment: All levels of the organisation want to know: are my best interests being taken account of at the most senior levels? Does my boss care about my career opportunities — or only how they can advance?[40]

Organisational trust is more nebulous but just as important in executing transformational change. Specifically, organisational trust is won by

- recognising 'excellence'
- inducing 'challenge stress' — achievable targets tied to clear progress feedback
- allowing discretion in how employees do their jobs (within regulatory and legal requirements)
- enabling job choices *with* accountability

- sharing information broadly
- supporting relationship building across groups, functions
- facilitating broad *personal,* not just professional, development
- showing vulnerability[41]

Often, a separate team is formed to manage or implement the communications effort and/or a specific person made responsible for the communications plan and its execution. Overall responsibility, however, lies with the Leadership Team, who should be accountable for internal and external communication emphasis, content and, ultimately, impact.

SUMMARY: MACRO ISSUES

While an open, creative Mental Mindset and Strategic Execution are essential to Leading Strategic Change, organisations should also be aware of four macro issues that can derail the best-laid plans:

- Focus. One of the clearest ways that the Leadership Team can convey the necessity of important change initiatives is to *reduce* execution team members' day-to-day commitments so they can focus on essential priorities. Sean Covey explains,

  > If you're currently trying to execute five, ten or even twenty important goals, the truth is that your team can't focus . . . [making] success almost impossible. This is especially problematic when there are too many goals at the highest levels of the organisation, all of which eventually cascade into dozens and ultimately hundreds of goals as they work their way down throughout the organisation, creating a web of complexity.[42]

  Illinois Tool Works, known for their execution-oriented culture, employs what they call the '80-20 Rule': what 20 per cent of one's activities are likely to be responsible for 80 per cent of the results? While qualitative, this is a good guide for leaders prioritising, and thus focusing, their team's execution efforts, as discussed in setting priorities (Core/New/Wow).
- Time Required. Often there are two, related issues here. First, the problem of overconfidence. Specifically 'in most organisations, an executive who projects great confidence in a plan is more likely to get it approved than one who lays out all the risks and uncertainties surrounding it. Seldom do we see confidence as a warning sign — a hint that overconfidence, over-optimism, and other action-oriented biases may be at work'.[43] Related to this is the tendency (subconsciously) to over-optimistically forecast the time required to drive change. Transformative change, especially in larger institutions, should be seen as a 3–5 year effort, *with sustained focus*. The question bedevilling many Leadership Teams is whether the external rapidity of change in the US healthcare system will be greater than their internal abilities to transform?
- Ability to Adjust. Every change effort encounters 'bumps in the road'. The challenge lies in being able to adjust. Inevitably, the Leadership Team will decide on a specific portfolio of initiatives, implicitly (or explicitly) seeking to succeed in a particular scenario of the future. But what if the world changes in ways not envisioned? As George Day and Paul Schoemaker challenge:

  > What important signals are you rationalizing away? Nearly all surprises have visible antecedents. However, people have a powerful tendency to ignore warning signals that contradict their preconceptions.[44]

  Related to this is the challenge of 'sunk costs' — the tendency to overweight the likelihood of success when resources are already 'sunk' into a project, particularly those initiatives supported by senior leaders. Gaining

objectivity when choosing to continue or close down a struggling major project is hard but can be ameliorated by the following:

- Look forward. Whether one paid US$70 or US$130 for Apple shares should be irrelevant to one's decision to sell them today for US$100. Accept investments made as done and gone. When projects stall, the ensuing discussion should *not* focus on how to get back on track but, rather, what is the best use of our scarce resources going forward?
- Persevere flexibly, not stubbornly — look for opportunities to redefine the problem
- Seek objective, outside views periodically if only to offset the insidious impacts of 'groupthink' and 'attribution bias'
- View decisions as experiments, helping the Leadership Team learn. Ask 'what have we learned, and are we still learning'? If still learning, it might be worth continuing (if fiscally responsible!)
- Do not ignore negative feedback (beware 'confirmation bias')
- Practice 'strategic quitting' — what are expected end point(s)?[45] Peter Drucker is reported to have argued for 'systematic abandonment' — a regular 'spring-cleaning' of activities or projects to enable the fostering of new business initiatives.[46]

- Top-Down versus Bubble-Up. The tension between the responsibilities of the senior team versus various organisational levels is inherent in Leading Strategic Change efforts. Richard Bohmer outlined in the *New England Journal of Medicine* the following 'team-based' redesign approach for realising major change in healthcare organisations:
  1. Make small-scale changes to structures and processes over long periods. 'Major change emerges from aggregation of marginal gains.'
  2. Utilise clinicians, with broad staff and managerial support. To broaden leadership capabilities often lacking in MDs, 'transformers invest heavily in leadership development, usually creating their own leadership programs'
  3. Support experimentation as 'few redesigns get it 100% right the first time. In practice, health care transformation is a long series of local experiments'.
  4. Be measurement- and data-driven, but 'make do with the data available . . . treating design change as a test of concept, rather than implementation of a known answer'.
  5. Rely on a senior group for 'establishing teams, setting their priorities, monitoring their progress, addressing institutional barriers to change, and integrating multiple teams' work'.
  6. Ensure there are unifying values and norms as 'any model of team-based redesign devolves authority and accountability away from top executives'.[47]

  In my experience, Leading Strategic Change requires the Leadership Team's focus and commitment — a top-down effort *supported* by identified 'team-based' projects tied to set milestones. Organisational efforts that are primarily 'bubble-up' are unlikely to realise the significant, sustained efforts essential to Leading Strategic Change. On the other hand, efforts that are primarily 'top-down' are just as likely to fail for not mobilising the capabilities and support of the entire organisation.

Cato, the Roman historian, wrote:

When Cicero spoke, people marveled.
When Caesar spoke, people marched.

At the end of the day, Leading Strategic Change depends on leaders mobilising their

organisation to *march* into an ever-evolving, ever-better future for US healthcare.

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APPENDIX A

Case Study of Leading Strategic Change: Coastal Medical's Journey

Coastal Medical is a major, primary care provider group in Rhode Island, caring for approximately 120,000 patients in over 20 medical offices. Run by physicians, it is committed to delivering high-quality, accessible, cost-effective care. In 2012, the entire organisation agreed to provide differentiated patient care based on value, not volume. As Meryl Moss, COO of Coastal, writes, 'In essence, Coastal sought to transition the traditional business model away from fee-for-service medicine to value-based reimbursement with the dual aims of meeting a myriad of robust quality measures while reducing the total cost of care.'

Over six months, led by Coastal physicians, each office or practice determined the best way to meet the expanded quality metrics inherent in new, shared savings contracts. The results were sobering: not only was there found to be wide variation among the Coastal practices, but no practice achieved the top-quartile of comparative statistics. What to do?

Coastal leadership realised that the engagement of all employees was essential for transformative change. Through several brainstorming sessions in 2013, the outline of the 'Primary Care Practice of the Future' — emphasising preventive care over acute interventions — was established. Organisationally, where before the medical offices wanted total control, the final plan centralised basic functions such as phone coverage and appointment scheduling, allowing the offices 'breathing room' to focus on the practice of medicine. Importantly, whereas before the offices were rather independent, now there would be standardised workflows, common patient handling processes and structured data capture to support system-wide quality measures. The results were dramatic: by 2014, Coastal was in the top 1 per cent of all SMC Medicare Shared Savings Program (MSSP) ACOs in quality. They easily renewed their NCQA III patient-centred home status.

In summary, Coastal Medical's transformation journey was neither quick nor simple. Transformative changes were ultimately successful because

- The change proceeded from a vision of how the medical staff wanted to practice medicine in the future;
- Leadership sought to engage the entire organisation in defining 'why' they needed to change as well as 'how' best to realise their vision;
- The executive team was willing to support experimentation and 'bubble-up' pilot programmes, making adjustments when results were lacking; and
- All internal stakeholders accepted that transformative changes take time.

Transformation is not easy. Coastal created their change through pilots — not one, massive shift but a series of smaller efforts — with the lessons learned then incorporated more broadly. Unsurprisingly, not all employees agreed on the new path forward. There was turnover. But the majority moved ahead. And the impacts continue to be impressive across multiple dimensions: quality, efficiency, patient support and employee satisfaction.

— *Meryl Moss, 'Creating Ever Better Ways to Provide Cost-Effective Care for Our Community: The Coastal Medical Journey', Jim Austin, et al., Leading Strategic Change in an Era of Healthcare Transformation, Springer, 2016, Chapter 7.*