# PART 1

# The Challenge to Health Care Organizations and Creating the Leadership Team

# 1

# INTRODUCTION

## From Management Myths to Strategic Intelligence

Better quality care for more people, improved health, and lower costs. From which source is this statement more likely?

A. A political campaign
B. A well-documented study about a health care organization

Most people will answer "A." Common beliefs and experiences teach us that you can't get more from less. But experiences may be limited, and many common beliefs are myths. We invite you to suspend disbelief while we take you on a tour of **management myths** that make people believe a health care system can't be improved without painful sacrifices. In this book, we will present what we have learned from health care organizations that are improving health care, decreasing per capita costs, and in some cases, improving population health. And we will provide the tools needed to accomplish this seemingly impossible task.

To gain the knowledge needed to master change, it may be necessary to unlearn a number of myths that made sense in a typical bureaucracy but don't work in the kind of learning organizations we'll describe. We use the term *myth* as defined by the *Oxford English Dictionary (OED):* "a widely held but false belief or idea."[1] Here are just a few myths we will be challenging:

1. The best results are gained by managing by the numbers.
2. People need to be held more accountable.
3. More data are needed to improve management.
4. Incentives will get people to change.
5. Focusing on errors, complaints, and problems will make an organization world class.
6. To get the best people, hire the top 10 percent.
7. Without stretch goals results won't be increased.
8. More people and more money are needed to improve results.
9. To improve quality, it costs more.
10. Leaders are born, not made.
11. People are motivated by a "hierarchy of needs."
12. To motivate people we just need to pay attention to them and be caring bosses.

We have seen the seemingly impossible made possible by health care organizations that challenged these myths and improved quality while cutting costs by achieving the following:

- Less rework (fewer medical errors and readmissions)
- Less waste (better use of facilities, fewer unnecessary tests and procedures)
- Increased collaboration (among health care professionals, staff, patients and their families)

If you aspire to be a leader of change and are willing to question popular theories of management, this book is for you. Many of you have attended lectures or workshops on quality improvement or leadership. But even the best of piecemeal learning will not prepare someone to master change, to transform bureaucracies into learning organizations. We have written this book based on our research and experience of working with health care organizations to provide the understanding and tools to integrate the elements of an effective organization. We are standing on the shoulders of visionary thinkers and have been privileged to learn from them: Russell Ackoff, W. Edwards Deming, and Erich Fromm. We have learned from many others, but these three have contributed especially to our understanding of systems, statistical thinking, theory of knowledge, and psychology.

Improving health care organizations means changing cumbersome bureaucracies into dynamic systems that are patient-focused, cost-effective, and propelled by collaborative learning. This requires culture change, and the first change will be with leaders throughout the organization. No one can do it alone. Leaders need to work together and enlist willing partners and collaborators to achieve these goals.

Knowledge leaders are also needed to network with people outside the organization to bring new ideas and knowledge into the system. A destructive myth that is all too common in many health care organizations is: "We know best." A not-invented-here syndrome rejects thinking from outside the organization and makes life miserable for able knowledge leaders. In one well-known health care organization, they either reject ideas that come from outside the system or, if they adopt an idea, they rebrand it with their own name. They have a habit of not referencing the original author. Learning organizations pride themselves on the ability to learn from many sources and also understand the need to recognize original contributions to their thinking, both from within and outside the organization.

Another commonly believed myth is that physicians will only follow physicians, and as one MD hospital director commented, "When MDs become administrators, they are no longer considered physicians." However, physicians and other health care professionals will follow a leader with the knowledge and personality qualities essential to change bureaucracies into learning organizations. It is a myth that these leaders need to be caring ombudsmen. The leaders we need sometimes pull people outside of their comfort zones. It is also a myth that a good leader has all the answers. The leaders we need are able to make use of the knowledge and learning of all collaborators.

To develop healthy communities, health care organizations must also collaborate with community leaders and public health leaders. In this book, we describe health care organizations that can become models for developing learning communities.

Leaders of learning organizations are different from the administrators of typical health care bureaucracies. Effective administrators are skilled at management functions such as meeting budgets, monitoring functions, and smoothing conflicts. In contrast, a learning organization needs not only good management but also different types of leaders who work interactively to facilitate collaboration, learning, and innovation.

A basic tenet for us is that the person with the relevant knowledge should lead. Some leaders are visionary strategists. Some develop and manage processes and information systems. Some facilitate collaboration at frontline care centers and among all health care providers: physicians, nurses, nurse practitioners, physician assistants, pharmacists, psychologists, social workers, and physical therapists—who also collaborate with technical and administrative staff, and most important, with patients and their families.

Three types fit complementary leadership roles in learning organizations:

- Strategic leaders
- Operational leaders
- Networking leaders

Typically, these leaders have different styles and skills. **Strategic leaders** at the top of organizations are able to design an organization's future and inspire the collaboration needed to implement the vision. In other parts of the organization, they propose new approaches that improve quality. Wherever they are, they are the strategists and architects of change. They need to partner with **operational leaders** who craft the roles and processes that bring the vision to life. The organization also benefits from **networking leaders** who facilitate collaboration between disciplines and organizations to solve complex problems and share learning.

To mold these different types of leaders into an interactive team, the leadership group must articulate a philosophy for the organization. This philosophy should clarify:

- The organization's purpose
- The practical values that are essential for achieving that purpose
- The basis for ethical and moral reasoning used to make decisions
- How results will be defined and measured

At a time when people distrust leaders, it is essential that they can trust a leader's philosophy, that they see a leader sticking to stated values, and that they have no fear of questioning actions that deviate from values that not only support a health care organization's purpose of delivering quality care but also encourage learning, collaboration, and individual initiative.

Effective leadership in knowledge organizations depends not only on the qualities of leaders but also on supporting processes and motivated, qualified people who practice the values essential to achieve the organization's purpose.

This book offers practical methods and tools that can be employed by all types of leaders. However, we have discovered that the skills most needed at the strategic level, what we describe in the framework of **strategic intelligence**, are particularly in short supply. One reason for this is that if they are taught at all, they are taught separately, and not as an interrelated system of skills. Leaders need to recognize the threats and opportunities facing their organizations and then be able to design an organizational vision that takes advantage of this knowledge, and finally, to inspire others to implement the vision.

*Strategic intelligence* prepares leaders for these interrelated skills, including

- Foresight
- Visioning
- Partnering
- Motivating

These are enabling skills that prepare people to lead productive change.

Strategic intelligence is buttressed by knowledge, not only knowledge of the health care business, but also knowledge about systems, how to deal with variation, the use of statistics for decision making, and the careful testing of theories. These theories are part of what W. Edwards Deming termed **profound knowledge**. Not least, strategic intelligence requires understanding what motivates people, and why they either embrace or resist change. Strategic intelligence combines both soft and hard skills. In the chapters that follow, there are exercises to develop strategic intelligence and profound knowledge. This knowledge challenges a number of management myths.

Make no mistake. Leading change in health care demands commitment, energy, persistence, and knowledge. Health care organizations, particularly hospitals, are among the most complex of organizations. Leaders of health care organizations tend to be overcommitted, responding to demands from all sides. Furthermore, layers of management shield those at the top from the data, views, concerns, and ideas

of employees and patients. To make full use of this book, leaders must carve out time for learning. They will model leadership for a learning organization by learning from the experience of all stakeholders—health care providers, employees, patients, and partners. As they make use of what they learn, they will become teachers as well as learners. Then they will be able to lead and drive change.

## Plan of the Book

Here is a quick summary of the book's organization. The book is divided into three major parts:

- Part 1: The Challenge to Health Care Organizations and Creating the Leadership Team
  - Chapters 1–4
- Part 2: Strategic Intelligence and Profound Knowledge for Leading
  - Chapters 5–9
- Part 3: Learning from Other Leaders and Creating a Path Forward
  - Chapters 10–11

### Part 1: The Challenge to Health Care Organizations and Creating the Leadership Team

Chapter 2 sets the stage for understanding the need for leadership. It describes why and how health care organizations can benefit from change to become learning organizations with these goals:[2]

- Improving quality of care for the patient
- Reducing per capita costs for health care
- Improving population health

These interrelated goals require systemic change in many organizational and medical practices. Some organizations have made great progress toward these goals, and the chapter describes diverse and exemplary learning organizations that are showing the way. Health care organizations are social systems with cultures that differ according to their social, political, and business environments as well as their traditions. Culture, both national and organizational, makes a difference. The people we have worked with in a few countries around the globe are more

hierarchical and less collaborative than those we have worked with in Sweden. Physicians at the Mayo and Geisinger Clinics are more collaborative than those we worked with in a number of academic health centers. However, it is a myth that these differences mean that principles of strategic intelligence and profound knowledge cannot be applied to all social systems. Social systems can learn and develop when leaders align innovations with other elements of a system adapted to its environment.

Chapter 3 describes the need for leaders in all parts of an organization to engage participants in the process of change. Leadership, contrasted to management, implies a relationship with followers. Effective leaders of change are hands-on team members, modeling learning and collaboration.

Chapter 4 describes how leaders establish credibility and create trust by formulating, communicating, and practicing a leadership philosophy that includes the organization's purpose, the values essential to achieve that purpose, and a definition of results consistent with the purpose.

## Part 2: Strategic Intelligence and Profound Knowledge for Leading

Chapter 5 introduces the concept of strategic intelligence, combining the skills of foresight, visioning, partnering, and motivating. These skills are essential for a leader or leadership team to lead change. They are buttressed by a leadership philosophy plus profound knowledge of organizational systems. *Profound knowledge* includes understanding variation, psychology (personality intelligence), and the theory of knowledge. This knowledge guides the proper use of methods and tools for continual improvement, innovation, and motivation.

Chapter 6 describes how leaders can study and manage their organizations as systems. Russell Ackoff's ideas have been instrumental in our understanding of systems theory and the need for organizations to be viewed as social systems. This starts with understanding the importance of common purpose and the interdependencies among elements of the system. It is a myth that you can improve an organization by improving each of its parts individually. The performance of the system depends more on the interaction of its parts than how the parts perform individually. The chapter describes key systems concepts such as boundaries, feedback loops, constraints, and leverage points. These concepts are useful to develop, test, and implement changes to optimize the system. To manage a system well, it is necessary to measure performance, processes,

and results. Another myth is that by holding people accountable, there will be fewer errors. Most errors result from bad processes, not individual mistakes. This leads us to the next chapter.

Chapter 7 describes how statistical thinking aids better and more effective decision making. The chapter describes different ways to understand variation and challenges the myth of managing by the numbers, using dashboards with colored lights to indicate whether or not things are going well. That leads to under- or overreacting without understanding patterns and causes. To understand whether events reflect *common causes* versus *special causes*, graphical methods can be employed to learn from data faster and more effectively. This provides the concepts and methods to understand and manage stable and unstable processes and potential losses due to tampering.

Chapter 8 introduces the concept of personality intelligence, the understanding of the emotional attitudes and values that motivate people at work. Understanding personality intelligence challenges the myths that everyone is motivated by material incentives and that everyone is motivated in the same way. Understanding what motivates people requires that a leader learn psychological concepts and also develop emotional understanding—that is, developing both head and heart. Leaders need to distinguish between behavior shaped by roles and processes contrasted with behavior shaped by motives. We describe changes in the motivating values of professionals raised in the era of a changing family structure and mode of production. Leaders will gain willing collaboration when they understand differences in people's motivation at work and engage their intrinsic motivation by placing them in roles, developing relationships, and clarifying a purpose that connects with their values.

Chapter 9 is about learning, as individuals and organizations. The myth that more information produces greater understanding is challenged. In a time of continual change, leaders need to question and examine their beliefs, assumptions, and knowledge about what makes organizations effective and efficient. They need to develop theories and be open to revising and adapting them in a complex, ever-changing environment. This chapter includes the Model for Improvement (MFI) that provides a road map to ensure that learning is applied. Included in the MFI is the Plan-Do-Study-Act (PDSA) cycle, the engine for improvement that enables the development and trusting of small-scale changes to accelerate learning and the application of knowledge. Also challenged is the myth that people will understand a strategic plan just because it is stated and repeated.

### Part 3: Learning from Other Leaders and Creating a Path Forward

Chapter 10 presents case histories of three health care organizations that we recently worked with and studied. These cases illustrate the concepts and methods described in this book. They show how strategically intelligent leaders have improved the quality of care, improved patient health, and lowered costs, and in one case, improved population health.

Chapter 11 presents exercises to turn knowledge into action that gets results. The previous chapters are reviewed with practical exercises to make use of this systems approach to leading change. This chapter provides methods and tools that leaders can use to begin and sustain the process of change.

The authors of this book have studied and worked as advisers to health care organizations in the United States, Canada, United Kingdom, Sweden, and Singapore. It has become clear to us that there is no way health care organizations can avoid changing, but as Deming often remarked: "Survival is not compulsory." New technology, new knowledge, changing values of patients and professionals, government policies, aging of the population in many countries, and rising costs are the factors forcing change. However, change can be either troublesome or productive. Health care organizations can try to react by shrinking service and sacrificing quality or by engaging all employees in creating productive changes, increasing quality of care in a way that reduces costs. They can view their purpose as improving the experience of patients and the health of the communities they serve or as maximizing short-term profit. Which road is taken depends on leadership. We have written this book to provide knowledge, methods, and tools to prepare leaders to choose a productive road, and embark on a sustainable, courageous journey.

## KEY TERMS

Management myths
Networking leaders
Operational leaders
Profound knowledge
Strategic intelligence
Strategic leaders

## ENDNOTES

1. *Oxford English Dictionary*, 5th ed. (Oxford: Oxford University Press, 2002), 1876.
2. These goals were inspired by W. Edwards Deming's view of a continuum of results. Brent James translated this into a continuum of care moving upstream from patient to population. Donald Berwick instituted these goals as the Triple Aim and they are promoted by the Institute for Healthcare Improvement (IHI) worldwide. Donald M. Berwick, Thomas W. Nolan, and John Whittington, *The Triple Aim: Care, Health, and Cost, Health Affairs* 27, no. 3 (2008), 759–769.