

**Healthcare @ The Speed of Thought:
Strategies for Transformative Leadership in a Digital World**

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1.0 Executive Summary

In *Business @ The Speed of Thought* Gates (1999) described the consequences for business and business processes using a “digital nervous system” enabled by the information age. In parallel fashion, *Healthcare @ The Speed of Thought* suggests that equally transformative pressures are placing similar demands on the healthcare system and its leaders. Further, significant change and transformative leadership are inextricably linked: the greater the change, the greater the need for leadership; and, the more transformative the change, the greater the need for transformative leadership. On such a continuum, incumbent and aspiring leaders have the opportunity to enlist new skills and behaviours to position them for what lies ahead: leading transformative change; aligning or building organizational cultures that would sustain changes around new practices; and, hardwiring new steady state behaviours and performance. While tactical change has its hurdles, there is no need greater, no challenge more daunting than when requisite change collides with an organization’s dominant culture. Transformative change is more difficult, if not impossible, if the existing culture is seduced by the success of its historical performance, is rife with antibodies imparting immunity to change or is blind to the signals and forces reshaping the environment within which it functions.

The information age is driving innovation and rapid change, activities that require both engaged people willing to adopt novel ideas and associated rewards and risks *and* nimble organizational cultures that can support them through the change cycle. Equally, hardwiring excellence in the digital era comes from new cultures and behaviours that concurrently value standards, compliance and accountability as a means to sustain them. Arguably, supporting these hard and soft cultural dynamics is where most enterprises would like to find their equilibrium; building cultures to embrace and thrive amidst change is the end game of leadership. Retooling outdated organizational cultures needs three things: the lens through which cultures poorly positioned for new paradigms can be challenged respectfully; the leadership skills to design and support organizational transformations; and, a means to hardwire and sustain the new steady state and organization over the long haul.

This paper will explore “transformational leadership” and the skills and characteristics that define its practitioners. Using a list of “Old World / New World” paradigms to compare and contrast eight selected transformative changes unleashed in healthcare by the information age, the case for transformative leadership and its support of cultural change will be described. From a literature review, the top six leadership strategies supporting successful transformational change will be outlined. Further to general leadership capabilities outlined in the Systems Transformation domain of the LEADS in a Caring Environment framework (i.e., systems / critical thinking, innovation, strategic orientation and change management), ten specific behaviours honed by the leadership experiences of the author are described as a means to translate theory into practice as leaders sponsor transformative and cultural change in their programs, professions or organizations. Using a matrix of leadership capabilities and behaviours, a means to map out leadership activities associated with a transformative change (e.g., deploying eMR technology) is presented as a tool / checklist to plan and sponsor such change.

Transformational leadership goes beyond competencies and content knowledge; it speaks to wisdom gained through experience, a strong sense of self and a robust suite of personal characteristics embedded in values and passion while practiced with integrity, commitment and courage. *Healthcare @ The Speed of Thought* is not business as usual; the changes ahead will be as challenging as they are numerous. More importantly, transformational leaders must share this tradecraft with their colleagues, organizations and, in some cases, the healthcare system itself.

2.0 Introduction

Twenty-first century healthcare is experiencing a renaissance in Canada and around the world. Paradigm shifts powered by the information age are challenging old cultures and tenets; where medicine, technology and population health intersect aging, chronic disease management and patient empowerment; where cost, value and access challenge professions, politicians and providers; and, where sustainability, ethics, accountability for finite resources feverishly clash with policy makers, funders and the media. The changes

ahead for healthcare are transformative: the pervasive and ubiquitous impacts of information; nuances of the empowered patient; the emergence of the knowledge worker and workplace; new models of governance and program delivery; system and provider integration; technology and their applications; the role of the professions; and, leadership development, among others.

Healthcare leaders have always faced challenges. In recent years, however, transformative change is accelerating its velocity to cyber speed, the ambient speed of business and communication in the digital era. *Healthcare @ The Speed of Thought* is based on the premise that leaders best prepared for this scale and speed of change will enjoy differential success with their solution sets and results. While healthcare has been steeped in crisis management (e.g., short notice for large scale change with significant risk / consequences), it has been particularly challenged by tectonic change until its obvious trends or effects reach critical mass or a tipping point. Successful organizations are increasingly defined by their ability to anticipate and react to early signals of change and their propensity to adjust behaviours and cultures that would thrive amidst such change; for example, witness the landscape of telecommunications, aerospace, finance, retail, travel and manufacturing and the like. In the digital age, successful change management is a chevron of innovation and superior performance.

Paradigms shaping 21st century healthcare are transformational forces; successful responses to their challenges will occur when leadership and culture deliver their respective contributions in tandem. Success will be achieved by those who can drive needed solutions while simultaneously reshaping and nurturing the optimal culture within which the team, program or organization operate. In some cases, this may require differential performance with existing skills; in others, a whole new suite of skills and behaviours may be required (Collins, 2008; Bowles, 2009; Leatt and Porter, 2003). Changing cultures is no panacea for all that would challenge the system and excessive attention to cultural change in the absence of demonstrable cause or need can be seen as a management fad, executive flavor of the month or, in extreme cases, a leadership cult (Strebel, 1996; Scott, et al., 2003; Bommer, 2005; and, Bush, 2012).

3.0 Healthcare's New Paradigms

With growing frequency, many have called for transformational change within healthcare as a means to deliver on expectations underpinned by the information age and the observation that 21st century problems will not be resolved by 20th century solutions or be “business as usual”. Representative are Christensen, et al. (2000, p.9) who advanced the view that gains in healthcare’s performance are linked to system transformation and disruptive change:

“...if hospitals and health professionals work together to facilitate disruption instead of uniting to prevent it...many [organizations] will realize the opportunities for growth...as disruption is the fundamental mechanism through which we will build a higher quality, more convenient and lower cost health care system. If leaders with such vision...step forward, we will all have access to more health care, not less.”

At the Institute for Healthcare Improvement (IHI), Berwick (2004) became an early advocate of healthcare’s triple aim imperative: reduce costs, improve outcomes and improve access. The Commonwealth Fund (2004) noted pressures for sustainable funding to support needed capacity vis-à-vis access; health human resources (supply, distribution and recruitment); and, working capital for needed infrastructure and information technology. Decter (2008) shared policy trends he felt would reshape health care such as region-wide governance structures; changing role and utilization of hospitals; investments in primary care; integrated care across organizations and professions; growth in scale and capabilities of home care programs; introduction, deployment and impact of e-health strategies; a national pharmacare program and methods to address drug use and cost; need for research and evidence-based care; and, pressures for the supply and management of health human resources. The Advisory Board Company (2014) shared its findings on the five most significant and universal disruptors shaping the healthcare in the United States and globally: the pressures and consequences of more chronic disease and the diseases associated with aging; the shift from episodes of care to population health; the impact of health analytics to drive gains in

quality and safety; the benefit and curse of medical technology; and, the empowerment of the consumer in healthcare.

Driven by the information age, medical technology, healthcare's growing economic and political challenges, the consequences of more people living longer with more diseases, solutions ahead are not going to be at the margin or business as usual; rather, they are transformative and, as Goodfellow (2014, p. 167) commiserates, long overdue:

“...entire industries have been reshaped by the digital revolution and health system and clinical integration [can] achieve better outcomes for less money; yet, professional and public interests have been barriers to change. Getting our act together has denied Canada the progress it requires to achieve standards and performance at the international level.”

To spark conversations, give license to new thinking, to anticipate new outcomes and sense of urgency, I have used a communication tool like an “Old World / New World” lens to chronicle (compare and contrast) emerging paradigms in healthcare. Whether for a strategic planning or executive retreat, a focus group discussion with vendors or a conversation with managers, Table 1 (page 30) is an example of how one can use selected elements to showcase paradigms and resultant change so that audiences might better understand, experience or react to the emerging world of healthcare and healthcare leadership in the digital age.

With paradigms, resultant change is more than incremental and has a bias towards new perspectives, innovation and disruption. Eaton (1996) described paradigm shifts as bifurcations where the need to transcend old ways and integrate new ways is both evident and an imperative. Once selected, paradigms define a new future where past performance is no guarantee of success and new rules refresh the starting line. Whether these paradigms change over the longer term (evolution) or in the blink of an eye (revolution), they drive transformative change and the requisite need for leadership to navigate their consequences. From Table 1, I have selected eight elements worthy of special note to demonstrate how using such a tool to compare and contrast

transformative pressures can help identify resultant challenges for leaders and their organizations and mobilize both for the change processes that follow.

3.1 Integrating Organizational Structures and Clinical Behaviours

The absence of integration, where providers operate in isolation of patients who must uniquely navigate silos of care amidst an onslaught of chronic conditions, is a notion whose days are numbered. Whether real (e.g., structured multi-facility networks, alliances, partnerships, mergers, shared services / back office organizations, etc.) or virtual (e.g., tele-health, e-health and data repositories), integration's many forms can dramatically change the behaviours of autonomous organizations and their leadership as the patient journey is made seamless across organizations. System and clinical integration have caught the attention of policymakers as a means to achieve healthcare's triple aim faster, a key deliverable for healthcare's many stakeholders.

Structural integration (horizontal and / or vertical) unleashes implementation strategies that are equally problematic, e.g., mergers, repurposing or closing smaller sites, program or bargaining unit consolidation and new governance structures such as regional health authorities, local health integration networks and shared services / back office organizations. Fuelling provider and professional angst are the requisite needs for massive and new investments in information technology, probably at the opportunity cost of bricks and mortar (fewer hospitals) and traditional or popular delivery models and providers. In addition, leaders must see a system beyond the walls of their own organization and the self-interest of existing models of care, e.g., better linkages amongst community-based primary care, specialists and hospitals, networks and alliances, etc.

3.2 Patient-Centred Care and the Empowered Patient

A significant phase shift is placing patients and families at the centre of healthcare's psyche, thereby shedding many practices and behaviours that favoured its providers and professions. Putting the patient first has been bottom-up movement for some time; digital devices, access to information and transparency have leveled the playing field,

empowering patients to participate and often challenge providers and policy makers to do better. The patient-centred lens is changing everything from visiting hours, to self-managed care and approaches to chronic disease management. Ball (2010) called patient and family-focused care a disruptive innovation causing a fundamental rethink of healthcare's perspectives and behaviours. In government-sponsored, tax-funded health systems, patients and families are also voters, a feature not lost on political and policy leaders, advocacy groups and the media.

In the future, hospitals are more likely to consider patients as their customers, not the individual physician. Patient satisfaction and outcomes are more likely determinants of hospital performance than in the past. Based on their experience, patients will have the ability to alter their utilization and the resultant shift in market share or volumes will have far reaching consequences for hospital funding, programing and the professions. Web-enabled communication and devices, information sharing, communities of interest, etc. empower patients to directly shape, control and share their journey of care and outcomes with their support system as well as service providers. Once experienced, there is no going back to the paternalism of the guilds, the lethargy of bureaucracies or the ambiguous accountability afforded by small or incomplete data sets.

3.3 The eMR and e-Health are Reshaping Care and Care Delivery

If the information age has wired healthcare's digital nervous system, the electronic patient chart is its neurotransmitter. From its roots as a provider-centric, jargon-laden document for internal use, its central purpose has become "the official health record" for clinical transactions and the care journey. With system and clinical integration and "e-formats", sharing information among circle of care providers and patients have become commonplace. Chart access activities have shifted from storage / retrieval to data security, the domain of data sets, privacy, firewalls, passwords and access through third party servers. Through applications like voice dictation, order sets, clinical algorithms and remote access, the speed and ease of use have reshaped bedside care and clinical practice. Data repositories, networks and the like have tested the limits of governance and

ownership models of clinical information, including the role of patients themselves as they navigate, access and interact with the system and its many providers.

In abstracted formats and composite data sets, this information became a tool to track patient outcomes over time, to study epidemiology and chronic diseases across populations and the evaluation of public policy and system reimbursement strategies. With market share applications, this data supports capacity planning, program deployment, assess access and referral patterns and predict the needs for health human resources. With financial overlays, it enables organizations to benchmark their relative performance against peers and to assist policy makers evaluate value for money.

With CPOE (computerized provider order entry), the eMR is a digital clock for clinical protocols, inputs, alerts and response times. These developments parallel the evolution of flight data recorders, instruments well recognized for their contributions to flight and aircraft management and safety, team performance and professional development. Chart audit applications with search engines can assess clinical inputs to care, turn around time and compliance with care maps. As the eMR shifts access and control of information from the clinical domain to patients, the traditional power structure also shifts from the provider to the patient, a movement heralded by many as long overdue. That patients have routine and unfettered access to their digital health record empowers their ability to engage their care providers as never before, a feature made commonplace by patient-centred and mobile health applications, e.g., Health Vault, My Chart, etc. And, evolving information system architectures bring new challenges (including costs) for those that would share information: connectivity, inter-operability and the cloud.

3.4 The Case of Funding Reform: Government becomes a Purchaser

The digital age has retooled reimbursement and funding strategies within healthcare. Enabled by increasingly robust data, reimbursement strategies are viewed through many lenses: quality, safety, outcomes, utilization rates, population serviced and compliance. Ontario's Quality-Based Funding is a means to leverage best practice performance targets for various procedures (e.g., diagnostic services, drug costs, length of stay, adverse events,

hospital acquired infections, readmissions, etc.) through Province-wide price points. To the extent that professionals, teams, programs and organizations can implement and sustain the requisite performance embedded in these rates, their relative success or failure will drive the bottom-line confidence in management, clinical care and the organization.

Funding reform has shifted the role of government from funder to purchaser. Since fee-for-service reimbursement rewards transactions and service volumes rather than outcomes (value for money), case costing for end to end care is used by purchasers to limit exposure to uncontrolled expenses and to incent providers to operate within standardized protocols and cost structures. No other aspect of leading and managing organizations can so test its capacity for rapid and sustained change as those that would challenge economic viability. Rapidly changing (annual) revenue cycles and reimbursement practices require nimble and responsive organizations if they are not to become victim to change management cycles that can take multiple years to deploy.

3.5 The Physician: From Independent Contractor to Sub-Contractor

The notion of the “privileged” physician caring for their patients within the construct of a hospital appointment is based on a skills and competence model, i.e., credentials. There has been general acceptance that physicians treat each patient on a unique path, a feature ICES and other agencies have chronicled as observable variation in clinical practice and protocols, referral patterns, resource utilization and clinical outcomes across physician groups and cohorts. In many instances, this variation has not been supported by evidence; in the extreme, it has even enjoyed a certain cache.

While the independent practitioner model vis-à-vis traditional employment remains the same, the emerging accountabilities are anything but. In the wake of newfound and accessible data and information, physicians and physician groups, are being held accountable for far more than the status of their credentials. Increasingly, physicians operate in structured relationships, accountability frameworks and reimbursement

formulae where failure to deliver or contribute to the collective performance trumps clinical independence and autonomy. Many hospitals have structured appointment processes where appointments are tied to performance metrics in a contractual relationship within a group practice or team, in contrast to the model where each member performs and behaves autonomously. The enrollment (sign up) model with physicians has become a service contract with predictable elements: parties to the agreement; contracted period / duration; description of services included / excluded; duties and obligations of the parties; and, performance metrics: procedures and volumes, on-call services, thresholds for access, outcomes, policy compliance as well as provisions for dispute resolution, arbitration and notice / termination.

May (2015, p.11) notes: “As more organizations move toward clinical integration in support of the triple aim, the model of the independent, autonomous physician is fading. Physicians are now expected to make decisions in teams, reduce utilization, document and code and practice medicine with complex performance goals. Ultimately, they must do much more than treat their patients.” Accountability and performance management, enabled by the digital record, is a game changer for the hospital – physician relationship and physician leaders. That a hospital would select or retain only those physicians who would contribute to contracted services, volumes and outcomes the hospital or provider group negotiated with its purchaser will likely be a source of both leadership tension and case law in Canada.

3.6 A New Leadership Role for Physicians

As physician performance management and accountability shifts away from credentials-based processes to those measured by clinical performance and outcomes, physicians serving in “medical director” roles, rather than “chief” or governance roles, will be more responsible and accountable for achieving needed targets and performance. This new mandate means that their leaders need to be prepared to serve in capacities that are separate and distinct from the profession (i.e., a dialysis program versus the Department of Medicine). Management of referral practices, resource use and complex matrix

structures (i.e., the provider) requires a different suite of skills than oversight of credentials, CME and departmental policies and attendance (i.e., the professional). Medical staff structures have moved from traditional professional, political and power configurations to those that address accountability, performance and development (Burroughs, 2015).

As hospitals find their performance and bottom-line more synchronous with that of its clinical staff, central to their gains will be physician engagement and the selection and development of physician leaders. Increasingly, success with targets in patient satisfaction, quality indicators, safety standards, compliance with best practices and other performance targets will define how well physician leaders and their teams perform individually and collectively. As Buell (2015, pp. 20-25) noted, this is not an intrinsic skill or perspective for most physicians: “being the most skilled surgeon or paediatrician is no guarantee of success. It will be their involvement [and effectiveness] with the critical competencies essential for their roles in leadership and executive responsibilities. When physicians go into the business world and leadership world, they have to see themselves not as a physician who happens to be an executive but as an executive who happens to be a physician.” As a former executive search consultant, I experienced first hand that many physicians feel that leadership is an intuitive skill, within their intellectual repertoire. That leadership, in the hallways up to and including the C-suite, has defined skills and competencies acquired through curriculum and practice, is both foreign and often discounted. As the healthcare system shifts more clinical leaders from the bedside to the boardroom with greater accountability for clinical outcomes and targets, there is a huge need to shift perspectives, address leadership gaps and succession planning and to develop competencies as prerequisites for transformative change (Leatt and Porter, 2003; Taylor, et al. 2008; CHLNet, 2014; Burroughs, 2015; Dye and Garman, 2015; May, 2015).

3.7 Healthcare’s Metamorphosis from a Service to a Knowledge Industry

Fuelled by technology and armed with data and evidence, the information age is transforming healthcare, the workplace and the people in it from a service to a knowledge

industry. As healthcare's workforce becomes more professional, with longer training programs, growing licensure requirements and greater accountability for practice and judgment in practice settings, the workplace has shifted from its humble cottage roots to a highly specialized, technology-driven, professional platforms where defined practices must co-mingle and interact seamlessly, across patient groups, teams, programs and, in many cases, organizations and communities. In some cases, integrating people and their unique knowledge, not so much their organization, will define the degree to which indicators in quality, safety or client satisfaction are achieved.

Equally important to the organization's ability to sustain discipline specific programs will be its success with recruitment, retention, recognition, lifelong learning, succession planning and leadership development. The capacity and capability to provide excellence in programming are a function of the knowledge worker; in other words, excellence in care and caring will erupt and thrive where human capital in the workplace trumps that on the balance sheet. This may be difficult where the existing culture places more value on seniority, scheduling and conflict resolution than on competencies, customer service and integrated workplaces and programs. Employees with years invested in their professional career place higher satisfaction expectations on their workplaces, especially when they have more employer and career options. As Ball (1999, p. 12) noted, knowledge economy skills enables teams to discover and leverage actions that will propel the organization towards its vision, and its outcomes and targets as a learning organization. "Traditional command and control hierarchical management styles and structures are being replaced with decision-making structures and new organizational cultures that build a new balance of empowerment and accountability. Successful, sustainable organizational transformation requires that the knowledge, skills and wisdom of the whole organization are channeled effectively."

3.8 The Quality of Care Journey

One of the most significant shifts enabled by the digital era has been the quality of care discussion. It has migrated from the professions, to programs, to boardrooms and to patients themselves. There are many discreet parts that have given rise to this, but most

agree that the trend is both essential and overdue, witness the evolution of standards for facility and professional accreditation, legislation for excellence in care and both privacy and freedom of information legislation, among others. Calls for transparency, disclosure, quality improvement plans for organizations, etc. are evidence that the information age is shining light on the hallowed halls of healthcare in ways and methods never contemplated and the tension is palpable. Transparency is, by itself, an interesting social construct that has been changed dramatically with today's social media.

With the information age, the industry can no longer hide random or large distributions of results; the quality and safety agenda have exposed statistically significant avoidable mortality and morbidity across jurisdictions and providers. That IHI, Health Quality Ontario, Institute of Clinical Evaluative Sciences and a plethora of agencies, organizations, patient advocacy groups and positions have mandates to improve the quality of healthcare, improve outcomes, reduce avoidable morbidity and mortality, reduce adverse events, etc. as well as legislative reforms is evidence of an industry experiencing the digital era: data, information, evidence and transparency. Society has come to expect first-time perfection, predictable outcomes and transparency despite the variation and imprecision inherent in disease, medicine, determinants of health and personal choice.

The seeds of this perfect storm are chronic diseases: a growing number of chronic health conditions where symptomatic versus curative care prevails; a growing number of people with one or more conditions; a growing number of conditions people accumulate through aging; and, a longer duration that people live with their condition(s). Patients with conditions that endure decades are more apt to understand the disease, take some form of control or acceptance over it and be more assertive with those who claim to have answers and cures. Well-educated people, armed by the information age, are a transformative force (Ball, 2010). Their capacity to challenge the status quo, fuelled the notions of professional fallibility and a general disdain for institutions and bureaucracies, has been manifest by their own capacity to assess their risk tolerances and information as current as the latest professional journal, yesterday's newscast or today's internet feed. While data and information have become ubiquitous, there are benefits and risks

associated with “Dr. Google”; knowing how to discern and navigate overwhelming amounts of information will be a new and essential element of the patient-provider relationship as is the ability to organize communities of interest for many clinical conditions.

Reinventing the patient experience, engagement and satisfaction, and mandatory reporting quality and safety-based outcomes are but three examples of empowerment and change enabled by comparative data, the duality of professional and corporate accountability, the move towards patient-centred care and public oversight of arguably any country’s largest and most expensive (therefore political) social policy field. At the end of the day, many foundational aspects of healthcare and the healthcare system are experiencing change that, by scale and consequence, have to be considered as transformational by those who would experience the system as well as lead it. Once crossed, it is a bridge without return.

These eight examples demonstrate how drivers of change can be viewed as transformative and compelling calls to action. In response, leaders have three arrows in their quiver: they can ignore them and support the status quo; they can downplay their merit, consequences or urgency in order to minimize the need for significant change and support transactional change at the fringe; or, they can incorporate them as waypoints along a path of continuous and transformative change to a new and durable steady state (Spinelli, 2006). Transformative leaders operate in the last domain, where change, driven by vision and urgency, operates as both risk and opportunity. But vision and urgency are insufficient cause to take people and organizations down paths they would not select by themselves or view as possible. Transformative leaders leverage these burning platforms to transform organizations, deliver destinations and outcomes thought improbable or impossible and, in so doing, build enduring cultures that thrive amidst change, seek innovation and support people. Moreover, these leaders are equipped with the skills and experiences such that they can be the captains, rather than the casualties, of transformational change and can build and sustain the new cultures their teams, organizations, partners and clients require of them.

4.0 The Dynamics of Transformative and Disruptive Change

Scott, et al. (2002) differentiated between “reform” and “transform” vis-à-vis change. In “reform”, the notional goal is evolution for marginal gain: do what you do, but do it better. In contrast, “transform” is a revolutionary response to crisis whose solution set was free to seek fundamental change, disentangled from cultural barriers. Bigelow and Arndt (2005) described transformational change as a means to focus on ways to break the current organization frame and to think outside of the box of dominant ideas. They state that transformational change is “voluntaristic” and that the role of leadership permeates any discussion because it is the leaders who create and champion a vision and motivate employees. Lean, reengineering, total quality management, patient-centred care are, by definition, transformative forces: they cause a fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in critical performance measures such as cost, quality, access, time to value, waste and speed (Adamson and Kwolek, 2008; Fine, et al., 2009; Champy and Greenspun, 2010; Ball, 2010; Guimaraes and de Carvalho, 2012; Toussaint and Berry, 2013).

Transformation needs the requisite leadership skills by change sponsors and, as Bigelow and Arndt (2005, p. 21) suggest, the ability to frame and ask the right questions. “Leaders are central to transformational change: all successes and all failures are laid unambiguously at their feet”. Geffner and Corwin (2014, p. 1) similarly place accountability for needed transformational change squarely in the C-suite: “contemporary CEOs must be change agents who can win the hearts and minds of employees, physicians, the community and a diverse array of stakeholders. A CEO in the new world order must have sufficient vision to fully understand the complex, strategic and practical implications of reform in order to lead the team, transform the organization and achieve the new metrics of success.”

Leaders cannot be the rate-limiting resource to change. They must be ambidextrous and possess the capacity to sponsor tactical and transformative change concurrently. In the case where tactical and transformative changes require a supportive organizational

culture, leaders have the additional challenge of culture shaping or culture busting. Failing to recognize paradigm shifts amidst the comfort of solid performance or inability to discern winds of change are common themes; successful leaders see the need for change while others, in the absence of compelling reason, seek to bask in the fruits of the status quo. Change ranges from the superficial to the transformative and the more the latter, the more significantly behaviours and attitudes must change in lockstep. Similarly, while structural change requires a new way of working, cultural change usually requires a new way of thinking and behaving.

The definition of “organizational culture” has been relatively consistent over time; perhaps one of its earliest definitions is its most enduring. Schein (1984, p. 3) described organizational culture as a “pattern of basic assumptions that a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems.” Sovie (1993, p. 69) added that cultures serve the needs of the organization and that it is the responsibility of leadership to create, maintain or sometimes substitute cultures that will enable the organization to execute its mission effectively and cope successfully with its environment, an environment besieged with change. Perhaps a signpost of the information age, Wikipedia uses similar language:

“Organizational culture is the behavior of humans who are part of an organization and the meanings that the people react to [in] their actions. Culture includes the organization values, visions, norms, working language, systems, symbols, beliefs, and habits. It is also the pattern of such collective behaviors and assumptions that are taught to new organizational members as a way of perceiving, and even thinking and feeling. Organizational culture affects the way people and groups interact with each other, with clients, and with stakeholders.”

A popular axiom observes that needed strategies or changes are often casualties of bad or outdated cultures: cultures eat strategies for lunch. The premise is that unyielding or dated cultures will thwart or actively undermine needed change for a variety of counterproductive reasons. Logic would infer that reversing this order – strategies that eat cultures for lunch - would better position an organization for rapid and substantive

change (Tremblay, 2014). However, there is not universal agreement that cultural change is the formula for waning performance. Leggat and Dwyer (2005) reported that teamwork, performance management and sophisticated training were conditions for, not an outcome of, successful cultural change. Instead of dismissing system problems as culture fixes, hospitals need to consider strategic investments in people management. Jackson (2013), in describing five myths about laying strategic failures at the feet of bad or dated cultures, made a similar conclusion: central to cultural change is that smart leaders know what data to use, which questions to ask, and who to engage.

Schein (1984) noted that the strength of a culture is directly related to four variables and their ability to enjoin people within that culture over time: homogeneity of the group; membership stability or longevity; duration of collective effort; and, the intensity of their shared experience. These speak to the very core of healthcare settings and explain why changing their cultures are so difficult: healthcare organizations provide life-changing care; are filled with long service, organized groups (e.g., programs, teams) and professionals motivated by high ideals and external accountabilities; and personal lessons learned are routinely shared with newcomers along the way. These are strong bonds that can both resist change or mobilize against it (Strebel, 1996).

In summary, the healthcare system is weathering challenges and solution sets that are both tactical and transformative. However, because many meet the threshold of cultural change, the leadership imperative shifts from tactical to transformative. Combine scale, short timelines and many stakeholders that need to be engaged, the case for transformational leadership looms large. When culture is steeped in belief systems (i.e., what worked before will work again, what didn't work last time will not work this time and past successes will work in the future) or relationships and dynamics that blind it to novel information or opportunities afforded by another, the task for a transformational leader is daunting. That being the case, what would differentiate a transformational leader from one that is not?

5.0 Strategies for Transformative Leadership

Whether tactical or transformational, leadership - the propensity to act when others didn't, couldn't or wouldn't - means making difficult decisions from a menu of competing interests, options and outcomes. Consequently, not all decisions are popular; some can and do rub against the dominant organizational culture. Seltzer, et al. (1989) described transformational leaders as those who broaden and elevate the interests of their followers, generate awareness and commitment of individuals to the purpose and mission of the group, and they enable subordinates to transcend their own self-interests for the betterment of the group.

Many authors have described leadership activities associated with successful change (Covey, 1992; Kotter, 1996; Kriegel and Brandt, 1996; Tushman and O'Reilly, 1997; Kouzes and Posner, 2002; Berwick, 2004; Golden, 2006; and Bowles, 2009) and the literature is rich with case studies where the tenets and practices of and by transformative leaders were pivotal to success: patient-centred building design (Mallak, et al., 2003); organizational commitment (Avolio, et al., 2004); meaningful work (Arnold, et al., 2007); managing the cynics (Bowles, 2009); nursing satisfaction and teamwork (Nielsen et al., 2009); leaving proponents of the old culture behind (Bohmer and Ferlins, 2008); perceived organizational success (Boga and Ensari, 2009); and, employee well being and trust (Kelloway, et al., 2012).

From the above, there are six leadership skills associated with leading transformative change successfully:

- the need for a compelling vision to translate the foreseeable future into tangible goals or results and, in so doing, convey risk of opportunities squandered;
- the need for urgency, to translate or extrapolate the status quo into a burning platform or avoidable crisis, be it resources, quality, strategy and to leverage the crisis to sponsor change, growth or the opportunity to do so later;

- the need to engage people, teams and stakeholders early, from designing the change imperative, along the adoption curve and celebration of success;
- the need for effective communication and transparency, noting greater risk in under-communicating than over-communicating;
- the need to manage timelines, organizational capacity and projects so that early wins can be achieved and leveraged for sustained engagement and hardwiring, behaviors and recipe for success; and
- leading change, particularly that which would challenge and retool a culture, requires courage, skills, values and a willingness to put the needs of the customer and organization first, traits common to transformational leaders but not universal to people.

6.0 Transformative Leadership: From Theory to Practice

In his coverage of the Teddy Awards, Klein (2014) attributes Teddy Roosevelt with:

“It is not the critic who counts; not the man who points out how the strong man stumbles or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly, who errs and comes up short again and again.... who spends himself in a worthy cause; who, at best, knows in the end the triumph of high achievement and who, at the worst, if he fails, at least he fails while daring greatly.”

Transformative leadership skills and competencies are didactic and well documented (Dickson and Lindstrom, 2010, Dye and Garman, 2015); however, proficiency in transformational change is not and its practitioners can experience variable success. Translating these skills into behaviours, experience, wisdom and confidence is the journey of life long learning and hallmark of any professional. As Roosevelt laments, leaders are the ones that joined the fray and learned from it.

Systems Transformation in the CCHL Leads in a Caring Environment framework (www.cchl-ccls.ca/site/pd_leads) describes the need for four leadership capabilities: systems and critical thinking; innovation; strategic and future orientation; and, sponsorship of change (Dickson and Lindstrom, 2010). However, these competencies must be combined with behaviours learned and refined along the way and the following

characteristics are worthy of special commentary as they contribute to transformative change. Gained through decades of leadership and honed through experience, they are key leadership attributes that can supplement transformative change. Appendix 1 (page 31) assembles these system transformation capabilities with leadership attributes and behaviours in a planning matrix to illustrate how a leader might begin to anticipate and map out change management activities stemming from a transformative challenge (e.g., deployment of an eMR) to their team, program or organization.

A transformational leader demonstrates character. In addition to professionalism, integrity, self-confidence, courage, these leaders are approachable, affable and available as they espouse their values, beliefs and vision amidst change. In sharing a vision, they are comfortable engaging staff, dealing with emerging concerns and anticipating tough questions. Transformational leaders are visible and, given the 24/7 nature of healthcare environments, they reach out to people in all the nooks and crannies of the organization, i.e., lounges, cafeterias, nursing units, waiting rooms, the lobby, offices and, sometimes, the parking lot. Character also means sincerity, passion, judgment, social graces, appropriate humour, perspective, decorum, resolve, and an ability to listen and show empathy. This takes time and a certain comfort and maturity that comes through practice, exposure, perhaps a coach or mentor, but always candid feedback and reflection. You cannot be a reluctant transformational leader: you have to want it and for all the right reasons. Transformational leadership is never off-duty or manifest only at the office.

A transformational leader possesses superior communication skills. Perhaps there is no other leadership skill as durable and universal as effective communication. Public speaking, non-verbal, verbal and writing skills are essential precursors to leading change. Through training, practice, exposure and, sometimes creativity, effective communication is more than content and consistency; it is about comfort and confidence, style and choice of words, use of humour and imagery and practice. Venues, formats and audiences are choices that need to be made, as are timing, selection of authentic messengers and frequency. Watch a video of your presentation(s) through the lens of the audience and note what *you* see, feel and think about the presenter and the content. People may not

remember what you said; they will remember how you made them feel. Social media are supporting a new suite of approaches, conventions, formats and styles that value speed and targeted audiences. They also have limitations and a short shelf life. Each and every communication tool has its strengths and weakness and no one strategy works for all communication needs.

A transformational leader builds teams and people. Building effective teams is not always something we get to do; rather, in the short term, most participate in established or newly created teams. This exposure gives one a sense of what makes teams work, what makes them effective or successful and first hand experiences with team play and dynamics last a lifetime. Selecting, commissioning, supporting and, perhaps decommissioning teams is a practiced skill gained through exposure and one's own success as a team member or leader. Whether selected as a representative, delegate, participant or contributor, teams bring talent, collaboration, decision-making, project management and a variety of skills and learning that endure beyond B-level and C-level roles. Even governance is a form of team play that is essential exposure for those who find themselves working with Boards and their governance processes and structures. Equally valuable is experience gained from other organizations and projects in the industry or broader community.

Another valuable insight is that around a change management tipping point: when to divert time and energy with those engaged in change to those that are not? At some point, it may be more appropriate that those actively resisting change are offered a choice: the opportunity to contribute to the goals ahead for the organization or the opportunity to join another organization where there is better personal fit. If there were a choice between getting to a goal together versus getting to the goal at all, most would wrestle with but ultimately select the latter. If a new culture is to be nurtured, one must be prepared to leave some vestiges of the old behind.

A transformational leader sees the big picture and senses urgency in its arrival. Transformational leaders embrace systems thinking through big picture awareness, analytical frameworks, critical thinking and knowledge of the art of the possible. A telling

characteristic is their penchant for environmental scanning for opportunities through a strategic framework or lens. This attribute stems from exposure to a broad range of experiences, network of colleagues, curiosity and lateral thinking. They connect dots and ruminate, ask “what if” and “why not”. They know how to reframe a challenge and recognize that many and divergent solutions lie upstream of the observable results. While a cleaning blitz might quell an outbreak of *C. difficile*, the more difficult yet durable approach would be improving staff orientation, management training and product knowledge, deployment of compliance audits and, for the clinical side of the house, an antimicrobial stewardship program and universal training in the effective use of personal protective equipment (PPE).

In setting the stage for urgency, transformational leaders frame change with answers to why and why now? Change must strategically align its components with evidence and the vision and values of the organization and authentic reasons why the current state is a significant risk. Leaders must be able to convey a non-negotiable imperative to change concurrent with the aspirations and outcomes of the journey and destination. While urgency is a counterpoint to complacency, a crisis averted is preferable to a crisis solved. While a crisis can be leveraged to authenticate the change imperative, crisis management should not be so overwhelming as to disenfranchise those who would be engaged over the long haul. Charismatic or transactional leaders can go only so far in motivating people with fanfare, hype and quick fixes; transformational leaders speak to another calling, of vision, effort and the value of people and the work they do.

A transformational leader demonstrates commitment to customers and service. This is a mindset: customer service and servant leadership. An aptitude to learn and an attitude that welcomes feedback (both compliments and criticisms) are characteristics not easily learned and applied. By placing oneself at the coalface of the customer experience and line staff activities – job shadowing, focus groups, huddles, informal conversations – and asking three simple questions (What did we do well? What can we improve? How can I help?), transformative leaders look upstream for root causes and solutions to the trends they follow. Customer service and servant leadership are a means to anticipate and

resolve an issue before it becomes a crisis. Shrinking market share and declining client or staff satisfaction results are lagging indicators. They scream that current strategies are already failing: transformative leaders need to have analytics and courage to say so. Equally telling about servant leadership is the notion of asking a sub-ordinate how one might help them define their goal package, assist with professional growth or reduce or eliminate barriers; and, don't ask if you're not prepared to listen or respond.

A transformational leader acknowledges and is mindful of organizational dynamics.

Sometimes leaders forget that they are central to the politics of their organization. Every leader has a finite amount of political capital and it is easier spent than earned: choose expenditures wisely. Information, access to people and committees, educational events and conferences, even seating order at special events, all to speak to seemingly intangible but real workplace dynamics that affect the success of leaders. Who supports what topics or projects or colleagues, which projects garner favour or results, whose disappointment trumps another's success, who speaks first or last, etc. are not lost on most leaders. Negative office politics may include private lobbying and advocacy, undermining behaviours, bullying and coercion, disruptive behaviours, false praise, blaming and shaming and many others. Casualties of these tend to be team dynamics, platform-wide projects and initiatives and celebration. Transformational leaders are not afraid to out these behaviours, to get their hands dirty by using team retreats, performance management, coaching, third parties and their own positional power. However, for every action, there is a reaction and legacies for both. Transformational leadership is not a panacea, a singularly effective leadership style that delivers no matter the challenge, timeline or organization. Similarly, effective leaders are not monolithic in their leadership style; excellent leaders recognize the conditions and circumstances when styles and approaches may need to be flexible and one leadership style does not fit all challenges, circumstances, people and organizations all the time.

A transformational leader engages people and thought leaders in the organization.

Building support through engagement is central to the success of transformational leaders. That sponsors and proponents of change need allies and early adopters, that

change needs momentum and ultimately a tipping point of followers and late adopters, leaders must build coalitions and engage and sustain a cadre of both formal and informal power brokers. Perhaps easier amongst teams and professions, this requisite skill is a challenge for many, particularly the C-suite. In the midst of significant, transformative change, leaders can find themselves at the junction of impossible and improbable: improve quality and performance but don't change anything; improve productivity and accountability but don't upset employees; drive high standards but don't disenfranchise non-compliant clinicians. Navigating these leadership conundrums is never easy. Transformational leaders find methods and new ways to commence and sponsor conversations (from the bedside to the boardroom), establish communities of dialogue, find levers and allies to socialize change and have the patience and wisdom to manage a cadence to change that delivers without precipitous fallout. Using external speakers, circulating articles and perspectives of thought leaders, sponsoring deep dive discussions and sponsoring team retreats, safe rooms for open dialogue are central to the ability of leaders to socialize significant change as its implications take shape.

A transformational leader supports innovation and risk. If a measure of transformational leadership is innovation (knowledge transfer, emerging best practice, differential outcomes and results, rapid cycle improvements – aka better, faster, quicker, cheaper, safer), then leaders must recognize the need for associated risk, time to value and flexibility. Healthcare is known for its aversion to risk, tendency towards bureaucratic and regulatory inertia as well as conservatism of the professions. For leaders, this means shedding some of that DNA: allow people to test ideas, bend or reduce rules and operate outside formal processes or structures. Health Quality Ontario's approach to quality improvement has a petri dish feel to it; hospitals are free to "experiment" with differential approaches to quality improvement as a way to incubate and disperse emerging best practices. Innovation has a way of accelerating the change imperative; however, it can also saturate capacity for change, a feature that also begs a leadership perspective. When faced with many opportunities for innovation, leaders are challenged to acquire new skills in economic appraisal and ethics: value for money, return on investment,

opportunity cost, and utility, benefit and choice. These can be difficult topics, often with more ambiguity than clarity in their wake.

A transformational leader engages in personal development. Equally important is the propensity of leaders to become engaged themselves, in new settings, communities of thought and tables of dialogue. Exposure to leaders in other organizations, industries and people of influence, combined with a commitment to lifelong learning are energizing for transformational leaders. This enables them to share ideas, experience affirmation with or challenges to their perspectives and reflect upon their motivations and approaches. While courses, workshops and conferences tend to be the mainstay of professional development, increasingly study tours, vocational vacations and volunteer efforts supplement this learning and development. Professional development must be more than what an employer might support; it speaks to the personal commitment one places on personal development and excellence as a leader.

A transformational leader creates opportunities for organizational and personal growth. In today's digital era, game changing solutions are everywhere and a particular change can reach critical mass or tipping point very quickly. Creating organizational capacity and readiness for change is critical as is the foresight to recruit, develop, engage and prepare change-ready leaders for a marathon of change that they will possibly identify, sponsor or support. Transformational leaders see change as an opportunity, not a burden, and with the mindset of early adoption, they seek the art of the possible, discern transferability and portability of solutions across industries and professions and mobilize their observations in tangible ways. Much of today's innovation stems from off the shelf technology applied to new situations and settings, e.g., patient tracking and self-scheduling, web-enabled teaching, mobile devices for disease tracking, remote wound and pain management, etc. Exposure to the art of the possible and new corporate alliances and partnerships usually begin with people meeting people.

7.0 Conclusion

In response to pressures and capabilities enabled by the information age, healthcare is experiencing a renaissance that is challenging some of its basic tenets to the core: from delivery systems to economic sustainability, from disease management to population health, from aging to accessibility, from service industry roots to the knowledge workplace. These paradigm changes are reshaping the industry and the future of Canada's healthcare system is in the hands of leaders who must be prepared for and successful with transformational change. Pivotal for leadership success is the ability to differentiate between marginal and transformative change. In Section 3, eight paradigms are described more fully, demonstrating how transformative change can be woven into a change mandate. While not every change is or can be transformative, an assessment like Table 1 (which compares and contrasts old and new paradigms) can help leaders discern and communicate significant change, diagnose problematic cultures and design responses that would deliver needed strategies, support a new culture and facilitate early wins.

In Section 4, we noted how leaders must have the courage to assess and respectfully challenge the organization's dominant culture *in situ* vis-à-vis its capacity to embrace and sponsor disruptive change, to deliver the requisite performance and to hardwire new elements of culture. These culminated in Section 5 with a summary of six steps needed to engage and support people and organizations through cultural change. In Section 6, healthcare leaders are provided with ten leadership behaviours to augment the four core capabilities described in Systems Transformation in the Leads in a Caring Environment framework as a means to gain and apply experience for transformational and cultural change. Appendix 1 illustrates how these four competencies associated with systems transformation can match up with key behaviours to assist leaders as they map out strategies and activities associated with a significant organizational change.

Central to leadership success is taking command and control of one's opportunities for personal and professional growth and applying lessons learned to future challenges and downstream career opportunities. For transformational leaders, success with new

paradigms is neither accident nor serendipity. They result from applied skills, experienced tradecraft and a willingness to champion and nurture such change. Transformational leaders possess and practice a suite of skills differentially suited for the visions they share, the people they engage and the stories and journey they share. Because the drivers of the digital age are also accelerants of change, the expectations for leaders possess additional jeopardy: speed and first time success. While neither magic bullet nor panacea for all that would challenge the healthcare system, strategies to develop and support transformational leaders are essential if the objectives of healthcare's triple aim are to be achieved.

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Table 1. Summary of selected features to compare and contrast how an old world / new world paradigm is transforming health care.

Feature	Old “Analog” World	New “Digital” World
Organizational structures	Bureaucratic / hierarchies Senior management Closed / cloaked Fattened Authority limited Sovereign organizations	Non-bureaucratic / matrices Project leadership Transparent Flattened Authority enabled Integrated structures and systems
Patients	Compliant Uninformed Episodes of care Acute care Powerless Transactions Access to care	Engaged Informed Population health Chronic disease management Powerful Outcomes Satisfaction with care
Staff	Service workers Satisfaction rates Seniority Competent	Knowledge workers Engagement rates Rewards and recognition Value-added skills
Culture	Inward and centralized Paper speed Political Risk avoidance Command and control Provider-centric	Outward and empowered Cyber speed Candid and open Risk mitigation Diffused autonomy Patient-centric
Clinicians	Independent contractor Autonomous Provider-centric Personal performance Reluctant leadership	Subcontractor Accountable Patient-centric Collective performance Engaged and developed leadership
Health record	Communication tool Quality audit Episode of care	Real time telemetry Quality compliance Unit of reimbursement
Quality	Informal structures Declared (subjective) Chart audits Few standards Low compliance	Formal structures Measured (objective) Outcome audits Many standards High compliance
Government	Funder Advocacy	Purchaser Accountability

Appendix 1. Example of a leadership checklist for transformative change (e.g., new eMR) to align transformative practices with transformative behaviours.

System transformation practices from LEADS					
Transformational leadership behaviours		Systems/critical thinking	Innovation	Strategic / future orientation	Sponsor change
	Personal characteristics	Difficult and challenging change initiative; Opportunity cost for other imperatives; May include complex governance structures	Risk in early adoption Cascade of change	Require robust plan, early success with selected variables	CEO; Delegate and support Team-based Engage stakeholders
	Communication	Case for change discussion paper; project team and charter; rollout plan, Gantt project management and ongoing messaging at milestones	Early wins; art of the possible; promote milestone benefits	End state: capabilities and performance Contribution to Mission and values	C-suite, Board MAC MSA
	Building teams and people	Chiefs and medical directors External champions	Select and groom early adopters	Clinical teams and user groups Patient-centred outcomes	Executive sponsors Steering committee User groups
	Orientation to customers and service	Correlate with impact on quality, safety, patient outcomes, performance and integration with community providers	Link to patient satisfaction results and feedback	LEAN Quality plan Safety Speed	Various user groups Patient user group
	Organizational dynamics	Align with Chair, MAC Sequester funds with Board	Project leadership	Alliances Leadership Capabilities Patient care	CIO with C-suite Budgets and metrics
	Engage people and thought leaders	MAC, MSA and Board Health Records Committee of MAC, professions and users	Support early adopters Site visits	Functionality Benefits “What’s in it for me”	CIO Engage super users and early adopters
	Vision and urgency	Case for change: risk / reward, functionality, top benefits and outcomes, connectivity, alliances	Site visits; case studies; art of the possible	Strategic plan Quality plan e-Health vision	Business case Sequester working capital; Gantt
	Innovation and risk	Case for change / early adoption First time success; partner with others; mitigation (Lean A3 approach); governance models	Showcase features and capabilities Site visits	Operating plan and sustained funding; channel capacity	Project lead: management or shared services model
	Personal development	Site visits; support early champions; design change management approach; case for change	Art of the possible; clinical outcomes	Life long learning, skills portability and transferability	Self
Opportunities for organizations and personal growth	Connectivity, organizational leadership, develop new project leaders, lessons learned	Best practices, lessons shared with peers and other providers	e-health agenda; performance with patients and peers; next steps	CIO Clinical teams and programs Patient champions	

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