The *LEADS in a Caring Environment* Framework: Achieve Results

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Graham Dickson and Bill Tholl

> *Leadership is about not only developing and communicating a vision and setting objectives but also following through to achieve results.*
>
> McKinsey and Company, 2015 [1]

All of us want to make a positive difference when we get up in the morning. Who doesn't like checking off their to-do list at the end of the day? And, as the quote above suggests, success for health care leaders is judged not by just having a clear and compelling vision but also checking off the achieving results box in our annual or quarterly performance reviews.

Let's look at what Simon Kennedy says about making a difference. Simon was one of Canada's longest-serving federal deputy ministers of health in a generation, at just over four years from 2015-2019. He has worked in a variety of portfolios across the federal government. Here's Simon's story:

> *My minister's 2017 mandate letter* [2] *from the Prime Minister set a clear goal: "To engage provinces and territories in the development of a new multi-year Health Accord." In realizing a new health accord, the federal government hoped to advance the twin objectives for Canadians of achieving improved access to necessary mental health and home care services.*
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> *While it has sometimes proven difficult for governments to find common ground on health care, I and my provincial colleagues were certainly able to start with the premise that everyone agrees on the need for a better and more accountable system. It also seemed important at the outset to acknowledge that the provinces have constitutional responsibility for health care delivery and position Health Canada as seeking to be a helpful part-*

G. Dickson (✉)
Royal Roads University, Victoria, BC, Canada
e-mail: graham.dickson@royalroads.ca

B. Tholl
Canadian Health Leadership Network, Ottawa, ON, Canada
e-mail: btholl@chlnet.ca

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ner—one with a clear point of view and interests, but a partner—in helping to meet the emerging health care needs of Canadians across the country. In my own view, a little humility goes a long way in finding shared solutions. Relationships are fundamental. Honesty and transparency are key to building the personal relationships needed to overcome obstacles.

A lot of hard work went into setting the table for how we would successfully work together. It seemed apparent that notwithstanding long-held institutional positions, there were many things all parties actually agreed upon, and the key was finding out how to structure an outcome that everyone felt good about. My experience from the old days working in trade negotiations was that the good negotiators gathered enough intel about the various competing interests to know where the final 'landing zone' might be.

To accomplish the two goals of improved access to mental health care and enhanced home care services, special purpose funding of an additional $11 billion spread over 10 years has been committed over and above core federal funding for health care services in that same time period. In order to help monitor and evaluate progress over this period, all jurisdictions agreed on a common set of health indicators for each of the two priority areas. I think this was a win-win for everyone: Additional funding was provided for important services outside of the core physician-and-hospitals infrastructure, and all governments agreed to an accountability mechanism that is simple and clear and could well be replicated elsewhere over time.

It always seemed to me that the most effective leaders, whether DMs or ministers or others, were those who could work in the 'here and now' and at the same time steer a course where managing these issues fits into a longer-term game plan. The urgent and the important co-exist. Short-term imperatives map against the longer-term agenda. In health care, in particular, I am under no delusions of cracking the secret over my term as deputy, however long that might be. It's clear there needs to be a longer-term game plan, vision and strategic patience. I have learned much about leadership from Indigenous leaders, who have a philosophy of taking decisions today that will have impact seven generations out! I see my role as the current DM as making it easier for those that come behind me to find the promised land.

Simon's story underscores how the four capabilities under the Achieve results domain come together. Having received very clear direction in the form of a mandate letter from the Prime Minister, Simon set about using his full bag of leadership tools, acquired over a series of different senior leadership positions outside the health sector, to deliver results. First, he was able to work with deputies from the provinces to address the needs of Canada's most vulnerable, those needing mental health and long-term care (Set direction). Then, based on this vision and on "evidence and shared values"—the need for an accountable system, respect for the constitution, and the importance of relationships based on humility, honesty and transparency—he and the provincial deputies made decisions to realize the goals of mental health and community care. Together, he and the provincial leaders then allocated resources over a 10-year time frame to take action, by employing both short- and long-term plans to achieve those goals. Finally, processes were put in place to assess and evaluate progress according to a standard set of indicators, with accountability to the Canadian electorate as a common denominator for ensuring longer-term sustainability.

Simon's story is one of many we feature in this chapter on how the four capabilities work together and how important it is to get off to the right start as a results-oriented health care leader. Before doing a deeper dive on each of the four capabilities that make up the Achieve results domain, let's take a moment to reflect on what we have learned from Simon.

Learning Moment
Take a moment to reflect on Simon's story outlined above.

- Like Simon, leaders always need to balance short-term imperatives or deliverables with longer-term results. Can you articulate the long-term results you are pursuing? What might they look like in the short term, if you were acting in a manner in keeping with those long-term results?
- Share Simon's story with a colleague. Discuss. Are there lessons in Simon's story that apply to leading your project, or organization?

As the McKinsey and Company study quoted at the beginning of this chapter suggests, "operating with a strong results orientation" is a major contributor to leadership effectiveness in both for-profit and not-for-profit sectors. From a results perspective Canada continues to lag most comparator countries, coming in ninth out of 11 countries (with the United States and France coming in behind) according to the most recent Commonwealth Fund rankings [3]. Across jurisdictions in Canada, we also see wide variations in the same performance metrics used by the Commonwealth Fund [4]. Such evidence should impel leaders—at all levels—to look for and leading practices to achieve better results. At the organization, department, or community level each of us should be translating those desired results into short- and long-term actions that align in order to contribute to their achievement.

Many health leaders' results are measured in terms of the financial sustainability of their health care systems or organizations. Bending the cost curve [5] (Jack White's phrase for reducing the rate of growth in health spending [6]) has gone to the top of the agenda. Close to 50% of total program spending by provincial governments in Canada, for example, is allocated to health, driven upward by both demographics and technology. "The sustainability of public sector health care spending has been at the forefront of a roiling policy debate for years in Canada (and abroad)" [5]. Many of the case studies featured in this book have bending the cost curve as either a constraint or an explicit public policy objective.

There are four primary factors that influence the results effective leadership can achieve. The first is that leaders need management skills to achieve results. Management practices—planning, organizing, budgeting and measuring—are rational, research-based practices that enable leaders to realize their vision. Daniel Pink describes management as technology [7] to be employed to achieve results; but it's technology that must be integrated with the people engagement approaches described in other LEADS domains [8].

A second key factor is the sea change that's happened in terms of our ability to measure results. The last 10 years have seen an "unprecedented increase in the volume and variety of electronic data related to research and development, health records, and patient self-tracking, collectively referred to as Big Data. Properly harnessed, Big Data can provide insights and drive discovery that will accelerate biomedical advances, improve patient outcomes, and reduce costs" [9]. The growing

technological capacity to collect big data or real-world evidence in the moment couples with growing capacity to systematically analyze data have generated the tools to make timely and accurate evidence informed decisions. Results-oriented leaders need to design and use delivery systems that make real-time results available to decision makers.

The third factor affecting effective leadership is the ability to align effort vertically and horizontally in an organization to achieve results. Implementation science is the study of methods to encourage and promote the systematic uptake of research findings and other evidence-based recommendations into routine practice. Its goal is to improve the quality and effectiveness of health services [10, 11]. Unless decisions and activities are aligned with the desired results, the meta-values of efficiency and effectiveness cannot be achieved. Results oriented leadership is tight on results, but loose on process: leaders see the results as the goal, and adjust processes in order to get there. By employing disciplined practices to convert research knowledge to action [10, 12] and engaging in strategic planning, action planning, project management and ultimately behaviour change, the leader can logically align decisions and action with the desired vision and results.

The fourth factor is that growing data analytics capacity and clear identification of best practices for implementation have increased expectations that leaders be held accountable for delivering better results [13–15] and increasingly, in Canada, creating value-based, learning health care systems [16, 17]. Without clear evidence of how you're doing and holding yourself accountable for course corrections, progress is impossible. Consequently, accountable health care is more of a priority for leaders than ever before in Canada and many other countries. We will say more about this priority in the "Assess and Evaluate" section of this chapter.

These four factors make Achieve results the most task-oriented of the five domains of the LEADS framework. Regardless of your role—CEO, mid-manager, front-line supervisor, clinician-leader, community or informal leader—using the Achieve results capabilities will help you clarify goals, set priorities, measure your effectiveness, stay on track, deal with inevitable surprises, take appropriate action to deal with shocks and be resilient enough to get right back on track.

The Achieve results domain differs from the others in another important respect: its order matters. Much like the "Plan, Do, Study, Act" cycle [18, 19], the four capabilities of Achieve results work better together and work best when in this order:

1. Set direction
2. Strategically align decisions with vision, values, and evidence
3. Take action to implement decisions
4. Assess and evaluate

So now, and building on Simon's story, let's turn our focus to looking at the four capabilities in the Achieve results domain of the *LEADS in a Caring Environment* framework, and how together they can help focus your leadership on the task of improving health for our citizens.

Set Direction

"Would you tell me, please, which way I ought to go from here?" asks Alice.
"That depends a good deal on where you want to get to," said the Cat.
"I don't much care where–" said Alice. "Then it doesn't matter which way you go," said the Cat. "–so long as I get SOMEWHERE," added Alice.

Lewis Carroll

To set direction is the first capability in the Achieve results domain. Leaders inspire vision by identifying, establishing, and communicating clear and meaningful expectations and outcomes. If you don't know where you are headed then any road will get you there; but you may be destined to travel it alone. Porter and Lee point out: "The first step of solving any problem is to define a proper goal. Efforts to reform health care have been hobbled by lack of clarity about the goal, or even by pursuit of the wrong goal" [15]. A vision—and related results—is the North Star for organizational or collective activity [20]. A good leader transmits a clear vision and direction, which motivates and energizes the team, especially during unsettling and difficult times [21].

Visions are leader and management-team driven and ideally, created collaboratively by engaging members of the organization and the public, which is the most effective way to win broader acceptance of a vision [22]. As we will continue to repeat throughout this book, distributed leadership is about owning what we all help create. What is also clear from our research [23] and the work of other writers [24, 25] is that visions need to be clear, compelling and inspirational. If a vision is not shared it has little power to direct collective action.

Simon's story also underlines the importance of thinking decades ahead. John F. Kennedy famously said in 1962: "I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to earth." He went on to say: "…we choose to go to the moon and do other things not because they are easy, but because they are hard" [26]. Jim Collins said inspirational leaders pursue "big, hairy audacious goals" [27] and Richard Farson said "the only vision worth pursuing is one that is impossible to achieve" [28]. In this chapter and throughout the book we encourage all health leaders to stretch themselves and, with President Kennedy in mind, to shoot for the moon.

How important is it for a health leader to have a clear and compelling vision in these extraordinarily unpredictable times? At least one study found significant relationships between visionary leadership and perceived organizational effectiveness [29]. But a vision can be hard to relate to if it's perceived as simply the purview of politicians or senior management. It must be owned by everyone who has a role in creating its results. Visions can also seem remote if it does not include a timeline and clearly defined, desired, results [30]. This is hard to overstate—it's easy these days to lose sight of where we are on a leadership journey or of the core purpose of an organization. Let us share a real story from the Canadian prairies that brings this home.

A CEO of several national health organizations, who grew up in the Canadian prairies, and happens to be one of the two co-authors of this book, is fond of telling a story about growing up in Saskatchewan. Canada, like Australia, Russia and the U.S. is a large country with vast prairies. "It is a rite of adulthood that every teenager growing up on the prairies is asked one day to take the wheel of the tractor and cultivate the field."

Dad had been making great progress. The field was half done with nice straight furrows when he said to me: "It's your turn now, Bill. Let's see what you can do!" So I took the wheel of the tractor and carefully set off down the field looking backwards to follow his furrow. I got to the end of the field and turned to see how I had done. I was crushed to see that my furrow was as crooked as a dog's hind leg. I turned to my Dad and asked "So what did I do wrong? How is it that your furrow is so straight?" He smiled and said wryly: "Well, the first problem is that you were looking backwards the entire length of the field and every time you hit a rock in the field, it set you off course and you over corrected to get back on track. The trick is to look forward, not backward."

"That's fine then, Dad, but how is it that you get back on track so quickly that your furrows look so straight?" "Well," he said. "I pick a fencepost on the horizon and I line up the tractor's smokestack with the fencepost and that helps me to get back on track quickly when I hit the rocks in the field."

The field of health care leadership, like the wheat fields of Saskatchewan, has many unexpected rocks and other obstacles. In facing them, leaders need to have a clear and compelling vision (I want nice straight furrows!) and must keep their eye on the fenceposts (results in line with the vision) and they must always be looking ahead rather than backwards as they lead the way.

Just as smaller family farms have gradually given way to large corporate ones, the health care system continues its transition from corner stores to corporations. More and more hospitals, here in Canada and elsewhere, are merging and (as detailed in Chap. 12) local regional health organizations are giving way to larger, province-wide health authorities. And, just as Saskatchewan farms are incorporating, looking to computerized equipment, even tractor drones, to improve overall efficiency and be more competitive, the health care system of 2020 is being buffeted by the technological imperatives of artificial intelligence, proteomics, precision medicine and robotics. Health leaders in 2020 and beyond will need to continue to learn, to grow and to stay ahead of what technology can do *for* them rather than *to* them. They need to be vigilant and need to beware of both negative and positive spillover effects of new technology and constantly remind themselves that technology should serve health care, not the other way around.

To take an international example of a horizon objective for health, the World Health Organization originally set the goal of "Health for All by 2000" back in 1978 [31]. Health for All 2000 garnered support from health leaders around the world. When the WHO realized it wasn't going to hit this ambitious target by year 2000, it didn't abandon the vision. Rather, it celebrated the significant progress that had been made in areas like reducing child and maternal mortality rates and, in 2000, recommitted its 191 nations to the new Millennium Development Goals, resetting the target as Health for All by 2020 [32]. This is an example of a worthy horizon objective, likely unattainable in the lifecycle of any one leader if ever (and certainly

not by 2020) but worth striving for. The most recent (2015) report from WHO refines the goalposts again moving toward a broader set of sustainable development objectives [33].

Another example of pursuing a horizon objective, as mentioned previously, is provided by the U.S. Institute for Healthcare Improvement's call to action in 2006 to reduce medical errors in the system. The CEO at the time, Dr. Don Berwick, challenged health care leaders to work together to reduce deaths from preventable errors (vision) by 100,000 per year (clear, desirable result) by eliminating avoidable adverse events. The resulting *100,000 Lives Campaign* [34] took off in the United States and spread to Canada, putting health care systems around the world on a different pathway toward reducing the incidence of preventable harm in the system.

In Canada, the same movement helped spawn the creation of the Canadian Patient Safety Institute in 2003. It launched with the daunting horizon vision of creating "the safest health care in the world." However, unlike Berwick's work, specific, desirable results, in keeping with the vision, were not articulated. In their absence, can we clearly identify our progress? We are still striving to achieve an error-free health care system; patient safety has become job number one for leaders in the Canadian health care system. But how are we doing? New tools have been put in place; new pathways have been found to turn knowledge into action; and efforts to engage patients and families have grown significantly (see Chaps. 6 and 13). But without a clearly defined destination, expressed as desirable results, we may wander in the wilderness without a clear destination or GPS to guide us to it.

Strong visions have been shown to enhance organizational and system performance [35, 36] but even compelling visions expressed passionately may only inspire others for a time. When we hit those rocks in the field, when reality sets in, and people begin to be frustrated with being thrown off track, it's vitally important for a leader to identify clear and meaningful expectations and long- and short-term results, which can be measured to show that the vision is being translated into action. Measurable results, in keeping with the vision and translated into short-term measures, can give a distant goal relevance and infuse day-to-day efforts with meaning and purpose.

Learning Moment

Visions are important; but articulating desired results may be even more important. Review your organization's strategic directions document.

1. Does it clearly outline the results it wants to create with its vision and mission? If so, what are they?
2. If it does not, what metrics do you think would be appropriate measures for having achieved the vision and mission? Outline three.
3. Depending on your answer to either 1 or 2, how does your work contribute to achieving those results?

Strategically Align Decisions with Vision, Values and Evidence

The second capability of the Achieve results domain is to strategically align decisions with vision, values and evidence. “The strategic vision and values that drive the organisational culture need to be values that are meaningful and that are clearly visible to patients and staff. They have to be more than ‘just words’” [20].

What do we mean by alignment? As a noun, it refers to “the degree of integration of an organization’s (or local service delivery system’s) core systems, structures, processes, and skills; as well as the degree of connectedness of people to the organization’s (or system’s) strategy. As a verb, aligning is a force like magnetism. It is what happens to scattered iron filings when you pass a magnet over them.

Visions and results; mission (purpose statements) values (organizational principles) and evidence are the forces that create aligned decisions. The key word is “decisions” because they are the domain of decision-makers and leaders, from executives to the receptionist (a.k.a. “Director of First Impressions”) to the family caregiver. Decisions are how you as a leader focus, direct and maximize the use of an organization’s resources to achieve its core purpose.

Figure 7.1 below shows how, in a perfect world, vision, mission, values and evidence come together to create a substantial sweet spot that defines the area of an ideal decision. The chart shows that a clear and compelling vision is necessary, but not sufficient to achieve results. The vision must align with the core mission of the organization, with the well-understood and shared values of the organization or endeavour, and the evidence that needs to be acted on for change to happen.

Fig. 7.1 Aligning mission, vision, values and evidence to make a decision

Of course, as in most leadership challenges, it's never a perfect world and there are no guarantees that it is easy to balance vision, values, mission, evidence, to create a decision. Indeed, given the dynamics of health care systems, some leaders on some days might say it is more akin to a perfect storm than a perfect fit, where unrealistic demands meet increasingly scarce resources. If decisions were purely rational, that might be the case; but given the politics of organizational life, strategic choices are not always logical, at least in the short run. In this context, leaders can only use their best judgment to make a sensible and timely decision.

In studying six Canadian health care organizations, Smith et al. [37] point out that successful leaders find effective ways to ensure executive teams actually act as teams (described in Chap. 6) to make decisions on setting priorities and allocating resources. Often, they don't: Peter Senge [38], in his discussion of organizational learning disabilities, describes executive teams as warlords who come to the table to carve up the spoils, rather than act as a fully functioning team. Smith and Mitton also stated that decision maker attitudes and behaviour were identified as a key determining factor in terms of getting commitment to a shared vision. They found that aligning structures, processes, behaviour and outcomes is critical to achieving meaningful results for high performance health care organizations.

Harking back to Simon's story, after several failed attempts under previous health accords to ensure accountability longer term, it was critical to have provinces and territories agree upon a standard set of indicators to assess both new investments in mental health and home and community care. This was necessary to ensure governments are accountable to the tax-paying public. Requiring that progress be reported regularly does set an important precedent for any future federal investments, such as discussions around introducing a universal pharmacare program for Canadians [39].

Simon's story also demonstrates the challenge of leading in the less than perfect world of health care, where real time data is often unavailable; or where data systems are not interoperable; or where data analytics are underdeveloped. Leaders are required to align multiple factors, including what other leaders are trying to do. Their collective efforts may support overall alignment but, again, they may not. For example, as an executive leader, you should try to make sure your board is "on board." Consider adding a generative role (where board members consciously think about issues in new ways to decide what they should focus on) to the board's more traditional fiduciary and strategic roles. "Given the complexities of 21st century health care, it has never been more important for boards, whether elected or appointed, to work as one" [40]. Having a board that is LEADS literate can be invaluable.

Let's now look at a case study on aligning vision, values and evidence to make a decision. One of Canada's Maritime provinces, Nova Scotia, decided to centralize its nine health regions into one province-wide authority, the Nova Scotia Health Authority (NHSA). Dr. Peter Vaughn took on the role of deputy minister of health with a mandate to create this single health authority. Here's Peter's story about some efforts to align elements of the system with the new vision and desired results (Interview with Peter Vaughn, former deputy health minister, Nova Scotia, August 15, 2019).

The overarching goal was to create an accountable health organization for all of Nova Scotia. What was a bit different for Nova Scotia compared to other provinces was that the changes had to be embedded into legislation. The intention behind legislating the accountability framework for NSHA was to prevent possible back sliding, as it makes it more difficult for subsequent governments to roll the changes back if it is the law.

In terms of lessons learned from our experience in Nova Scotia as shared right across Canada, governments tend to conflate strategy and structure. They think that changing structures is in itself a strategy and it is not. Every business school student knows that strategy precedes structure. Appropriate governance structures are necessary but not sufficient.

In implementing the decision to centralize the system, we pursued what I might call a "Porter-esque" value strategy. We needed to change the ministry, which most other mergers hadn't done. We also needed to build an analytical capacity that didn't really exist before that. We needed to modernize our data acquisitions, foundations, data bases and information sharing arrangements.

What many people do not appreciate, and is worth highlighting, is that we not only set up a new health authority, but we entirely redesigned the ministry to focus on data analytics and advanced analytics. This has not been done anywhere else in the country.

Peter uses the term "Porter-esque value strategy," meaning one based on the work of Michael Porter [41] who created a framework for restructuring health care systems with the overarching goal of increasing value for patients, while controlling health care costs.

We will continue Peter's story in the next section. Suffice it to say, aligning of vision, values, mission and evidence created the decision to change the ministry.

Aligning Efficiency and Effectiveness

The reference in Peter's story to the Porter value strategy highlights the importance of making decisions to strike the right balance between efficiency and effectiveness. If we become so efficient or lean that we no longer have the residual capacity to be resilient, or can no longer meet patient needs, then the organization or endeavour we are leading can crash and burn. The changes in Nova Scotia were about seeking a new approach to delivering health service that is both efficient and effective.

Demands for efficiency therefore must be aligned with demands for effectiveness, keeping them in dynamic balance. To do that we must first recognize their essential differences: being effective is all about doing the right things (such as establishing the right direction, identifying results and measuring the right things) while efficiency is all about doing things right (like use the most efficient management processes and building systems to accomplish your goals). An ideal decision aligns the two.

A good example of an over-emphasis on efficiency is how Lean, the business re-engineering process, is often used. Over the past five years we have seen an unprecedented shift to using Lean to improve efficiency in health care. Lean uses management processes to eliminate waste and redundancy to improve overall efficiency. It seeks

effectiveness by linking those processes with the value proposition you are striving for—that is, the results you desire. But what often happens is that the technical, process re-engineering dynamics of Lean are emphasized without also ensuring the leadership behaviour required of supervisors, clinicians and employees is integrated into the learning process. Lean cannot work unless people are willing to implement its discipline; they have to be able and willing to change their behaviour to set up and sustain its processes (that is, they must be motivated to do the right things). This is where the Achieve results capabilities meet the people focus of the other LEADS domains and capabilities. Dickson et al. [42] describe the symbiotic relationship that exists between Lean and LEADS, where process improvement and people engagement by necessity come together; and optimal decisions, based on vision, values and evidence can be made.

Take Action to Implement Decisions

The third capability under Achieve results is about converting decisions into action. To demonstrate this capability, health care leaders must act in a manner consistent with their organization's values to yield effective, efficient public-centred service and implement decisions that ensure changes happen to achieve results. Decisions that aren't acted on are meaningless, busy work at best; and demoralizing to your team at worst. Leadership is not simply making decisions about what should be done; in a paraphrase of Nike, it's just doing it.

Based on our research and casual empiricism, there are leaders who act or demonstrate leadership *in action* and there are those who don't, demonstrating leadership *inaction*. A decision requires new behaviour. Behaviour change is action. We have talked at length about the psychology of behaviour change in the other chapters. In this chapter we're looking at how external management practices—such as organizational or project design, action planning, measurement, and techniques such as project management—can also facilitate action. They align effort by organizing people to act together and reducing choices to a practicable level. For example, action plans create the task focus needed to achieve a common set of targeted goals and objectives and break down tasks into discrete and doable steps, which suggest clear, actionable behaviour.

Leadership in action often means overcoming system inertia and the culture of acceptance of the status quo. The decision Simon and the other provincial deputies made to invest money in mental health and improved community access, for example, will require leaders, clinicians, employees and citizens to act differently, constructing new relationships, developing new plans, engaging in new projects, allocating money appropriately, etc.

Another example comes from the context of implementing quality and patient safety decisions. Braithwaite et al. [43] identify common, reoccurring features that should be followed to generate action. They are: conducting effective and detailed

planning and project management; good communication and collaboration processes for key actors; and tools, checklists, algorithms, standards and clearly defined roles or articulated expectations, which need to align with the goal of the decision. The authors also emphasize the fundamental importance of engaging clinician and stakeholders to integrate them into these actions. Without both, the quality of care can be put at risk, and patient safety can be compromised. Leadership inaction is often a mirror image of these action steps.

Let's now continue Peter's story about some of the actions employed—and some that were not—to implement the decision to create a new provincial health system.

> *One of the first actions we took was to downsize the ministry by 300 because under the legislation, our new job was to act as governors of the health care system. With the Accountability Framework in place it became the job of the authority, not the ministry, to run the health care system. Our job was to fund and oversee it centrally. We also needed to put in the kinds of metrics that both of us could agree would be evolved over time, which they would be accountable for.*
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> *Physician engagement is another key to any successful accountable health organization. Here's where things went off the rails. We saw very clearly the need and desire for a co-leadership model with physicians. We did a lot of work and made a lot of good progress. One wild card in the change process was that the renewal of the contract with Doctors Nova Scotia was long overdue. This renewal coincided with the setting up of NSHA and Doctors Nova Scotia went outside to hire a prominent labour lawyer who worked for all the major unions. The government saw this as a major ramping up of union demands across the board, and reacted perhaps predictably. Five years later there is still a lack of physician engagement.*
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> *It was terrible timing in terms of coming at a time when we really needed physicians on board to achieve the results. This was out of my hands as deputy minister and became a much bigger deal than we had anticipated as the dispute dragged on.*
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> *A second step was to build the strategy, after the structure was in place. But as it turned out the provincial government, for fear of being held accountable politically decided not to put strategies out into public domains. This was the second wild card. We could not get the government to allow us to engage the public with the strategy. This was a key piece. For, while we were holding the NSHA to account, government was not being held to account.*

As Peter's story tells us, leadership *in action* led to the restructuring of the Ministry of Health in Nova Scotia and the creation of a meaningful accountability framework for the new NSHA. But leadership *inaction* led to physician estrangement and public disengagement. The lesson is—you as a leader must understand the dynamics of change a decision requires and turn that understanding into action others will support. That's where the Engage others and Develop coalitions domains of LEADS complement the capabilities of Achieve results. Results-oriented leaders try to anticipate where the agenda is headed, recognize threats and opportunities sooner and are prepared to seek forgiveness rather than wait for permission when conditions warrant. People judge us not by our words but by our actions. When there's a disconnect, our credibility suffers. With the unprecedented pace of change in health care, dithering is increasingly dangerous. Finding the right balance of action and inaction is an art; one based on experience, judgement and intuition of the leader.

Learning Moment

Consider all the actions Peter had to take to implement the decision to undertake transformational change for an entire system.

1. Which ones speak to the elements we have identified as important for implementing success?
2. What kinds of wild cards or surprises have you encountered in implementing decisions?
3. Contemplate when you have seen leadership inaction in your workplace. What factors contributed to inaction? Upon reflection, are there steps that could have been taken to mitigate those factors?
4. Have you, yourself, ever over-reacted? What were the consequences? What would you do differently?

In a project or organizational context, desired action—according to our definition of leadership—is when people "work together to achieve a constructive purpose: the health and wellness of the population we serve". Health and wellness results require the implementation of policies, strategic directions, goals, action plans, and clinical services. They are the actions of "working together."

Leaders know that individuals take action not just for organizational success, but also to pursue personal values and interests. Emotions such as fear of consequences and/or the potential for conflict may restrict their willingness to act. Similarly, their own understanding of their context and role may make them disagree with a proposed action. That's why actions need to reflect an understanding of context; and to recognize people need to be given the freedom to choose the best actions to achieve the desired effect in their area of expertise, for the clients they serve. That means policies and plans must allow enough flexibility for the person acting on them to interpret them for their context; and the power to act as required. Accountability systems, compliance processes and organizational plans that don't do that will drive out initiative and promote leadership inaction.

Leaders are always asking both themselves and others to change and act differently from how they are acting now. It is one thing to take on that challenge for oneself (the Lead self domain of LEADS). It's something else to demand it of others—leaders doing that need the tools and techniques to align effort in collective endeavour. People need the conditions that enables and encourages them to act; good leaders create those conditions for them—and for themselves.

Learning Moment

Observe your colleagues and others in a particular context of the workplace (overall organization, department, unit or subsidiary site). Reflecting on your observations, answer the following questions:

1. Do people in your workplace act in a timely, energetic or committed fashion, as needed?
2. If so, what features of organizational practise facilitate that?
3. If not, what features of organization design or practise are an impediment to action?
4. If you were leading the part of the organization you observed, what would you do to facilitate greater action?

Assess and Evaluate

The fourth capability in the Achieve results domain is to assess and evaluate. We define this capability as leaders measuring and evaluating outcomes. They hold themselves and others accountable for results achieved against benchmarks and correct the course as appropriate.

The assess and evaluate capability describes the pointy edge of leadership accountability—the process of knowing whether our responsibilities have been achieved, accepting the consequences or sharing the credit. Peter and his team understood that to assess something is to measure it:

> *We had clear ideas of the plans, processes and metrics to build data and analytic accountability and capacity. Ultimately it was the metrics in the accountability agreement that formed the first element of the implementation strategy. We needed to have very clear metrics to drive resource allocations and to address the historical frustrations of political ad hoc-ery that I experienced as a CEO of a region. This was fundamental to our success.*

To assess something is to measure it. To evaluate something is to determine its merit or worth. A leader may need to know, for example, how many operations are being conducted in any particular hospital: that's assessment. Knowing how efficient or effective those operations are is an evaluative process—and one that is done by designing and employing benchmarks or targets to ascribe merit or worth to that result. All leaders in health care face measurement challenges. Some things—like spending—are relatively easy to measure. Other things—like caring for a patient, for an employee, or for self—are much harder. Many of the benefits and costs of health care appear to be intangible, but they're not: it's just more difficult to find the appropriate measure. Assessment and evaluation create the need for measurement and accountability, because measurement helps us be accountable. Accountability is different from responsibility, because you can be responsible for something but not held to account for it. It's important in leadership to be accountable for what you are responsible for.

Remember Peter's story? Here is how he framed the design or creation of the new NSHA and revised Ministry of Health:

> *In terms of adopting a Porter-like paradigm, we were looking to transform to a value-based, accountable organization or accountable health care organizations north. Triple aim was certainly part of the conceptual framework.*

Accountable health care organizations are designed to use population outcome data to assess and evaluate performance and then generate accountability by tying provider reimbursements to those quality metrics [44, 45]. Their purpose is to use data to reduce, wherever possible, the total cost of care for an assigned population of patients (hence the reference to Porter), while targeting services to be more effective. This trend surged after the Accountable Care Act ("Obamacare") became law in the United States in 2010, and accelerated the move to accountable healthcare organizations. With more than 800 in place in the US, and the number growing, many Canadian jurisdictions are looking southward to emulate the patient-centred, co-creation philosophy behind them [46].

Two elements fundamental to effective functioning of accountable health care organizations are measurement and metrics, and accountability.

Measurement and Metrics

The NHSA put into law a set of metrics to be used to guide actions in health service delivery in Nova Scotia. Likewise, Simon's story underscores the need for common indicators or metrics to measure progress. For metrics to be useful, however, they must be:

- Valid and reliable—the technique used actually measures the phenomena it is intended to and will produce similar results each time it is used.
- Realistic—data can be accessed in a reasonably cost-effective and efficient manner.
- Expressed in a measurable range—measures express themselves in an organized sequence of variable results
- Modifiable—changeable through deliberate and constructive action.
- Independent—the collection of indicators (maximally realized) describe the desired end-state; but each measure contributes a different factor than the others.

From a leadership perspective, metrics need to measure the desired results of the vision and the decisions and actions taken to realize it. Too often people measure the wrong things because they are easy to measure and easily accessed. It's often much worse to have good measurement of the wrong thing—especially when, as often happens, it's used as an indicator of the right thing—than to have poor measurement of the right thing [47]. One of the biggest challenges leaders face is to avoid defaulting to the simplest of measures—cost—as the sole determinant of effectiveness. Cost needs to be balanced with other measures of effectiveness, such as staff turnover or the quality of patient experience, even though they may be difficult to operationalize. Similarly, process measures (i.e., flow through in an emergency ward) are too often emphasized over measures of outputs and outcomes (i.e., when they left the emergency ward, did they recover as expected?) A colleague of ours who was an assistant deputy minister of health once told us that he asked his staff to determine how many metrics the ministry measured. The answer was 1734 and of those, almost none were outcome measures.

Results oriented leaders are tight on outcomes and loose on process—that is, the end result they want to achieve is the fence post at the end of the field: it doesn't move. But the processes needed to get there can be adjusted and altered as rocks in the field are encoutered. Leaders must have the right balance between outcome metrics and process measures, or those course adjustments cannot be made.

From an organizational leadership perspective one of the fundamental principles of effective measurement systems is that they need to be integrated into all facets of the organization's operations. If the priority is safety, for example, all departments and units must understand it is a major strategic imperative and everyone has a role in making it happen, or the effort may be resisted and languish. Just as responsibilities and accountabilities cascade at all levels of the organization, so is there a logical progression of processes and procedures needed to bring a meaningful quality measurement system to life (see Fig. 7.2).

There are two measurement models you might wish to look at, the balanced scorecard created by Kaplan and Norton [48], which still has significant traction in health care [49] and, as pointed out above, the Triple Aim construct promoted by the Institute for Healthcare Improvement in the United States and by the Canadian Foundation for Healthcare Improvement [50] (The IHI has introduced a fourth aim recently; staff engagement). Both models expect the leader to go beyond measuring financial results and assess results including customer or patient satisfaction, productivity (such as clinical accomplishments), employee engagement and how well important clinical practices are being implemented. The principles and procedures in both can be applied by leaders at any level.

Once you have chosen a measure, evaluate whether performance on it is satisfactory (or not), judge whether action needs to be taken and accept responsibility for undertaking that action. And finally, the more transparent you are—particularly in the final stages of a change process—the more potential there is others will understand and support the action that needs to be taken.

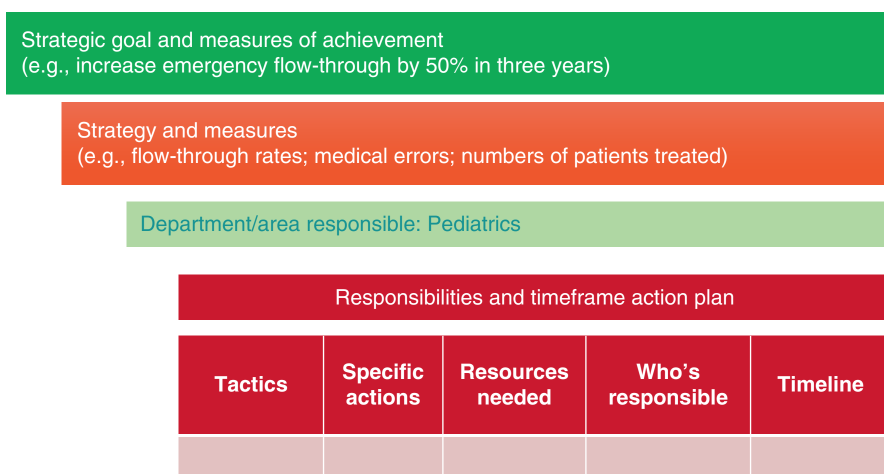

Fig. 7.2 Aligning measures and metrics with decisions and actions

Accountability

Accountability has two forms. First, there is consequential accountability, which is accepting consequences, or being held to account for achieving your assigned responsibilities. The second is procedural accountability, which is being held to account for processes and protocols that are expected to be adhered to, such as clinical protocols or financial protocols.

Many organizations establish benchmarks, a result that sets a level of acceptable performance. These can be determined by comparing one's results to certain standards, often data from other jurisdictions. Reports then show performance relative to the benchmark on charts that make the implications of the data transparent. Many organizations have policies dictating consequences if performance is significantly below par (we elaborate on one such model below). This kind of measurement formalizes accountability: "People live up to what they write down" [51]. Holding yourself consequentially accountable for reaching benchmarks [52] means accepting responsibility to make changes to processes if the results don't stand up.

When measures suggest significant changes are required, consequential accountability may conflict with procedural accountability. It may be the process is not being followed effectively, leading to poor results; or, the process itself may be unable to achieve those results. It is your job to ensure transparent processes are put in place and followed, or to change processes that don't work to improve results. Now let's look at a health care organization that has put measurement and accountability to work. Here's Bruyère's story ((Personal interview with Amy Porteous and Isabelle Bossé 2019 Apr 15).

Bruyère is a Catholic hospital located in Ottawa, Canada. It specializes in providing complex continuing care for the community at large.

Bruyère's Legacy Plan was introduced in 2014, along with the adoption of the LEADS framework as a common leadership platform at the hospital. The plan includes a number of components that all work together to enhance leadership growth and long-term organizational effectiveness. Early on in its journey, Bruyère selected a few indicators to track the progress of this long-term strategy. Four main categories emerged and key metrics were identified for each (see Fig. 7.3).

Figure 7.3 describes in some detail the four results that Bruyère was looking for from its Legacy Plan. The scorecard allows for a review of progress and shows progress relative to the four objectives set out above for staff engagement and succession planning.

More than 100 people are engaged in the Legacy Plan at Bruyère. This represents approximately 5% of the total number of staff. Twenty per cent of them are in non-management positions and have been identified as "high potentials" by their immediate supervisors. Bruyère also keeps track of "mission critical positions" by assigning a criticality index and retirement coefficient to each leadership position. This data helps the organization prepare for future leadership vacancies.

In terms of producing tangible results, one of the early objectives of the program was promoting from within, and 20% of individuals engaged in the Legacy Plan have been promoted into higher level positions since the beginning of the program. Also, participation in leadership development opportunities (internal and external) has more than doubled since the implementation of the plan. This is encouraging. Since embarking on this journey, Bruyère has learned three key lessons:

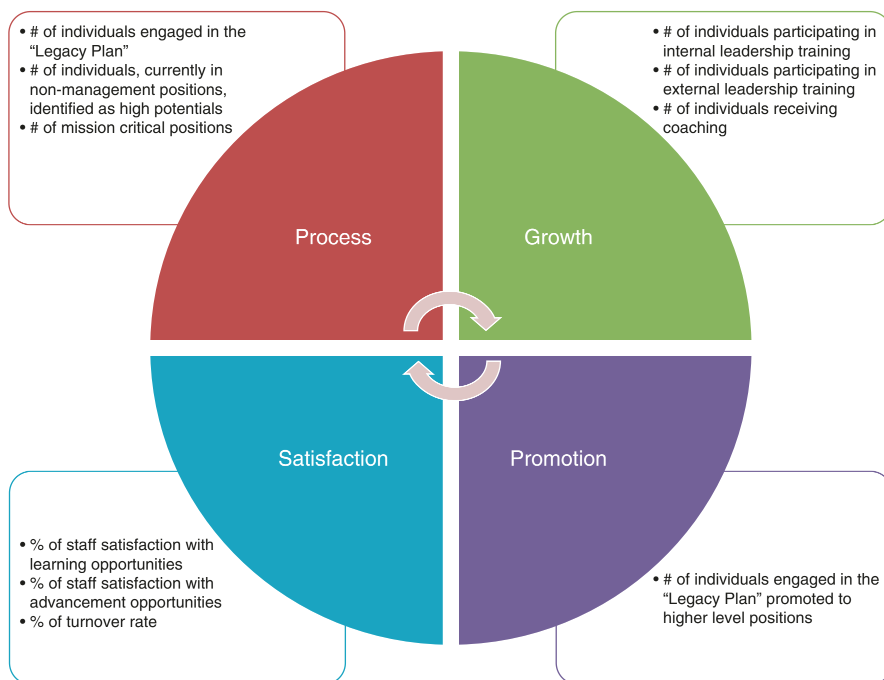

Fig. 7.3 Bruyère Legacy Plan scorecard

- *Lesson 1: Keep it simple. Aim for a simple process for identifying future leaders and, whenever possible, align it with other internal business processes (such as recruitment and performance appraisal) while building on existing metrics to avoid duplicating efforts.*
- *Lesson 2: Amp up the accountability factor. Ensure you have the right oversight and reporting mechanism for all things related to succession planning and leadership development. Not only will this help with positioning and implementing this important initiative, it will also help sustain the gains.*
- *Lesson 3: Make the technology work for you. Get a tool that will make it possible to easily track all data related to the succession plan. This will be instrumental in identifying high potential talent and developmental needs as well as determining where to focus your limited resources for maximum impact.*

Assessing and evaluating service is not straightforward. The imperatives of quality and quantity do not always align, but organizational values and culture always must. In every instance the leader must look inside (Lead self) for the guidance and fortitude to address the problem; and use the Engage others capabilities to stimulate staff and patient involvement.

Finally, in terms of accountability, leaders who thrive as opposed to just survive are acutely aware of the need to align authorities and accountabilities carefully. Having accountability for delivering on results with little or no authority over the policies or programs to get the job done is a recipe for stress and one reason for the historically high churn rate among senior health leaders. It also helps explain why younger leaders are reluctant to take on more senior roles. This has been identified

recently as a fatal flaw in many efforts to regionalize responsibilities for health care decision making [53]. It's also where good leaders may turn to the serenity prayer: "God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference."

Summary

This chapter provides an overview of the Achieve results domain of the *LEADS in a Caring Environment* framework and its four inter-related leadership capabilities:

- Set direction
- Strategically align decisions with vision, values and evidence.
- Take action to implement decisions
- Assess and evaluate

We have shown how, unlike the other domains, order matters—the capabilities can't be used in just any combination. Like a plan-do-study-act cycle, the four capabilities build one upon the other to help leaders Achieve results as part of a continuous improvement process.

The reader might also ask about how the four capabilities of Achieve results apply to the equity, diversity and inclusion challenges facing health organizations today:

Achieving Equity, Diversity and Inclusion-Informed Results

The four capabilities of Achieve results are all relevant to equity, diversity and inclusion. Goal-oriented leaders who are committed to equity, diversity and inclusion will dedicate resources to address issues around them and embed the following processes in their department, division, or organization.

First, leaders must establish a baseline of knowledge through environmental scanning and audits of data on equity, diversity and inclusion, such as staff, clients, and services if they do not already exist. Next, they must consult a diverse range of interested stakeholders in high-level meetings to reach a (near to) consensus direction for equity, diversity and inclusion initiatives that align with organizational vision and values. These plans must be resourced, implemented, and acted upon and supported with evidence-informed tools.

One made-in-Canada toolkit, developed from the Empowering Women Leaders in Health initiative, is available on the LEADS platform. Tools include equity, diversity and inclusion-aware hiring and promotion practices and supportive organizational policies, processes, and culture. Continuous monitoring, reassessment, and evaluation to track progress towards equity, diversity and inclusion goals and resetting direction for continuous improvement must be embedded in organizational processes for optimal results.

Each of the four capabilities of the Achieve results domain is aimed at clarifying and focusing you on the results of change, and on how to use those results to gauge progress and for course correction. This is the most task-oriented of the five domains. In our experience, the discipline required to succeed in the Achieve results domain, particularly for the capabilities of Take action to implement decisions and Assess and evaluate, is very challenging for health leaders. You need to stay focused on your fencepost and be ready for rocks in the health care field.

We certainly adhere to the adage "if you can't measure it you can't manage it." While measurement is often used effectively at the clinical level, it is used less effectively at the unit and organization levels. That may be because of rapid amalgamation of small health units into big ones, requiring the coordination of disparate and fragmented data and information systems. However, modern technology gives us the tools to collect, interpret, and use big data; and leaders need to build the information systems that are required and become capable of using them for better course correction and direction setting (in keeping with the cyclic nature or our four Achieve results capabilities).

We've also noted, with the rapid adoption of variations on the accountable health-care organizations method, traditional approaches to aligning authorities and account-abilities need to be revisited. Legislative approaches to locking in the new structures and processes can help prevent backsliding, as is the case in the United States with Obamacare and in Canadian jurisdictions including Nova Scotia and Manitoba.

Your challenge is whether you will take charge of the opportunities that assess-ment and evaluation provide, or wait for the government, media and the public to do it for you.

Learning Moment

To use this questionnaire, find the right category for your level of leadership, then assess how well you demonstrate the four Achieve results capabilities. Choose the appropriate level to make that assessment.

Which capability do you want to bet better at? Why?

Achieves Results Self-Assessment (for on-line access to self assessment tool please visit www.LEADSglobal.ca.)

Informal leader (patient, family member, citizen) responsibilities

In order to be a goal-oriented leader, I

1.	Contribute to direction setting (vision and results) when asked; and/or suggest new directions when results for citizens are not optimal	1 2 3 4 5 6 7 N
2.	Ensure my input into decisions, pertaining to the organization or project's direction, is in keeping with the vision, values, mission and available evidence	1 2 3 4 5 6 7 N

3.	Behave in a manner consistent with expectations as laid out in action plans for my area of interest and/or responsibility	1	2	3	4	5	6	7	N
4.	Participate in, or advocate for processes to measure, assess, and evaluate organizational/project performance; and monitor those results to determine course corrections	1	2	3	4	5	6	7	N

Front-line leaders

In order to be a goal-oriented leader, I

1.	Ensure there is a clear direction to be achieved by my unit; and that it is aligned with the organization's vision and desired results	1	2	3	4	5	6	7	N
2.	Make decisions in my area of responsibility that align with the vision, values, or mission statement of the organization; and that are consistent with the direction and available evidence	1	2	3	4	5	6	7	N
3.	Take the actions necessary to keep me and my staff focused on the desired results for my unit	1	2	3	4	5	6	7	N
4.	Assess and evaluate the desired results of my unit's work; and monitor those results to determine course corrections	1	2	3	4	5	6	7	N

Mid-level leaders

In order to be a goal-oriented leader, I

1.	Set direction for the department, in line with the organization's direction, through operational plans that outline key milestones, timelines and expected results to be achieved by all units	1	2	3	4	5	6	7	N
2.	Make decisions, relative to my department's responsibilities, that align with the vision, values, or mission statement of the organization; and that are consistent with available evidence	1	2	3	4	5	6	7	N
3.	Take the actions necessary to ensure ongoing availability of critical services in my department	1	2	3	4	5	6	7	N
4.	Ensure valid measurement tools are in place for assessing and evaluating my department's responsibilities; and that are used to improve services when necessary	1	2	3	4	5	6	7	N

Senior leaders

In order to be a goal-oriented leader, I

1.	Set direction for my portfolio, in keeping with the organization's vision and results, through strategies and metrics that will fulfill the key responsibilities of my portfolio	1	2	3	4	5	6	7	N
2.	Can clearly describe how current decisions in my strategic area align with overall organizational vision, values, mission, and relevant evidence	1	2	3	4	5	6	7	N
3.	Gain support of other senior leaders and staff for successful implementation of strategies, and for changes to those strategies when those changes are validated by new evidence	1	2	3	4	5	6	7	N
4.	Hold myself and others accountable for assessing and evaluating metrics consistent with our strategies, and monitor those results to determine course corrections and/or new directions	1	2	3	4	5	6	7	N

Executive leaders

In order to be a goal-oriented leader, I

1.	Collaborate with province, board, colleagues, and staff to create a compelling statement of values, vision, and desired results for the organization	1	2	3	4	5	6	7	N
2.	Develop strategic processes and plans that align strategies with the organization's values, vision, available evidence and desired results; and that outline decisions for organizational improvement	1	2	3	4	5	6	7	N
3.	Provide necessary support (e.g. systems, processes, resources) for implementation of the organization's strategic decisions	1	2	3	4	5	6	7	N
4.	Ensure that measures, benchmarks and targets are established to assess and evaluate desired results for the organization; and use them to course correct where necessary; or set a new direction for the organization	1	2	3	4	5	6	7	N

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