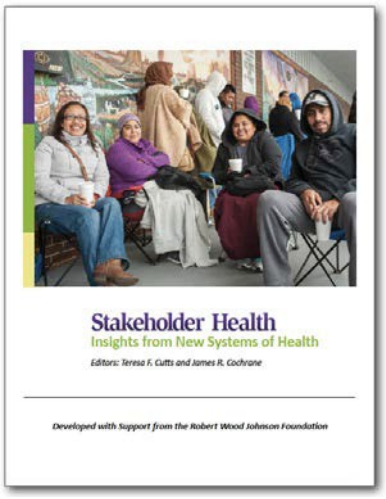
Stakeholder Health

Chapter 3
Accountable Lives: Leading Complex Health Structures



From

Stakeholder Health: Insights from New Systems of Health

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Developed with Support from the Robert Wood Johnson Foundation

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CHAPTER 3

Accountable Lives: Leading Complex Health Structures

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The Stakeholder Health (SH) learning community focuses on how we can be deeply accountable for the possibilities latent in the communities and systems for which we provide care. Our focus is on the lives of leaders playing their (our) roles in large institutions, adapting to the profoundly changed present climate of opportunities and challenges. For the most part, Stakeholder Health believes the new climate has great advantages for the future of health and health care. To maximize the possibilities before us, we believe leadership must be intentionally adaptive, not resistant.

This chapter sharpens the focus on being accountable for *our lives as leaders*. This does not require a new paradigm that would split accountability into private and public spheres. The unity is found in a focus on the character of leaders and how that is expressed in the fullness of our lives. Questions of personal character resonate with the same triad that marked the original monograph's recommendation for community: a) a move toward social complexity in *our lives*, b) in sustained partnership, and c) using our own assets.

The embrace of complexity and partnership at social scale set off a learning storm that continues to be manifested in the rest of this collaborative document. This has great implications for our leadership roles within the organizations called health systems, which are as socially complex as the communities we are trying to engage. The priority on partnership also marks a necessary leadership shift as our institutions, like community, are best understood as webs of stakeholders. The third shift, toward a focus on the assets we already possess, is the linking one. Though daunted by the obvious challenges of equity, transparency and trust in such highly structured and hierarchical systems, we know we must find our way with the assets, resources and intelligence to be found among us, our stakeholders and our partners. This is good news, not bad, as it helps us see what is already happening within the health care ecosystem that we can support and strengthen.

The point of the chapter is to frame the work of positional leaders within healthcare organizations in the light of the conceptual framework of Stakeholder Health, understanding the opportunities to align partners in healthcare, public health, and community to achieve optimal health for the whole.

A well-lived leader's life follows the vein of possibility like a miner who seeks precious metal or gemstones. Sometimes it's not that hard—the vein is exposed, waiting for someone to notice that we should point the shovel here, not there. And sometimes, when the policy environment changes radically, as if from mining to farming, the path forward may seem more challenging to find. In institutions accustomed to difficult work, it would be quite unusual to hear from leaders: "We can find money in the less dramatic healthcare arts of prevention; we can work in the sunlight of community, and spend less time in the artificial light of the ER, and do so with partners who share our life's desire for healing."

Our institutions were founded before health, healthcare and public health were differentiated fields speaking different languages. In a sense, we are now called back to the more integrated mission

for which we were originally founded. The shift in healthcare, as if from mining to farming, has two distinctive implications for executive leadership.

First is the challenge of *managing the shifting power dynamics* among and between existing stakeholders in the full range of systems that make for health in a particular community. The new possibilities and requirements of population health change the balance of opportunity and power among our very highly privileged institutions. Technology, connectivity, science, transparency and logic all unleash potential gains for the whole community, and they may also strengthen the roles of those formerly viewed as "lower" in the hierarchy. Physicians, who are used to being on an unchallenged pinnacle, find themselves on teams with other needed expertise. We will always need and appreciate highly specialized surgeons, for example, but success in an integrated model of health also rests on the intelligence of many more mid-level providers and an entire ecology of community health workers. The new financial value and improved health outcomes will come from integrating the intelligences of the latter into organizations built around the former.

The new balance will be a more profound change than we have yet experienced. The new roles do not simply *assist* the old roles; if successful, they will make it possible to have *fewer* inpatient beds and operating rooms and fewer operators. If it were purely a matter of power, nothing would change. But we are experiencing another climate shift driven by science and technology that will melt our institutions as surely as Greenland is shedding ice.

We—leadership—are often the *most* powerful and privileged people in the institution, so in the process of securing the possibilities of this era we may be experiencing the loss of some of our power. We will still need smart people at the center, but the value of the intelligence nearer the edges grows in every way. The organization with the smartest, leading-edge people is more likely to be most adapted to the community and the financial advantages found there.

Second, these new possibilities, found in the new models of health, have *practical implications for where we as leaders spend our time*—more among the broad range of stakeholders and less at our desks or with "internal" constituencies. We will spend much less time deciding, more in listening, blending, finding common alignment. This includes listening to those who were paid little attention in the past—and with those who have been (and in some ways still are) competitors. Less time spent convening in the penthouse suite, more on others' streets.

The work of leadership looks filled with freedom and resources to those on the outside, but healthcare organizations are among the most tightly regulated of all. They are accountable to a welter of federal, state, county and city regulations, and then doubly bound by multiple levels of credentialed guilds. Every guild's professional organization is awash with presentations about transformational change even as they work to continue the patter of old privileges. The lived reality is that much of this compliance to law and guild tethers the organization tightly to past science and policy, while it moves into the future with caution and in anything but an even or predictable manner. Some say the first job of the President of the country is defense; so too, with the senior leadership of a hospital. It is simply not possible for any executive at any level to be non-compliant with any of the law or regulatory strictures or ever to be seen to take any of them lightly, forcing much leadership energy and time on defense. This makes severe and often perverse demands on time and cash that have nothing to do with either medical or management science and the health of the public.

This is not an entirely new reality for health leaders, who have always had to navigate the swift and shifting currents of science, technology and public policy. There are times when those flooding currents cut entirely new channels. We seem to be in one of those times.

As leaders we embody the changes we seek. The associated stresses, tensions, ambiguities, perversities and confusions inherent in leadership live inside our bodies, too. Healthcare leaders are among a highly privileged elite, and they spend the vast majority of their waking hours among other highly privileged people. For some years in Memphis, Methodist Le Bonheur Healthcare ran a small program called "Life of Leaders" which wove into a "Mayo-like" (exemplary executive physical) model of health assessment an array of life assessments built on the Leading Causes of Life (Gunderson with Pray, 2009). The experience was initially aimed at clergy who can go years with hardly ever a chance for a safe, frank dialogue about their *own* life, its changes and challenges. The process was then offered to highly placed executives and it revealed that they also lived vulnerably in the open, being constantly seen as the answer to everyone else's problems and hopes.

Healthcare leaders embody a mediating role. They lead structures relevant to every single human in their service areas whom they will often need at the most profound and vulnerable moments in their life journey. The work of leader is typically wide open to view, even when they are not doing anything official, such as walking across the parking lot or getting a cup of coffee. This embodiment is the heart of their challenge: "the body keeps the score." Even a slight rebalancing of whose company they keep may have huge effects in what they know and what their system sees them as knowing.

Hospitals are often compared (with no small irony) to military organizations, especially in terms of the strict authority of hierarchy and command. Armies, of course, are not what they used to be and have had to learn to adjust quite radically to new forms of adversaries. They, too, have undergone fundamental change in shifting their attention to the social factors that currently also shape health over time instead of focusing primarily on one event at a time. "Winning" now demands an empowered, highly adaptive fighting force guided by intelligence as much about psychodynamics as weaponry. How much more true for a healing force? Retired General Stan McChrystal embodies the changes he experienced as a combat leader, now applying those insights to healthcare and other transforming fields (McChrystal, Collins, Silverman & Fussell, 2015). His team focuses on helping organizations develop qualities of robustness and resilience so as to adapt to emergent challenges and opportunities.

The Stakeholder Health logic similarly opens up challenges and, more importantly, opportunities for leadership, by working to bring into active self-conscious alignment the multiple stakeholder and partners whose vital strengths are the sinews of the strength and vitality of the entire health system itself. Whereas the hospital system alone has tended to be the focus of its leaders, this radical re-centering of relationships will, in the future, define the daily walk and work of those who sit in key positions of influence within the highly complex webs of changing relationships among all stakeholders. This will become obvious at the point of care inside the clinical spaces with a shift to teams of mutually empowered professionals not just passively waiting for the direction of the physician. Now the term "clinical space" will include anywhere clinically relevant, and the choices made there, the counsel given, and the activities and interventions undertaken will cross over the whole spectrum affecting health through time. This includes new entrants in the provision of healthcare such as Wal-Mart, CVS, and Rite-Aid. It also includes homeless shelters, places of worship and play, and hairdressers. Financial value is created by lowering the acuity and expense of the care, which totally flips where the money is made from the center to the edge of the system. Few in the hospital world have actually grasped this yet, though there are already outstanding examples, such as Kaiser Permanente's steps toward "total health."

Tectonic tensions are building inside the rigid hospital system we have, between the old world and the inevitable movement toward the new. Changes include those needed in what are often called "corporate support services", including those at the very core—facilities, purchasing, finance, HR and Governance. All of these services now need to be accountable for creating a dynamic web of effects that bring alive

the generative relationships within the whole system, with the reasonable expectation that this will positively affect the health of the whole population served. Other chapters in this volume focus on implications for where hospitals put the hundreds of millions of reserve funds they are required to have on hand. Those funds must be considered as multi-relevant assets. Why not place a few percent of them in safe community development partnerships to strengthen the housing trends in the poorest neighborhoods?

Similarly, suppliers, now judged primarily in terms of price, are also crucial variables in the functioning of the whole system: Who we buy from and how their discrete services serve the purposes of a larger system matter. Suppliers, especially of relational and information technology, must be viewed through a more complex lens that sharpens their role in the flow of trust-building information among the partners relevant to aligning our efforts. It is hard enough to list all the factors relevant to the new reality. How is any human supposed to lead it? "Others, besides us, such as corporations like Whole Foods, have already begun to use the principles we promote here (see sidebar below).

LEADERSHIP PRINCIPLES IN ACTION: STAKEHOLDER HEALTH ALIGNMENT WITH NEW CORPORATE MODELS

The authors of both *Firms of Endearment* (*FoE*; see Sisodia, Wolfe & Sheth 2014) and *Conscious Capitalism* (Mackey & Sisodia, 2014) offer many examples, though specific to the corporate or for profit business world, that highlight the structures noted in this piece on leadership. Below are examples and tenets from these new models that fit the leadership principles that Stakeholder Health proposes be put into action within a healthcare setting.

The first distinctive implications for senior leadership involves managing the changed positional and power dynamics among and between existing stakeholders that make for health in a particular place. The authors of *FoE* cite examples of how they are working more closely with local suppliers of produce, cheeses and locally and humanely grown poultry and meat to offer workforce and economic development locally, decrease the carbon footprint and build local goodwill. This changes the landscape of the environment, business relations and stakeholder relationships, for the betterment of the whole.

Secondly, Stakeholder Health notes that such new relationships shape where leaders spend their time—"inside out": outside the walls of offices and more in the "field" listening, blending, finding common alignment and synergies. John Mackey of Whole Foods (Mackey and Sisodia, 2014) shares the story of getting his leaders and employees outside of the confines of the workplace by having them visit places where their products are created and micro-grants have offered local opportunities. He admits that it is hard to put a standard ROI on the impact of these sabbaticals, but all see that for his employees the visits have expanded their work and world, with phenomenal impact on philanthropy, worker productivity, and worker retention.

Likewise, the authors of *Conscious Capitalism* (Mackey & Sisodia, 2014) resonate with the idea that leaders embody the changes they seek, often take a mediating role, and live in the fishbowl of transparency. This openness can be a potential double-edged sword. To be a leader in these times is to have all of your past and potential dirty laundry scrutinized by all, often in inappropriate ways and contexts. John Mackey shares the pain he experienced when being investigated for potential fraud for posts he had made innocently prior to a proposed merger with Wild Oats, as well as the public vilification of his character and motives. On the positive side, leaders can model exactly what they are trying to embody in their institution. John Mackey's letter to his various stakeholders, taking $1 a year for pay from 1997 onward, is a positive example of how "walking the walk and talking the talk" can be powerful.

Our leadership views the need for adaptive, creative, conscious leadership, adjusting to ever-shifting times and work. Our military metaphor, often noted to be too aggressive, nonetheless points to what is needed to transverse the ever changing landscape of payment changes in healthcare and economic downturns in businesses.

The flip of funding flow in our proactive mercy model is also illustrated by this model from Whole Foods (see sidebar) of how so many diverse stakeholders are funded and/or supported or negotiated within the integrated whole, with fairness and equity.

Interestingly, this "flow" also mirrors our advocacy of leadership that works from Inside Out (focusing first on those outside of our hospital walls), Right Side Up (flipping the power dynamics and lifting those stakeholders usually at the bottom of the power pyramid up to the tip), and Out of Control (relishing and adapting to the surprises and changes that will inevitably occur in the market in terms of revenue cycles, particularly "down" quarters in those cycles).

Whole Foods Stakeholder Model

A leaders' role in facilitating the change within our organizations is the mirror of the SH approach to long-term transformation of communities (Health System Learning Group monograph, 2013). The same trilogy of tactical competencies comes to the front:

a. *Move toward social complexity*, in this case, the complex lives, broadly defined, of all the stakeholders. And move toward that complexity as we find it in the places, networks, roles and power relationships in which we find ourselves.

b. *Move in partnerships* nurtured for the scale and duration of the problem—and opportunity (as far as we can imagine into the future).

c. *Invest resources proactively*. The money we need is the money we are already spending on less generative purposes. Be a first mover with the fuel found amid the partnerships already in place.

Stakeholder Health leaders realize their own institutions are so utterly part of the community that the line between inside and outside is dissolving. The business of the hospital is no longer accomplished within its own walls by its employees performing discrete interventions for patients. The wall between within and without disappears as the success of the healing relationship depends on a more complex set of actors spread over a sustained period of time.

One of the things that goes away is the sharp distinction in the roles of the complex lives of the stakeholders. Employees are patients and are at the same time members and often leaders of key partner institutions, influential in the informal and formal networks that encompass the life of the community and members of insurance pools, patrons of stores. Their families spread even farther into the interstices of community, as do those who work for our suppliers. It is easier to remain apart, ignorant of this complexity; easier to think in terms of this and that, inside and outside, us and them. Thinking and acting that way isolates the leaders of what is often the largest institutional identity in the social system—the hospital—in a bubble of our own making without lessening the lived inter-penetration of all the facets of the lives of those in the system.

The institution being led is not apart from the community system in which it functions, finds its life and seeks to fulfill its purpose. This creates anxiety for those who need predictability and control. Yet it is also good news for those able to turn toward the complexity and enter new forms of collaboration with purpose and mission.

Many of the hopeful innovations shared elsewhere in this document are driven by encouraging and releasing the power of the capacities of people in the system who would have previously been contained within a limited prescriptive service role. The icon of this at Wake Forest is the highly effective witness of the Supporters of Health, released from their former role as housekeepers to play a creative role in our toughest communities. In fact, almost every role in the hospital is filled by someone with capacity beyond their conventional job description. High-end doctors can volunteer out of their faith identity. Security officers have been trained as counselors for enhanced roles as *first mental health* responders. People all over the system can be released to play community leadership roles on boards of all kinds of health-relevant organizations. Nurses can be trained as spiritual caregivers. Chaplains can be integrated into transitional care teams in nursing homes, and visiting pastors can be raised up as community healers.

Such cross-functional empowerment opportunities are endless and powerful if aligned with a common vision of cooperation to create a healthier community. This is a goal that resonates with the healthcare systems we help to lead because it fits their avowed missions while also contributing to their financial viability. The opportunity lies in the complex lives of the stakeholders because that complexity is what makes it possible to connect with integrity beyond the simple role definitions that have kept us isolated in our conventional silos. The leadership challenge involved in managing complex roles is no simpler or harder than the challenges handled successfully in earlier times. It is worth the trouble to find those hidden skills and capacities. In a time of shrinking reimbursements and reversed incentives, we must look within ourselves to find what we need. Our counsel is that there is plenty, once we look.

Our challenge as leaders is that complexity cannot be managed as if it were “over there,” pertaining to someone or something other than our own lives, our own prerogatives, our own institutions. The complex system of community is not apart from the complex system of our own organization. There is a highly permeable boundary between what is really one system. Our employees, patients, suppliers, Boards and every other person involved cross back and forth constantly.

As leaders we too often think apart from the whole. This has practical implications for the daily work of management. We may understand this via three shifts in the relationship among the patients, families and communities—and the employees, staff and medics who share those roles from time to time. Each of the shifts changes what the leader pays attention to themselves and to what the leader asks their organization to attend.

INSIDE OUT

The first shift is *inside out*—the original exemplar being the 604 partners of the Congregational Health Network of Memphis. The leadership move is to make one’s *self* and then one’s *organization* connectable with the agents of health that surround the hospital as the ocean surrounds a whale. A community filled with consumers of services is now filled with agents of health who are working in partnership with an array of people, coalitions and organizations that provide services woven in community and by community.

The population in this view is not an entity to be managed, but the thing doing the managing. Those “outside” are not passive consumers. They are agents of their own health through a rich ecology of roles, networks and relationships. The leader of the hospital can make those visible and hold every “internal”

system accountable for its connective capacity to the assets "outside." What makes this less daunting than it seems is that all those inside live even more of their lives outside. Once they are freed to speak out of both sites of intelligence, it turns out there is an enormous reservoir of experience and practical knowledge about where and how to connect, and about which hospital policies impede or prohibit the weaving.

Some of these are almost too obvious to see. For example, Wake Forest has long provided free parking to visiting clergy who only had to register to get a badge that worked the exit gate. It was a positive shock when looking for a way to engage the hundreds of community faith groups to realize that more than 1,600 pastors were already registered! How can we strengthen the role they are already in with the patients? Complexity like this is not a problem but a profound opportunity. At Wake Forest another 14,000 people called employees play complex and powerful roles of many kinds in their families (often patients) and communities (where these patients live) that could be systematically honored and strengthened. A leader can set off a cascade of opportunities by making it okay to connect.

In a time of fear, we are all being asked "if you see something, say something." How much more should we be doing this about positive things that could affect the lives of our institutions, communities and, of course, patients? That will not be possible in any organization until its leaders shift what "accountability" means to balance compliance with the old defensive rules with the new behaviors of connectivity so vital to success in complex human populations.

RIGHT-SIDE UP

The second shift of mind is more challenging, but follows from the first. It is the flip toward paying attention to the "bottom" of organizations, the reverse of the old ways. This right-side up attentiveness focuses on creating space and roles for the power and intelligence of those who populate the base of the organization. This is not choosing the new against the old, the janitor against the surgeon, but rather, a blending of all the intelligences available in service of a common goal of health at population scale. Organizations have long carefully tended to the needs and preferences of those of us who live at their "top," but leaders need to pay a balancing dose of attention to those whose roles have been under-valued and strengths left unattended. We need to turn our time and attention upside down in order to get right-side up.

Because leaders lead by modeling what is most important to them, this raises high the need for modeling humility, which may seem like weakness to some but is in fact an essential art and a vital key to the adaptive learning that the future calls for. Good leaders never miss an opportunity to tell about how a successful innovative practice began with the humble recognition of a learning moment. Leaders who once were proud mostly of their *teaching* institutions, now must model the value of a *teachable* institution.

Other chapters lay out an array of tools and techniques, especially those mapping assets, for paying attention to voices and lives in difficult parts of the community. It is somewhat easier, yet more awkward, to bring that kind of curiosity to one's own colleagues and fellow employees. We do not know of any health system that has systematically mapped the webs of influence of its employees in the community they are trying to "serve" (which is the same one the vast majority of the employees live in). Like community assets mapping, the search would be rewarded by an inconvenience of opportunity. The most significant attention should be focused where historically the lowest interest has been shown—among the lowest wage roles. Many of those individuals spend considerable time with patients and thus have a great deal of relevant clinical intelligence. They often have laser clarity about institutional life too and an often-bitter grasp of the relationship between the non-profit corporation and the vulnerable neighborhoods in which they—and many patients—pass their lives.

Stakeholder Health believes that population health schemes will work where our current patient care techniques work. But for those estranged from, stigmatized by or fearful of the present patterns of care and exclusion, population health will fail. We can wait to pay heavily in finance and retrospective data analytics for that failure to happen. Or we could read our communities with new eyes by asking upside-down questions to read the future right-side up.

This right-side-up-ness is not cheap, for it requires the leader to invest in trust with their time and through their behavior. One can't ask and then not act. The lowest wage workers have been recipients of leaders' previous priorities since their first day of work. They've been watching and noticing what matters and may well be wary of giving their trust too quickly to the sound of a new day. Current leaders—or the smarter ones who will replace us—need the intelligence of the whole organization about the places where the biggest opportunities and threats of community scale live. *(See again the sidebar above on Leadership Principles in Action: Alignment with New Corporate Models)*.

Stephen Covey, in his Learning at the Speed of Trust *manual (2009, pg. 1) notes that:*

"The ability to establish, extend, and restore trust with all stakeholders-customers, business partners, investors and co-workers-is the key leadership competency of the new global economy."

WEBS OF TRUST

The last shift—toward webs of trust—is even more far-reaching for those of us leaders taught to equate high reliability with high compliance. The new equation is that high reliability equals high adaptive capacity multiplied by speed of trust divided by high compliance.

$$\text{HIGH RELIABILITY} = \frac{\text{HIGH ADAPTIVE CAPACITY X SPEED OF TRUST}}{\text{HIGH COMPLIANCE}}$$

Compliance with established best practices, laws and customs is like an anchor that is essential in organizations dealing daily with thousands of variations and wild things that happen to humans along our path in life. But, in practice, compliance functions to hold us from a premature embrace of the *next* best practice. Ask the poor and they will tell you that deviation from best practice is not random; the short cuts are biased against them and anyone else who presents an inconvenient difference. Compliance is meant to protect the most vulnerable. But it does not favor the possibilities *beyond* the current best practice. The current "best" has fostered systems compliant with the social and economic patterns of privilege that have created very predictable patterns of risk, disease and injury far below what either science or faith deem the minimum acceptable. The current best is not even decent, much less optimal. In this time of change, it is critical that healthcare leaders hold the line protecting patients while pushing that line farther toward mercy and justice, which science, and now policy, make possible.

Trust can accelerate strategy and execution while distrust can and does decelerate those processes. Trust works like waves that create a ripple effect beginning with self trust extending to interpersonal trust that can lead to organizational and community trust (Covey, 2009). Notice that this is an inside-out process that begins with the leader's personal credibility and his or her capacity to extend trust to others. "Trust Taxes" are those decisions and behaviors in an organization that undermine trust (HR decisions, excessive risk-management, etc.) whereas "Trust Dividends" (restoring retirement matches, empowering employees to make decisions, etc.) are those deposits that accelerate momentum in an organization and community. This is a keystone behavior and habit that is bedrock to strategy and execution.

Trust is better and more efficient than mere control. The challenge is that the webs of relationship relevant to the processes involving the health of entire populations are extensive and novel. In the state of New York, for example, the current process of "reinventing Medicaid" involves changing the relationship among current competing hospitals, which is hard enough given the billions of dollars at stake. Far more challenging is figuring out how to value and integrate hundreds of community based organizations that have critical roles in the social factors now recognized as crucial in shaping longer term outcomes for patients. All of those organizations have long related to the same people and operated in the same neighborhoods, but never in a model of shared risks, gains and outcomes. An old-fashioned system of highly controlled, rules-based compliance cannot possibly meet these challenges.

But how is it possible even to imagine a web of trusted relationships at such scale? The health of the community will not be achieved by including all the neighborhoods in the dominion, control and compliance of the hospital. Hospital leaders will not be the princesses or princes of their dominion managing their populations like the landed aristocracy managed passive feudal era peasants in order to satisfy the reimbursement logic. Hospitals and our leaders need to move across the moat, but with the best intentions of serving, not for purposes of control.

Thus, the third twisting of mindset is for leaders to move their organization towards understanding that it is literally out of (not in) control. As soon as we became liable for long term health dynamics of the large fraction of the humans living around us, we became subject to shared power with many others who control crucial nodes in the social networks affecting the choices of the people about their health and timing of treatment. We are not in control; but then neither is anyone else, so we should not be afraid. We remain the largest component of most community systems, capable of significant influence on those systems—as long as we don't try to control or "manage" them.

In our time of radical transparency, choice and connectivity, control is fractured and dispersed widely throughout the system. The advantage goes to those capable of embracing that complexity in their own institution and in the context of the larger community, by embracing large scale partnerships and by investing resources in long term goals that will help the whole system find its life.

Conclusion

All of these implications are equally true whether the institutional leader is focused on profit for shareholders, on taxpayers, or on a non-profit mission governed by a volunteer Board. It should be obvious, however, that mission-driven organizations have a powerful advantage in embracing the three leadership fundamentals presented here. We have—or should have—fewer distracting priorities that would make partnership with health-relevant organizations inherently difficult. And we have—or could have—internal alignment about the priorities of our own resources that would make the reallocation more logical (if not easier). We at least know why we are here and are glad that reason aligns nicely with what our most powerful stakeholders want (better health at larger scale at less cost).

The daily work of leadership in large institutions is about paying attention and signaling to the organization what is most important. Not just to one's direct reports, but to everyone who can see them, who notices what the leader is noticing and where they put their time, body and energy. Leaders of course cannot cease caring about the legal, regulatory and compliance issues that lend structure to quality and decency in healthcare. They are not free to make a margin that fails to pass industry standard audits. And they cannot remain within the old as if the new is not already breaking in.

How does one live between the old and the new? Technically, the leader helps the organization know how to recognize the things that will matter most on the journey forward and bring them into view alongside the metrics and methods that matter the most now. This makes for a more complex and

less predictable, but still intelligible "balanced scorecard." It includes measures that allow us to be accountable for the increased priorities found in partnerships that would previously have been described as "external." And it includes entirely new roles and accountabilities on the edges of our organizations. Many of these are community oriented but are not designed just to be for "community benefit" as customarily defined in terms of compliance for non-profit tax purposes. Rather, they are designed to melt the wall so as to allow the sustained viability of the organization to thrive in more complex partnerships with a wider array of active partners. The leader's job is to notice all of that and to figure out how to create patterns of reporting and accountability so that the whole organization can be more self-conscious of its new role in a more complex relationship to community.

The first insight of Stakeholder Health remains the most challenging—embracing the social complexity of the individuals, including ourselves, and that of the component systems, including our own. Thus the first most basic quality the leader acting on these recommendations must embody is to take courage, and not be afraid of the future. That is the way that embodies the faith of the founders and not just their words, rules, HR policies or bylaws any more than we would want their outdated surgical tools and primitive anesthetics. Healthcare leaders know they are here for more than themselves. And they know they have more to work with than their own cleverness. In that sense, they are all faith-based, no matter who founded their institution. Fear makes us blind and slow; when we back into the community, we are surprised by its complexity and miss the opportunity to participate in its future. Setting fear aside allows us as leaders to find the path for our kind of institutions into the future. Optimistic uncertainty opens eyes for partners with intelligence, assets and energy with whom we can find our way.

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ACKNOWLEDGMENTS

We owe deep thanks to Michael Bilton of Dignity Health, Senior Director, Community Health and Benefit, San Francisco, CA, for his insightful editing and review of this chapter.

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Suggested Citation: Gunderson, G., Cutts, T., Scoggin, S., Winslow, G., Battles, C., & Strauss, T. (2016). Accountable Lives: Leading Complex Health Structures. In Cutts, T. & Cochrane, J. R. (Eds.), *Stakeholder Health: Insights from New Systems of Health* (pp. 23-32). USA: Stakeholder Health.

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