

SUPPORTING HIGH PERFORMANCE GOVERNMENT

Leading Large Scale Change

October 19, 2005

Leading Without a Mandate: Strategies for Building Momentum

Panelists:

Dennis P. Whalen Executive Deputy Commissioner, New York State
Department of Health

Farzad Mostashari Assistant Commissioner, Bureau of Epidemiology Services
and Chair of the Primary Care Information Task Force, New York City Department
of Health and Mental Hygiene

Pamela S. Brier President and Chief Executive Officer of Maimonides Medical Center
and former Chief Executive Officer at Bellevue Hospital Center

Moderator:

Carol Raphael President and Chief Executive Officer of the Visiting Nurse Service of New
York

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Executive Summary

Introduction

Accenture and the Research Center for Leadership in Action of the Robert F. Wagner Graduate School of Public Service, New York University are co-hosting an Executive Briefing series for public sector managers to discuss the multiple managerial and leadership challenges of implementing large scale change. The series seeks to:

- Encourage the exchange of ideas between senior managers of complex change programs and those emerging leaders charged with undertaking similar efforts.
- Support a cadre of new leaders interested in undertaking such challenges, providing them with the insights, learning and the collegial support that will help sustain their work over time, and
- Promote further learning about how successful complex change initiatives are designed and managed, and capture this information in written reports.

Each session is organized around a central strategic and managerial question of particular relevance to large-scale change. The session held on October 19, 2005, entitled “Leading without a Mandate: Strategies for Building Momentum” focused on the challenges to creating institutional, cultural, and technological change in an effort to implement interoperable electronic health record systems in New York.

Background and Context: The Movement towards Interoperable Electronic Medical Record Systems

The effort to implement electronic medical records (EMRs) is a very recent one, though one that is both advancing rapidly and gaining in momentum as technological growth in the area of information systems is taking place exponentially. The effort has been espoused by members of both the private healthcare and public sector, the most prominent members of the latter including President George W. Bush and the Secretary of Health and Human Services (HHS). Evidence of the President’s commitment to widespread adoption of electronic health records is his creation in 2005 of Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS, and his call for moving towards EMRs for all Americans within the next decade. In so doing, the Bush Administration heralded the United States’ entrance into what has become an international effort to modernize health care delivery and management, and its willingness to face the challenges and obstacles associated with this effort. The list of these challenges ranges from resistance on the part of physicians and clinicians to use new technologies to the lack of technological infrastructure and precedence to the lack of capital and funding to develop such systems.

Alongside this national movement towards technological progress in health record maintenance are also concerns about how to ensure that the health record information systems that are adopted are

interoperable, that is, shareable across healthcare institutions, care providers, and the private and public entities that offer healthcare coverage. Thus, ensuring such interoperable electronic health records entails not only overcoming technical challenges related to compatibility between systems and cultural resistance to new technologies, but also fears among healthcare institutions about increased competition and the loss of patients, as well as fears of the increasing depersonalization of health care provision.

[For historical and contextual information on the movement towards and challenges involved with the adoption of electronic medical records in the U.S., see Shortliffe, Edward H. “Strategic Action in Health Information Technology: Why the Obvious Has Taken So Long.”]

New York State is joining this national movement towards interoperable health record systems. The movement involves numerous stakeholders, including the State Department of Health, the New York City Department of Health and Mental Hygiene, several prominent public and private hospital systems, health management organizations, and private vendors of information technology systems. The panelists for the October 19th discussion on this movement included three of the key members of this ongoing and constantly evolving effort, each of whom play a different leadership role in encouraging the adoption of interoperable electronic health records systems across the public, non-profit and private sectors of health care:

- Dennis P. Whalen, Executive Deputy Commissioner, New York State Department of Health
- Farzad Mostashari, Assistant Commissioner, Bureau of Epidemiology Services and Chair of the Primary Care Information Task Force, New York City Department of Health and Mental Hygiene
- Pamela S. Brier, President and Chief Executive Officer of Maimonides Medical Center and former Chief Executive Officer at Bellevue Hospital Center.

The discussion was moderated by Carol Raphael, President and Chief Executive Officer of the Visiting Nurse Service of New York.

Each panelist was asked to consider and explore the following statement, “Making health records available electronically is a solution that numbers of interested parties agree is a good idea—but that no one entity owns.” Or more generally put, how can leaders lead and create large-scale change across a decentralized industry comprised of diverse stakeholders with neither a mandate nor any direct authority over others? From their different institutional perspectives, the panelists discussed the approaches they use to mobilize multiple stakeholders from different sectors, their choices about which institutions are most critical to engage in this effort, how they understand and manage different and often competing agendas and budgetary constraints, and how they defined their unique roles in order to carve out a leadership position in this complex network.

Key Challenge: Leading without a Mandate to Implement Interoperable Electronic Health Record Systems

Traditional (“top-down”) approaches to leading and creating change are simply not feasible in efforts where the various stakeholders and agents of change are diverse and unaffiliated, or in a recently decentralized industry, as is true of this case study. In these contexts, where neither a mandate nor clear authority is given to any one agency to lead, new and more creative leadership approaches are needed to mobilize change.

Approaches for Leading and Building Momentum Without a Mandate

The panel discussion raised several different though related approaches for leading without a mandate:

Leading by Convening: State Department of Health in a Nuanced Role

One creative approach to leading without a mandate is to lead by convening. Within some contexts, one organization may stand out as being central or having a position of authority. Rather than attempt to wield a “heavy hand,” leaders within such organizations can choose to capitalize on their unique position of centrality to serve as a convener of diverse and competing interests and stakeholders. This convening role entails ensuring fair and equal representation among different interests, providing overall guidance and direction, managing and mediating conflicts, all the while moving deliberative processes towards the achievement of concrete goals. Where possible and when necessary, a convening organization can exercise its leverage and position to advance the overall goals of the effort.

Executive Deputy Commissioner Dennis Whalen raised some of the unique contextual and environmental challenges faced by his agency in leading the movement towards interoperable electronic health record systems by acknowledging that his agency lacks a mandate or clear authority to mobilize the diverse set of stakeholders involved in and necessary to the change effort. Comparing this effort with previous transformations in the healthcare sector, Commissioner Whalen likens the current effort to “navigating in fog.” In the past, healthcare was highly regulated, and the State Department of Health in particular held a unique position of regulatory authority. However, transformations in healthcare management have led to a deregulated and further decentralized system: “We once had a highly regulated system; we decided how much to charge and how much to pay. The State regulated forms and processes, and that went away. We got rid of that system, and hospital and payer processes went out the door when that happened.”

Within this newly deregulated environment, and for many other reasons, the State is less willing to rely only on its regulatory or standard setting authority to order or mandate the adoption of electronic health records systems, let alone those that could be shared across institutions and providers. At the same time, the State recognizes its position and leverage with respect to the healthcare industry as a whole. On the one hand, the deregulated system creates “a shift in the locus of regulatory authority and standards setting and protocol,” and on the other, “the same players are looking for some level of guidance” around the creation of electronic record systems. In this way, Commissioner Whalen sees fog as offering “challenges, but also opportunities.” These opportunities entail exploring new methods of providing leadership within a decentralized, rapidly shifting, and often competitive industry.

The lack of regulatory authority is not the sole reason for the State’s use of alternative leadership approaches. Indeed, Commissioner Whalen recognizes that the creation of interoperable EMRs is a problem and task shared across a decentralized field and industry, and therefore, necessarily one that involves not only a diverse set of interests and wills, but also diverse sets of expertise. In contrast to other areas in which the State or City might be able to employ a “top-down” approach, Commissioner Whalen states the intention of the State DOH to employ a “softer approach than issuing regulation. Acknowledging that he is “not confident to say that [DOH] can take experts from within government and come up with answers,” he recognizes that “you need to bring in other stakeholders.” In other words, “How to promote change that uses collaborative discussion” rather than regulation and mandate?

For the State Department of Health and Commissioner Whalen, the approach towards leading without a mandate entails consciously choosing and adopting a new role, not as a regulator, but as a convener: “The approach is to bring together stakeholders... We have engaged United Hospital Fund to bring together stakeholder groups.” As the closest thing to a center within a decentralized field, DOH had the ability to mobilize and convene a diverse and often competing set of stakeholders within the healthcare sector in New York State. Doing so involves recognizing and exploiting its unique position as both one of the large direct providers of health care in the state (i.e. through its network of public hospital systems), as well as a large “purchaser and payer” of health services (i.e. through Medicaid and Medicare). First, as a large direct regulator of healthcare quality, DOH can wield its advantage in order to bring others to the table. Second, its unique role as the public authority for providing healthcare coverage, and its role in directly paying for healthcare services, allows it to exert influence over the field. As Commissioner Whalen put it, “Once we say Medicaid is doing it this way, that helps to create broader change.”

At the same time, in a decentralized system, the leadership gained by DOH through its authority as funder and its competitive advantage has its limits and challenges. Commissioner Whalen lists three of these limitations and dangers. First, progress is taking place at a rate faster than the State can keep up with or control. Hospital systems and healthcare providers are already independently moving towards electronic health systems, and the State is neither interested in nor able to interrupt this progress. Second, given the State’s role as a payer and purchaser of services, its undertaking of the role of convener may wrongfully give the impression that the State will eventually provide funds for the adoption of electronic health records—funds, which in a time of state budget constraints, are in scarce supply. Third, given the rapid pace of technological change, and the lack of models for creating widespread interoperable health information systems, the State as convener needs to ensure that the system(s) it helps to create is not obsolete, but enduring and adaptable beyond the current political administration. A fourth limitation was raised by all participants and focused on the problem of representation, in particular, the representation of patients. As arguably the most important stakeholders in the process, patients are also the least empowered, organized and represented. Any attempt to convene a collaborative process should necessarily represent the interests of these crucial stakeholders, but as Farzad Mostashari pondered, “Who is the one person or entity who can represent patients?”

In addition to these dangers, DOH faces two practical challenges and risks in convening a collaborative process without any clear decision-making authority: “[W]e are trying to [create broader change] in light of the context of change and meanwhile have shared decision-making where the State does not have all the answers.” The second challenge is how to manage the sharing of information and ideas with those

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outside government: “You always worry about stakeholders running with ideas and taking things too far and then you have to make a pronouncement that that is not what is happening.” In short, how can the state create a truly collaborative partnership, while retaining control and final decision-making authority so to ensure that its goals and aims are met?

The approaches used by Commissioner Whalen to manage these risks and challenges are traditional facilitation tactics. As convener and facilitator, the State’s role would be to guide and re-center the conversation and process, as well as continually ensure that the process was aligned with the standards and interests of the federal government and the state. As a public authority responsible for managing public health coverage, the State has a responsibility for ensuring that the system(s) adopted not only meet the standards of the federal government, but also the interests and standards of the state as well. In this way, it can wield its position as a regulatory agency to keep the process in line with the larger vision. At the same time, DOH has to ensure that its role is not being viewed as competitive or adversarial to other partners: “We are going to try to spin this off as something separate from the state. It is easier for the state to be a convener rather than a competitor.” Ultimately, and as hoped by DOH, this would allow others to also fulfill a leadership role. As briefing audience member observed, “I’ve watched people lead who are not part of the Health Department. It’s not just a Health Department initiative.”

Leading through Incentives: The Power of (Hints of) Money

When mandates and regulatory authority are not available tools of change, leaders often resort to incentives, usually financial, to motivate others to change its policies and practices. However, in many contexts, adequate funding and capital needed to provide such incentives are not available. Even when large amounts of funding are not available at the moment, it still may be possible to mobilize change through incentives, if the agent seeking change is known as a potential source of future funding or financial assistance. For powerful organizations or agencies, offering small amounts of funding tied to specific goals may influence the field or industry by suggesting the direction of the agency’s future policy. If the funding opportunity provided is the first of its kind, it may help set the tone and direction for other potential funders as well.

All of the panelists mentioned this more traditional approach to leading without mandate, namely, leading through the use of financial incentives. The panelists suggest that this approach is most applicable to the State DOH. Certainly, the distribution by this agency of large amounts of funding and capital seems an obvious approach to creating industry-wide change. However, the current fiscal climate raises some serious limitations to the use of this approach: “[T]here is a funding question. If we don’t have funds, we can’t incentivize without budgetary change.”

Nevertheless, the use of financial incentives to mobilize large-scale change seems possible in this case even with limited amounts of money. This is possible for at least two reasons. First, as already mentioned earlier, the State DOH is the largest purchaser and payer of health services in the state, and therefore was able to bring stakeholders to the table due to its financial authority. Medicaid and Medicare are, after all, the two largest funding streams in the state available for health care. In addition

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to this convening facility is a second means of using financial leverage was through distributing even small amounts of funding. Or in Dr. Mostashari's words, "You can't underestimate the power of hints of money." The State Department of Health has recently released the first Request for Proposals for funding to develop health information technology. Although this RFP offered only a small amount of funding, the State is nonetheless able to exploit its leverage. As the first funding opportunity of its kind in New York, the RFP is intended to set a direction and tone for how health information technology would be developed across the industry. The particular requirements and conditions in this first RFP might not only set the standard and point of reference for other public and private funders in this area, but may also indicate to healthcare institutions the particular concerns and directions held by DOH around the implementation of electronic EMRs, such as how they meet state and federal standards, as well as how well the health IT systems developed would interact with other systems. (The RFP encourages collaboration among types of institutions.)

Leading by Example: Maimonides Medical Center as a Microcosm of the Industry

When no one organization or individual has the mandate or authority to lead or create change, leaders may emerge from among the ranks of the stakeholders. Organizations that have undergone similar initiatives, albeit at a smaller scale, may have valuable lessons to teach others, and can lead through their experience and example. In simple terms, these organizations and leaders lead by the notion of "if we can do it, so can you." This approach—leading by example—is challenging, particularly when the agent of change is horizontally related to other stakeholders. Not only does this leader have no authority over its peers, but it may also be viewed as a competitor with more self-interested motives than that of advancing the industry or cause as a whole. The experience of Pamela Brier at Maimonides Medical Center provides several key lessons about how to lead by example, including the importance of understanding and attending to the specific concerns of stakeholders, providing attention to detail, and instilling trust and credibility in others regarding the leaders' altruistic motives. This approach does have its limitations, as it may only serve those others that are ready and capable of emulating the leader's example.

Another approach to leading without a mandate is that which is employed by Pamela Brier, the Chief Executive Officer of Maimonides Medical Center. As a key private sector stakeholder without any regulatory or funding authority over the healthcare industry in New York, Ms. Brier and Maimonides are nevertheless able to exert influence through its widely acknowledged position as a hospital system that has successfully implemented one of the most advanced internal electronic health record information systems in the State. Maimonides Medical System had undergone the lengthy and comprehensive process of implementing a hospital- and network-wide system of electronic medical records, including contending with the resistance from the multiple internal stakeholders within the hospital itself.

Ms. Brier describes this process in great detail: "[Maimonides] is a hospital with five thousand employees who feed into our systems. We tried to instill this visionary approach...And we knew that we couldn't impose a system [on the employees]. We had people who were terrified of computers, from clerks to obstetricians." Overcoming these cultural changes involved demonstrating how the vision of

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interoperable EMRs was in the direct interest of employees, or specifically, “how is your job going to change: more free time, do your job better, have time to talk to patients.”

The second important tactic used by Ms. Brier and Maimonides is that of ensuring that employees and end-users of the system view the new system as easy to use: “The system is only as good as the ability of the people to use it.” She recognizes that “[f]or nurses and doctors, [the question was] can you give up those little scraps of paper? Well, for one, it will be helpful for you [to adopt EMRs], but two we are going to make it easier for you.” Ensuring ease of use involves diligence and sensitivity and a willingness to go beyond usual levels of attention to provide technical support. This attention to detail and need allows Maimonides to engage the potentially most difficult stakeholders in adopting electronic record systems, doctors: “You wouldn’t want to spend a day on this earth as a hospital CEO unless you have doctors on board and engaged. People say you can’t bribe doctors with systems, but we have gotten our network of voluntary doctors to use our system, because we went to their practices in the dead of the night, helped them, consulted with them, and designed it to solve day-to-day problems that doctors were encountering.” Ms. Brier claims that, “It’s those things that made us successful internally, that allow us to think, and what allows us to think externally with others.”

Ultimately, it is Maimonides’ experience of having successfully undergone this challenging process that allows it to set an example and demystify the process for others in the field, as well as address the concerns of cynics. Despite it being a single hospital system, Maimonides Medical Center is nevertheless “decentralized” in the sense that it remains a private hospital system with a diverse network of voluntary doctors. Accordingly, the adoption of EMRs involves a diverse set of stakeholders who could not be mandated to adopt a new system, but for whom change would require creative engagement. Ms. Brier describes this engagement as involving “a combination of mandate and cajoling.” Maimonides thus serves as a microcosm for how interoperable EMRs can be successfully implemented across a decentralized field, where its experience of having undertaken a large-scale change process can provide lessons to the industry as a whole.

Moreover, this task of leading by example is one consciously undertaken and embraced by Maimonides. As Ms. Brier explains, “I tell my people it’s not enough to do your job, but you have to be a proselytizer.” Furthermore, Maimonides appears to be applying the same diligence, attention to detail, and willingness to go above and beyond the call of duty in engaging external stakeholders as well: “It is harder to engage those that don’t work for you. The trick is to offer to do something more for others. We are trying to take the lead and bring our own human resources [to others].”

Despite Maimonides’ efforts to lead by example, Ms. Brier acknowledges the limitations of its effort: “[I]t is very tough going, and the project is contained, compared with our ambitions.” The first limitation relates to how applicable a best-case example can be to the field at-large. This is a particularly important consideration since the healthcare sector is necessarily imbalanced in terms of financial resources, competitive advantage, and technological infrastructure. As Ms. Brier explains, “[W]e know that hospital care is not the be-all, end-all for health care...[T]he playing field is now shifted to where patients are in a continuum of care...[W]e have to figure out a way to work with competitors and others...The fact that they are competitors is an issue, but we are not all starting at the same level. Half of the hospitals in the country are not as financially stable and technologically able as us.” Along these lines, Farzad Mostashari raised the related fact that most disadvantaged populations

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are more likely to be involved with community health centers, who “don’t have the IT settings and resources” that many hospital systems do. Thus, Maimonides’ example and leadership may be limited only to those hospitals and systems that have the infrastructure and resources to keep up, potentially further exacerbating the inequity in the field. This is certainly evident as a danger, as Ms. Brier herself acknowledges: “We are going to try to partner with groups that do have some infrastructure.”

A second limitation to the potential of leading by example stems from Maimonides lateral position with respect to the stakeholders it is attempting to lead. As a potential competitor with other hospitals, Maimonides must build trust with other healthcare providers that its interest in implementing electronic clinical information exchange was not about “poaching records”—the belief that having records that are shareable with other hospitals may allow other hospitals to steal patients—or compete for patients, but rather about the benefit to patients. Thus, while the setting of industry precedent was not new for Maimonides (it was also the first hospital system to implement patient safety standards in New York), the unique challenge of serving as an example of a hospital system that had successfully adopted EMRs, however, involves demonstrating that this could be done without jeopardizing other hospitals’ business and competitive advantage: “We are a hospital that has successfully done this and we are willing to share. We had to promise that no one will tangibly gain through this data. We have to be constantly sensitive that one will not get the advantage over the other.” Maimonides’ ability to lead by example is also limited to the extent that it can gain the trust of competing hospital systems and the industry as a whole, and successfully provide assurance that interoperable data systems is not about “poaching” records or patients, but about improving the delivery of health care.

Leading through Expertise: The Power of Translation or of Distilling Complex Data

When no one organization or agency has clear authority to lead, those stakeholders or participants that are acknowledged to have specific kinds of expertise may either emerge or be recognized by others as a natural leader. This is especially relevant to efforts involving highly technical goals or products, where the ability to “speak” to technical issues is critical to leadership. In such cases, the leader can leverage and mobilize change by communicating and managing information or technical details, and effectively serving as a translator or broker. Not unlike the role of convener, the technical expert can influence change processes at critical points, simply by focusing the attention of stakeholders on key areas or matters. If the leader has knowledge in and can speak the language of multiple systems, it can increase its leverage as a leader by serving as a linking pin between various groups of stakeholders.

Leading through expertise is evident in Ms. Brier and Maimonides’ role serving as an example of success or best practice in its field. Acknowledged by its peers as having accomplished the difficult task of adopting an intra-network electronic medical record system, Maimonides is well positioned to lead through its expertise and experience. Leading through expertise is also evident in Farzad Mostashari’s role, not only as that of a public health expert, but also that of a technical expert with knowledge about health information systems: “I’m not a techie, but I can speak the lingo sometimes. If the conversation gets technical, I can bring something to the table. That is a way in which you can get included.”

In a process where the technical intricacies and “psycho-babble about systems” (P. Brier) tends to diffuse focus of stakeholders, Dr. Mostashari is able to comprehend and translate technical details to ensure the City’s inclusion in the process, as well as to ensure the inclusion of those he seeks to represent—City residents, community health centers, etc. In this way, Dr. Mostashari serves as a key

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broker and translator of knowledge and information, focusing attention on areas important to his agency and perspective.

[Ronald Burt discusses how individuals or organizations that fill structural holes—“gaps between two individuals with complementary resources or information”—can enjoy certain advantages and competitive advantages. These lessons can be applied to the case where an individual can fill a structural hole in knowledge and technical expertise to leverage a position of leadership. See Burt, Ronald S. *Structural Holes: The Social Structure of Competition*. Cambridge: Harvard University Press. 1992.]

Leading by Inspiring: Creating Change through “Vision” and Principles

Traditional views of leadership tend to focus on the notion of “carrots and sticks”—that is, the use of mandate and authority or the use of incentives that exploit stakeholders’ self-interest—to create change. In contrast to this notion, which assumes an inherent resistance to change on the part of the stakeholders, a viable alternative approach to leadership involves the use of vision and principles to inspire change. Leaders can indeed create change by articulating a vision or set of principles, garnering investment to this vision, and remaining true to this vision. This is especially possible in fields, industries, or organizational domains in which a common set of values underlies diverse interests. This was certainly true in the case at hand, where concern for the quality of healthcare and the well-being of patients can serve to trump or override concerns about profit, fears of competition, and general resistance to technological change. Reminding stakeholders about these higher-order principles and vision can sometimes help to assuage or reduce resistance, and mobilize change. Articulating a niche – a vision that emanates from a unique role in the system – can enhance the ability to leverage leadership

The internal “buy-in” that Ms. Brier was able to achieve at Maimonides Medical Center was in part possible through attention to users’ technical concerns and needs, and in part by inspiring a sense of higher purpose: “[I]f you talk about the right things and talk about the patient, and think about what makes sense in a human sense rather than fiscal sense...there is something about striving for things that are good and I do think that others do want to come along.” In other words, another approach to leading the diverse set of stakeholders is to inspire them to see a larger vision or purpose and move beyond fears of competition, record “poaching,” or even ‘technophobia.’

This approach to leading without a mandate is nowhere more evident than in Farzad Mostashari’s description of his own approach: “The style of management I’ve used is less top-down and more about inspiring [people]. I’ve had people come to work with me, and take pay cuts because they are inspired to do the greater good.” His approach, representing that of the City Department of Health and Mental Hygiene’s (DOHMH), is to first define a clear vision and set of core principles: “At the City level, we don’t have the same regulatory authority that the state has...The first thing for us was to have a vision. We spent months learning and thinking to come up with a vision. ‘Why are we doing this?’...[W]e decided to look at the issue from our perspective and say what are we trying to achieve and then set our strategy from there.”

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For DOHMH, this ultimately means bringing “the public health perspective to the discussion.” As a public health agency, DOHMH’s stated concern is how better information systems and interoperability can “improve the population-wide quality of care and public health surveillance.” Related to this explicit concern for ‘public health’ is a concern for the needs and interests of disadvantaged populations: “The other core principle is disadvantaged populations. We have to make sure there is not an adoption gap [in interoperable EMRs]. Community health centers are important. They have not been involved nor considered important... We said that we will convene these groups, and we have had a tremendous response, have used CHCANYS [Community Health Centers Association of New York State].” In addition to this trade association, DOHMH brought in and relied upon an intermediary organization, the Primary Care Development Corporation, to help represent community health centers.

This summary already mentioned Pamela Brier’s use of a “visionary approach” in overcoming technophobia and cultural resistance within Maimonides’ own system and across its network of doctors. A second useful purpose of this approach is evident in Dr. Mostashari’s use of vision to overcome conflicts: “We propose public health as an alternative organizing principle. If three or four parties disagree, sometimes the fourth perspective is the one that unites all. And it’s not such a hard organizing principle [to embrace] to save lives.” Recognizing that stakeholders held multiple frames and principles—on the one hand, the desire for competitive advantage, and on the other, a higher sense of purpose about delivering quality care—Dr. Mostashari exercises consistency and loyalty to DOHMH’s higher-order vision and core principles to continually engage and manage competing and conflicting perspectives. This loyalty or return to vision is referred to by Ms. Brier as “being true to yourself.”

This “truth to vision” also seems useful in managing a phenomenon that might be referred to as ‘technical digression.’ All of the panelists mentioned this digression to technicality as a problem. As Commissioner Whalen explains, “You need a good BS detector because the techies can take off, and you lose the vision. The conversation becomes all about system and not vision.” Dr. Mostashari reiterates this concern about technical digression in his statement that “[Information technology vendors] are well-represented; the challenge for us is not to get into a product selection cycle.” Moreover, clarity and loyalty to vision also helps the City DOHMH to maintain its perspective and not get distracted by the technical details: “We need to tell vendors, ‘You must do all this, and as long as you do that, you can add flourishes.’” As Dr. Mostashari describes, “There is a dance between the technical and the vision.”

A related discussion regarding the Health Insurance Portability and Accountability Act (HIPAA) of 1996 raised the issue that frequent references to these privacy laws as obstacles to the implementation of interoperable EMRs are often no more than a “smokescreen” or “diversion to take people away from the real thing.” Here, Pamela Brier notes that clarity of vision helps to sort through the ‘smokescreen’ to focus concern on the “far more entrenched issues regarding the unempowered.” Most important among these “more entrenched issues” is that as a patient, “you don’t have a lot of power,” and that interoperable electronic record systems might help patients better navigate care within, across and beyond healthcare institutions. Here again, truth to the vision—of improving and streamlining healthcare delivery for patients and empowering patients in the process—helps to cut through the privacy law “smokescreen” that frustrates progress in the implementation of interoperable information systems.

Additional Strategies and Considerations for Leading without a Mandate

In addition to these four approaches to leading without a mandate, the panelists mentioned several other strategies for mobilizing change across a decentralized industry of diverse stakeholders:

- Pursue change incrementally

In a process that involves large-scale change and numerous stakeholders at multiple levels, change may inevitably take place incrementally. When the process of change seems overwhelmingly complex, leaders may focus initially on achieving short-term, concrete results. This incremental sense of progress helps to ensure continued interest and participation among stakeholders, while demonstrating that change is indeed feasible. Moreover, concrete examples of success can help to focus ongoing efforts. Pursuing change incrementally, however, involves performing a sort of triage. Leaders may have to focus their change efforts initially on those with more capacity and infrastructure or on certain goals that are more easily attainable. Doing so may discourage other stakeholders who feel left behind, or those who favor goals not initially pursued.

The notion of pursuing large-scale change incrementally was mentioned several times. This is evident in Mr. Whalen’s self-characterization—“I’m an incrementalist, after thirty years in government”—as well as in Ms. Brier’s description of the process of creating change: “My notion about change is to start small, do something tangible, implement it, put it into routine production, and move onto the next task.” Ms. Brier certainly employs this strategy in deciding to partner with “groups that do have some infrastructure” before those that lacked resources and technological infrastructure. Such triage certainly seems necessary in advancing changes across a broad and diverse set of stakeholders.

[Incremental change as a means towards achieving policy and planning goals is best described by Charles E. Lindblom in his seminal article, “The Science of ‘Muddling Through’,” *Public Administration Review*, Vol. 19, 1959.]

- Promote and ensure equity in progress

Incremental change may be necessary and advisable in many large-scale change efforts in order to convey a sense of continuing progress and maintain the continued participation of stakeholders involved. However, there is often a trade-off between achieving short-term success and ensuring equity among the stakeholders. While it may be necessary for leaders to first work with more advanced systems and resources to demonstrate concrete results, leaders should also ensure that all key stakeholders are involved in and benefit from the process. Otherwise, the incremental path towards goal attainment will fall short of the overall vision. The demoralization of groups left behind initially may even dismantle the entire process by discrediting the leader’s ability to convene and the stakeholders’ claims to higher-order (not self-interested or profit-motivated) interests.

Participants on the panel raised concerns about the pace of change as being too slow given the fast pace of technological change, and the rapidly rising costs of health care. For this reason, some

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participants recognized the incremental nature of change in this process, wherein stakeholders with more resources and more advanced infrastructures would initially adopt interoperable EMRs. However, given the inequity in infrastructure between different but equally important stakeholders (e.g., hospitals vs. community health centers), the participants also maintain that a better balance needs to be found between “moving the ball concretely” and ensuring that “there isn’t an adoption gap” (Farzad Mostashari). This was in part built into the process through the specific role taken up by the City DOHMH in its representation of community health centers and other institutions that served lower-income communities. In the end, what may allow such an incremental approach to lead to the large-scale, industry-wide change that is at the heart of the panelists’ “vision” will be the duration and lifetime of the process, the willingness of the State to continue convening a diverse representation of stakeholders, and the conscious effort on the part of stakeholders to include and build the capacity of less advanced organizations. Otherwise, if the initiative stops after having created change in only the most advanced stakeholders, the goal of achieving interoperable systems across the field and at multiple levels may fall to the wayside.

[An excellent example of how one convening entity ensured equity in collaborative planning and policy processes can be found in Norman Krumholz’s article, “A Retrospective View of Equity Planning: Cleveland, 1969-1979,” reprinted in *Readings in Planning Theory*, edited by Scott Campbell and Susan Fainstein. Cambridge: Blackwell Publishers. 1996.]

- Constantly shift strategy (the “chess board” metaphor)

For large-scale change efforts that are complex and that necessarily take place over long periods of time, an important consideration is adaptability and flexibility. As political conditions change, new challenges arise, and the composition of the stakeholder group evolves, leaders may need to utilize new strategies. Alternatively, the strategic vision may need to encompass the “whole board”, and multiple strategies applied simultaneously. This notion of shifting strategies is certain applicable to convening entities, who may need to shift attention to different stakeholders at different points in the process, as well as for advocates of specific interests, who may need to make use of different approaches—e.g. deference to technical expertise, mobilization of members, media strategy, etc.—depending on the specific goals and challenges at hand.

Another strategy that seems critical to success is that of remaining adaptive and flexible, that is, constantly adjusting and shifting strategy as conditions change. This seems particularly important given the breadth and complexity of the issue, the incremental process of change, and the fact that the ultimate goal of change—creating interoperable electronic medical record systems—would take place over time and different political administrations. As Dennis Whalen explains, “I think it’s important to understand and be conscious about the politics and to adjust the plan accordingly. You have to play the inside game, manage internally and find champions and manage them. You have to play the outside game. You will reach a point where you will need outside help—the press, higher level mandates, etc. It’s a great complex game—a chess set—and you have to keep adjusting your strategy.”

- Deliberately ensure diversity and representativeness of perspectives

For convening entities and stakeholder participants alike, achieving a multi-faceted goal or vision requires a process that is representative of the complexity of the issue at hand. Doing so not only helps to ensure equity and diversity, which are ends in themselves, but also may allow organizations to leverage positions of leadership or strategic advantage. This is possible precisely because large-scale change efforts almost always involve numerous and often conflicting interests. For example, a convening entity who wishes to ensure that a particular interest or goal is incorporated into the larger vision may achieve this goal by ensuring that the organization(s) representing that particular interest are at the table. By doing so, the convening entity can influence the overall process without overtly representing a particular interest. Moreover, by inviting the new participant, the convening entity gains a strategic alliance that can help it to advance its own interests. Individual stakeholders, on the other hand, may observe that certain values are underrepresented or missing from a collaborative process and may seek to explicitly espouse and represent that value or interest. Espousal of this unique role or value may help the stakeholder to secure its place at the table.

Alongside the notion of remaining loyal and true to vision seems to operate a conscious effort on the part of certain stakeholders to ensure representativeness and diversity of perspectives in the dialogue and process. This is evident in Dennis Whalen and DOH's attempt to ensure that the stakeholders "represented organizations of many." He explained that, "I don't think there needs to be just one organizing principle. You can have many...The question is how to keep these organizing principles together and yield what we are interested in pursuing." As convener, DOH's function is both to ensure that a diversity of perspectives and interests were represented in the process, and also to manage this diversity and direct it towards progress. As such, DOH may exploit this function to its advantage by deliberately inviting and including organizations who are known champions of particular goals or interests that it wishes to achieve. For example, if DOH is interested in ensuring compliance with federal standards and regulations, it can make deliberate efforts to include an expert on federal health information sharing regulations whose role at the planning table is to provide this perspective. In this way, DOH can achieve particular values or interests without directly being seen as the champion of them. Moreover, as convener, DOH can also ensure its position of leadership by helping to overcome value conflicts between one or more stakeholders.

In contrast to this role, the City Department of Health and Mental Hygiene pursuing a different strategy. As one of the stakeholders in the process, they are not responsible for ensuring the overall diversity of the group, but rather for ensuring that a particular perspective is represented. Indeed, it seems that Dr. Mostashari and DOHMH shaped their "vision" and organizing principles based upon and in contradistinction to other interests that were already represented, such as that of "patient safety." In this way, they ensure a representation of diversity of interests by espousing and advocating for one of the perspectives and principles that appeared missing or underrepresented at the stakeholder table, that is, "public health."

Dr. Mostashari cleverly extends the notion of 'interoperability' in describing the process of deliberately building diversity into the initiative: "The key word is interoperability. We are not trying to create one system of medical records, but multiple systems that can talk to each other. The idea is the same. We don't have to have the same operating principle, but can have multiple organizing principles that can talk to one another." Just as interoperability in information technology systems does not mean that all stakeholders need to adopt the identical system, but

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merely that they need to ensure compatibility and communicability across their different systems, so to is the deliberate intention to ensure diversity—both through judicious convening and through espousing particular vantage points—is not about creating one homogenous operating principle, but is rather about aligning and directing multiple interests towards a common goal. This notion of maintaining but managing different interests helps to avoid one serious concern, raised by one discussant, that “having all the stakeholders in the room at all times creates a lowest common denominator [of interests].”

[Conflict and debate are Patsy Healey, “Planning through Debate: The Communicative Turn in Planning Theory,” *Town Planning Review*, Vol. 63, No. 2. 1992. The notion of overcoming conflicting perspectives or institutional frames was discussed in Donald A. Schon and Martin Rein’s *Frame Reflection: Toward the Resolution of Intractable Policy Controversies*. New York: Basic Books. 1994. A good discussion of creative leadership approaches can be found in Wilfred Drath’s *The Deep Blue Sea: Rethinking the Source of Leadership*. San Francisco: Jossey-Bass. 2001. Drath introduces two leadership approaches—‘interpersonal influence’ and ‘relational dialogue’—which contrast with a ‘personal dominance’ approach, in that they both recognize “leadership as the crafting of a sensible but unresolved whole out of differing and even conflicting worldviews.”]

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