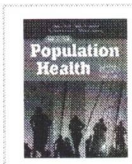


Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462
Chapter 11 Changing Organizational Culture

© chomplearn/Shutterstock

CHAPTER 11
Changing Organizational Culture

Somava Saha

EXECUTIVE SUMMARY

Recognizing the need for change is easy; creating and implementing effective change that leads to equitable and sustainable improvement in population health outcomes are much harder. This chapter reviews common reasons that change efforts fail—failure to build the will for change, failure to generate ideas that lead to effective change, and failure to execute change in a way that makes it readily adoptable and sustainable. It also offers three frameworks for approaching complex adaptive change to drive population health improvement and, using case studies, demonstrates how these frameworks can be applied.

Based on the work of Chip and Dan Heath, the first framework, *Switch*, moves beyond presenting data to motivate people to undertake the change and clarify the path forward. This framework can be applied to create large- and small-scale changes.

A second framework, based on the work of Kate Hilton and Alex Anderson, describes the psychology of change, with a focus on building and sustaining the will to change and shifting culture—a necessary component for the final steps of the third framework.

John Kotter's well-established framework offers an effective eight-step pathway for change, especially one that requires mobilization of large numbers of people. It describes a way to ensure that people are mobilized and that the system itself is changed.

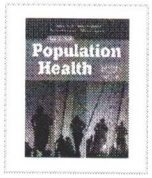
Taken together, these frameworks and case studies offer a set of approaches to the complex, adaptive change that is necessary to achieve sustainable population health improvement.

LEARNING OBJECTIVES

1. Identify the reasons why most change efforts fail.
2. Identify key elements of successful change efforts.
3. Develop an approach to change that is designed to move people and systems together to create sustainable change, building on three frameworks offered here.

KEY TERMS

Agency
Change
Change management
Organizational transformation
Pathways
Population health
Sustainable



Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462

Chapter 11 Changing Organizational Culture
Introduction

▶ Introduction

A receptionist, a medical assistant, a nurse, and a doctor work as a team at a community health center that is part of an integrated health system in Colorado. Their clinic director, Helen, who has just returned from a major conference, tells them with great excitement, "I've just signed us up to be one of the champions of a new model that could improve our care of patients with hepatitis C!" With some trepidation, but also a willingness to try given that they like and trust Helen, the team agrees to pilot the initiative, "Connect for Health, Colorado."

Over the next several months, the team is asked to attend several meetings and perform new tasks, many of which do not seem to directly benefit their patients. Because the system isn't set up for these tasks, they add complexity to the workflow and at least an hour or two to their already long workday. When Helen asks the team about joining a second initiative that builds on the first, the team unanimously votes "no." What went wrong?

This scenario is ubiquitous in health care today. Well-intended change, especially at the outset, can make life more difficult for the people who are engaged in it, and often the result is a failure of the initiative to sustain or scale. Improvement initiatives abound, and yet we don't see much real improvement or organizational transformation. Some changes, like implementation of electronic health records (EHRs), have brought healthcare professionals to a point of near revolt. High levels of burnout have been reported across the healthcare workforce, and some clinicians are leaving the medical profession, in part because they are losing hope that real change is possible. The Institute for Healthcare Improvement (IHI) grouped "failed change efforts" into three areas: failure of ideas, failure of will, and failure of execution.[1]

Failure of Ideas

Ideas fail when they do not effectively diagnose the problem or generate a set of solutions that would work. Most failures of ideas arise from not having the right people engaged to correctly identify the problem or to create the right portfolio of solutions—that is, those who are most affected by the problem, like patients. Effective codesign and innovation strategies can assure that the right problem is tackled and that a set of realistic solutions can be tested.

Failures of Will

Failures of will occur when everyone, from leadership to front-line staff, lacks the motivation and agency to effectively engage in the process of developing or implementing the solutions. People don't support change when they haven't been invited to provide input about what might work for them. Often, they work around the change if such pathways are possible.

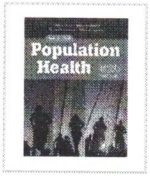
Failure of Execution

A failure of execution occurs when new solutions are not implemented in a way that works. In our experience, most failures of execution arise from not anticipating how the change will affect the human beings involved or from not building systems in which the change becomes the new, sustainable norm.

Failures and solutions in these three areas are interrelated and, depending on whether the change is simple and incremental, complex, or transformational, one might combine a set of change strategies that best address the type of change and the context.

Strategies for Success

In this chapter, we will primarily focus on change management strategies to create changes that address failure of will and failure of execution. We will introduce three frameworks that have been used by people across industries to create more effective change: one that focuses on improving will (Switch[2]), one that explores the psychology of change[3] with an emphasis on sustaining the will to change and shift culture, and one that is useful in supporting the execution of complex change (Kotter's eight-step change model[4]). In this chapter, we will apply these frameworks to real-world examples of large-scale transformations at Cambridge Health Alliance and in 100 Million Healthier Lives. The chapter will conclude with reflection regarding the responsibilities of change leaders.



Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462

Chapter 11 Changing Organizational Culture
Framework 1: Switch

▶ Framework 1: Switch

A favorite recent book on creating effective change is *Switch: How to Change When Change Is Hard*,[2] written by brothers Dan and Chip Heath in consultation with hundreds of change makers. Based on sound behavioral science and organizational psychology, it synthesizes a simple yet powerful model for moving humans through the process of change. In the authors' clever analogy, people are like the riders on elephants traveling down a path.

The rider represents the rational brain—the part of us that deals with facts and statistics and consciously decides what to do based on a careful analysis of the facts. The elephant represents our unconscious choices (our limbic system of instantaneous responses that judges within the first moments of meeting someone whether we like them or not) and our emotions and needs (Do we feel safe? Are we hungry? Do we feel loved?). The path reflects our environment, the process of change, and the systems that make life easier or harder.

Most of the time, the elephant is in control. However, when we try to create change, our tendency is to focus messaging on the rider (i.e., using data and statistics to convince people to change through evidence-based practice). If this method were effective, all healthcare professionals would eat healthily, exercise five times a week, and not smoke or drink.

Nearly everyone chooses to make difficult changes during their lives. For instance, getting married and having a baby are complex changes that require us to give up control and resources and take on substantial responsibility. The reason people are willing to make these changes—the "pull" factor—is that the motivation overcomes the negatives. In our analogy, the elephant can be motivated to race down the path to change by sharing stories; using tools to build motivation; making change joyful, meaningful, and easy; and connecting change to purpose.[2]

Switch Framework Case Study 1: Adopting Systemwide Change

Cambridge Health Alliance (CHA), a large integrated safety net academic health system in eastern Massachusetts, was undergoing systemwide transformation to become a patient-centered medical home (PCMH) and accountable care organization (ACO). These complicated, multidimensional concepts were difficult to explain, and the brand

names were misleading (for some people, "medical home" connotes "nursing home" or "funeral home").

Switch principles were applied to help people "find the meaning." Rather than present the concept in slides multiple times over the course of a year, the concept was introduced individually to each team and clinic, in the following way:

1. We met people at their home site and invited them to form groups of six. Each of the six group members was asked to take on the role of a patient who might walk through the door (e.g., a 22-year-old single mom with a 2-week-old infant, a 67-year-old Spanish-speaking gentleman with diabetes and an amputation, or a 58-year-old woman caring for her recently widowed 83-year-old mother).
2. Participants in each group were asked to speak from their assigned patient's perspective in answering the question, "What would you want your healthcare system to look like?" The group was given arts and crafts supplies and asked to "play" in building the system together. In this way, groups rediscovered the principles of the PCMH.
3. After showing a simple, motivating visual about the Switch model, the groups were invited to help build it. Assurance was given regarding the leadership's commitment to changing the business model to align with these principles.
4. To build confidence, data points and stories were shared about other organizations that had made this type of change and achieved significant positive results.
5. Finally, participants were invited to act.

By the end of a year, 93% of all frontline team members understood the vision, rated it 7 out of 10 or higher in importance to them, and felt confident in their roles.[5] Most important, a number of self-proclaimed skeptics had become champions, describing this as one of the most meaningful transformations they had engaged in over their careers. Peer-to-peer spread of ideas was encouraged—and the ideas spread like wildfire.

An often overlooked but highly critical element of creating change is the difficulty or simplicity of the path itself.[2] Whether the path to change is easy or hard to follow makes a huge difference in which way the elephant will go; conscious or unconsciously, it will most often choose the path of least resistance. Complexity, difficulty, and ambiguity can make paths harder. Anything we can do to reshape and simplify the path will make it more likely that people will adopt the change.

There may be very valid reasons why a pathway should be modified for a particular patient. Even Cleveland Clinic, with its strong history of reliably implementing hundreds of evidence-based clinical pathways, does not prevent people from choosing to do something that is not consistent with a recommended pathway. But by making the recommended pathway the easiest path to follow in the clinical workflows and

EHR, the doctor's administrative burden is lowered, and exceptions are requested only when they are truly indicated. In this way, Cleveland Clinic has shaped the path successfully for *easier* adoption of change.

Switch Framework Case Study 2: Ensuring End-of-Life and Healthcare Proxy Discussions

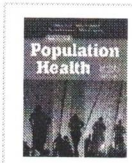
Promoting change to ensure that conversations occur about healthcare proxies and patients' end-of-life preferences is a complex task. At CHA, where providers are stretched thin, exhorting them to do the right thing was unlikely to work. A family medicine physician facilitated the development of a cross-clinic improvement team that included medical assistants, nurses, physicians, receptionists, and support personnel (e.g., information technology). The team created an elegant workflow for ensuring that healthcare proxy and end-of-life conversations would take place:

1. Work was divided among different roles based on the flow of the patient.
2. The process was integrated seamlessly into the standard flow of team-based care.
3. The process was incorporated into the EHR as a trigger to initiate it.

The following process was put in place:

- A packet with all the forms necessary for a healthcare proxy was prepared.
- A standard flag in the integrated health maintenance section of the EHR prompted the receptionist to give the packet to the patient on arrival.
- The medical assistant answered questions and entered the order for a healthcare proxy into the chart for the clinician to sign.
- The clinician documented patients' preferences about their end-of-life care in the healthcare proxy order with one more click of a button.

Within one year, over 60,000 healthcare proxy orders were entered into patients' charts, and tens of thousands of patients' preferences about their end-of-life choices had been recorded in the EHR. It became the standard of care *without a single physician educational session.* Knowing that physicians already believed in the importance of these conversations, the rest of the team was rallied to shape the path around the process so that the right choice became the easiest one to make. The Switch framework helped focus efforts and built confidence that the change would be good for the people involved.



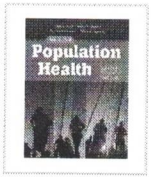
Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462

Chapter 11 Changing Organizational Culture
Framework 2: Psychology of Change

Framework 2: Psychology of Change

In an approach that dovetails well with Switch, Hilton and Anderson (Psychology of Change Framework to Advance and Sustain Improvement) point out that motivation presents an opportunity to create agency, defined as "the ability of an individual or group to choose to act with purpose."[4] Agency has two key components—power (the *ability* to act with purpose) and courage (the *emotional resources to choose* to act).[3]

Following the initial sessions at CHA (see Switch Framework Case Study 1), we invited people to form a practice improvement team comprised of care team members, patients, and families to select and begin working on a target area. By making it easy to go from motivation to action, we built agency—the power and courage to act.



Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462

Chapter 11 Changing Organizational Culture
Framework 3: The Kotter Eight-Step Change Model

▶ Framework 3: The Kotter Eight-Step Change Model

The Switch framework applies to many contexts, but when tackling large-scale change, it is sometimes best complemented by the eight-step change model outlined by John P. Kotter, an Emeritus Professor at the Harvard Business School.[4]

Although Kotter's eight steps are often done sequentially, one can reinforce another and also align with Switch strategies (**TABLE 11-1**).

TABLE 11-1 Components of Kotter's 8-Step Change Process

1. Establishing a Sense of Urgency
2. Creating the Guiding Coalition
3. Developing a Vision and Strategy
4. Communicating the Change Vision
5. Empowering Employees for Broad-Based Action
6. Generating Short-Term Wins
7. Consolidating Gains and Producing More Change
8. Anchoring New Approaches in the Culture

Modified from: Kotter, J. P. Leading Change. Boston: Harvard Business School Press, 1996.

1. Create a sense of urgency— elephant
2. Build a guiding coalition—rider, elephant
3. Form strategic vision and initiatives—rider, path
4. Enlist a volunteer army to engage in broad-based action—elephant
5. Enable action by removing barriers—path
6. Generate short-term wins—rider, elephant
7. Sustain acceleration—path
8. Institute or anchor change in culture, systems, and processes—path

Taken together, the Switch and Kotter eight-step frameworks have been applied to create and sustain complex system change. The following two case studies demonstrate the application of a Kotter-Switch approach.

Eight-Step Framework Case Study 1: System Transformation

As described in Switch Framework Case Study 1, CHA cares for 140,000 primary care patients, 75% of whom are on public insurance. Its transformation was precipitated by a funding crisis that occurred when the state's expanded healthcare coverage for Medicaid beneficiaries enrolled nearly four times as many people as expected. The governor informed CHA that $40 million in supplemental funds to cover Medicaid shortfalls would not be paid and that reimbursement for $100 million in Medicaid services delivered for the previous year was questionable. There was no need to create a sense of urgency—there was literally a "burning platform" (*Step 1*).

Rather than panic, the CHA leadership team engaged the organization in envisioning how the organization should look in the year 2015—an approach that proved critical to success.

It was obvious to the leadership that *Vision 2015* should focus on sustainably achieving the organization's mission—*to improve the health of our communities*—rather than on digging out of a financial hole. Three visioning sessions were held with the medical staff:

1. A session where participants considered the principles of an organization they would be proud to be a part of in the year 2015.
2. A session that invited participants to help shape the path to achieving these principles.
3. A session wherein participants assessed care gaps in the current system and made the decision to build a system in which extraordinary care became ordinary—an integrated system that would act seamlessly across primary care, specialties and hospital and community-based services to meet the needs of the community.

Achieving this sustainably would require shifting the business model from *fee for service* to *global payments/shared savings*—a financial structure that would incentivize the organization to provide what its patients needed (e.g., social care, primary care, or mental health care).

The recommendations from this process became the vision for the organization, and acknowledging the value of these services, the state restored CHA's funding and agreed to support the organization through a change in payment model.

All employees were invited to remain and help build the vision. Over the next several years, new recruits as well as the many who stayed were inspired by the vision and became part of the change.

Step 2 of Kotter's approach was applied by building a Guiding Coalition. The Medical Home Steering Committee (subsequently, the ACO-PCMH Steering Committee) was comprised of a team of senior leaders from across the organization (e.g., Chief Medical Officer, Chief Operating Officer, Chief Administrative Officer for the ACO, Vice President of PCMH Transformation). In the first year, work was informed by five redesign workgroups (including frontline staff and patients); in the second year, ten

operating teams made recommendations (e.g., regarding care redesign, collaboration, compensation) that formed the basis of a strategy and operational plan for the transformation (*Kotter Step 3*).

To avoid "spooking the elephant," senior leaders sponsored a Leadership Academy for a critical mass of mid-level leaders and approximately 10% of all physicians to help them own the vision and feel confident in creating change. The senior leaders mentored leadership teams in carrying out projects that aligned with the vision, thereby facilitating broad-based action (*Steps 4 and 5*).

The staff was engaged in envisioning what they would want as patients or community members. Care delivery sites were encouraged to make these improvements, with senior managers removing barriers from their path as needed. Throughout the organization, staff received training in basic design and improvement methods. Innovators and early adopters were invited to enter into learning collaboratives to accelerate transformation and were asked to share their stories at monthly cross-site mid-level leadership meetings, poster sessions, and in the organizational newsletter.

It wasn't easy, but it worked. By aligning the transformation with achieving the mission in a way that made sense for everyone, the collective "elephants" were harnessed, and the path was shaped. As a result, the underlying care model was changed, and, with the engagement of key staff (from CFO to medical assistants) over the next five years, CHA went from 1% to 60% global payments or shared savings.

Within months, dramatic improvements were documented on many levels—from employees' joy in their work, to patient health outcomes, to utilization and costs. These quick wins (*Kotter Step 6*) were useful in refining the care model and spreading it across the organization in waves based on readiness. At two and a half years, a Commonwealth Fund evaluation found that health outcomes had risen to the national 90th percentile at many CHA transformation sites, exceeding their matched controls in the non-transformation CHA sites and of sites across the state. The transformation sites also demonstrated reduced overall utilization and far greater employee joy in work.[6]

Once it was clear that changes were effective, CHA leadership worked with the state to help create a funding glidepath to support CHA's transformation and that of similar hospitals across the state. As CHA shifted its financial arrangements and operational structures to achieve the vision over the five-year period, the changes became anchored in processes and expectations (*Steps 7 and 8*). For example:

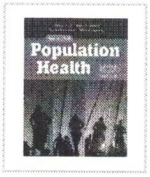
- The EHR was redesigned to support teams and integrated care planning.
- Physicians began to share offices with team members to facilitate closer communication and ease of workflow.
- Teams became co-scheduled—which required bringing 18 labor unions on board to support better and more consistent care.
- Business plans were created using new payment model options.

- New data systems and care management processes that crossed payer and delivery systems were created.
- New strategic partnerships with tertiary care and community-based organizations were forged.

With the necessary supports in place to care for the whole person—mental, physical, and social needs in addition to physical health—CHA achieved better outcomes for its patients, its communities, the organization, and its employees. The goals of the transformation were reinforced and became a new norm. The transformation was neither simple nor easy, but it was *meaningful*—and its core message of reshaping the organization to help achieve the mission "to improve the health of our communities" was powerful.

Eight-Step Framework Case Study 2: 100 Million Healthier Lives

When "100 Million Healthier Lives" was launched by IHI, the healthcare field wasn't quite ready for social determinants of health. However, evidence was emerging that the Triple Aim goals[7] of improved



Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462
Chapter 11 Changing Organizational Culture
Framework 3: The Kotter Eight-Step Change Model

population health, patient experience, and cost—a national imperative—would not be achievable without cross-sector partnerships to address social determinants.[8] Managing costs was essential but had not been achieved in most places.

For decades, the United States had relied on a siloed system of health production without accounting for the substantial interaction between mental, physical, social, and spiritual well-being—despite the World Health Organization definition.[9] Although public health had always operated in a place-based way, the interconnectedness between place and health[10] was not well understood in health care or most other sectors. The business and social service sectors weren't ready to engage in partnership.

A burning platform (*Step 1*) would be necessary to engage a critical mass of change leaders to go on the journey toward change. People had to believe change was possible even without well-developed models or a defined path. Fortunately, a number of major national organizations—Robert Wood Johnson Foundation (RWJF), the Institute for Healthcare Improvement (IHI), the Commonwealth Fund, the American Public Health Association (APHA), Centers for Disease Control and Prevention (CDC), Prevention Institute, Public Health Institute, Communities Joined in Action, Stakeholder Health, the National Academy of Science, Engineering and Medicine, and even the Federal Reserve—were ready to engage. These organizations were not yet working or messaging together, and there was no common playbook or group shaping a common path to make change easier. It was highly unlikely that the elephant would move in the face of this level of complexity.

Using a social networking strategy, a basic community organizing approach of public narrative—for example, "the story of me, the story of us, the story of now"[11]—one-to-one conversations with these organizations and other changemakers yielded recommendations about a common movement that could be built. Stories were shared by people in the system's various siloes—stories of people falling through the cracks. Data were shared showing that a reduction in hospitalizations from better primary care would be insufficient to stem the tide of chronic disease or an aging population or to close gaps in equity. With the collective acknowledgment that what different actors were doing separately wouldn't be enough, the decision was made to build a shared movement based on unprecedented collaboration, innovative improvement, and system transformation.

Within three months, over 200 leaders from all walks of life—national organizations to community residents—came together to launch 100 Million Healthier Lives. A leadership team representing more than 30 organizations codesigned a meeting to inspire and to create the confidence to move into uncharted territory. Health was defined as more than the absence of disease. Latino children with Down's syndrome danced their cultural dances; poems and stories of real change were shared. A former member of NASA shared the story of the space race—another far-reaching goal that was set before there was the collaboration, technology, or science to achieve it.

Working groups led by credible leaders across organizations established paths in the 18 areas identified in initial discussions. Conversations focused on assets as well as needs and on what we would do together that we couldn't do alone. At the end of the day and a half meeting, on October 8, 2014, at 2:52 PM, the assembled group committed to an audacious common goal—100 million people living healthier lives by 2020. Changing the way we thought and worked to improve health, well-being, and equity was the highest priority.

Convened by the IHI, the meeting had taken place with 35 partners (potentially reaching 35 million people). One week later, there were over 70 partners (potential reach = 70 million people)—over 100 million people were within reach at three months. Leadership was distributed among the members in the form of collaboration hubs around areas of shared interest. With Robert Wood Johnson Foundation funding, a first national initiative was launched to create SCALE (Spreading Community Accelerators through Learning and Evaluation), the proof points in 24 communities. Highly engaging and trust-building experiences were developed for these communities, focusing on courage and agency to act as well as skills and pathways to make action more likely to be effective. At the end of two years, these communities elected to spread the change to four to ten communities around them, holding over 54 leadership academies with 100+ communities to engage them in the movement and take collective action to advance health, well-being, and equity across sectors.

None of this could have happened without building pathways to make change easier. Major groups in each of the hubs worked together on specific strategic priorities. One of these was the 100 Million Healthier Lives Health Systems Transformation Hub, where groups such as the American Hospital Association, IHI, Network for Regional Healthcare Improvement, Public Health Institute, and Stakeholder Health (with a collective reach of over 10,000 healthcare organizations) joined to build common frameworks and tools to support healthcare organizations on this journey. "Pathways to Population Health: An Invitation to Health Care Change Agents"[12] emerged from this effort. The framework creates a path forward for healthcare organizations to reclaim their mission, purpose, and power to improve health, well-being, and equity. With its supportive tools and graphics, Pathways to Population Health[12] is designed to make a complex journey simpler and easier—and to restore a sense of abundance and possibility for healthcare systems (**FIGURE 11-1**). Hundreds of healthcare

organizations joined the effort in its first year, in part because it came from trusted messengers and in part because it made their journey easier.

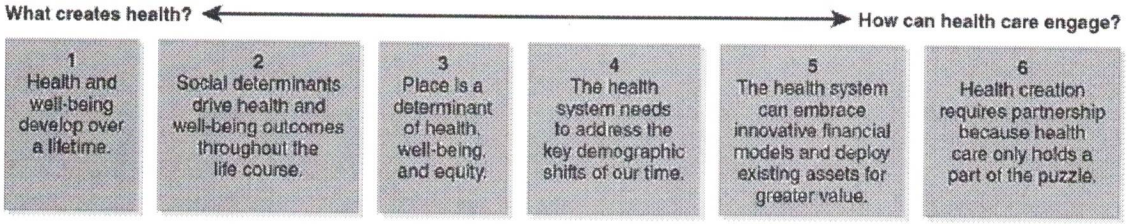
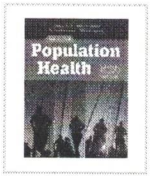


FIGURE 11-1 Foundational Concepts of Population Health Improvement from Pathways to Population Health.

Together, members of 100 Million Healthier Lives are making the journey easier for one another and demonstrating that real change is possible when assets are brought together across silos. Most important, having become a community of purpose across

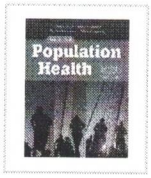


Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462

Chapter 11 Changing Organizational Culture
Framework 3: The Kotter Eight-Step Change Model

geopolitical and sector boundaries the members have demonstrated that change spreads at the speed of trust. Practices (e.g., partnerships between organizations and people with lived experience of inequity) are spreading along with breakthrough improvements that achieve 50% or better outcomes.

We must sustain the gains, demonstrate that they can scale, and make the necessary changes in systems, processes, and culture the new norm. Fortunately, we are learning that Switch, the Kotter eight-step model, and the Psychology of Change tools and frameworks can apply even at large scale—especially when combined with our best learning about growing networks.



Population Health: Creating a Culture of Wellness, Third Edition
ISBN 9781284188462

Chapter 11 Changing Organizational Culture
Takeaways for Change Leaders

▶ Takeaways for Change Leaders

Poorly designed change processes can add to the burden and complexity of work at best and cause substantial harm at worst—from poor health outcomes to damaged trust with communities. What matters is to plan change well, to quickly identify the pain points, and to actively shape the path to change. Whether the change is small or large, there are methods of creating change that one can learn and apply for far better outcomes. Frameworks like Switch, Kotter's eight-step model, and the Psychology of Change can help to make change easier.

"All improvement will require change, but not all change will result in an improvement."[14] Building in a process of continuous learning and co-design with those who are most affected by the change is crucial. Being both humble and strategic —and always attending to the needs of the people and the process of change itself— can make a profound difference in the well-being of people during and as a result of the journey. Both matter.

Study and Discussion Questions

1. How might Helen have approached her change initiative differently if she had applied Switch or Kotter's eight-step model to her scenario?
2. Where do you see Switch and Kotter's models applied in the 100 Million Healthier Lives case study?
3. Think of a change effort you have been a part of (in work or life) that didn't go well. How might you diagnose what went wrong using Switch and Kotter's eight-step model?
4. Think of a change effort that went wonderfully well. What elements of Switch or Kotter's eight-step model could you identify?

Suggested Readings and Websites

Heath C, Heath D. *Switch: How to Change Things When Change Is Hard.* New York: Crown Business Press.

Kotter's Eight-Step Change Process is outlined in two books:

1Kotter JP. *Leading Change.* Cambridge, MA: Harvard Business Review Press.

2Kotter JP. *Accelerate.* Cambridge, MA: Harvard Business Review Press.

Both books may be accessed via https://www.kotterinc.com/8-steps-process-for-leading-change (accessed June 15, 2019).

Hilton K, Anderson A. The Psychology of Change [white paper]. Available at http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx (accessed June 15, 2019).

Synthesis papers on 100 Million Healthier Lives are available at www.100mlives.org/initiatives (accessed June 15, 2019).

Pathways to Population Health website is available at www.pathways2pophealth.org (accessed June 15, 2019).

References

1. Nolan TW. *Execution of Strategic Improvement Initiatives to Produce System-Level Results.* Cambridge, MA: Institute for Healthcare Improvement; 2007.
2. Heath C, Heath D. *Switch: How to Change When Change Is Hard.* Toronto, Canada: Random House Canada; 2010.
3. Hilton K, Anderson A. *IHI Psychology of Change Framework to Advance and Sustain Improvement.* Boston, MA: Institute for Healthcare Improvement; 2018.
4. Kotter JP. *8 Step Process for Leading Change.* E-book available at https://www.kotterinc.com/8-steps-process-for-leading-change/ (accessed May 3, 2019).
5. Zallman L, et al. *PCMH Workforce Survey.* Cambridge, MA: Cambridge Health Alliance Institute for Community Health; 2011.
6. Hacker K, Mechanic R, Santos P. *Accountable Care in the Safety Net: A Case Study of the Cambridge Health Alliance.* Boston, MA: Commonwealth Fund; 2014.
7. Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. *Health Affs.* 2008;27(3):759–769.
8. Whittington JW, Nolan K, Lewis N, Torres T. Pursuing the Triple Aim: the first 7 years. *The Milbank Q.* 2015;93:263–300.
9. World Health Organization. Constitution of the World Health Organization. [Online] April 7, 1948. Available at https://www.who.int/about/mission/en/ (accessed June 15, 2019).
10. Haley A, Zimmerman E, Woolf S, Evans B. Neighborhood-level determinants of life expectancy in Oakland, California. Center on Human Needs. Richmond, VA: Virginia Commonwealth University; 2012.
11. Ganz M. Public narrative, collective action and power. Chapter 18 in Sina Odugbemi and Taeku Lee (Eds.), *Accountability Through Public Opinion: From Inertia to Public Action.* Washington, DC: The World Bank; 2011: 273–289.
12. Stout S, Loehrer S, Cleary-Fishman M, Johnson K, Chenard R, Gunderson G, et al. *Pathways to Population Health: An Invitation to Health Care Change Agents.* Cambridge, MA: Institute for Healthcare Improvement; 2017.
13. Langley GJ, Moen RD, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide.* San Francisco: Jossey Bass, 1996, p. xxi.