ADAPTIVE STRATEGY BASED AGILITY: DEVELOPING AND VALIDATING A NEW STRATEGIC MANAGEMENT CONSTRUCT THROUGH EXPLORATORY FACTOR ANALYSIS IN TYPE C HOSPITALS

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ABSTRACT

Hospitals operating in volatile, uncertain, complex, and ambiguous (VUCA) healthcare environments require a strategic-level capability spanning sensing, seizing, reconfiguring, and institutionalizing adaptive routines. Existing agility and dynamic capability instruments capture parts of this cycle but rarely integrate the institutionalization stage that sustains adaptive gains. This study conceptualizes and tests Adaptive Strategy Based Agility (ASBA), grounded in Dynamic Capability Theory and Institutional Theory, examining whether twelve theoretically derived indicators cohere into one reflective factor. A quantitative, cross-sectional design surveyed 100 Directors/Senior Managers of Type C hospitals across four major Indonesian cities (Jakarta, Bandung, Semarang, Surabaya). Twelve indicators spanning sensing, seizing, transforming, and institutionalizing clusters were measured on a five-point Likert scale and analyzed via principal-component Exploratory Factor Analysis. Sampling adequacy was superb (KMO = .926), and Bartlett's test was significant ($\chi^2 = 677.682$, $df = 66$, $p < .001$). One component was extracted (eigenvalue = 6.847), explaining 57.06% of variance. All twelve indicators loaded strongly (.707–.803; communalities .499–.645), exceeding conventional thresholds and supporting a unidimensional structure. ASBA is empirically supported as a unidimensional strategic capability bridging dynamic-capability microfoundations with institutional theory's institutionalization mechanism, offering hospital management a diagnostic lens for strategic adaptability and a validated indicator set for confirmatory testing.

Keywords: *Adaptive Strategy Based Agility; Dynamic Capability Theory; Institutional Theory; Exploratory Factor Analysis; Hospital Strategic Management; Scale Development.*

INTRODUCTION

Hospitals, particularly medium-capacity Type C institutions that form the largest segment of Indonesia's private healthcare landscape, operate in an environment characterized by rapid epidemiological shifts, tightening regulation, and intensifying competitive and digital pressure (Tenggono et al., 2024). Directors and senior managers of these hospitals are routinely required not only to detect change but to convert detection into timely resource reallocation and, ultimately, into standard operating practice. Dynamic Capability Theory explains how firms sense opportunities and threats, seize them through decisive action, and transform their resource base accordingly (Teece, 2007; Teece et al., 1997). Institutional Theory, in turn, explains how organizations come to resemble one another through coercive, mimetic, and normative pressures, and how practices become taken-for-granted routines through habituation, objectification, and sedimentation (DiMaggio & Powell, 1983; Tolbert & Zucker, 1996).

Although both theoretical traditions have separately informed the strategic management literature on agility, most existing instruments measure only fragments of the adaptive cycle. Organizational and strategic agility scales typically emphasize sensing and responding (Doz & Kosonen, 2010; Reed, 2021), while dynamic capability scales emphasize

sensing, seizing, and transforming without a distinct institutionalization stage (Kump et al., 2019). In the healthcare context specifically, recent Indonesian evidence shows that strategic agility does not always translate into sustained strategic renewal, and that its mediating role can be statistically fragile unless paired with mechanisms that embed change into routine practice (Tenggono et al., 2024). This points to an unresolved measurement gap: no validated construct currently integrates the full cycle from environmental sensing through to the institutionalization of adaptive strategic routines within a single, hospital-relevant instrument.

This study addresses that gap by introducing Adaptive Strategy Based Agility (ASBA): the organizational capacity of a hospital to continuously sense strategic shifts, seize opportunities through prioritized and timely action, reconfigure resources accordingly, and institutionalize the resulting practices into durable organizational routines. ASBA is deliberately positioned as a first-order reflective construct; twelve indicators, organized conceptually into sensing (Monitoring, Understanding, Anticipating), seizing (Speed & Accuracy, Prioritization, Termination), transforming (Reallocation, Alignment, Support for New Strategies), and institutionalizing (Capturing Experience, Reflecting Performance, Institutionalizing) clusters, are each expected to load on a single underlying latent capability, rather than on separate sub-dimensions.

Accordingly, this study pursues three objectives: (1) to conceptualize ASBA as an integrative construct grounded in Dynamic Capability Theory and Institutional Theory; (2) to examine, through Exploratory Factor Analysis, whether the twelve theoretically derived indicators cohere into a single latent factor among Directors/Senior Managers of Type C hospitals in four major Indonesian cities; and (3) to establish an empirically supported item pool as the foundation for subsequent confirmatory validation. The remainder of this paper reviews the relevant theory, details the EFA-based methodology, reports the empirical results, and discusses their theoretical and managerial implications.

LITERATURE REVIEW

1. Dynamic Capability Theory

Dynamic Capability Theory defines the capacity of a firm to purposefully build, integrate, and reconfigure internal and external resources to address rapidly changing environments (Teece et al., 1997). Teece (2007) subsequently decomposed this capacity into three interrelated microfoundational clusters: sensing opportunities and threats, seizing them through timely resource commitment, and transforming (reconfiguring) the organization's asset base to sustain the resulting advantage. These clusters need not occur sequentially and are frequently pursued in parallel (Teece, 2007). Building on this framework, Kump et al. (2019) developed and validated a psychometric scale explicitly operationalizing sensing, seizing, and transforming as measurable organizational capacities, demonstrating that Teece's conceptual triad can be rendered into a reliable, quantifiable instrument.

In healthcare settings, dynamic capability has been shown to underpin patient agility and digital transformation outcomes. Van de Wetering and Versendaal (2021) found that IT ambidexterity strengthens hospital departments' capacity to build a digital dynamic capability, which in turn positively influences patient agility, defined as a department's ability to sense and respond adequately to patients' needs. Similarly, evidence from Indonesian private hospitals shows that dynamic managerial capability significantly enhances strategic agility ($\beta = 0.80$, $p < .001$) and digital readiness ($\beta = 0.54$, $p < .001$), underscoring the relevance of the sensing-seizing-transforming logic to hospital-level strategic decision-making (Tenggono et al., 2024).

2. Institutional Theory

Institutional Theory explains why organizations operating within the same field tend to converge toward similar structures and practices under coercive, mimetic, and normative pressures (DiMaggio & Powell, 1983). Within Indonesia's regulated and increasingly competitive private hospital sector, institutional pressures have been shown to shape managerial capability formation directly (Tenggono et al., 2024). Complementing this isomorphism perspective, Tolbert and Zucker (1996) describe institutionalization as a sequential process of habituation, objectification, and sedimentation, whereby a novel practice, initially adopted as a provisional response to a specific problem, gradually becomes a taken-for-granted organizational routine. This institutionalization lens is critical for ASBA because it explains a fourth, often-overlooked stage of adaptive capability: without objectification and sedimentation, sensed opportunities and seized initiatives risk reverting once managerial attention shifts elsewhere.

3. Strategic Agility and the Emergence of ASBA

Strategic agility has been defined as the capacity to adapt strategy to a changing business environment through strategic sensitivity, leadership unity, and resource fluidity (Doz & Kosonen, 2010). In a cross-sectional study of 250 healthcare professionals in Indonesian public and private hospitals, Zulfikri (2025) found that organizational agility significantly mediates the relationship between digital transformation and competitive advantage, enhancing responsiveness and operational efficiency. However, strategic agility instruments generally stop short of specifying how such adaptive gains become embedded in standard practice. Tenggono et al. (2024) found that strategic agility significantly mediated the relationship between institutional pressures and strategic renewal, but not the relationship between dynamic managerial capability and strategic renewal, suggesting that agility alone is an incomplete mechanism for sustained strategic change.

ASBA is proposed to close this gap by combining the dynamic-capability logic of sensing, seizing, and transforming with the institutional-theory logic of institutionalization. ASBA is defined in this study as a hospital's integrated capacity to continuously scan and interpret its strategic environment, convert insight into fast and prioritized action, reallocate and align resources accordingly, and embed the resulting practices into durable organizational routines. Consistent with this study's methodological standard for newly developed constructs, ASBA is specified and tested as a single, first-order reflective construct: all twelve indicators are theorized to load directly on ASBA itself, with no formal statistical sub-dimensions or higher-order factors between the indicators and the latent construct. The four labels used in Table 1 (sensing, seizing, transforming, institutionalizing) are a narrative device drawn from theory to organize and justify indicator selection; they are not modeled as separate sub-constructs and are not expected to emerge as separate factors in the empirical analysis, an expectation that is directly testable through the single-factor EFA specification reported below.

Table 1. Theoretical Indicators of Adaptive Strategy Based Agility (ASBA)

Cluster	**Code / Indicator**	**Theoretical Anchor**	**Conceptual Rationale**
Sensing (Dynamic Capability)	MON – Monitoring	Teece (2007); Teece, Pisano & Shuen (1997)	Systematic scanning of clinical, regulatory, and competitive signals so that emerging threats and opportunities are detected before they escalate.
	UND – Understanding	Teece (2007); Kump et al.	Interpreting scanned signals into meaningful implications for

Cluster	Code / Indicator	Theoretical Anchor	Conceptual Rationale
		(2019)	hospital strategy, translating raw environmental data into actionable strategic knowledge.
	ANT – Anticipating	Teece (2007); Van de Wetering & Versendaal (2021)	Forward-looking projection of patient-demand and policy trajectories that allows the hospital to prepare a response before disruption occurs.
Seizing (Dynamic Capability)	SPA – Speed & Accuracy	Teece (2007); Doz & Kosonen (2010)	Rapid yet precise strategic decision-making that converts sensed opportunities into timely managerial action.
	PRI – Prioritization	Teece (2007); Reed (2021)	Deliberate ranking and selection among competing strategic initiatives under resource scarcity.
	TER – Termination	Teece (2007); Helfat & Winter (2011)	Willingness to discontinue obsolete programs or services so that resources can be redirected toward higher-value initiatives.
Transforming / Reconfiguring (Dynamic Capability)	REA – Reallocation	Teece (2007); Warner & Wäger (2019)	Redeployment of financial, clinical, and human resources to support newly seized strategic priorities.
	ALI – Alignment	Teece (2007); Doz & Kosonen (2010)	Coherence between the hospital's strategic direction, structure, and daily clinical-operational routines.
	SUP – Support for New Strategies	Teece (2007); Tenggono et al. (2024)	Managerial and leadership sponsorship that sustains momentum for newly adopted strategic initiatives.
Institutionalizing (Institutional Theory)	CAP – Capturing Experience	Tolbert & Zucker (1996); DiMaggio & Powell (1983)	Systematic codification of lessons learned from strategic adaptation episodes into organizational knowledge.
	REF – Reflecting Performance	Tolbert & Zucker (1996); Zucker (1977)	Habitual evaluative review of strategic outcomes that feeds back into the sensing stage, closing the adaptive loop.
	INS – Institutionalizing	DiMaggio & Powell (1983); Tolbert & Zucker (1996)	Sedimentation of successful adaptive practices into standard operating procedures, structures, and taken-for-granted routines.

4. Expected Measurement Model

Because ASBA is conceptualized as a first-order reflective construct, all twelve indicators, Monitoring, Understanding, Anticipating, Speed & Accuracy, Prioritization, Termination, Reallocation, Alignment, Support for New Strategies, Capturing Experience, Reflecting Performance, and Institutionalizing, are theorized to be caused by, rather than to cause, the latent capability. Formal directional hypotheses (H1-H12) with associated significance tests are appropriate for the confirmatory (CFA/PLS-SEM) stage of this research program, where standardized loadings carry t-values and p-values; at the present exploratory stage, Principal Component Analysis with a single-factor extraction was instead used to test the more basic proposition that these twelve indicators share sufficient common variance to be represented by one latent factor, rather than by two or more distinct factors. This unidimensionality proposition, evaluated through sampling adequacy, communalities, and total variance explained, constitutes the central testable expectation of the EFA reported below.

METHODOLOGY

1. Research Design and Unit of Analysis

This study employed a quantitative, cross-sectional survey design. The unit of analysis was the Type C hospital, and the unit of observation was the Director or Senior Manager responsible for strategic decision-making at each hospital. Type C hospitals were selected because they represent the most common category of privately-owned hospital in Indonesia and face significant resource constraints that make adaptive strategic capability especially consequential (Tenggono et al., 2024). The population comprised Type C hospitals located in four major Indonesian cities: Jakarta, Bandung, Semarang, and Surabaya. A total of 100 valid responses were obtained. For Exploratory Factor Analysis with twelve indicators, a sample of 100 satisfies the commonly applied 5-to-10 respondents-per-item heuristic (Hair et al., 2019) and is further supported by the sampling adequacy diagnostics reported in the Results section.

2. Measurement and Data Collection

Data were collected through a structured questionnaire administered to Directors/Senior Managers, using a five-point Likert scale ranging from strongly disagree to strongly agree. Each of the twelve ASBA indicators (MON, UND, ANT, SPA, PRI, TER, REA, ALI, SUP, CAP, REF, INS) was measured with items derived from the conceptual definitions summarized in Table 1. The study adopted a cross-sectional time horizon, consistent with the exploratory, scale-development purpose of this phase of the research program.

3. Data Analysis

Exploratory Factor Analysis (EFA) was conducted in SPSS using Principal Component Analysis for extraction. Because ASBA was theorized a priori as a single, first-order reflective construct, factor extraction was constrained to one component (FACTORS = 1), consistent with confirmatory-oriented applications of EFA used to test a hypothesized unidimensional structure (Hair et al., 2019). Sampling adequacy was assessed via the Kaiser-Meyer-Olkin (KMO) measure, with values above .90 considered "superb" (Kaiser, 1974), and via Bartlett's Test of Sphericity, with significance at $p < .05$ indicating that the correlation matrix is suitable for factor analysis (Bartlett, 1954; Tabachnick & Fidell, 2007). Communalities and component loadings were evaluated against the conventional .50 threshold (Hair et al., 2019).

RESULTS AND DISCUSSION

1. Sampling Adequacy

The Kaiser-Meyer-Olkin Measure of Sampling Adequacy was .926, exceeding the "superb" benchmark of .90 (Kaiser, 1974), indicating that the twelve ASBA indicators share sufficient common variance to justify factor analysis. Bartlett's Test of Sphericity was statistically significant ($\chi^2 = 677.682$, df = 66, $p < .001$), confirming that the inter-item correlation matrix is not an identity matrix and is therefore appropriate for factor extraction (Table 2).

Table 2. KMO and Bartlett's Test

Indicator	Value
Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy	.926
Bartlett's Test of Sphericity – Approx. Chi-Square	677.682
Bartlett's Test of Sphericity – df	66
Bartlett's Test of Sphericity – Sig.	.000

2. Communalities and Factor Loadings

All twelve indicators exhibited communalities above the conventional threshold, ranging from .499 (Alignment) to .645 (Anticipating), and component loadings ranging from .707 (Alignment) to .803 (Anticipating), all comfortably exceeding the .50 minimum recommended for practical significance (Hair et al., 2019). Detailed values are presented in Table 3.

Table 3. Communalities and Component Loadings

Code	Indicator	Communality (Extraction)	Component Loading
MON	Monitoring	.571	.756
UND	Understanding	.502	.709
ANT	Anticipating	.645	.803
SPA	Speed & Accuracy	.617	.786
PRI	Prioritization	.591	.769
TER	Termination	.533	.730
REA	Reallocation	.606	.778
ALI	Alignment	.499	.707
SUP	Support for New Strategies	.586	.765
CAP	Capturing Experience	.619	.786
REF	Reflecting Performance	.540	.735
INS	Institutionalizing	.538	.734

3. Total Variance Explained

Consistent with the a priori single-factor specification, only one component was extracted with an eigenvalue of 6.847, accounting for 57.062% of the total variance among the twelve indicators (Table 4). This exceeds the 50% minimum variance-explained benchmark typically applied in scale-development research (Hair et al., 2019) and, because

only one component was extracted, the solution could not be rotated, a diagnostic outcome that itself reinforces the unidimensionality of ASBA.

Table 4. Total Variance Explained (Principal Component Analysis)

Component	Eigenvalue	% of Variance	Cumulative %
1 (ASBA)	6.847	57.062%	57.062%

4. Summary of Indicator Validity

Taken together, the sampling adequacy, communality, loading, and variance-explained results indicate that all twelve theorized indicators, Monitoring, Understanding, Anticipating, Speed & Accuracy, Prioritization, Termination, Reallocation, Alignment, Support for New Strategies, Capturing Experience, Reflecting Performance, and Institutionalizing, function as valid components of a single, unidimensional ASBA measure at this exploratory stage. No indicator fell below the .50 communality or loading threshold, and none was flagged for removal or re-specification prior to the confirmatory (CFA/PLS-SEM) phase

Discussion

The EFA results provide strong preliminary support for ASBA as a unidimensional, first-order reflective construct. The superb sampling adequacy (KMO = .926) and the substantial variance explained by a single component (57.06%) indicate that indicators spanning four conceptually distinct clusters, sensing, seizing, transforming, and institutionalizing, are perceived by hospital Directors/Senior Managers as manifestations of one coherent underlying capability rather than as separate, loosely related competencies. This finding carries a specific theoretical implication: it suggests that, at least at the level of senior hospital management, the boundary between dynamic-capability processes (Teece, 2007) and institutional theory's institutionalization mechanism (Tolbert & Zucker, 1996) is not experienced as a boundary at all, but as a single, integrated adaptive cycle.

This integration addresses a specific gap identified in prior Indonesian hospital research. Tenggono et al. (2024) reported that strategic agility significantly mediated the relationship between institutional pressures and strategic renewal, but failed to mediate the relationship between dynamic managerial capability and strategic renewal, a result the authors attributed to the limited uptake of mechanisms that translate managerial capability into lasting change. By explicitly embedding an institutionalizing cluster (Capturing Experience, Reflecting Performance, Institutionalizing) alongside the classic sensing-seizing-transforming triad, ASBA offers one candidate explanation and remedy for that mediation gap: without deliberate institutionalization, seized opportunities may not translate into renewal precisely because they are never sedimented into routine practice (Tolbert & Zucker, 1996).

The pattern of loadings also merits substantive interpretation. Anticipating (.803) and Monitoring (.756) among the sensing indicators, and Speed & Accuracy (.786) and Capturing Experience (.786) among the seizing and institutionalizing indicators, produced the strongest loadings, suggesting that Type C hospital directors most readily recognize forward-looking environmental scanning and rapid, well-documented action as the most salient markers of adaptive strategic agility. Alignment (.707) and Understanding (.709) produced comparatively the weakest, though still substantial, loadings, which may reflect the more diffuse, cross-functional nature of these behaviors relative to the more discrete, individually attributable behaviors captured by the other indicators.

These findings should be interpreted in light of the exploratory, single-phase nature of the present analysis. EFA establishes dimensionality and provides an empirically defensible item pool; it does not, by itself, confirm the measurement model against an independent sample or establish convergent and discriminant validity in the manner that Confirmatory

Factor Analysis (CFA) or PLS-SEM would (Hair et al., 2019). The unit-analysis design underlying this research program specifies PLS-SEM (SmartPLS 4) as the subsequent confirmatory technique; the results reported here therefore constitute the necessary first phase, indicator purification and dimensionality testing, upon which that confirmatory phase should be built.

CONCLUSION

This study introduced Adaptive Strategy Based Agility (ASBA) as a new, theoretically integrated construct bridging Dynamic Capability Theory's sensing-seizing-transforming triad (Teece, 2007; Teece et al., 1997) with Institutional Theory's institutionalization mechanism (DiMaggio & Powell, 1983; Tolbert & Zucker, 1996). Using data from 100 Directors/Senior Managers of Type C hospitals in four major Indonesian cities, Exploratory Factor Analysis provided strong support for a single, first-order reflective factor: sampling adequacy was superb (KMO = .926), Bartlett's test was significant, and all twelve indicators loaded above .70 on one component explaining 57.06% of total variance.

Theoretically, this study contributes an integrative construct that treats sensing, seizing, transforming, and institutionalizing as a single latent strategic capability rather than as loosely coupled competencies, offering a candidate explanation for why strategic agility alone has, in prior Indonesian hospital research, shown inconsistent mediating effects on strategic renewal. Practically, ASBA provides hospital boards and directors with a diagnostic instrument spanning the full adaptive cycle, from environmental scanning through to the sedimentation of new practice, that can be used to benchmark and strengthen strategic adaptability in resource-constrained hospital settings.

Limitations And Future Research

Several limitations should be acknowledged. First, the sample of 100 respondents, while adequate for EFA, is modest relative to the broader population of Type C hospitals in Indonesia, and generalization should be made cautiously. Second, this study relied on a single respondent per hospital, which cannot rule out common method variance; future confirmatory work should consider multiple respondents per hospital or objective performance indicators as validity checks. Third, and most importantly, this paper reports only the exploratory (EFA) phase of a two-stage validation design; the twelve-indicator, single-factor structure established here should be subjected to Confirmatory Factor Analysis and, per the original research design, PLS-SEM based structural testing (SmartPLS 4) on an independent sample to establish convergent validity, discriminant validity, and construct reliability (composite reliability, AVE) before ASBA is used as a predictor or outcome variable in nomological-network studies. Future research should also test ASBA's relationship with firm performance and business sustainability outcomes, and examine whether the construct generalizes to Type A, B, and D hospitals and to public-sector healthcare institutions.

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