Governance and Management Roles in Transforming and Integrating Independent Organizations within Interdependent Local Health Networks

By Ted Ball, Dennis Pointer, and Liz Verlaan-Cole

As Ontario's healthcare system undergoes a fundamental change over the next three years, the degree of success achieved will depend on how the role of local governance, the role of local management and the role of *Local Health Integration Networks* are designed. This essay, and the attached survey on the role of the governance and management have been designed to provoke the thinking of Board members and CEO's of hospitals, CCAC's, community agencies/clinics, primary care teams and public health units in the Ontario healthcare system.

The key questions are: does everyone understand their role in an integrated system of services; does everyone understand the service outcomes for which they will be accountable in the emerging system; and, is everyone aligned on the change process that is meant to facilitate service integration at the customer level within each network?

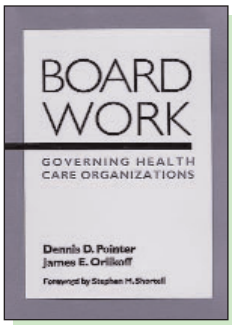
Many change processes fail because roles, functions, responsibilities and accountabilities are ambiguous.

So, does everyone in your community today have a common understanding of the respective missions/ functions/ roles of local governance and management; the Ministry of Health and Long Term Care; and, the *Local Health Integration Networks?*

Do the partners within your network hold a "shared vision" for the future healthcare delivery system that your community intends to create? Does each partner understand their unique purpose or *mission* within the network?

If there is clear alignment on your community's vision and the outcomes you are seeking, and on everyone's role in the emerging system, how can local board members contribute to the success of the change journey ahead? How can they make a positive contribution to their community's future?

The first thing that needs to be addressed is: who do board members actually "represent" in this process? What is their role? How is their role different from



management? How is their role different from the provincial government? How is their role different from the *Local Health Integration Networks* (LHINs) being set up across Ontario?

We have provided the **Pointer-Orlikoff** best practice governance template on the next page to facilitate your reflections on your board's roles and responsibilities.

Before you reflect on the roles and responsibilities of governance, you need to get very clear on the *purpose* of a board member of a healthcare organization in Canada: best practices suggests that their purpose is to **represent the interests of the *"owners".***

So who are they?

The owners of our publicly funded healthcare organizations are: the citizens of your community; the customers/patients that you serve; and, the taxpayers of Ontario/Canada.

For some board members, this may entail a fundamental paradigm shift in thinking and behaving. In this model, the board's job isn't to represent the self-interests of the organization, but rather, to be in *stewardship* ("in service to") the larger community, and to the mission of the organization – through the CEO, their one employee.

Boards that engage in dialogues across the continuum of care usually discover that all board members of healthcare organizations within an area represent the very same "owners": that is, the people of their community.

Healthcare organizations within a delivery network are therefore not in competition with one another. At least, they shouldn't be.

Regular community dialogues with governance leaders engaged in creating LHINs should enable people to discover that they do in fact represent the same interests: **the public interest!**

Public sector healthcare governance boards have five key responsibilities:

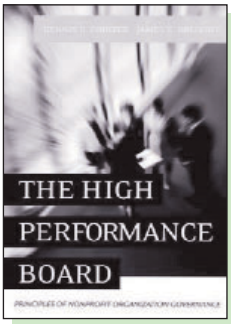
- Specifying ends/results that their organization are to achieve – within the institution or agency, and, within an integrated delivery system;
- Monitoring/evaluating/and coaching the CEO – while holding him/her accountable for achieving the specific and measurable results set by the board (including outcomes listed in the *Performance Agreement* with MOHLTC);
- Ensuring the quality of care (clinical, quality, patient safety and service quality) provided;
- Ensuring the organization's financial performance and condition; and,
- Ensuring the board's own effectiveness.

Here are some issues arising from each of these five responsibilities:

1. DEFINING ENDS

In his September 9th St. Lawrence Market health system integration speech, Health and Long-Term Care Minister Smitherman confirmed that within the government's vision for an integrated delivery system are independent governance boards for each of the institutions and agencies in the network.

Boards therefore still have overall accountability for the performance of their healthcare service delivery organization. In partnership with their management, boards must set high-level customer and financial outcomes – for which they hold the CEO and Chief-of-Staff accountable.



HEALTHCARE GOVERNANCE BOARD WORK

To make a difference and add value on behalf of the owners, a board must have a shared, coherent, and empowering answer to the fundamental question of governance: What type of work should we be doing?

	Policy Formulation Role	Decision-Making Role	Oversight Role
responsibility for **Ends**			
responsibility for **Executive Management Performance**			
responsibility for **Quality-of-Care**			
responsibility for **Finances**			
responsibility for **Itself**			

The Pointer-Orlikoff Healthcare Governance Model

Through a best practice *ends monitoring process*, boards need to engage in on-going dialogues with management to establish the indicators/outcomes/targets that need to be achieved within the organization and within the system over the short, medium and long-term.

If board members are truly representing the "interests of the owners", then one of the key outcomes they should be seeking is system integration.

The fact is that customers/citizens/patients/families/taxpayers all want a healthcare delivery system that provides a "seamless customer experience". How will your organization define the results you want from service integration?

Best practices would suggest that a balanced approach needs to be taken using a framework that includes customer, financial, process and learning & growth outcomes (the Harvard-based Balanced Scorecard).

It is through collaboration and sharing of evidence-based decision-making that the partners within a system will succeed. This is not the "regional authority" model – where a LHIN CEO and system board command and control the local partners.

If *Local Health Integration Networks* had been given the authority to simply impose integration plans and strategies, we know what the results would be: resistance. So, how could the partners within your LHIN happily develop a *Local Health System Balanced Scorecard* and begin to act on an integrated health system agenda?

Best practices suggest that the senior managers within a local delivery system need to collaborate to develop an *Integrated Local Health System BSC* – and then bring it back to their respective boards to determine the ends or outcomes that are required to fulfill each partner's unique *mission*.

Governance boards exist to ensure that the system is designed in the public interest – not the interests of providers, or healthcare mandarins, or powerful local institutional interests.

Each board needs to determine their organization's integration priorities that reflect their unique circumstances – and for which they will hold their CEO accountable.

With this governance/managerial configuration, each of the independent boards within a network would hold their respective CEO's accountable for achieving "their part" of a system integration strategy – contained in an **Integrated Health System Balanced Scorecard** that they helped create.

"Governance boards exist to ensure that the system is designed in the public interest – not the interests of providers, or healthcare mandarins, or powerful local institutional interests."

In this best practice model (IHS/BSC), collaboration is not something that is imposed by an external authority, it is willingly agreed to internally across the network – and within each organization. The system will integrate because everyone can clearly see the advantages of it – particularly the consumers of healthcare services, and, indeed, the owners of the system.

With this governance and managerial architecture, independent organizations can determine how they will change their current operations to integrate services at the customer delivery level – and thereby create the interdependent system of services that consumers require, and that financial analyst's say will provide a more efficient use of public resources.

2. MONITOR & EVALUATE EXECUTIVE MANAGEMENT PERFORMANCE

Boards govern through: (a) the policy development process; (b) the performance monitoring process; and, (c) the accountability process.

INDICATORS FOR BOARD PERFORMANCE	
Ends	**The extent the vision is being fulfilled and key goals are being accomplished**
Management	**The extent the CEO's performance is in line with board expectations**
Finances	**The extent the organization's financial performance is in line with board-specified objectives and expectations**
Quality	**The extent quality of care (as defined by the board) meets standards**
Self	**The extent the board is fulfilling its responsibilities and executing its roles**

The Pointer-Orlikoff Healthcare Governance Model

The question is: have boards done a good job of monitoring and evaluating the performance of their organizations? Have they provided their CEO and senior executives with feedback – from the owners' and customers' perspective? Have they been in stewardship to the customers who are served?

Best practices suggests that a board's job is to select the CEO and Chief-of-Staff and then hold them accountable for the results produced – through the BSC monitoring process. Their job is to ask probing questions of management on behalf of the organization's owners.

The purpose of a community governance board is to "push the envelope" on behalf of their community. Clearly, the board and the community want the CEO and the organization's staff to succeed. Indeed, the "owners" have no interest in "who is to blame".

Their bottom line: **they want access to the excellent healthcare system that they are now paying for in their taxes, and in their new health premiums.**

"Accountability" must no longer be designed as a blame/shame and punish system – but as a methodology that is designed to mobilize the support required to make everyone successful at achieving agreed-upon outcomes. Success, not blame, is the goal.

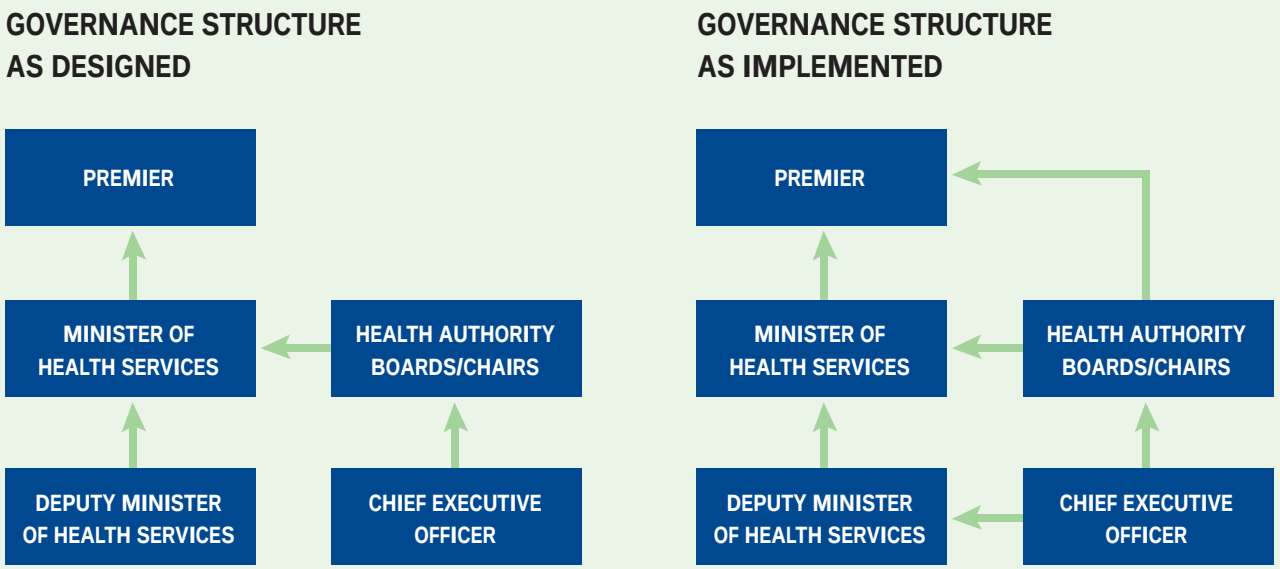
"Boards need to ensure that their CEO does not respond to the not so subtle efforts to create dual accountability."

One of the keys to success is sustained learning and growth. In order to be in stewardship to the people served, the board needs to ensure learning and growth throughout the organization.

Best practice boards of learning organizations allocate between 1% and 5% of their payroll budget for the *learning & growth* of their employees.

While boards are advocates for their community, they also need to ensure that their staff have the supports they need to successfully achieve the organizational and local health system outcomes for which they will be held accountable at the organizational level.

GOVERNANCE STRUCTURE OF REGIONALIZATION BRITISH COLUMBIA



SOURCE: OFFICE OF THE AUDITOR GENERAL OF BRITISH COLUMBIA 2003: 22

Rather than designing systems and processes to blame CEO's, best practice approaches seek to support CEO's. In such models, boards clearly have a strong interest in having their CEO be successful – because when the CEO achieves all the outcomes required, then the organization will be successful at meeting the needs of the "owners".

Boards also need to ensure that their CEO does not respond to the subtle and not so subtle efforts to create *"dual accountability"* – where they are accountable to both the board, and to local public servants.

In their recent paper on ***Regionalization: Making Sense of the Canadian Experience,*** Steven Lewis and Denise Kouri point to the report of the Auditor General of British Columbia which warned against the tendency in power-driven systems to shift from having CEO's accountable to their boards, to having CEO's accountable to public servants. (see illustration of dual accountabilities in the chart above)

Boards need to ensure that there are systems, structures and processes in place that will facilitate *the right balance of empowerment and accountability* throughout their organization.

Through on-going monitoring and evaluation processes, boards should explore the meaning of the results of annual staff and physician culture surveys that demonstrate their organization's levels of job satisfaction and their internal capacity to transform.

Boards also need to begin asking probing questions about alignment opportunities and HR issues to address the fact that the healthcare sector has become "the most toxic work environment in Canada."

In the current system, there are people and processes that facilitate a powerful voice for CEOs, physicians, public servants, politicians and unions.

But who speaks for the healthcare consumer? Who speaks for the owners? How is your board doing at this function? How good have you been at "representing the public interest"?

If you think you can improve, how will your board adjust your existing governance systems, structures and processes to reflect these essential requirements in the emerging system?

3. MEASURE QUALITY & EFFECTIVENESS

The "owners" of Ontario's healthcare system are deeply concerned about quality and effectiveness of care. Indeed, the public is increasingly alarmed at the existing data on quality, effectiveness and preventable deaths.

While government officials dwell much more on the need for tighter financial controls, the owners are becoming increasingly alarmed about patient safety issues.

Best practice governing boards need to engage in on-going dialogues with their CEO/Chief-of-Staff/Senior Team/ MAC on the quality outcomes/results being achieved on behalf of their "owners" and their "customers".

Boards need to hold their CEO and Chief-of-Staff accountable for agreed-upon outcomes on quality, effectiveness and customer satisfaction indicators.

Boards need to create a "safe environment" for the CEO and senior executives to be open to learning from others in the system. Boards should be constantly seeking and asking for the evidence upon which decisions are made – and about what others in the system have learned from their "best mistakes".

Today, Canadian hospitals have a preventable error rate that is double the rate in the United States. What is your organization's "fair share" of the 25,500 preventable hospital deaths in Canada each year? What are you doing to ensure quality and safety?

The owners really want boards to pay much closer attention to these types of quality and safety issues in the future.

4. ENSURE FINANCIAL VIABILITY

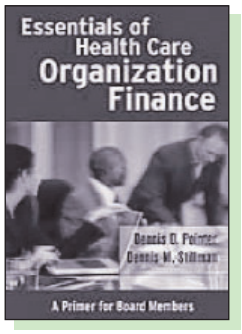
While fully acknowledging the importance of a balanced budget, boards should be deeply skeptical of *Performance Agreement* designs that are mostly about financial controls and micro-management. This is the "worst practice" habit from the reengineering and restructuring era that we now know led to significant increases in morbidity and mortality in the U.S. hospital sector in the late 80's and early 90's.

That's why the Balanced Scorecard was invented – to balance the bottom-line financials with the other essential perspectives for strategy implementation.

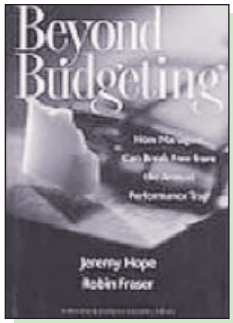
Boards can oversee the financial activities of their organization through the *Balanced Scorecard Monitoring Process* – so they can ensure that there is a leveraged use of resources, and a strategic budgeting process that is focused on achieving results.

Boards need to probe to see that budgeting within the organization is strategically focused on achieving the outcomes/results that have been set by the board in partnership with management. Does your current budget reflect your organization's mission and your board-approved strategy or *Ends Policies?*

Within local delivery systems, boards may require their CEO's to ensure that *supply chain management* methods are utilized within the network to ensure a leveraged use of public resources across the continuum of care.



However, boards that "sign-off" on their *Performance Agreement* with the MOHLTC will want to be certain that the organization has sufficient resources to achieve all the outcomes that are being required by their Performance Agreement.



Boards would be well advised to work closely with their CEO on these Agreements – because they are the ones who will be held accountable to the board for keeping the board's agreement – with the government, or in the future, with the LHIN.

Boards should note how the current design of the *Performance Agreement* is in fact a "fixed performance contract". Board members and senior managers should take the time to learn about such structures.

In their ground-breaking new book ***"Beyond Bugeting"***, Jeremy Hope and Robin Fraser say that "fixed performance contracts cause managers to behave in dysfunctional ways at every stage in the budgeting process – particularly if they cannot meet these contracts. At best this results in managing the numbers. At worst, it results in outright misrepresentation and fraud."

"Fixed performance contracts cause managers to behave in dysfunctional ways. At best, this results in gaming the numbers. At worst, it results in outright misrepresentation and fraud."

How will your board help your staff through this potential quagmire – if your existing Agreement with the government has inadvertently been designed to promote gaming and fraud?

5. ENSURE GOVERNANCE EFFECTIVENESS

Ontario has always been blessed with wonderful, high-caliber, competent board members.

But it doesn't matter how competent board members are individually, if the macro governance processes are designed (however inadvertently) to be dysfunctional and dyslectic, then that will be the board's contribution to their organization – more confusion and ambiguity.

Best practice governance renewal processes enable a board to design their own governance systems, structures and processes – as well as their own measurement system for governance effectiveness.

While there are a variety of methodologies for measuring board effectiveness today, an emerging best practice approach is the *Balanced Governance Scorecard* – in which the top two quadrants for customers and finance are the same as their Organizational Scorecard.

Boards then determine the internal support processes that they need, and, the learning & growth that will be required for them to be effective at governance.

Boards need to invest time and effort in making the adjustments required by the new *Performance Agreement* system, and by the introduction of *Local Health Integration Networks.*

The fact is that the status quo will not exist in three years from now. The system will change. The question is: to what extent have we created a "safe environment" in which local health-care delivery partners will work collaboratively together on behalf of the customers/patients/community/taxpayers/owners?

Robert Fritz, author of ***The Path of Least Resistance*** says that as complex adaptive systems undergo multiple change dynamics, the tension in the system will either be rooted in *creativity* and *innovation*, or, it will be rooted in *fear* and *anxiety.*

Where is the creative tension in your organization and within your local delivery system today? Are you currently experiencing *creativity* and *innovation*, or *fear* and *anxiety*? (You can see which result you will produce in your community in the box on creative tension on the next page)

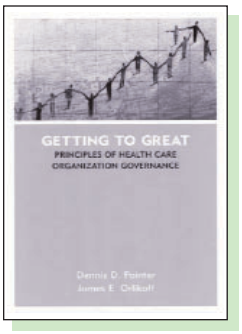
In this highly turbulent, fast-changing and often threatening environment, board members need to model how to determine and implement change – including introducing their own effectiveness measurement system.

Balanced Governance Scorecarding is a methodology that enables boards to evaluate their own effectiveness on the basis of the results being achieved.

In the past, healthcare governing boards have not shared a *common language* or *common framework* for governing. Boards of hospitals, CCACs, public health units, community health centres, etc. have tended to "talk past each other".

This lack of connectedness at the top has been replicated throughout the delivery system where consumers get caught daily in the service gaps that exist throughout the system.

To achieve alignment within a *Local Health Integration Network,* independent community boards will need a *common language/common framework* to achieve system alignment, and to facilitate genuine interdependence.



Systems can be independent and interdependent at the same time – if they use the same strategy implementation process.

Health Minister Smitherman said last February that ***"our vision is of a system where all providers speak to one another in the same language."*** A *Balanced Governance Scorecard* provides such a common language and framework for building new synergistic relationships between the partners at the community level.

It is a tool for silo partners to develop an implementation strategy for integrating the system across the entire continuum of care.

CREATIVE TENSION: WHERE IS YOUR COMMUNITY TODAY?

TENSION	BEHAVIOUR	RESULTS
• FEAR • ANXIETY	• BLAMING • SELF-INTEREST • POLITICAL • QUICK FIX	• BURNOUT • STAGNATION • DOWNGRADING
• INNOVATION • CREATIVITY	• COOPERATION • TEAMWORK • PRODUCTIVITY/QUALITY • TRANSFORMATION	• ACHIEVE GOALS • SUCCESS • REWARDS

From Silos to Systems

The Ontario government's *"Made-in-Ontario Solution"* to health system integration is a design which leaves local governance and management in place in each network.

The McGuinty Government has officially rejected the "regional "authority" model that would create a control structure for the delivery system at the operational level.

Rather than the usual dynamics of resistance to an imposed authority, members of LHINs must therefore come together to design the delivery system collaboratively. Is that possible in your community?

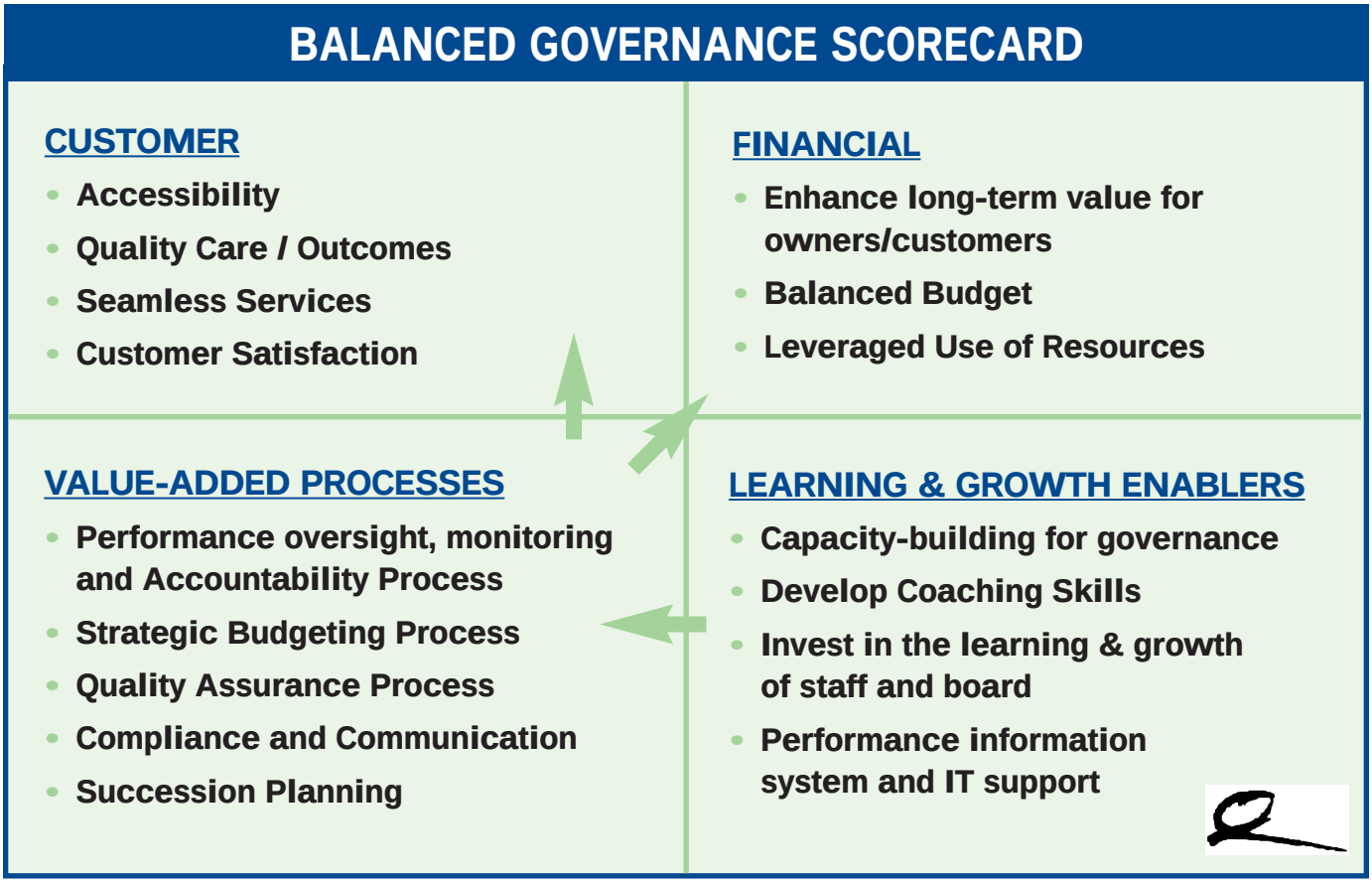
"How can you get the independent organizations in your local service delivery network to discover that they can also be interdependent at the customer level?"

Contemporary organizational science encourages us to understand the dynamics of healthcare systems through the lens of complex adaptive systems theory – and to reject the mental blinders that encourage us to respond with the usual s*tructural quick-fixes-that-fail.* (The pattern is so common in the healthcare system that it has become an archetype in the field of systems dynamics.)

Rather than a vehicle to mobilize local partners to implement common strategies for integration, LHINs may well be designed to be controlled from Queen's Park – at both the bureaucratic and political levels.

That's the BC model.

However, centralized political bureaucracies usually only want the "optical illusion of control", rather than real control and real accountability for the results that are produced.



Historically, Queen's Parks' habit has been to design systems, structures and processes for blaming, rather than for real accountability. There are no *mutual accountabilities* for achieving the outcomes that MOHLTC says they want achieved.

What is the Ministry accountable for achieving? What are the mutual accountabilities that would ensure that the system achieves the outcomes set for 2007?

The problem is that such unbalanced and unreasonable system designs don't work. They always set off waves of defensive routines and power dynamics that waste time, energy and the creative capacity of the system's leadership.

However, the countervailing force in a system is at the centre. Centralized bureaucracies like the MOHLTC seek control, in part, because over the years, the community partners have proven to be incapable of self-organizing in the public interest. Indeed, they are still being rewarded by the existing system for staying in their silos within the system.

So, while the rhetoric about integration increases, the rewards and incentives are still vested in maintaining the silos – and their links back to the various fragmented MOHLTC departments and to the silo interest groups like the OHA/OMA, etc.

Indeed, centralized bureaucracies are severely threatened by local integration initiatives. They push for "co-operative partnerships" with Queen's Park to "run the system" and "call the shots" -- even while decentralizing through the new local network structure.

To navigate a complex oscillating system, you need to be able to recognize and do something about the countervailing forces at play.

Do a reality check: are the healthcare organizations in your community stuck in the silos that Queen's Park continues to reinforce – while calling for integration? What is the true history of co-operation, collaboration and partnership in your community? Has your community learned any lessons from past failed attempts at system reform?

How can you get the independent organizations in your local service delivery network to discover that they can also be interdependent at the customer level? How do you get people to give up personal power agendas and focus instead on the strategies required to achieve your community's vision?

THE TRAGEDY OF THE COMMONS

This *Systems Thinking Archetype* illustrates one of the common mistakes in designing complex systems: combining perverse incentives for individuals or silos in systems where – ultimately – survival requires cooperation and coordination of effort and resources.

Named after an essay by ecologist Garrett Hardin (1968), the tragedy occurs over the use of a "common pasture" where the villagers of a community graze their livestock and where the incentive structure is designed to reward everyone for increasing the size of their livestock herds.

In time, the common pasture is bare dirt, all the livestock die, and the villagers starve. What is missing from the commons system are appropriate incentives, governance and decision-making processes that ensure that the size of the herds grow to the level where it matches the growth rate of the grass.

As an illustration for the healthcare sector, Hardin's story reveals why it is essential that individual silos see the larger picture and develop incentives and decision-making processes that will enable a community to collaborate and coordinate in their individual and collective self-interests.

What the balanced scorecard framework offers is a tool and strategy implementation process that can be used to organize complexity at the organizational, governance and system levels.

At the system level, healthcare organizations have often been trapped in senseless silo competitions between hospitals, and, between hospitals and community agencies within a community.

Historically, the component parts of local delivery systems have been designed and controlled by centralized silos within the Ministry of Health. As a result, the component parts of the delivery system are usually engaged in a set of relational dynamics that systems thinkers call a *"system archetype"* – a repeating pattern of behaviours/thinking that always ends in failure.

The archetype in this case is called ***"The Tragedy of the Commons"*** where, the end result is: everybody loses!

Health Minister Smitherman's articulation of his government's vision for the Ontario healthcare system includes: ***"Our vision is to build a true system: one that's integrated and driven by one common cause – to deliver the highest quality outcomes for people."***

Below is a template or framework for dialogue for an *Integrated Health System Balanced Scorecard* that is designed to achieve the high level vision put forth by the Minister –as well as allowing for the more specific visions developed within each community network.

While this approach empowers communities to design their local healthcare delivery system, we do not yet know if the MOHLTC will retain their fragmented silos at the Ministry. If they do, then the mixed design of "centralized control" and "community empowerment" would clearly work against one another.

The community dialogue template outlined below starts with the key questions: what outcomes or results do we want for our community and our customers; and, what outcomes must we achieve in the financial quadrant?

HEALTH SYSTEM BSC – CONTINUUM OF SERVICES

CUSTOMER OUTCOMES

- **The people we serve receive high quality, appropriate, timely services which are necessary for them to achieve their health outcomes;**
- **Consumers experience a "seamless system" of services.**

FINANCIAL OUTCOMES

- **We are eliminating the costs associated with inappropriate and unnecessary interventions, gaps and redundancies.**

VALUE-CREATING PROCESSES

- **Quality-of-care is our core process;**
- **Our system's continuum of service transcends all providers;**
- **Services are continually evaluated for impact on health outcomes.**

LEARNING & GROWTH ENABLERS

- **We use an easy to update, confidential consumer information system;**
- **We use an up-to-date, comprehensive knowledge base of evidence on health outcomes;**
- **We have a common language/common framework for implementing strategy.**

Then, to achieve these financial and customer outcomes, what are the value-creating processes that you would require to achieve your customer and financial outcomes?

And finally, the key question about what you need to do in order to succeed: what skills, competencies, information and learning and growth enablers do you need to change your processes so that they achieve your financial and customer outcomes?

This is the best practice learning process that needs to take place at the (a) work unit (microsystem); (b) organizational; and, (c) delivery system levels. It is essential that board members and senior managers within the component parts of the delivery system are part of such a learning process.

As you begin the integration dialogue with your local system partners, you need to think about how you are going to improve your governance and managerial processes – so that they are aligned with the results being sought at both the provincial and local levels.

While the *Pointer-Orlikoff Model* provides a best practice healthcare governance model, and while the *Balanced Scorecard* provides a best practice framework for strategy implementation, these models must be adjusted to the emerging realities of each community's unique circumstances.

These are not easy, simple tasks. Sholom Glouberman and Brenda Zimmerman say they are not simply "complicated" issues requiring complicated solutions, but rather, they are "complex" issues requiring complex responses. ***(Romanow Commission, Discussion Paper No. 8)***

Board members need to understand that healthcare delivery systems – particularly the hospital components – are the most complex of organizational systems ever designed by humans.

However, often lost in all this complexity is the most important – and yet simplest – design principle that we have: **our mission,** or **our purpose** for existing.

So, what is your organization's purpose within a network of local healthcare services across the entire continuum of care? What are the key relationships across the system that provides your customers/patients with the most value?

Rather than design the delivery system with a provider-focus, governance boards and individual board members need to focus everyone on their purpose – starting with themselves.

"As LHINs are established, it is essential that board members from the partnering organizations genuinely reflect the broader public interest."

So, why are board members part of this process? What is their unique role in the creation of LHINs?

You need to remember: **governance boards exist to represent the "owners" – the citizens of your community; the customers/patients that you serve; and, the taxpayers of Ontario/Canada.**

As the LHINs are established across Ontario, it is essential that board members from the partnering organizations genuinely reflect the broader public interest – rather than the interests of their silos.

With their roots in a public interest perspective, and a knowledge of best practice design principles, LHINs can be designed provincially and locally to achieve the outcomes that they are intended to achieve – that is, enhanced integration of services at the customer level through the willing and enthusiastic co-operation and collaboration of local delivery system partners.

Boards that take their mandate seriously, and are prepared to play full tilt at creating the future that their

"owners" want, will want to think about how they will change – and what they will change in the modern integrated delivery system that you are about to build in partnership with your other network members.

What we know is this: there are no "one-size-fits-all" solutions to plug into your board; into your organization; or, into your local health services delivery system.

What the frameworks of the *Pointer/Orlikoff* and the *Balanced Scorecard Models* provide are some best practice lenses and perspectives for thinking through what you need to do in your unique circumstances. This is how you can achieve "customization" within best practice "standardized frameworks".

So, how will this process unfold over the next few years?

Historically, health reform has been provider-centred and highly political – not because healthcare providers are inclined to be self-centred and manipulative, but because the change processes are actually designed to encourage everyone to behave that way.

However, if reform is to be successful this time, it must be designed to achieve the right outcomes.

Edward Deming, the father of Total Quality Management said that 93% of the problems in human organizations are caused by the design of the systems, structures and processes, and only 7% of the time is the problem people-centred.

The repeating pattern of failed healthcare reform in Ontario is that we always fail to deal with the key system and organizational design issues – and instead we blame people: the doctors, the boards, the CEOs, the restructuring commission, the unions, the public servants, the politicians, etc.

Instead of redesigning the system, we do structural quick-fixes like hospital mergers and other restructuring commission decisions that were unleveraged and non-strategic.

To help you step out of the politics, the fear and the anxiety of system change, and to let you focus on some of these key system design issues – the best practice relationships, structures, and processes – we have designed the attached ***Governance & Managerial Transformation Readiness Survey.***

The survey has been designed to provoke your thinking about your current circumstances through some best practices lenses – just as you will begin to collaborate with your *Local Health Integration Network* partners.

We recommend that the survey be used as a dialogue tool between Board Chairs and CEOs over a 90 min. dialogue and exploration of the issues.

IS YOUR ORGANIZATION READY?

GOVERNANCE & MANAGERIAL TRANSFORMATION READINESS SURVEY

Fill out the attached survey to discover:

- **How fit is your organization?**
- **Is your Board and management ready for transformation?**
- **Are your strategies, structures, skills and people aligned with a shared vision and a strategy?**
- **How can your organization move towards integration within your network?**

BOARD'S ROLE	CEO'S ROLE
VISION	**SHARED VISION**
• Continuously review, explore and refine the organization's vision to fulfill your mission • Require highly participative processes for shared vision, strategy development and feedback	• Ensure teams and staff throughout the organization have ownership of the evolving vision and strategy • Lead and manage transformation process
APPROVE STRATEGIC DIRECTIONS	**DEFINE & COMMUNICATE STRATEGY**
• Long-term as well as short and medium-term strategy and targets • Partnerships and system integration • Ensure strategy will fulfill mission	• Identify financial and non-financial drivers • Capacity-building for BSC input through cascading process • Partnership and system integration
OVERSEE FINANCIAL ACTIVITIES	**MANAGE FINANCIAL RESOURCES**
• Performance review/monitoring process • Fiscal policy/strategic budgeting • Ensure leveraged use of resources • Approve major capital expenditures	• Fiscal policy/strategic budgeting • Forecasting and strategic budgeting • Propose major capital expenditures • Balance the budget
COACH THE CEO/CHIEF-OF-STAFF & PARTNER WITH SENIOR MANAGEMENT	**ORGANIZATIONAL & PEOPLE ALIGNMENT**
• Decision support • Performance feedback/advice • Ask probing questions on behalf of the "owners" and "customers" • Function as coach, guide, mentor	• Workforce acquisition/retention and performance management • Alignment of processes, systems, structures, culture and skills to achieve the strategy • Coach direct reports/model learning • Provide the right balance of leadership/ management and empowerment/accountability
SELECT & MOTIVATE EXECUTIVES	**BUILD CAPACITY OF STAFF**
• Executive performance and compensation • Succession planning/executive development • Invest in learning & growth of board and staff	• Invest in learning & growth of staff • Model learning • Practice developmental facilitation and coaching
ENSURE COMPLIANCE	**MANAGE EXECUTION**
• Regulation requirements • Quality care and risk management • Stakeholder/funder communications • Hold CEO/Chief-of-Staff accountable for outcomes	• Performance measurement/reporting/ review • Partnership with Chief-of-Staff/senior team/Board • Determine leveraged actions to close the performance gap • Stewardship for success

AUTHOR'S TEAM

Dennis D. Pointer and Associates of Seattle, Washington and **Quantum Transformation Technologies** of Toronto, Ontario have formed an R&D partnership on best practices for governance and management. The R&D/author's team is composed of:

TED BALL is a partner in *Quantum Transformation Technologies.* He has spent the past 10 years learning about organization transformation and whole system redesign in the health, education and high technology sectors. Ted's focus has been on the integration of systems thinking-based tools for strategy development, strategic alignment and strategy execution.

Ted is a leading expert in accountability systems design, cultural transformation, transformational leadership development, and coaching.

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DENNIS D. POINTER is considered to be the world's leading expert in healthcare governance.

Dr. Pointer is the author of ten books including *Board Work* and *Really Governing*, both James A. Hamilton Book of the Year awards.

Quantum Learning Systems and Dennis D. Pointer and Associates have been actively collaborating for the past few years on best practices in health system transformation and integration.

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LIZ VERLAAN-COLE is a partner with *Quantum Learning Systems.* Liz uses the depth of her experience in transformational change to work in partnership with CEOs and Directors to implement strategy using the Balanced Scorecard.

Liz is one of the pioneers of the *Capacity-Building Approach for Transformational Change © Quantum Learning Systems.* Their approach: The best solutions come not from outside experts or internal survivors, but from those who are dedicated to creating sustainable benefit for customers.

Liz holds a BSc and an MBA, both from the University of Western Ontario. She has written extensively on integrated health systems and transformational change in the public sector.