Systemic Dialogue Tool

Essential Perspectives For Health System Transformation

Customer, Patient, Citizen Perspective /Financial Resources/Structure & Value-Creating/ Skills & Capacity Enablers, and, Cultural Perspectives

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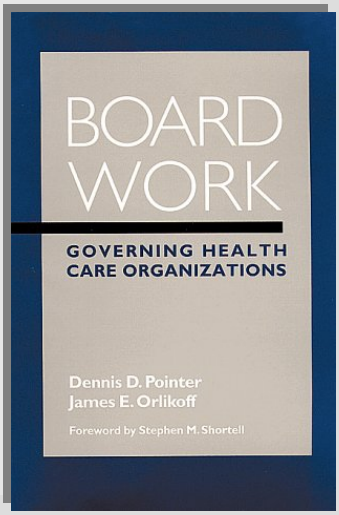
"One of Quantum's great strengths is that they get people to see the 'whole system' and the 'big picture' so we can better integrate the component parts of governance, management, and our service delivery systems. They have raised the bar on both the science and art of systems thinking."



-Dennis D. Pointer
Co-author of *Board Work*

Customer/Patient/Citizen Perspective

Current Reality	Emerging Vision
· Provider-Driven Services/Designs.	· Customer-Driven Services/Patient Experience Design Processes.
· Paternalistic & bureaucratic services – where patients are surveyed and focused-grouped – "as appropriate" –	· Partnerships with empowered patients/clients/customers.
· Fragmented services offered across a series of unconnected silos.	· A "seamless" *customer experience* across the continuum-of-services.
• Patients struggle to get access to their medical data.	• Empower patients have full access to their medical/health information.
• Patients & families confused and uncertain about whom to call about what, and how to move from provider to provider.	• Patient/system navigation services available to patients and families.
• Healthcare trapped in industrial-age thinking & lack of alignment with communications in a modern society.	• The virtualization of patient-provider and provider-provider interaction allows health professionals to use the telephone and email for patient interaction.
· Focus on silo-providers fosters and supports silo-thinking/behavior/ relationships. Patients/clients get caught in the gaps.	· Focus on the 'continuum-of-services' – from a <u>customer</u> perspective – that fosters and supports integrated thinking/ behavior/relationships.
· Focus on episodic acute care/ rescue medicine/treatment and recovery.	· Focus on health outcomes of the population served – while providing episodic acute care, etc.
• Other than some strides on Family-Health Teams (FHTs) and minor growth of Community Health Centres (CHCs), not much activity to improve primary care.	• Well-developed primary care system – with more effective health promotion & prevention, as well as enhanced self-management of chronic diseases.
· Gaps in services.	· Eliminate gaps.
· Inconsistent quality/standards.	· Consistent quality/standards.
· 25,500 hospital patients die from preventable accidents.	· Ultra-safe system designs. • Design systems for "perfect" care.
• 1 in 13 patients harmed.	• Theoretical limits.
· 2 to 3-Sigma quality ranking.	· 6-9 Sigma quality ranking.
• Acute care focus.	• Homecare/LTC/Prevention.
· Waiting lists. Services not universally accessible.	· Reasonable access/universally.
· 35% increased funding over the past five years – without any real improvements.	· Provide quality, accessibility and patient satisfaction improvements – while

	holding overall increased costs down to 3%, next year, and perhaps even less in 2013-2015.
· **Declining levels of patient satisfaction.**	· **Increasing customer and family satisfaction levels.**
· **Government consults with provider groups, not patients.**	· **Government includes patients in policy consultation processes.**
• **Introduce *Excellent Care for All Act*.**	• **Implement the Act -- and MOHLTC's strategy for patient-driven care.**
· **Declining public confidence.**	· **Public confidence restored.**

Financial Resources Perspective

Current Reality	Emerging Vision
• **5% to 7% annual growth**	• **3% annual growth (health & education)**
• **Perverse economic incentives.**	• **Economic incentives are strategically aligned to the vision.**
• **Current funding practices (global budgets & fee-for-service) has allowed the benefits of productivity gains to accrue to providers vs. "savings" for taxpayers.**	• **Align economic incentives to drive the desired strategic changes. If we want high patient satisfaction rates, we would reward them.**
• **Invest in acute care hospitals & doctors for care & treatment.**	• **Invest in home care/long term care/chronic care/partnerships with patients.**
• **Central authority funds silos through LHINs.** • **Promised "devolution" does not happen.**	• **Fund local systems (devolved "next generation" of LHINs/Regional Authorities)**
• **The majority of resources are allocated by Queen's Park – based on history, crisis, politics and "perceived" power of stakeholders.**	• **Resources are allocated by the Local Networks --based on continuous capacity planning for needs and standards for quality, patient/client satisfaction – as well as staff and physician satisfaction rates.**
• **LHINs have not developed the internal capacity to allocate resources based on evidence. They currently only allocate about 5% of total resources, the rest is still driven by Queen's Park.**	• **LHINs or regional authorities develop the capacity to allocate resources – in ways that create the outcomes required.**
• **Goal is to maximize resources for your silo.**	• **Goal is to allocate resources appropriately in the system to meet the community's needs.**

• **Budget process bureaucratic at the local system & organizational levels.**	• **Strategic budgeting. Resources flow to achieve the results required.**
• **Politics/power drives resources.**	• **Evidence-based decision-making and strategy drives resources.**
• **Waiting list = asset.**	• **Waiting list = liability.**
• **Risk Avoidance.** • **Threatening/blame environment.** • **Innovation is risky.** • **Cover your ass.**	• **Risk-based approach to decision-making and resource deployment that fosters innovation.** • **Unleash capacity for innovation.**
• **Unleveraged use of resources.**	• **Leveraged use of resources.**
• **30% of work is re-worked to serve bureaucratic interests. Significant waste everywhere.**	• **Redesigned work processes – from customer perspective – saves up to 30%, while improving quality by up to 50%.**
• **"*Gaming the numbers*" requires time and effort. These are not the managerial skills we need to 'fix the system'.**	• **Cut time invested on budget process by 50% -- while achieving bottom-line results in a *Balanced Scorecard*.**
• **RFP processes create "illusion" of an honest, open & fair process. Inflexible rules-based thinking drives out problem-solving, innovation and partnership.**	• **Partnership with suppliers/focus on outcomes and mutual accountabilities.** • **Collaboration with suppliers yields better results.**
• **Fewer and fewer number of consulting suppliers available.**	• **Boutique/market niche suppliers available.**
• **60% of organizations don't link budgets to their strategy.**	• **Strategic budgeting drives results.**
• **Rules & regulations drive the system towards dysfunctional chaos.**	• **Designing processes to achieve strategic outcomes drives the system.**
• **No collaboration on "back office" costs across the system.**	• **Collaboration on *supply-chain management* generates major savings.**
• **Lack of transparency.**	• **Complete transparency.**
• **Annual deficits.**	• **Balanced budgets.**
• **Resources are locked in silos -- with lots of examples of how perverse incentives produce sub-optimal results.**	• **Resources flow through the delivery system like blood through our bodies (i.e. flow to areas in need).**

Structural/Value-Creating Perspective

Current Reality	Emerging Vision
• **Hospitals are the hub of the system.**	• **Primary Care is the hub of the system.**

• **Little focus on the "determinants of health" or health promotion strategies.**	• **Health promotion/illness prevention/determinants of health are part of the Provincial Health Strategy.**
• **System is specialist-driven.**	• **Primary care is the "golden thread" driving the system.**
• **The systems, structures and processes have evolved overtime and have been cobbled together with unaligned assumptions in each silo.**	• **Systems, structures and processes are aligned and intentionally designed to achieve the outcomes required.**
• **Lack of alignment and long-standing perverse incentives produce chaos in the system.**	• **Organizational alignment produces synergy within organizations and across the delivery system.**
• **System is fragmented. Patient fends for her or himself, moving from silo to silo.**	• **System is seamless. Coordinates needs of complex patients, using *Case Managers* for those that are especially difficult.**
• **Sickness-focused. Episodic/Individual.**	• **Health status & outcomes-focused. Systemic/ Population-based.**
• **Tight centralized control and influence over the delivery system by unaccountable public servants @ Queens Park/LHINs.**	• **Assumption that people are competent -- when accountabilities are clear, and the supports required are in place.**
• **Assumption that performance problems result from lazy, unmotivated and uncaring people that need to be carefully monitored and controlled.**	• **Knowledge that poorly designed systems, structures and processes leave people feeling powerless and uncaring. 93% of the time, performance issues are *system design* issues.**
• **Designed to encourage political behaviour/power games.**	• **Designed to produce collaborative behaviour and teamwork.**
• **The system is designed to provide care and services to individuals (a diabetic, for example.)**	• **The system is designed to meet the needs of a defined population (diabetic, for example), while retaining responsiveness to individual needs.**
• **Governance represents the self-interests of the organization.**	• **Governance represents the "owners": the citizens/community.**
• **Systems, structures and processes are designed to control & regulate people.**	• **Structures systems and processes are designed to facilitate collaboration, co-ordination and teamwork.**
• **The Ministry of Health is really the "Sickness Ministry". It is in fact the Ministry of Doctors and Hospitals. (Too early to tell if the return of *Health Promotion & Illness Prevention Branch* actually changes thinking @ Queens Park.)**	• **The Ministry of Health is driven by a health strategy that includes population health & wellness. They enable the system to transform itself by designing the right incentives & supports. *Health Promotion & Illness Prevention* becomes a driving force in decision-making.**

• **Some LHIN's behave like system bosses in command & control of service providers.**	• **LHIN's behave much more like system facilitators and change agents, coaches, etc.**
• **Designed to meet needs of providers.**	• **Designed to meet needs of patients/clients – while creating better work environments/conditions for staff.**
• **Boards encouraged to micro-manage & check up on management. Many Boards are dysfunctional, few "add value".**	• **Boards are generative & focus on quality/safety & the patient/client experience. Boards "add value".**
• **Management stuck in an endless loop of strategy development as circumstances change.**	• **Focus on executing leveraged strategic change that is patient-centred. Learn and recalibrate strategy.**
• **Functional view. "*Push system*".**	• **Process view. "*Pull system*".**
• **Resources flow in silos, producing fragmentation/gaps in services/ lack of co-ordination.**	• **Resources flow to system, promoting system integration at the customer interface.**
• **Independent silos focused on provider interests/turf. While LHINs have caused a greater sense of "system", it is still fragmented.**	• **Interdependent services provided by independent organizations -- focused on the needs of the system's common customers and owners.**
• **Machine-like organizational design.**	• **Organic-like design.**
• **Designed to be complicated.**	• **Designed to be complex & adaptive.**
• **Gaps and redundancies.**	• **Continuum of Service.**
• **Fragmented information system.**	• **Integrated database/patient record.**
• **Command-and-control/ bureaucratic/rule-driven.**	• **Participative, self-organizing on measurable outcomes, "mission-driven" and "innovative" -- rather than the traditional focus on *bureaucratic control*.**
• **Bureaucratic processes for blaming.**	• **Mutual accountability processes.**
• **No processes for strategy execution. No measurable targets.**	• **Office of Strategy Execution & Strategic Learning/ Strategic Budgeting.**
• **Physicians are the supreme source of knowledge/dictator of therapy.**	• **Physicians participate in integrated services and act as "facilitator of choices".**
• **No accountability for outcomes.**	• ***Accountability Agreements.***
• **"*Accountability*" means blame. Blame causes cover-up. Constant cover-ups means we don't address design flaws in our systems, structures and processes.**	• **Systems, structures and processes are designed to provide the support people need to achieve the outcomes for which are accountable.**
• **LHIN/MOHLTC Accountability Agreements are about blame & control. There is no sense of "mutual accountability". There isn't a "fair & reasonable business bargain".**	• **Aligned incentives and supports create the conditions for success & celebration.** • **Accountability processes mobilize the support you need to be successful.**
• **Fragmented supply-chain management.**	• **Integrated supply-chain management.**
• **No economies of scale.**	• **Economics of scale.**

• **Missing essential integration with public health (SARS crisis) and primary care.**	• **Public health and primary care is integral part of the LHIN system of planning & integration.**
• **Lack of co-ordination with health-related social services.**	• **Integrate with health-related social services: *population health focus*.**
• **Economic incentives are not aligned to a strategy of patient-centred care.**	• **Aligned economic incentives with rewards for patient/client satisfaction.**
• **Complexity makes it easy to do things wrong, hard to do things right.**	• **Well designed workplace systems, structures and process make it easy to do things right and hard to do things wrong.**
• **The system is designed to be complicated.**	• **The systems complexities are reflected in complex adaptive system design.**
• ***The Excellent Care For All Act* provides leadership & direction on the patient/client experience.**	• **Patient-Centred Care Experience-Based Design And Partnerships With Patients transform the patient/client experience.**

Skills and Capacity Enablers

Current Reality	Emerging Vision
• **Focus on management skills for a hierarchical organization structure that is focused on rules.**	• **Focus on learning skills. Five disciplines of a learning organization – systems thinking, team learning, shared vision, mental models, and personal mastery.**
• **Skills for project management & risk management to avoid and stay out of trouble.**	• **Skills for designing and aligning complex/adaptive systems, structure and processes to achieve outcomes.**
• **Leadership vacuum for transformation at all levels. Leadership seems to be about "personal power", rather than about the ability to facilitate the collective intelligence of people – or serve others.**	• **A new generation of leaders focuses on *adaptive leadership* and on building the system's internal capacity for strategic change and innovation.**
• **Lack of capacity for organizational & system transformation.**	• **Build the system's capacity for strategic transformational leadership.**
• **No *common language/ frameworks* for managing change.**	• ***Common language/frameworks* for talking about, planning for and implementing change.**
• **Bureaucratic skills for managing processes in silos.**	• **Collaborative skills for achieving outcomes for patients/clients/customers.**
• **Strategic planning/strategy development.**	• **Skills for leveraged thinking/strategy execution/performance**

• **No strategy execution skills.**	**monitoring/achieving targets.**
• **Traditional linear strategic planning skills/mindset. (90% failure rate).**	• **Systems thinking skills/strategy implement skills and learning organization process/behaviors. (30% success rate).**
• **Hierarchical leadership rules -- with ridged "control" processes/tools/methods.**	• **Facilitative leadership, team learning, lean thinking, collective intelligence and problem-solving skills are required by everyone.**
• **Command & control staff/suppliers.**	• **Partnerships & collaboration everywhere.**
• **Lack of integrated knowledge base on evidence-based clinical/administrative processes and outcomes.**	• **Integrated knowledge base of evidence-based processes and outcomes.**
• **Mistakes are "undiscussables".**	• **Mistakes are a valuable source for learning. We learn from our "best mistakes".**
• **Blame & blame avoidance dynamics.**	• ***Mutual* accountabilities for outcomes.**
• **Significant deficits for integration competencies/ silo-focus rewards and incentives.**	• **Capacity-building for integration/system-focused rewards and incentives.**
• **Skills, structure and culture focus on "control" -- or at least for the "illusion of control".**	• **Stewardship/facilitation/ coaching -- skills for *adaptive leaders*. Focus on innovation & service to others.**
• **Focus is on "knowing" stuff.**	• **Focus on "learning" stuff.**
• **Analytical skills.**	• **Emotional intelligence & analytical.**
• **Traditional "Boss Skills".**	• **Learning Organization Skills.**
• **Managing silos in dyslexic systems.**	• **Designing integrated systems.**
• **Analysis**	• **Synthesis**
• **Control.**	• **Innovation.**

HealthCare Sector's Culture Perspectives

Current Reality	Emerging Vision
• **Thinking & behavior driven by *Fear & Anxiety*.**	• **Thinking & behavior driven *By Creativity & Innovation*.**
• **Blame & blame –avoidance dynamics are driven by a rules & regulations mindset – backed up by on army of process/regulations police.**	• **People collaborate and innovate by tapping into their collective intelligence to achieve better results.**

• **Assumption is people are incompetent and need to be "controlled".**	• **Assumption of Competence.**
• **Command & Control/Fear/Rules**	• **Participative/Facilitative/Innovative**
• **Short-Term/Fire-Fighting**	• **Long-Term/Consistent/Sustainable**
• **Personal power/authority/politics**	• **Stewardship. *"In service to…",* rather than *"in control of".***
• **Boss Mindset/Behaviors**	• **Coach Mindset/Behaviors**
• **Entitlement Culture**	• **Accountability Culture**
• **Silo thinking and behaviour**	• **Systems thinking and behaviour**
• **Little sense of accountability for the results produced.**	• **Culture of accountability and personal responsibility focused on results.**
• **Blame and blame avoidance dynamics drives thinking & behavior.**	• **Accountability for outcomes – with best practice *Accountability Agreements.***
• **Fear**	• **Passion/Creativity**
• **Anxiety**	• **Confidence/Innovation**
• **Cynicism**	• **Commitment**
• **Unsafe/Lack of Trust**	• **Trust/Supportive/Safe**
• **Disrespectful**	• **Respectful/Emotional Intelligence**
• **Scarcity Mindset**	• **Abundance Mindset**
• **Sense of Chaos**	• **Sense of Purpose**
• **Low staff/physician morale**	• **High staff/physician morale**
• **Toxic work environment.**	• **Model of a "healthy workplace".**
• **Political dynamics with focus on power/tuff/control/money. 'No vision'.**	• **Align on a *shared vision* of local systems -- within a provincial system.**
• **Provider-focused and provider-driven -- with a paternalistic attitude towards patients/clients.**	• **Patient & family-focused and driven by a "partnership attitude" with patients and their families.**
• **Pride in what we know. Don't look at old issues from new angles -- or with "new lenses".**	• **Curiosity about what we know we don't know -- and about the stuff we "didn't even know, we didn't even know."**
• **Culture of blame starts with the CEOs -- who the government publically criticizes. The three political parties are agreed: "CEOs are bad." CEOs are therefore defensive, and provided with sub-optimal conditions for leadership.**	• **Culture of innovation & collaboration liberates CEOs (aligned on a *shared vision*) to transform the system and their organization. CEOs LHIN managers and public servants at Queen's Park engage in partnership behaviors to build a coherent system of care.**
• **Focus on optics/politics/strategic communications to survive and thrive.**	• **Focus on quality/patient satisfaction/engaging staff & physicians on decision-making to thrive.**

Adaptive Leadership

"Artfully guide people through a balance of disorientation and new learning. Leaders need to hold the group in an optimal state of tension and disequilibrium that stimulates a quest for learning -- without jarring people so much that they simply aren't able to learn."

- Ron Heifetz
The Work of Leadership

MISSION

"TO LIBERATE AND COACH HEALTHCARE KNOWLEDGE WORKERS TO CREATE WONDERFUL CLIENT/PATIENT EXPERIENCES WITH LEADING-EDGE STRATEGIES AND TOOLS."

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