How Will Governance Transform In Our Evolving Healthcare Services Delivery System?

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In 2010 I suggested that our health system would begin to implode in the Spring of 2012 -- and complete it's implosion over the budgets of 2013-2015 (when the federal government cuts the annual growth in transfer payments for healthcare by 50%).

Unfortunately, most healthcare executives don't tend to plan ahead in three, five and ten year cycles. They have also heard about the "healthcare crisis" for their entire careers. So experience has taught them to only think ahead about one year. Nevertheless, what is the bottom-line meaning of the Provincial Budget of 2012 and the realities of 2013-2015?

Using the provincial auditor's figures as a basis, hospitals may have to carve as much as a billion dollars out of their funded programs over the next three years. OHIP may have to carve out another $1.5 billion -- $338 million comes out this year, the rest will follow.

However, that $2.5 billion is just "the start" of what is expected to be several years of "paradigm shifting" provincial budgets for our healthcare system.

The Minister of Health says she wants to shift funding to those services/organizations that are providing value-for-money. So while some organizations may lose 3% to 5% of their budget each year for the next three years, those organizations that have proven to be cost-effective (i.e. Community Health Centres, community-based mental health programs, health promotion programs, etc) can expect up to 12% growth in their budgets over the next three years.

Simply put: community-based chronic care/home care/preventive care will grow – while teaching hospitals and community hospitals will shrink.

As the full impact of this year's provincial budget begins to hit our healthcare delivery system, and as healthcare leaders across Ontario wake-up to the realization that provincial budgets over the next three years will result in even deeper cuts, the painful paradigm shift is beginning to awaken more and more health system leaders to the idea that "things really do have to change" -- at the governance, management and operational levels.

Everything about our healthcare services delivery system – how it is funded; how accountability will be practiced; how resources will be allocated; how performance will be measured and monitored for both managerial and governance purposes; how strategic priorities shift to quality, safety and the patient/client experience – are each at different stages of evolution as our healthcare delivery system begins to adjust to the new economic realities of 2012-2015.

Whether you are shrinking, growing, merging or re-aligning, the scale of change will be very significant over the next three or four years.

Change, of course, often causes misalignment between the incentives posed by the environment and each organization's defining characteristics. In periods of evolutionally change, this misalignment is relatively minor. It emerges gradually. Organizations simply need only make incremental adjustments.

However, when the internal and external environments undergo revolutionary change on the scale required by Ontario's current economic circumstances, "business as usual" is simply no longer possible. Organizations – and those who work within them – must undertake a major transformational change if they are to survive and thrive in such radically altered environments.

What will change? The Minister's ***Action Plan*** proposes a new integrated health model – with primary care as the hub, and access to care shifted from emergency rooms to community care.

After extensive and on-going dialogues with dozens of experienced and insightful leaders across Ontario, I would estimate that at least 30% of organizations within our healthcare delivery system today are actually "on board" with the healthcare reform program. They are ready and eager to go. These organizations and their leaders are fully engaged in their own organization's journey of continuous improvement and learning. These are the "*early adopters*" and the "*innovators*".

By comparing experiences with numerous health system experts, I would suggest that perhaps another 30% of our Health Service Provider (HSP) organizations are "on the fence" – with a "wait-and-see" attitude – while another 30% fully intend to resist change by digging in, keeping their head down and faking "compliance" in the hope that nobody important notices them. The final 10% just don't get any of it.

Change management scholars call this the "*30/30/30/10 Rule*" for complex adaptive systems. "**On Board**", "**On the Fence**", "**Opposed**" and "**Out-of-It**"

While most of the province would have very similar results, I just came back from the annual *Care Connections Conference* sponsored by the *North Simcoe Muskoka LHIN* -- where over 300 stakeholders gathered for the day to plot out their "next steps" in their extensive journey (involving hundreds of stakeholders and patients) as they collaboratively design North Simcoe Muskoka's future healthcare delivery system.

The common wisdom among change management scholars is: "innovation takes place at the edges of systems". So I went up last month to visit "at the edge" -- in the town of Orillia, on the shores of Lake Simcoe -- where the architects of the NSM LHINs future healthcare system gathered for a full day of learning and dialogue about the system they want to create together to meet the needs of their committees.

The conference was anchored emotionally and intellectually by the opening panel of "lived experience" in our healthcare services delivery system: a series powerful and compelling voices for patient/client-centred care that reminded everyone why the system exists, and how much it needs to improve.

At this multi-workshop conference, I popped into the *Governance Dialogue Workshop* (which was attended by about 100 staff and board members over two sessions). The purpose of this workshop was to get participants to really think about how Boards of Governance could shift their traditional ways of doing things – when they are focused on "the patient experience", rather than on the interests of the organization; and when they are focused on the public interest -- and the "whole system" perspective -- rather than simply the narrow self-interests of their organization.

NSM LHIN Board Chair **Bob Morton** explained to the workshop participants, "while we are focused on following best practices from the 'lessons learned' about system governance, we seem to be breaking new ground here." "But that's okay," said Mr. Morton, "we can make it up, and adjust it as we go along."

This is the type of wisdom, confidence and determination that has guided this LHIN from the beginning of their transformation journey. Rather than assume that the LHIN had any of the answers, NSM LHIN CEO **Bernie Blais** and his team have spent the last four years facilitating over 700 people in health system design exercises called the "*Care Connections Project*" – in order to create the future that they want for their communities.

After dozens of conversations with diverse stakeholders at this conference, I can tell you this: they <u>trust</u> one another, and they trust the LHIN-led system design process.

My guess on stakeholders in the NSM LHIN is: 75% "On Board"; 10% "On the Fence;" 10% "Opposed"; and 5% "Out-of-It". That is a remarkable degree of alignment within a LHIN!

Director of Health System Transformation, **Susan Plewes** says: "We think our health system design process is working well because it truly is a collaborative effort based on our collective intelligence. So the ownership of our future local service delivery system is extensive. Patients, managers, boards and healthcare providers are all determined to build a better system for the people we serve."

Stakeholders across North Simcoe Muskoka are engaging in a fundamental examination of their communities' healthcare needs (and the services that they receive) -- and are focusing on how to improve services to people. Maybe it's the water in Lake Simcoe that has caused everyone to pull together to advance the common interests of the "whole group", but I think it may actually be caused by good leadership at both the governance and managerial levels – as well as by a true sense of *stewardship* on the part of the LHIN board and staff -- and on the part of the various stakeholders who have played such a valuable part in designing the future system.

From the very beginning of this process eight years ago, the folks in the *North Simcoe Muskoka Network* determined that rather than fight for their silo/their town, they would collaborate for a "common cause". The LHIN Health Service Providers engaged in a wide variety of problem-solving exercises -- where participants have been able to come together to talk, explore and surface the most basic *assumptions* -- examining them openly in the true spirit of continuous improvement and with a focus on the best interests of patients/citizens/owners. This requires a "safe environment", and the spirit of a *Learning Organization/Learning Community*.

That spirit seems to have invaded the hearts and minds of boards and senior staff of Health Service Providers within the NSM LHIN's boundaries. Just as fear is contagious, so apparently is optimism. In North Simcoe Muskoka they are collectively and individually surfacing and testing the basic assumptions about why they exist, and about their silo and system governance roles. People don't feel threatened. They feel like true partners who are prepared to explore the best options for change.

Major *assumptions* about governance that need to be surfaced and tested as the system transforms are:

- What is the Board's role in a redesigned healthcare services delivery system?
- Who does the Board "represent"?
- What is the silo board's "system role"?
- Who are the "stakeholders" that the Board needs to consider?
- What are the Board's key *strategic imperatives* – the outcomes their Board, and their organization, and the local system must achieve?
- What can the Board do to ensure that their organization embraces the "patient/client-centred care perspective"?
- How can HSP governance boards across each local healthcare delivery system ensure that collaboration produces a more customer-focused, higher-quality and more cost-effective delivery system at the operational level?
- What are the common "*system performance metrics*" and "*patient-centred metrics*" for which all CEOs need to be accountable?

As our healthcare system begins to undergo transformation, some Board members continue to believe that it is their role to "represent" certain constituencies (doctors, nurses, researchers, etc.) or that they "represent" geographic areas (i.e. "I'm here to represent the interests of name-of-town/neighborhood.")

While bringing these unique and valuable "perspectives" to the board table (to merge with each of the many other perspectives on a skills-based board) is positive, if Board members actually come to the governance table to "represent" groups, rather than to represent the Board's a shared purpose and vision, then governance will certainly fail.

In our emerging healthcare delivery system, instead of "representing their silo" -- or their "stakeholders' group", or their "geographic territory", Board members are being asked to focus on the broad interests of the citizens of their community – as well as the taxpayers and the patients/ customers/clients of their organization. They are being asked to "let go" of their narrow perspectives, in order to embrace a larger, more encompassing vision – a *shared vision* of a patient-centred/people-centred delivery system that meets the needs of their community.

In "***Trouble in the Board Room: The Seven Deadly Sins of Ineffective Governance"***, Jamie Orlikoff points out that when Boards operate as representational governance, "members of the Board do not consistently focus on the best interests of the system, or of the organization as a whole. Rather, they focus on the best interests of the component parts of the system, or on specific constituencies".

Orlikoff says, "representational governance is the antithesis of integration and the mortal enemy of effective governance."

Dennis Pointer and Jamie Orlikoff are experienced governance coaches specializing in the healthcare sector. They have seen how the individual component parts of local healthcare networks can end up working against the good of the whole community – and their own best interests. This is often referred to as an "unintended consequence" of a silo mentality, and of a vested interest group mentality.

Another mortal enemy of stable and effective governance is "interest group activism" facilitated by the old models for hospital corporation membership structures that actually invite small "p" politics. As a result, rather that leading change and supporting change agents, some Boards have become entrenched in the old ways of governing and managing. Sometimes they are hijacked by political campaigns by interest groups like doctors. We've had a lot of that happen over the past several years.

While the OHA made "governance training" a high organizational priority over the past eight years, their *Governance Excellence Program* may have actually reinforced the status quo at hospitals across Ontario. Indeed, hospital board performance has not, to my knowledge, measurably improved with the existing approach to board development at the OHA. We need to understand why. We need to discover more effective ways of getting Boards to transform themselves -- before those who argue "we should get rid of boards", win the day.

Orlikoff says "there are many reasons why Boards tend to resist change. Some are comfortable with the old paradigm and, in their complacency, do not wish to change. Some Boards realize that they must change – but do not know how. Like the deer caught

in the headlights, they become paralyzed into deadly inaction. Other Boards deny that change is even occurring."

But, the fact is: the status quo cannot survive!

I see that the OHA is beginning to switch from their traditional *Governance Check List* approach and are now offering workshops on *Generative Governance* with Harvard Senior Researcher **Dr. Cathy Trower** -- which I believe is the most appropriate approach to governing in our current circumstances. Ontario's own **Jim Nininger** has been advocating for *Generative Governance* for the past five years or more. This approach doesn't make governance easier, it makes it harder in many respects.

Thankfully, we've gone way past the "tipping point" for whole system change in Ontario. Those who are hoping for a halt to system reform – or even a little break – will be disappointed, in my judgment. It seems that **Health Minister Matthews** really does intend to transform the system. I sense this is her "legacy". But will she succeed? Will the system in fact transform? There are hopeful glimmers everywhere across the system.

While there are numerous transformational changes that are occurring, NSM LHIN and Champlain LHIN are two areas where interesting health "**system design**" initiatives are emerging. I keep saying: "**the leverage is in design**" – functional design, structural design and work process design. If we design for "patient/client-centred care, the system will transform.

So, what is the "*transformation*" that everyone is talking about? What does it mean?

The **Institute for Healthcare Improvement (IHI)** says that "system transformation" implies "a profound change in form, structure, and/ or character. It is emergence from what you were -- to something radically different. For example, from a caterpillar to a butterfly – many things are changing at once in an integrated and systematic manner".

At this point in Ontario's transformation journey, the whole delivery system should be thought of as being in a "state of emergence" – as we enter into what some of my colleagues and I called the "***2nd Curve Healthcare System***" (Click Here).

The **Institute for Health Improvement** refers to this shift as "an overall system design where every aspect of the system must revolve around the patient – where the patient and family, in partnership with the system, drive everything."

This is the powerful vision offered by McGuinty Government's the "*Made-in-Ontario Model*": networks of independent health service providers who are interdependent at the customer service/operational level. But in order for this Made-In Ontario Model to actually work, independent Boards of governance – representing the "owners" – need to learn how to "hold management accountable" for achieving agreed-upon customer /patient / client outcomes – within a balanced budget, and with a balanced best practices Board/ CEO relationship.

Unfortunately, government's disrespectful communications towards hospital CEOs seems to have encouraged a number of Boards over the past few years to engage in negative dynamics with their CEOs. While there were several cases where there were legitimate performance issues, too often, these dynamics have had their roots in politics, power and ego.

In my Blogs, ***Disruptive Governance Parts I*** ***and*** ***Part II***, I estimated that up to 75% of healthcare boards today had performance records that range from providing "little value", to being "dysfunctional" – and actually causing harm. Despite that totally realistic assessment by my panel of six governance coaches and former hospital CEOs, I sincerely believe that it is better to transform governance, than to get rid of it.

While we absolutely need to create accountability systems, structures and processes, perhaps the pendulum has been violently swung to the opposite extreme -- and now needs to settle into an appropriate place – a prudent, more balanced place. It is very clear that Queen's Park and some LHINs are freaked out and desperately seeking to control and regulate everything. This is the problem that needs to be acknowledged and changed.

In this environment, it is simply not possible to balance "innovation" and "risk management" at the same time. Bureaucrats under siege from scandals that they were part of, are now regulation and control process crazy. If they can't micro-manage or control, they at least want to create the "illusion of control". How do we turn down the temperature? How do we get people to settle down, think straight, and ensure that there is an environment for innovation, as well as prudent risk management?

While Governance Boards hold important responsibilities for finances, the fact is that the most "value-added" gift that citizen Boards can actually bring to their organization today is a deep commitment to quality, safety, system integration and customer satisfaction.

We need Boards who will encourage staff to have, what the Minister calls an "obsession with patient/client-centredness". We need Board members who will celebrate the incremental victories in these areas as the organization progresses along it improvement path. When the *North York Hospital* board members showed up in force to talk to the staff about their quality projects at the hospital's annual Expo four years ago, there was a surge in further improvements in the following six months.

This is an approach to management/governance/life called "*Appreciative Inquiry*" -- and it works.

In addition to having a clear focus on quality, safety/and with customer /staff / physician satisfaction issues, Boards need to demonstrate their understanding that the real leverage for change is in the **design** of the systems, structures and processes in their organization -- particularly at the hand-off points with other organizations along the continuum of care.

Boards need to shift their focus from "operational" issues, to "system design" and "organizational design" issues -- if they are to truly "add value" during system transformation. We need board members who understand quality improvement, safety and best practices for organization and whole system transformation.

Indeed, the ultimate success of a *Health System Transformation Strategy* will be dependent upon each organization mobilizing to redesign and align their part of the system to the overall vision of an efficient, effective, high-quality, patient-focused and seamless healthcare system – at the local network level, at the organizational level, and at the customer level.

Leading-edge change managers suggest that for the system to work effectively in the future, we need to liberate the knowledge and wisdom of our front-line healthcare service providers as we redesign the system. Are our Boards ready for their role in such a top-down/bottom-up transformation? This is a different way of thinking.

In ***Board Work: Governing Healthcare Organizations***, Pointer and Orlickoff have argued that for governance to effectively lead healthcare into the future, new mindsets, structures and skills will be necessary. They point out that "effective governance is not a happy accident. Rather, it is the result of an integrated process of planning, coordination, implementation and evaluation".

They say that "when a Board is governed by chance or tradition, (or simply reacts to whatever situations arise), it abdicates its responsibility for leadership and contributes to organizational atrophy." If Boards in Ontario are to continue to survive, they need to decide on their role and function in a transformed system.

In my view, the most important contribution that Boards could make is to ask the CEO (and all of management) to transform themselves and the organization into a true *Learning Organization* that has the capacity to tap into its collective intelligence to determine what to do, and how to do it, as their local healthcare system, and their organization, transforms.

In the unfolding external environment (which many objective observers today describe as "threatening", "chaotic", "blame-oriented", "risk averse", "rules-driven", etc.) Boards need to become a counter-veiling force – particularly in circumstances where it is simply not possible to be innovative.

"Innovation", afterall implies risks. However, as everyone knows, today CEOs and managers live in a "risk averse environment" that has been subjected to wave upon wave of new rules, regulations -- as well as elaborate, complicated and expensive processes to create the "illusion of control".

Skills-based Boards need to become very ambitious on behalf of the "owners" of the organization, and on behalf of the "owners" of the whole delivery system. They need to

be engaged in the strategic priorities setting process -- from a public interest and whole system perspective.

This is a very different mindset that will change “how healthcare governance is done”.

So here is my suggested paradigm shift on system governance: given that our health service provider boards, LHIN Boards and the Minister of Health all hold high-level *governance roles* for the well-being of the whole system, if our system is to successfully transform, shouldn’t there be a much greater degree of alignment among our system governors?

Are you listening governors? Are you listening CEOs? Minister?

In order to successfully transform, we need your collective and aligned leadership, or if you guys can’t get your collective act together, the healthcare system needs to be liberated to transform itself – bottom-up and self-organized!

Choose one of these options!

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