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## **Collaborative & Generative Governance Will Be Required To Succeed In Our Emerging Complex Adaptive Health Service Delivery System, PART II**

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The **Institute Of Medicine** just released (June, 2012) their report, [A CEO Check-List For High-Value Health Care](#) which provides the top ten strategies that have proven to be effective and essential to improving quality and reducing costs in healthcare.

Can you guess the number one item on the **CEO's Check-List**?

It is governance.

Capable CEO's know how to utilize a resource provided to them called: the Board. While CEO's need to play full tilt as a 50/50 partner with their Boards, the bottom-line is that the Board is the final decision-maker. They are the highest authority in the organization.

While that is the official structure, the reality in the health sector is that we will never recruit a skills-based board that will be capable of challenging the judgment of the CEO - who swims in the complexities of the health sector every day. So how do Boards "add value"?

**Gwen Dubois-Wing & Jean Trimnell's** workshop on *Reframing Healthcare Governance Through A Complex Adaptive Systems Lens* got the participants at the OACCAC Annual Conference to "let go" of their fragmented way of thinking about governance issues – so that people could see the "bigger picture" of reality and to learn to live with the creative tension of holding onto two opposite polarities at the same time.

While governance should avoid governing by check-lists, such lists can in fact be helpful to understanding what is expected of and needed from Boards. This "blog" is actually a background report on the five core **GOVERNANCE RESPONSIBILITIES** that are aligned with the concept of *Collaborative and Generative Governance*:

### **1. Approve Strategic Direction & Priorities.**

When organizations learn about how the current and future provincial budgets will affect their bottom-line over the next three years, they will need to re-think their existing strategy -- based on the new transformational funding formulas that will be emerging from Queen's Park over the Summer and Fall of 2012. Healthcare service providers will

be shrinking, growing, merging or realigning within the next six to twelve months as a result of these new economic incentives.

As the future emerges over the Summer/Fall, healthcare organizations will learn more about how HBAM and other economic incentives will work over the next three years at webinars organized by the MOHLTC. To accelerate leveraged changes within the health system, the Minister has also created a *Transformation Secretariat* at Queen's Park to work in partnership with line ADMs, and with LHINs to support transformation efforts across the system.

The impact of Queens Park's new funding formulas and emerging priorities will of course require a new strategy for each health service delivery organization. So who is the lead on strategy at your organization?

While governance boards do not create strategy, their approval of the overall policies and priorities sets the organization in motion. It is the CEO who is responsible and accountable for developing and executing strategy – and learning from it.

The extensive changes in the external environment that are happening will require every healthcare organization to re-examine their strategic plan in order to determine what they need to do to adjust to their emerging circumstances – this year, and over the next three to five years.

In best practice CEO-led organizational strategy development exercises, there is extensive engagement of front-line care providers rooted in a deep understanding of patient/client needs.

Beyond lean thinking are the *Patient Experience Design Methodologies* that tap into the insights/knowledge/wisdom of health service providers and the patients/clients/residents who experience the services that are being delivered. Front-line workers and patients/clients should also be involved in the *Strategy Development*, *Strategy Execution*, and *Strategic Learning* phases of their organization's transformation journey.

But what about the Board? What is their role in strategy? What can they contribute to the strategy process?

A number of surveys conducted by think tanks and consulting firms indicate that many Board members don't really fully understand the key "drivers of value" for the organizations they govern. This is particularly true in healthcare – a sector that change management guru Peter Drucker has called "the most complex of organizational structures ever created by humans".

The challenge of getting at the "true drivers of value" can be addressed through the framework of a best practice **balanced scorecard process**, and by adopting leading-edge **performance monitoring practices**. These modern methodologies for rapid complex change enable organizations to focus on timely, relevant and accurate information about

the progress being made at achieving the outcomes, or, as John Carver called them, the “ends policies” that Boards set – in partnership with their management.

The *Carver/Policy Governance/Pointer & Orlikoff/Modified Policy Governance/Balanced Governance Scorecard* and *Generative Governance Model's* each prescribe the Board's role as “approving strategic direction”, rather than “doing strategy”. It should therefore be very clear: **the CEO is the Chief of Strategy**.

However, given that the healthcare sector has an ingrained blame/shame culture, many senior managers today report that they don't feel that there is a “safe environment” for being innovative or leading-edge strategists. The environment for senior decision-makers is very clear: “tow the line, and follow the rules”.

So we've got a big problem. Without innovation, our health system will fail. Indeed, there seems to be a consensus among a critical mass of operational leaders that I have spoken to over the past several months that the current obsession with creating the “*illusion of control*” -- with lots of rules, regulations and high-cost protocols -- has almost driven out innovation in the healthcare sector. There are still some pockets of innovation – but only where there is a courageous CEO -- backed-up by an informed and strategic Board.

While perhaps 15% to 20% of healthcare organizations could have been classified as “innovative” in the past, I think that figure today has shrunk to between 5% and 10% of organizations. Do you agree? Do you too find that there is less and less innovation, and more and more emphasis on compliance to processes – which actually has the unintended consequence of driving out innovation and creating environments that are fear-based?

Innovation means “risks” – and this is a risk averse environment.

Many healthcare executives today chat at conferences between sessions about the unnecessary costs and the unintended consequences of many of these new provincially mandated processes. People trade stories about the terrible consequences of following bureaucratic rules. But they comply. They must. They are not safe. They must survive in the blame and blame/avoidance dynamics of the health sector. So survival, rather than results, is often the primary motivation of healthcare executives today.

This is why I am suggesting that the Board's highest priority job in today's chaotic fear-based environment is to create a *Supportive Environment For Innovation* -- an environment that encourages and celebrates “out-of-the-box” thinking, while holding a more balanced perspective on prudent *Risk Management* and on *Accountability for Outcomes*.

Indeed, the “art of governance” is in finding the “right balance” of unleashing the creative capacity of the organization – starting with the CEO – and then holding the CEO

accountable for achieving bottom-line measurable results that meet the needs of patients/clients/taxpayers and the community.

While many healthcare executives and public servants that I speak with acknowledge that “the pendulum has swung too far out of whack”, there is no intention to proactively fix the problems that have been created by these pendulum swings. These people say that now with Ornge’s unpeeling, it could be “several years” before the pendulum settles into the appropriate spot it needs to occupy.

I’m suggesting that the highest priority of Boards should be moving the pendulum to the spot it needs to be now. This is the spot where “prudent risk management” is balanced with a climate that encourages “innovation”. Boards need do this because CEOs and senior civil servants don’t feel empowered to address what they know are “sub-optimal conditions for innovation”. Boards can hold the CEO accountable for compliance -- while at the same time creating a “safe environment for innovation”.

This is the *polarity* that needs to be created, and then managed.

If Boards simply wait patiently -- along with everyone else for the next five or six years until the pendulum finally settles in a reasonable position -- a lot of damage will result in the waiting period. If a critical mass of Boards communicated their concerns about the “risk averse environment” created by inflexible rules, protocols, practices and command and control language and tone inspired by the blame avoidance dynamics that starts at Queens Park, then things would change. Boards should cause this change.

## **2. Guardian for Quality/Risk Management and Compliance.**

Today *Health Service Provider* (HSP) board members must also be a “watchdog for uncompensated risk” – as well as a “guardian for compliance”. “Compliance” includes legal, accounting and regulatory requirements – as well as oversight for best practices for quality-of-care and for human resource management.

The problem is that government has become so obsessed with its own e-health and Ornge scandals that the reactive thinking and behavior (*culture*) of the MOHLTC and their crown agencies, the LHINs, have encouraged our community of governance Boards to become much more focused on “compliance”, and staying out of trouble, than focusing on quality, safety and the patient experience.

While compliance and risk issues are of vital importance to the “owners” of our healthcare system, the most important role for governance in our emerging system will be as a “**guardian for quality and safety**”/ as an “**advocate for improving the “patient/client experience**”/and for “**oversight for learning, continuous improvement and accountability for outcomes**”.

So, how does a Board become effective at enabling their organization to improve upon the patient/client experience – including the quality of services and their safety -- as set out in the *Excellent Care For All Act*?

We have used “altitude” to describe the appropriate role of the Board in providing guidance and oversight of management’s 24/7 operating responsibilities. We even talk in the boardroom about a specific altimeter setting -- with 15,000-20,000 feet most often mentioned. John Carver’s model put the issue out bluntly: **Boards should never engage in micro-managing the organization.**

It worked well in the past, and can still work well today. However, we cannot confuse a role guide, with direct governance responsibility to represent the interests of the patients and families that Boards exist to serve -- and the ultimate responsibility that the Board has for the safety and quality of the services people receive.

Governance coach and former Board Chair of world-leading *Virginia Mason Health System*, **Tom Van Dawark** ([ORCA PARTNERS](#)), says “the Board and its’ individual members need to understand ‘the patient needs’ in order to establish the urgency for achieving **Safety-Focused/Patient-Centered Care**, and to be able to connect the heart with the mind in Board deliberations. That cannot be done without hearing directly from patients -- nor can it be accomplished from the confines of the boardroom. It is ground zero for patient engagement.”

A number of hospitals in Ontario are now exploring the *Patient & Family Advisory Council* model that is being adapted from the *Institute for Patient- and Family-Centered Care* in Georgia at **Kingston General Hospital** and at the **Thunder Bay Regional Health Sciences Centre** where patients and staff report significant improvements in both patient and staff satisfaction scores.

The *Patients’ Association Of Canada* is also just completing their Trillium-funded study on the “**Role Of Healthcare Governance and The Patient Voice**” – so there is lots of new information available on how Boards, managers and service providers can improve patient care. While it takes the whole team to be successful, the Board really does have a key role in quality, safety and the patient/client experience.

*The Institute For Health Improvement* (IHI) suggests that each board meeting should begin with a patient story – told by a patient, about a current experience, including the good, bad and ugly. They suggest that individual board members should routinely round with staff to visit with patients and families where care is provided -- be it the bedside, clinic or home. They suggest that as much as 25% of Board meetings should be on topics related to quality and the patient experience.

It has also been suggested that the Board needs to ‘walk in the shoes’ of a victim of preventable harm – to genuinely understand, for example what a readmission means to the personal, business and social life of a patient and their family. Safety and quality performance improvement should always be recognized by the Board – but always

followed by asking how many patients were still affected by not being at zero, 100%, or top quartile performance.

Trustees should also be expected and supported to directly engage with patients and families. By doing so, the Board is not changing or usurping the role of the CEO; it is performing a core governance responsibility and establishing a much more effective collaborative with the CEO to lead safety and quality improvements -- and enhance patient-centered care.

By getting to a higher level of altitude, and by focusing on these issues, Boards can play a vital role in the transformation of their organization over the next three years.

### **3. Ensure a Leveraged Use of Resources.**

In the emerging system, Boards will need to continuously “push the envelope” on cost-effective strategies like “clinical program reconfiguration”, “back office consolidation”, “lean thinking”, and “experience-based design” to ensure that we have a more leveraged use of taxpayer dollars.

The *Drummond Report* is simply the latest study to tell us “things have to change” in how health care is managed. Nevertheless, the existing system is still very much provider and bureaucratic-centred, not patient-centred. Boards need to become “champions for the patient perspective” and the “voice of the owners” as the system is redesigned.

Some Boards will discover that their organization’s happy challenge will be managing up to 12% growth in revenues over the next three years. Experience has taught us that we ought to slow down, and plan-to plan-for growth, or plan-to-fail and waste resources.

Boards need to ensure that there is *a leveraged use of resources*, and that the organization develops the internal capacity to manage growth -- or, as it will be in many cases, manage the downsizing.

Whether its growth or downsizing, Boards must ensure that patient/client interests are front and centre in the decision-making process. However, if a Board feels that they and their organization cannot be “patient-centred” because of bureaucratic processes imposed by the LHIN -- or from Queen’s Park -- they need to “push back” and “speak out” on behalf of the owners.

Champions are not silent! They drive out fear. They create safe, transparent environments in which real transformation and measureable improvements can occur. These are things really worth fighting for – don’t you think?

### **4. Support the CEO – while holding them fully accountable for results.**

I hear Board members complain that too often Board meetings are just “approval forums” and lack opportunity for any meaningful discussion on strategy and its execution. I also

hear CEOs complain about the severe pendulum swing towards micromanagement and external controls that have reduced their ability and flexibility to “get results”.

Boards and CEOs need frank discussions about the circumstances/context to which their organization must respond.

Rather than these destabilizing power swings between ‘centralized control’ and ‘decentralized control’, we need to latch onto fair and balanced processes that enables Boards to understand what is happening in the external and internal environment -- so that they can “add value” and guide/coach where they can – understanding that the management gurus say that healthcare’s chaotic system design and perverse incentives really do make it “the most complex of human organizations ever invented”.

But there are frameworks for organizing best practices for strategy development and strategy execution and strategic learning.

The *Balanced Scorecard Monitoring Process* used by many healthcare organizations ensures that Board meetings become opportunities for Board members to share their knowledge, discuss strategic tradeoffs and lend decision support – from the perspective that Boards hold. The perspective that Boards need to hold is: “**What is in the best interests of the owners and the customers?**”

To govern effectively, Board members need to see both financial and non-financial information that clearly demonstrates current and anticipated performance. However, Boards can’t operate blind-folded. They need the right information -- if they are to actually “add value”.

If they are to provide value, Boards will need to learn how to become a coach/guide/mentor who can effectively advocate on behalf of the “owners” and the customers/clients/patients/residents – by asking “probing” and “generative” questions that provoke management’s best thinking and generate deeper explorations of what could be possible.

Boards that are good at this describe it as “creative tension”. They see their role as: “stirring the pot, in a safe environment”. While most board members really enjoy their role in a generative model, some don’t like it at all. They want more “control”.

There isn’t a healthcare board with the skills/capability/knowledge/judgment to manage the organization that they govern. That is why they hire a CEO. But Boards need to ask themselves how they can “add value” to the CEO -- to ensure that they succeed. After all, when the CEO succeeds, the Board succeeds ... and the owners succeed.

Now, there is an apparent paradigm shift: **we actually want our CEOs to succeed!**

Some Board members have told me that they believed that the government wanted them to “get tough” with their CEO. That’s one way of looking at it. But I think the more prudent question is: **How is your Board ensuring that your CEO will succeed?**

Unfortunately, sometimes Boards play “gotcha” games that can produce blame and blame-avoidance dynamics across the whole organization. Whether Boards intend it or not, their behavior in the boardroom can and do often produce fear and anxiety throughout the staff – sometimes contributing to very serious failures in performance.

“Failures in performance” in a hospital are called “preventable deaths” and “preventable harm”. So the stakes here are very high. That is why Boards also need to be a force for stability and stewardship for the longer term. However, over the past several years, several Boards have in fact been a source of instability within numerous healthcare organizations. Indeed, I estimate that 10% to 15% of Governance Boards in Ontario are dysfunctional.

Several hospital Boards have even been hijacked by internal physician politics, and by so-called “community interest groups” -- to the point of firing competent CEOs as a “political solution” to appease some groups. In the emerging delivery system, Boards should never engage in such primal organizational politics. Boards must make absolutely sure that they remain “on the balcony” – above the fray of self-interested stakeholders.

Boards also need to focus on *stewardship* (being “in service”, rather than “in control”), and on the longer-term public interest – not the short-term politics of the organization, nor by the concerns of any of the self-interest groups in the mix. In our emerging system, the focus will be on “evidenced-based decision-making”, not “power politics”.

## **5. Selecting, Developing and Motivating Executives.**

In Ontario, hospital Boards have two employees: the CEO and the Chief-of-Staff (sometimes replaced with a Medical Advisory Committee Chair). While the Board has a major responsibility to select these two individuals, as “stewards” for the longer-term viability of the organization, the Board also needs to encourage the development of leaders throughout the organization.

They can do this by ensuring that between 1% and 5% of their organization’s payroll budget is invested in the on-going learning and growth for in-tact staff teams. This *Learning Organization* approach is also how Boards can ensure that there is a “talent pipeline” within their organization.

Because we have not done that very well in Ontario, many astute observers are saying: “*Gosh, where is the next generation of leaders who have a stake in our future healthcare delivery system?*” While 70% to 80% of the budgets of healthcare organizations are for people, many healthcare Boards don’t place a high priority on HR issues.



However, best practices for *Learning Organizations* suggests that the Board is responsible for ensuring that there is “a process” for “**talent management**” and for “**succession planning**” – as well providing high-level “oversight” for a best practice **Accountability Process** that is designed to align senior and middle managers to the organization’s Board-Approved Strategy.

We also need to acknowledge “the whole truth” about the violent pendulum swings that have become the norm in Ontario. We’ve moved over the past eight years from a system where the concept of “accountability” wasn’t a priority, to our existing system today where the concept and practice of *accountability* has produced the “unintended consequence” of assigning blame, discouraging pro-active thinking, and *stifling innovation* in an environment where leaders are encouraged to at all costs “avoid blame”, and above all: “Cover Your Ass” (CYA).

These circumstances -- and what to do about it -- must be openly and honestly addressed by Boards in a safe, supportive learning environment with their CEO and senior management team.

The key to success in the emerging system in Ontario will only be found in a more balanced perspective. The fact is that Boards and CEO’s need to become true partners if their organizations are to succeed. While “*partnership*” is a relationship of equality, the reality is that the Board is the “managing partner” – they have 51%; compared to the CEO’s 49%.

Given that equation, there is clearly a “boss” in this relationship. But for the most part, Boards and CEO’s should always strive to be equal partners – equally committed to achieving the agreed-upon outcomes.

The CEO’s responsibility to manage and lead the organization is distinct – but complementary – to the Board’s oversight responsibility. Best practices suggest that the CEO should be accountable to the Board for overall organizational performance – as measured by the organization’s Balanced Scorecard, and their distinct contribution to it.

Boards ought to have an **Accountability Agreement** with their CEO that sets out the outcomes expected in a *Balanced Scorecard* – and the “supports required” to achieve these organizational outcomes – as well as the outcomes listed in their **Service Accountability Agreement** with the funder: the LHIN.

To successfully transform, organizations must ultimately engage their front-line care providers in designing the actual work processes, structures and systems for patient care/customer service. What can Boards do to contribute to this transformation? Well, Boards can play a highly leveraged role in change -- if they rank “*staff engagement*”, “*physician engagement*”, “*union engagement*”, “*organizational learning*” and “*patient-centredness*” highly when evaluating their CEO.

As budgets and new funding formulas become clearer and better understood over the next several months, organizations will be required to develop their strategic response to their emerging circumstances. That's the CEO's job. But competent skills-based Boards can "add real value" to the leadership and strategy development efforts as organizations respond to their emerging environment.

While most community governance Boards are very unlikely to understand all the operational complexities of the healthcare system, regular *Board/Strategy Team Dialogues* should be designed to achieve alignment, common understanding – and, ultimately, Board support for strategy. As communities and organizations begin to redesign themselves, we will need to be guided by evidence, and by the wisdom and values of the community.

So, rather than getting rid of community governance -- or setting targets for reducing the number of Boards -- why not transform governance instead? Why not make it work?

We need to "fix governance", by getting "governance to fix itself".

As organizations undergo the strategic renewal process -- driven by their unfolding economic realities -- Boards ought to take the time to explore how they could truly "add value" through their own process of governance renewal; and, how they could "add value" to the CEO to ensure their success.

**Forward this Governance Report, Part II to your colleagues, and scroll down to my previous blog, Part I.**