September 14th
DISRUPTIVE GOVERNANCE: An Alternative to Eliminating Local Community Governance Boards, *Part II*
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There will be a number of organized vested interest groups lined up on October 7th to influence the thinking of a new or renewed government – just three weeks from now.

The line-up will be full of people who want to talk about *structure*. Should the *Local Health Integration Networks* be spared? Should the LHINs be replaced – but reduced in numbers? Should community governance survive? Should the government re-open the Health Ministry's regional offices?

It's always about the various vested interest groups' visions for "control". That's why everyone focuses on "power relationships", rather than mission and vision. It is always about "*who is the boss*", rather than "*what are we seeking to create*?" It is always about "*vested interests*", seldom about the "*public interest*". It is always "*service-provider focused*", never "*patient-focused*".

As the new, or renewed government settles in on October 7th, they will be surrounded by dozens of screaming banshee warriors, disguised as vested interest groups, who will be, once again, settling in to "partner" with the government, so that they ensure that we retain as much of the status quo as possible.

However, before the new government makes any decisions about the structure and the macro design of the health system, they need to be able to articulate a "*vision"* for the healthcare delivery system that they want to create over the next four to eight years.

Strategy and *structure* are what the government will need to implement their vision for a "patient-centred" delivery system. So, what is it that they are seeking to create, and to what extent is it a "shared vision" with the governance and managerial leadership of the health services delivery system?

If Hudak is elected and gets rid of LHIN's, perhaps these organizations could be tasked immediately after the election with one last important responsibility: to bring their local network partners together (over November/December/January) to explore the government's initial "vision for patient-centred care"; and, to ask local governance and managerial leaders to provide their "best thinking" on what systems, structures, processes and supports would be required to make that vision a reality in their community -- and in their organizations.

If the Liberals win, they need to decide if they intend to actually make devolution work this time, in their third term.

Today, we have a health system that is crying out for leadership and direction. Several hundred community governance and senior management teams could become eager followers -- if there was a mission-driven, visionary and supportive political and bureaucratic leadership that would engage the health system's governance and managerial leadership to determine how to transform our system to be more "patient-centred", as set out in the election platforms of all three political parties.

So what will the new high-level visions, strategies and structures mean to Ontario's healthcare service delivery organizations over the next few years -- and how should Ontario's healthcare service providers "get ready" for the fundamental changes ahead?

In *Getting To Great: Principles Of Healthcare Organizational Governance*, Dennis Pointer & Jamie Orlikoff, warn us that "change always causes misalignment between the incentives posed by the environment and the organization's defining characteristics. In periods of evolutionary change, this misalignment is relatively minor, it emerges gradually, and the organization need only make incremental adjustments."

Pointer & Orlikoff point out that "when the environment undergoes a revolutionary change, a major misalignment occurs – business as usual is no longer possible, and the organization must undertake a major transformation to survive, let alone thrive." They say: "a revolutionary change 'out there' precipitates and necessitates a revolutionary change by, and inside, the organization."

So, how could you do that? How do our healthcare organizations get ready for the very different future that I have said will unfold because of Ontario's and the world's, economic circumstances -- no matter which party is elected on October 6th?

While there are some great examples of positive Board-driven change in the U.S. (*Kaiser Permanente* and *Virginia Mason Health Care* are two wonderful models of Board-led disruptive innovations), there just isn't much spark in Ontario's stodgy, "old-school" health governance system.

Today, we have a governance system that is characterized by infrequent Board turnover; a lack of clarity around accountability; a lack of consistent understanding of roles and responsibilities; an inappropriate emphasis on partisan politics; a lack of an appropriate mix of skills to fulfill the scope of responsibilities that healthcare Boards have in a very complex high-consequence industry; a lack of training on how to become the "voice" of citizens and patients; and, an apparent conviction by some, that Boards primarily exist to act as "compliance police" for the regulators, rather than as representatives of the "owners" and the "customers".

During my six months of "agonizing reappraisal of governance" I had reached the point where the data and the "horror stories" about dysfunctional and ineffective governance told among my small circle of governance coaches, retired CEOs and former Board Chairs were just overwhelming. Those conversations finally led me to the conclusion that -- since we've never succeeded in getting governance to work very well anyway – maybe

we should just eliminate local governance altogether. Scrap them! At best, they are a waste of everybody's time.

I found my conclusion very depressing. I never saw *governance* as separate and apart from *management* and *operations*. Because I understand organizations as organic complex, adaptive systems, I always looked at governance, management and operations as "an integrated whole." It all has to work together as a "system".

We are dealing with a highly complex organic system that is run by <u>people</u>. So it is a lot about "healthy human relationships"; "collaboration"; "team-learning"; "emotional intelligence; the practice of a skill called "dialogue"; a feeling called "trust"; and, a mindset called "stewardship".

While I was originally trained as a political scientist (whatever that means?), I didn't know anything about "governance". I first learned about healthcare governance from my friend Michel Lalonde, the CEO of the Hawkesbury General Hospital, back in the early '90's.

While many CEO's dominate their Boards (some are "led around by the nose"), Michel wanted "more value" from his community governance board. He engaged his Board in discussions about *policy governance* issues -- seeking to get them to really understand the distinction between his role and theirs. He firmly believed that healthcare organizations needed strong and effective community Boards that are able to, and are prepared to "push the envelope" on behalf of their communities – and by holding the CEO accountable for two equal priorities: <u>quality-of-care,</u> and a <u>balanced budget</u>.

Michel was always just ahead of his time. Back then, he bought governance guru John Carver to Hawkesbury, and sent members of his Board to training sessions in the United States that focused on the Board's duty to serve the "owners", and to become a source of what Michel called "*generative governance*".

Having reviewed the work of Michel's dearest friend, Jim Nininger, on the topic of "*generative governance*", I now see the model for which they advocate as much more about a "state of being", than a prescribed detailed list of activities to undertake. It is really about the Board's ability to ask probing, wicked and perplexing questions – and being comfortable with the fact that we don't have answers yet. But most Boards can't tolerate that kind of ambiguity.

Many Boards have recruited smart, bottom-line, no-nonsense business people who believe they understand the complexity of the healthcare sector and are capable of judging how the CEO is doing. So embracing ambiguity is hard for some Board members. But there will be a lot of ambiguity and complexity that Boards need to struggle with as our healthcare system is transformed over the next four to eight years.

If the next government decides to keep local community governance, what should their role be in their organization, and in their community?

Jim Nininger, who is now the Chair of the *Community for Excellence in Health Governance*, defines "**governance**" as the process that deals with the <u>leadership</u>, <u>stewardship</u> and <u>oversight</u> of an organization. His model fits with CCACs, community support agencies, hospitals and LHINs. He says that good governance "concerns itself with the direction of an organization's activities, and includes policy-making, structure, decision-making processes and accountability mechanisms -- as well as operating values, behaviours, traditions and other elements of organizational culture."

In his essay on **Adaptive Leadership**, Ron Heifetz points out that "because trustees are more emotionally distant from the day-to-day action of the organization, they are often in a better position to see things from a balcony perspective. They can observe the whole dance floor – without getting caught up on the dance". Exactly.

Working in concert with the CEO, *generative thinking* invites Boards to take a fresh look at opportunities and challenges from a broader perspective. Using knowledge and data -- plus Board "wisdom" and "insight" -- generative leadership provides long-term impact and meaning to healthcare organizations by providing a platform for dialogue and by creating a fresh understanding of complex and ambiguous situations.

Generative thinking could be the "fun part" of governance -- bringing a deeper meaning and value to Board service. Board members could be great resources for the CEO and senior managers if they were located at the right "altitude". If Board members have the passion for the mission -- combined with objectivity and distance -- their reflections can indeed provide incredibly valuable insights. I've had a number of CEO's tell me about "big ahas" and new insights that they got from their Boards. Too often, however, decisions come to the Board packaged, digested and all that's left is official Board approval.

That works to some extent when a Board is in its *fiduciary role*, and maybe sometimes in its *strategic role*. But if Boards really do have a *generative role*... if they actually led by example on *disruptive innovation*…maybe they could help their organizations change…and maybe they could collaborate with their partners in their local delivery system to create better and more "patient-centred services" across the whole continuum-of-care, not just their silos.

That is: services that provide patients/clients/residents with an experience of high-quality services, delivered safely, seamlessly, and with compassion and care.

So, maybe we need to transform our governance Boards to a higher level of functioning – a "*higher altitude*" -- from which they can bring true community *wisdom* to the boardroom as their "value-added" contribution to the organization.

This means giving-up the assumption that Boards are capable of judging how well the CEO is doing as a professional manager. It moves them to a higher altitude of judgment

about the outcomes achieved and the "lessons learned" -- rather than the approaches taken, and the decisions made.

So, question to the incoming government: should Ontario get rid of local community governance boards because they promote system fragmentation, or, should we keep community boards, but push them to a "higher altitude" -- with a clearer focus on the patient/client experience, and with a mission to serve the broader community interest?

As I underwent my agonizing re-appraised of governance over the Spring and Summer, I could feel my determination to "get rid of Boards" weakening because all these exciting new ideas about citizen-engagement really appeal to my sense of idealism, and to my political and philosophical bias towards local grassroots empowerment -- over centralized, hierarchical, professional, faceless bureaucracies. I believe in the "wisdom of people".

However, the "bells-went-off" for me about *generative governance* when I spent a few days this summer with Tom Van Dawark, the former Board Chair of *Virginia Mason Health Care* -- a highly successful best practice health system in Seattle -- where the Board, in a true partnership with management, played a catalytic role in transforming their health system's operations to provide much safer, higher-quality services -- and where patients and families are now much more satisfied with their overall patient experience.

Well, how could Boards do that? How could they "add value"?

The *Virginia Mason Story* is truly an inspiration for all healthcare Boards. With deep conviction and knowledge of what is possible, Tom Van Dawark says: "Boards must be the first to change if we are to successfully meet the urgent need to reduce harm. To truly transform safety and quality performance, governance boards must first re-invent themselves as enhanced, safety-focused boardrooms in which everyone with a stake in safety has a voice, and where safety-focused best practices are implemented to continually improve outcomes." (Learn more about *Safety-Focused Boards* @ **ORCA Partners**.

Hugh MacLeod, CEO of *the Canadian Patient Safety Institute* agrees. He points to extensive research that shows that **governance is the key system leverage point for building safer, higher-quality health services**. I'm convinced CPSI is right. Indeed, the current work being done to implement the *Excellent Care For All Act* in Ontario today has the potential to become ground-breaking leveraged actions towards very positive system changes that Ontarians will actually "experience" within the next year or two.

There is no question in my mind that, had the McGuinty government focused on quality during their first term, instead of integration, the transformation of the healthcare delivery system would have surged ahead. Instead, integration issues became about "turf" – rather than how to create a "seamless experience" for patients and their families as they move across the continuum-of-care.

Still, there are perhaps only 20% to 30% of healthcare service provider organizations across the province who are now on this critically important continuous improvement path. Emerging from the election, what we will need to succeed in transforming our healthcare delivery system is momentum for reform and leadership for innovation. Where is the leadership for that?

Are Boards in Ontario really ready to demonstrate that they are ready to shift from being "*Compliance Police Officers"* to "*Strategic Transformation Leaders"?* Do our local governance boards accept that their mission and purpose is to work on behalf of the "owners"? The "*owners*" being: the citizens and the customers they serve.

Are our community governance boards in Ontario really prepared to transform the way they govern? Do they have the passion to make "quality", "safety" and the "patient/client experience" the razor focus of their governance process? And, how could they do that?

In the February 2007 edition of the **Trustee Workbook**, published by the *Centre for Healthcare Governance*, authors Orlikoff and Totten describe how Boards that are tired of being "*Compliant Custodians*" – and are ready to assert *Strategic Transformational Leadership* – need to learn how to practice something called"**disruptive governance**".

Disruptive Governance, according to the authors, involves implementing innovations and practices that change the culture and behavior of the Board and the organization – by creating a collective body of knowledge, and a new set of habits. Orlikoff & Totten point out that "*disruptive governance* embraces governance practices that force trustees out of their comfort zones and releases the untapped energy, creativity and passion that most boards never experience". By practicing disruptive governance, Boards challenge themselves to stretch continuously toward exceptional performance – and dramatically increase the probably that they will actually "add-value" to their organizations.

Over the course of my conversations about the state of healthcare governance in Ontario, my colleagues and I identified four types of governance boards: *dysfunctional*, *ineffective, effective* and *exceptional* Boards. I invite you to assess and reflect on our definitions about the state of governance, and our collective diagnosis of our current circumstances.

We said that **Dysfunctional Boards** don't add-value. They spend their time and efforts talking about the past; and, unintentionally, through their behavior, they do harm. We decided that **Ineffective Boards** don't really matter -- but that they are a major waste of time and effort that could be spent much more productively.

Effective Boards, we decided, were the ones that split their time equally discussing the past and the future. They avoid the 'blame-game' and focus instead on measurable improvements. They ask questions that provoke thinking. They work in partnership with their CEO, and they celebrate improvements in performance with all of their stakeholders.

Exceptional Boards, we concluded, were those that practice *disruptive governance,* and provide *generative governance*. They spend the majority of their time talking about the

future and discussing with management how to make the ever-evolving vision come true. They provide high-level coaching, guiding and mentoring to the CEO and they engage in an aligned synergistic partnership with the senior management team.

The consensus among the governance experts I spoke with over the past several months is that perhaps only 20% to 30% of the healthcare sector's Boards are <u>effective</u>; while 50% to 60% are <u>ineffective</u>; and 10% to 15% are <u>dysfunctional</u>. Our consensus was that there are not many truly "<u>exceptional boards</u>" -- we thought perhaps 5%.

Those of you who are good at counting will have by now calculated that my little focus group of local governance experts, former Board Chairs and retired hospital CEOs are saying that, in "our collective judgment", up to 75% of our governance boards don't actually work very well in Ontario.

Does this reflect what you see, hear and experience as a leader in Ontario's healthcare delivery system? If it does, and if we were to still keep local governance, how do we get our Boards to actually "add value"?

The *Centre For Healthcare Governance* says that **Effective** and **Exceptional Boards** that "add value", practice "*disruptive governance*", and use more of their meeting time talking with each other – as opposed to "listening passively to reports"; "plodding through over-structured agendas"; and, "approving recommendations of little importance". Orlikoff and Totten say that Boards practicing *disruptive governance* use their discussions "to share uncertainly, frame the future, build consensus, synthesize new approaches and develop new paradigms."

So, what should the new government do about local community governance? Keep it, or scrap it?

When I reflect on what I know about politics and governance – and about what I understand to be the significant transformation challenge facing the next Minister of Health – my head and heart tell me that the Minister will need a small army of determined and committed citizens across Ontario who are going to "share the vision" for a transformed healthcare delivery system. It is going to require a lot more than a single courageous Minister to take on the challenge of leading and modeling the required transformation.

From my work in the field of change management, I deeply understand that "9 out of 10 people would rather die, than change". So, where are the leaders for change? Who will be leading us to the world of 2nd curve health systems?

In a previous blog (March 15th), I talked about how our current environment has produced a serious "*leadership vacuum*" in Ontario's healthcare service delivery system. If we are going to succeed in transforming our healthcare delivery system, we need leaders who will mobilize behind fundamental, transformational change.

Before the Spring 2012 provincial budget, the government will need to determine their high-level system vision, structure, strategy process and timeframes for key outcomes over the next eight, six and four years.

I hope that in that mix of decisions, that the *Community Governance Model* survives -- but with a razor focus on: **improving the patient/client/resident/citizen experience of high-quality, safe care**, as well as **balancing the budget**. This is the same direction that has now been set out in the McGuinty Government's "*Excellence Care For All Act*"; in the NDP's platform for "putting patients first"; and, that the PC's are endorsing in their *Changebook* policy platform.

Since each of the political parties are clearly committed to "*patient-centred care*", the question is: do community boards have a useful role to play in that vision?

I think perhaps *"disruptive governance"* might be the way in which we could make disruptive innovation happen throughout our healthcare system. It could be just what we need to nurture our organizations to grow and blossom as true *learning organizations*.

But we need to fundamentally think and behave differently -- if we are to successfully transform our healthcare service delivery system. We also need *disruptive governance* – in a sea of tranquility and reflection – where the collective intelligence of health service providers are utilized in partnership with patients and their families to redesign the systems, structures and processes to be: <u>patient-focused</u>, <u>safe</u>, <u>high-quality</u>, and <u>compassionate</u>.

This is my alternative to eliminating local community governance boards. Do you think our Boards are ready for such a transformation?

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