

September 6th

DISRUPTIVE GOVERNANCE: An Alternative to Eliminating Local Community Governance Boards, *Part I* Ted Ball

Wisdom is the product of knowledge, plus experience, plus reflection, minus ego. Think about it.

Knowledge + Experience + Reflection (-ego) = Wisdom

Over the past six months, I spent way too much time in an “agonizing reappraisal” (reflection) of my beliefs and assumptions about healthcare governance. It has taken me twenty years in the school-of-hard-knocks, and from on-going efforts to keep up with the leading governance literature -- as we moved from the *Carver Model*, to *Modified Policy Governance*, to the *Pointer-Orlikoff Model*, and, for me, finally, just two years ago, to the *Balanced Governance Scorecard* model.

As he went into retirement, my friend and colleague on a number of innovative projects, Dennis Pointer, who, along with Jamie Orlikoff, is one of the co-authors of *Board Work* (which I think is still the “gold standard” for healthcare governance in the world), said he thought that the work that my colleague Ken Moore of Quantum Innovations and I had done with a *Governance Design Team* of Board members and senior managers at North York General Hospital was a “real and lasting contribution to the field”.

He said we had uncovered a significantly improved governance model and process for achieving strategic alignment between management and Board -- and for defining the respective roles of management and the Board in the strategy development, strategy implementation, evaluation and strategy re-calibration cycles.

While that was a very kind thing for him to say, what I know is that the *Balanced Governance Scorecard* designed for NYGH worked brilliantly for a year or so -- until the Board Chair died, and the CEO left. The tool and process had enabled the Board and senior management to discover a new relationship – at a “higher level of altitude” –in which there was, for a brief period of time, a real surge in synergy between Board and senior management – followed by significant leaps in performance on many of the key operational indicators at the hospital.

So we know we can get governance to “add value”, but the circumstances are always changing.

Today, a new CEO...new Board Chair...new Board members...new circumstances...new understandings...different dynamics...all of these combine together to require the NYGH Board and management to develop new ways to continue their on-going improvement path. We did not, it seems, invent the “holy grail” of governance tools. We did not create a silver bullet that would “fix governance” for a generation.

The fact is that organizations and human systems are constantly evolving. So why was the last six months of dialogues with my governance colleagues about the theory and reality of governance, “an agonizing reappraisal” for me?

Regular readers will know that I am, at my core, an idealist. I believe that people are brilliant; that there is a “*collective intelligence*” that can be tapped; and that we can get the “theory of good governance” to actually work in the real world of practice. Indeed, I believe that together, we are capable of wisdom.

While I always put lots of energy into my idealism, I’m also very much of a pragmatic realist who has been observing the system with my eyes wide-open -- and with a chronic habit of telling the truth, as I understand it. Over the past several years, the pragmatist in me has been assaulted with examples of dysfunctional and ineffectual governance that is on display throughout the healthcare delivery system today.

While we are always thanking our local community volunteers for their investment of time in the governance process, as a chronic truth-teller, I’ve been saying something quite different in these blogs. I’ve suggested that “***Dysfunctional Hierarchies Kill People!***”

That is sort of in-your-face, don’t you think? But everyone knows it’s true. The fact is Boards and senior managers of hospitals, CCAC’s, community agencies – as well as -- government policy-makers -- need a very public wake-up call on how erratic and threatening behavior within our hierarchies causes poorer performance at the operational level – including increasing the number of preventable deaths.

Health system leaders need to be aware of the consequences of Board-created chaos on the number of preventable errors. Our “nice volunteers” need to understand that the stakes involved in healthcare transformation are very high -- and that they need to explore what they, as community leaders, can do to actually “add value” to their local healthcare delivery system; and, what they need to do to avoid the “unintended consequences” that can cause harm in their organization, and in their local delivery system.

Six months ago when I started my “agonizing re-appraisal”, I was so discouraged about the sorry state of healthcare governance in this province that I began applying system design tools to think through designs for systems, structures and processes that would no longer include a local community governance component as part of the macro healthcare system architecture.

I’m not the only person to have had “dark thoughts” about community governance lately. There have been a couple of recent articles calling the very existence of local governance into question. A few authors have suggested that the next provincial government simply “blow-up” local community governance boards.

In their recent article “***LHINs And The Governance Of Ontario’s Healthcare System***” on [HealthyDebate](#), Terry Sullivan and Karen Born report that many people believe that

the McGuinty government made a serious mistake when they did not get rid of local governance. They say: “unlike other provinces, when the LHINs were established, Ontario chose to retain Boards...some see this as a major impediment to change because powerful hospital administrators and Boards sometimes work against the LHIN’s efforts to rationalize and integrate services.”

The assumption identified by Sullivan and Born is that hospital CEOs -- backed by independent community Boards – will continue to focus on the narrow interests of their organizations, and be opposed to better integrated and more rationalized services in their communities if they continue to have their own Boards. While there could be some truth to that, it doesn’t have to be that way -- if Boards truly understood that their duty is to the community interest, not to the institution’s narrow self-interests.

When the legislation on the LHINs was first proclaimed in the McGuinty Government’s first term, health service provider organizations were told that they need to be “independent and interdependent –*at the same time*.” Remember that? This same paradox should have allowed the LHINs to be “consistent and inconsistent – *at the same time*”, but by then, the second wave of civil servants were brought in from the hospital sector, and they said: “be consistent!”

As it turned out, the LHINs never evolved as local facilitators within a network of health service providers -- whose mission was to achieve system-level improvements through collaborative efforts to create a “seamless customer experience” across the continuum-of-care. They were no longer encouraged to find “innovative local solutions”, to their unique problems. As time passed, everyone seemed to forget that LHINs were set up to be *Crown Agencies* -- accountable to the Minister -- with devolved local funding authority.

That vision never materialized.

Instead, back at Queen’s Park, the resource allocation decisions continued to be made in the internal Ministry silos -- dominated by a need to demonstrate, or at least to look like they are “in charge”, and most importantly, “in control”. After all the health sector scandals, “risk management” and C.Y.A. (“Cover-Your-Ass”) behaviors ensured that most healthcare executives, governors and bureaucrats would avoid innovative solutions as “too dangerous”. “Stick to rules and procedures” was the message everyone understood was important.

Innovation means that there is “risk” involved. However, “blame-avoidance” and “blame-shifting” are the normal behavioral outcomes in a culture that values rules, regulations and process, rather than learning, innovation and outcomes.

There is no question that the tone and way the McGuinty Government responded to the various “health sector scandals” – including blame-shifting, CEO-bashing and devoting lots of energy to the “optics” of increased regulatory controls -- created a climate that is increasingly dominated by fear and anxiety.

In complex, adaptive human systems, primal emotions like “fear” and “anxiety”; as well as threats that include “blaming” and “shaming”; are all -- in combination -- very powerful influencers of how people think, feel and behave in our healthcare system today. It is called the “*abuse syndrome*”. The husband clobbers the wife... the wife hits the kids... the kids kick the dog... the dog bites the cat... the cat...

It is important that I acknowledge within these critical comments about the sub-optimal performance of our healthcare system, that there are also, at the same time, some really great things happening throughout our healthcare delivery system. There are some wonderful examples of innovative, transformational leadership at the hospital, CCAC, community agency and LHIN levels across Ontario.

However, like in so many cases in Canada, we fail to recognize that we have examples of world-leading developments in health care innovations. So, it is not all bad in our healthcare system. Indeed, throughout the essays available on TEDBALL.COM are wonderful examples of positive innovation everywhere in Ontario.

However, let’s shake our heads: while 30% of our healthcare service provider organizations are continuously improving, the fact is that 70% of the system is not just “not thriving”, many healthcare service provider organizations, and some local healthcare delivery systems are in fact having trouble even surviving in their current circumstances. Most are struggling on several key performance indicators, including: patient/client satisfaction rates; quality & safety measures, staff/physician satisfaction rates; etc.

It is important to understand that in almost every case where you find healthcare service organizations that are on some sort of an improvement journey – particularly those organizations that have been inspired by the McGuinty Government’s *Excellent Care For All Act* -- you will find Boards that are -- along with their CEOs and senior managers -- staying on the leading-edge of innovation. This seems to be true for between 20% to 30% of our healthcare organizations. But most Boards, and most CEOs, are not like that.

Indeed, rather than “modeling” learning and improvement themselves, many Boards and CEOs have contributed to the fires of fear and anxiety that are coursing through our healthcare system today. In an atmosphere that has been characterized by disrespectful communications about all those “overpaid hospital CEO’s”; about “status quo community Boards”; about “the unnecessary LHINs”; about “the dishonest healthcare consultants”; and “about the greedy self-interested doctors”; some Boards, deeply immersed in this culture, simply joined the fray of command-and-control, and fully participated in cynicism and disrespectful behaviors.

And the dog bites the cat...the cat eats the mouse... here we go again -- the abuse syndrome roll-out.

While many community leaders will have their various rationalizations for their behaviors over the past few years; when I say that “*dysfunctional hierarchies kill people*”; I am “outing the truth”: the chaotic circumstances in which our healthcare

delivery system has been operating in for the past several years is causing serious harm – and unintentional outcome -- produced by well-meaning citizens operating with false assumptions.

However, having now told the truth about the current state of healthcare governance and their contribution to the chaos, and to the sense of “leaderlessness” that we seem to have, I am now relieved to report that I no longer want to “scrap community governance”. Instead, I want to see it “fixed”.

I am delighted to report that I have emerged from my agonizing re-appraisal, and from my discovery journey -- having re-gained my sense of idealism -- and having learned about the compelling case examples that teach us that Boards can in fact have a major impact on quality, safety and patient/client/satisfaction rates.

I'll say more about my alternative to eliminating community governance and provide my thoughts on the meaning of “*Disruptive Governance*” in next week's blog, Part II. Only seven sleeps from now! I'm feeling better already. You?

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