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SO, YOUR HEALTH LINK WANTS TO SUCCEED: Measures To Overcome Five Key Learning Disabilities

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In a *Health Link* structure, it is the "lead partner" who has agreed to serve as the "managing partner" or "administrator" for the voluntary partnership of health service provider organizations. They have agreed to be accountable to the LHIN -- for the overall success of achieving the outcomes that have been promised in the LHIN and MOHLTC approved ***Health Link Business Plans***.

Of course, it is not only the managing partner who has to worry about success. In this first wave of 25 *Health Links*, each of the HSP's senior teams -- and their Boards -- will of course be concerned with being among the 30 percent of organizations who will actually succeed at achieving their *Health Link's* promised outcomes. These guys really don't want to fail.

However, the truth is: nobody has ever done a "*Health Link*" before, and the partnering organizations need to be willing, open and ready to learn together, and to discover together, just how to achieve their outcomes. I notice that I annoy some leaders when I point out that only 30% of *Health Links* will actually succeed. But evidence clearly teaches us to expect a 70% failure rate for *TQM/CQI, merger, re-engineering, lean thinking, Balanced Scorecarding,* etc.

While nobody wants to fail, people have to remember: this is also not a "game of perfect". **Health Minister Matthews** says: "**Dream. Imagine. Then strive to make it happen**." I like that.

People must be open to learning how they -- and everyone else -- can improve. If humans are involved, it means that in many cases, people will also have to "forgive" one another for past circumstances. If people can't forgive past hurts, there will be no trust, and no learning.

What we know from past experience over the last twenty-years of reform efforts that the health sector has a variety of learning disabilities that causes us to sub-optimize our efforts.

So, what are the learning disabilities that *Health Link* leaders – and the managing partner organization – will want to address? In his essay "**The Challenge of Stewardship: Building Learning Organizations in Healthcare**", **Alain Gauthier** lists Five Learning Disabilities common to the healthcare sector that could present serious barriers to the successful transformation of *Health Link* partners.

These include: the high levels of fear and anxiety in the system; the lack of a shared vision at the system delivery level; the fragmented service delivery processes; the fact that the system is silo-based, and provider-focused; with managers and organizational leaders who are too often driven by ego, rather than being "open to learning"; and, confused governance, and therefore confusion over the strategic direction.

1. <u>High Level of Fear & Anxiety</u>

Gauthier points out that fear and anxiety among healthcare workers and frustration and anger among physicians have produced organizations that are emotional molotov cocktails -- driven by the blame and blame avoidance dynamics that have become ingrained in healthcare's hierarchical command and control structures -- and ways of "being" (culture).

In the current rules-based, process-focused, project management culture, the people who gravitate towards positions of power are "gate-keepers" who enjoy being in command and control. In an innovative, entrepreneur environment, people who gravitate towards to positions of power are the coaches and liberators of talent.

While only **Tim Hudak** ever seems to address our horrible financial realities, at some point soon, the Liberals must address the "whole truth" about our true financial circumstances. We also have to face head-on the emerging probably of institutional job loss, without sufficient growth in the community sector, and the distinct prospect for thousands of RN's facing salary reductions -- if they are fortunate enough to even land jobs in the community sector.

Shame on us for not equalizing wages for hospital and community nurses ten or fifteen years ago. Shame on us for not pushing RNs to their full existing scope-of-practice.

Now there is no money, and while it sometimes seems like the system is in denial, there are in fact many, many deeply worried people. How are we going to address these difficult and complex issues in acceptable and intelligent ways? How are we going to deal with fear at the core of our delivery system? In the Drucker Foundation's ***Leader-to-Leader*** periodical, **Larraine Segil's** essay "*Leading Fearlessly*" points out that fear is damaging. It causes insecure behavior that can run from defensiveness and negativity to paranoia and operational paralysis.

"If an organization breeds fear, it soon slides into corporate sclerosis. Process is used to create a series of hurdles – not for the purpose of learning, or the validation of ideas and projects – but rather as a means for denying innovation and slowing change", according to Segil. So are *Health Links* in an <u>entrepreneurial model</u>, where people are aligned on a shared vision and where innovation is encouraged? Or, are they to be a <u>bureaucratic model</u>, where making up and following rigid rules and sticking with prescribed norms is the way to go?

Deming said, if we chose to change, our first priority must be to "**<u>drive</u> <u>out</u> <u>fear</u>**".

That means getting a better grip on the appropriate balance between both the "*entrepreneurial*" and "*bureaucratic*" models. We need to liberate talent to solve problems, but we need to measure and account for our performance.

Health Links do need to create internal structures and decide on processes/methodologies to achieve at the clinical level what they have agreed to achieve. LHINs need to behave as "shepherds" & "coaches" –true helpers -- keeping in mind that *Health Links* are accountable to the LHINs for bottom-line results.

As "liberators of talent", senior and middle managers across the *Health Links* need to provide emotionally intelligent leadership that drives-out-fear, creates a supportive learning environment, and ignites innovation and learning. My hope is that the spirit of **Deb Matthews** words are filling the hearts and minds of MOHLTC and LHIN officials -- as well as everyone at the operational level.

In the early developmental phase of the "*Linkets*", we need to keep in mind, these new organizations are just now at the forming stage of team development. The key here is the creation of a "safe environment" -- an environment where relationships are built, and trust is strengthened at the clinical level, middle managers' level, as well as at the senior management level.

The challenge to overcome is the so-called "abuse syndrome" -- where MOHLTC creates a command and control, blame-oriented Accountability Agreement with LHINs, who, in turn, engage in commanding and controlling relationships with their HSP's – who in turn, repeat the pattern on down to the front-line care provider -- generating a culture throughout the system that is characterized by fear & anxiety.

Fear and anxiety injected into healthcare operating systems causes dysfunctionality that can be measured in error rates and failure in 70% of cases.

Best practices and the "lessons learned" from whole system transformation efforts suggest that we should expect that 30% of *Health Links* will emerge with the leadership and the strategy required to actually transform. And, as we always say: it starts with "vision".

2. No Shared Vision

Alain Gauthier points to the health sector's well-known addiction to what system thinking scholars call the "**Fixes-That-Fail**" *system dynamics archetype*. This recurring pattern is used in order to get by each successive crisis.

In Ontario, our "structural quick-fixes-that-failed": include: DHCs, local MOHLTC offices, some LHINs… and maybe now some of the 75 to 80 *Health Links*-- if they are allowed to become unaligned structures, where HSPs find it difficult to collaborate.

Mr. Gauthier says of healthcare bureaucracies: "they have practiced cost-shifting, implemented across-the-board cost cuts, forced mergers, and engaged in restructuring without understanding the consequences of their actions." He says, "when they are

confronted by new challenges such as outcome measurements, they look at reengineering, continuous improvement teams and visioning as just another wave of ‘quick-fixes' – without realizing the philosophy and organizational alignment that these approaches imply."

You will have noticed that under stress, our healthcare sector typically tends to exhibit one of two different behaviors: (1) immediate action, as in response to a system crisis like SARS; or, (2) bureaucratization, by drawing processes out for so long, they finally disappear –while providing policy-makers and operational managers with the temporary "illusion" that "everything's under control"-- because we have a "very tight process".

The problem is: neither of these habitual "normal responses" will produce a successful transformation. Instead of grasping for the next structural-quick-fix, *Health Link* partners need to slow down, get in alignment, and develop the *shared vision* of the partners through extensive dialogue.

In the case of **North Simcoe Muskoka**, their community has had an intensive four-year dialogue among the health service provider partners to create a shared vision they call "*Care Connections*".

The *Dufferin Area Health Link* brought together fifty people last May -- including the CEOs, senior staff, physicians, LHIN Board & Staff and Governance Boards of the member partners in their *Link* -- to develop a "shared vision" using *Mindmapping* techniques. Rather than the classic visioning to wordsmith a "*Vision Statement*", Headwaters CEO **Liz Ruegg** wanted to have the first iteration of their *Link's* vision to be the product of people's passion and imagination. This technique is great for groups of 25 to 75. (Click to see **Mindmapping Workshop** evaluation & brochure)

Of course while it is great that the *North Simcoe Muskoka* and *Dufferin Area Health Link* have a top-down shared vision from the Boards and senior managers, if they don't also facilitate a bottom-up vision for seamless high-quality services, the top-down vision will not likely come true.

To work, shared visioning must be both a top-down, and bottom-up exercise.

Unless there is mobilization at the front-line of care to create a better system, patients and taxpayers will just get the "same/old" fragmented services delivery by a new brand -- called "*Health Link*".

In their health system research, the *Balanced Scorecard Collaborative* discovered that where transformation strategies failed, less than 5% of front-line healthcare workers even knew what the vision was.

There are a whole range of methods for tapping into the collective intelligence of cross-functional teams across the entire continuum-of-care. Change practitioners call it "**The Whole System/In One Room**" – maybe 200-300 people from all levels – including 50 patients and family members who will cause the dialogue to "get real" by their very presence in the room and in the break-out groups.

While I have personally tested half-a-dozen *Large Group Intervention Methodologies*, I think the most appropriate method for *Health Link* partner dialogues at this early stage of development is called the "**Systems Thinking Unconference**" – an off-shoot of **Open Space Technology**.

If you want to know more about how to extract collective intelligence from large groups, you can go to "**ABOUT US**" on this website-- where you'll find **Misha Glouberman**, who has taken *Open Space* & *Unconference* methodologies to a new level of art. Misha and I collaborate to combine systems thinking with collective intelligence.

Getting 250-300 people to explore a "*focused question*" -- using a systems thinking design tool as a lens that requires everyone to see the "whole system" and its key leveraged components -- will lead to transformational thinking from the group. I believe our unconventional unconference methodology is the very best way to generate trust, collective intelligence, fellowship and commitment to action.

By looking at the *Health Link* through the lens of a systems thinking tool for system alignment, and tapping into the collective intelligence of a mix of stakeholders (e.g. patients/families, front-line staff, middle managers, board members and LHIN planners), people will design systems that work.

People interested in the type of report an *Open Space or Unconference* can produce can review the report generated by 150 physicians and 150 primary care non-physicians facilitated by **Sholom Glouberman** and myself. (Click on ***Primary Care Reform In Alberta: Open Space Report***)

If you are interested in how to tap into the collective intelligence of *Health Link* middle managers and front-line staff, ***Large Group Interventions Technologies*** is a great book by Bunker and Alban that can also provide you with a number of interesting of methods for tapping into the collective intelligence of your system. But I really think the ***System Thinking Unconference*** works best. Trust me. I know it might seem scary, but handing over control actually works!

3. Fragmented Organizational Designs & Processes

Gauthier points out that "most healthcare organizations are highly fragmented -- where an extreme degree of specialization is compounded by very different "**mental models of reality**". This is equally true of *Health Link* partners.

Among the traditional polarizations that he addresses in his essay are: primary care practitioners vs. specialists; physicians vs. nurses; administrators vs. clinicians; clinicians vs. support services; acute vs. non-acute care; and, institutional vs. public health/community-based care and home care. That is a lot of polarizing perspectives!

In our fragmented and often dysfunctional healthcare system today, we design both the macro healthcare system, and the internal organizational systems/structures/processes at the service delivery level, as a series of poorly connected silos-- where patients/clients experience the opposite of "flow". The result: consumers experience gaps-in-services, a

lack of co-ordination, as well as increasing rates of clinical errors –particularly at the "hand-off" points, right across our service delivery system.

Over the past several years, significant efforts/resources has been invested (by mostly the hospital sector where 1 in 13 patients are harmed, and where 25,000 people a year die in a preventable accidents) in quality and safety programs. But hospitals and CCACs, home support services, etc are all at different stages of development on these measures. Now the challenge is: how can the partners come together on a quality/safety & patient experience agenda?

Without a *common language* and *framework* for thinking together, experience tells us that many of the professions across the silos will simply "talk past each other" – holding onto completely different assumptions, beliefs and mental models about their shared circumstances -- their ***Shared Reality***.

Without a shared understanding of the realities that must be faced, and without a ***Shared Vision*** for the whole delivery system; organizations and healthcare professionals will simply remain within their silos – with little understanding of how each silo impacts on the other -- or even how other silos impact on them.

As we move into the Fall, a number of *Health Links* are just now organizing *Dialogue Workshops* and *Visioning Workshops* – engaging *Health Link* senior managers, Board members and frontline caregivers from across the partnership to talk about what they want to create together. Many of the *Health Link* presentations I have seen emphasize that the partners are still just now actually getting to know and understand one another.

That's a good way to start! Strategically, it's called: "***Slow down, in order to speed up***."

Today, there is lots of churning going on. Lots of organizations are just now in the process of "getting ready" to deliver on the commitments they made in their *Health Link Business Plan*. Some are just now taking baby steps as *Linkets*. Some are changing quickly, and significantly to adjusting to emerging budgetary realities. Others are now exploring their strategic options at internal **Board/Staff Partners' Retreats**.

But let's be clear: this is the "lull before the storm".

After a very brief 6-month start-up period, the **Health Link Transformation Program** was officially launched on May 15th with 25 Health Links now in their initial development phase. The rate of change will no doubt soon pick up. But measurable progress will only be made when a critical mass of managers across the *Health Link* partners can see "the big picture" – from multiple perspectives – rather than simply seeing the same old fragmented pieces of the puzzle.

So, after ten months of intensive *Health Link* development, what have we got? Do we have front-line workers who "see the big picture", and are working towards it, or, do we have the same/old fragmented pieces of the puzzle -- the MOHLTC has invested $1 million in start-up funds to support each of 25 new organizations. The successful *Health Links* will be those who invest that money in skills development.

In ***Back to Basics,*** **Gordon Dryden** provides the following advice to those who are drowning in complexity. He says:"Remember jigsaw puzzles: they're much easier when you can see the whole picture first". "Seeing the whole picture" can only happen when we "let go" of the mental blinder: "**My reality is <u>the</u> reality**."

Only then can we open our minds and hearts to "*seek to understand*" the perspectives of others.

4. <u>Silo-Based & Provider-Focused vs. Customer-Focused & Person-Centred</u>

"*All systems are perfectly designed to produce the outcomes they achieve. If you want different outcomes, you need to design a different system*," is how my mentor, **Herbert Wong** would always put it.

Many of the existing systems, structures, processes and incentives continue to encourage healthcare organizations within a local delivery system to focus on their <u>independence</u>, rather than facilitate or encourage <u>interdependence</u>.

This is why our health care system is so crazy-making! There isn't significant alignments for on-the-ground, pragmatic strategic change that matches the rhetoric for health system reform. If *Health Links* are only focused on operations at the clinical level, and not on the design of the system, they will simply continue to remain <u>silo-based</u> and <u>provider-focused</u>.

While the provincial government officials often lectures the healthcare sector on the need for <u>integration</u>, <u>coordination</u> and <u>cooperation</u>, the fact is that their own core designs and Ministry silos actually entrench fragmentation, competition and political behaviour as the principle means of survival and growth in our healthcare system.

At the governance level, Gauthier points to "the lack of deep relationships with the community as a larger system" as the ultimate outcome of our existing fragmented designs. So, are our *Health Link* partner Boards there to represent the interests of the "owners" of their organizations-- while fully understanding the perspective of <u>all</u> stakeholders. Or, are they there to represent their silos' best interests?

Boards of health service providers have signed-off on a ***Business Plan*** that outlines what their *Health Link* will accomplish, but to what extent do they ask "wicked", and "probing" questions about the transformation plan at each *Health Link*? If Health Service Provider Boards don't shift their attention from their silo's performance, to the system's performance, patients will be experiencing the same old silo-dyslexia.

If boards are to foster innovation in their organizations, they should practice **Generative Governance**, learn about their potential to improve quality and safety -- as well as enhancing the patient experience.

If **Alain Gauthier** has accurately described the "larger picture", and the true context in which healthcare organizations operate, it should not be surprising that there is some confusion, a lack of focus, and unbalanced approaches at both the governance and

managerial levels of delivery system. That confusion, and this lack of alignment, is going to be deeply felt on the front-line of the system as the delivery system transforms.

If that's the case: Boards need to slow down, engage in dialogue, and build on each member's ideas -- until new solutions or possibilities emerge.

If the "*Fewer is Better Tribe*" of advocates (who want to get rid of governance boards) lose their battle for merger mania, then community governance boards could end up playing a huge role in shifting the healthcare service delivery system -- simply by changing their focus on their silos, to holding management accountable for being system/customer/and person-focused.

Boards also have a role in building trust -- in their organizations, and in their *Health Link Partnership*. If you are a board member, please be open to thinking differently. You can help drive real change, when you are also open to change and to whole system transformation.

According to **David Carnevale**, author of ***Trustworthy Government,*** one of the most detrimental aspects of traditional controlling organizations "is a deeply ingrained defensiveness characteristic of low-trust, traditional bureaucratic organizations that undermines necessary learning. Trust expedites learning."

Carnevale says that "healthy learning organizations are managed with the objective of liberating and using employee know-how to improve work processes. The emancipation of employee know-how is enabled through a different philosophy of organization and job design, communication patterns, labor-management relations, participatory methods, and other processes that reduce the climate of fear and allow staff the necessary psychological peace of mind to fully engage their work".

In true **Learning Organizations**, the *assumption of competence* is supported through the encouragement of *openness, transparency, curiosity, creativity, innovation* and *stewardship.* Middle managers and teams of front-line healthcare providers need to be provided with systems, structures and processes that will enable them to use their know-how to improve work processes.

5. Confused Governance

In the past, individual silo boards were encouraged to see their role as cheerleaders for their silo's growth and their sector's growth. The boards thought their role was to advance the cause of their silo -- rather than the interests of the "owners" of the silo -- the citizens of their community.

We know that dysfunctional relationships between governance and management often leads to dysfunctional relationships everywhere in the system.

Gauthier points to the confusion that occurs when "Board members have been mostly driven by somewhat narrow financial considerations, and have not consistently expressed the voice of the community." In the past, when the provincial government focused their

primary attention on the financial quadrant of the Scorecard, the unintended consequence was for Boards to "let go" of the other perspectives: the customer outcomes, the quality and safety measures, the internal processes, and the learning & growth enablers for staff.

Now the Minister has been very clear that *Health Links* are about "improving the patient experience", and about "improving quality".

While there are wonderful examples of leading-edge governance boards who have significantly shifted their governance style towards "*generative governance*", we also have examples of boards making very meaningful contributions as they focus on "quality" "safety", and on the "patient/client experience".

Where Boards have dutifully focused their CEO's attention on finance alone – without the balance – the typical strategies brought forward by management, and approved by boards were: reengineering, downsizing, and reorganization of the silos.

If you read my various blogs on the quality of board governance in Ontario's health system -- you will know about how dysfunctional board behaviors in hospitals, CCACs, LHINs and community agencies I wrote that at least 15% of health care governance boards – according to my anonymous "*Panel of Governance Coaches*." -- are dysfunctional.

But today, in the chaos, are voices of influence saying "**We need fewer boards, fewer organizations**." This seems to be the new "structural-fix-that fails".

I don't agree with the "fewer is better" crowd.

If the **Canadian Patient Safety Institute** (CPSI) is correct: that Boards can add significant value to patient safety, quality and the patient experience when they are designed to do so; then why would we want fewer of them?

In a complex adaptive system that is thriving, you will find *bio-diversity*. Been snorkeling on a barrier reef? *Bio-diversity* enriches everything. Heard the expression "teaming-with-life"?

The lean left-brainers will argue that a single board for all the *Health Links* partners will somehow lead to all sorts of wonderful things. But it would just be another "structural-quick-fix-that-fails" -- and it would certainly lead to several years of sustained chaos.

When we add right-brain to our left – known as "whole brain thinking" – we can see how the multiple perspectives of governors from different organizations would provide a more holistic view of the patient/client journey along the continuum-of-care.

When the Public Health Units and health-related social support services are included in the mix of HSPs from the LHIN, then the question can be asked: **How can each silo-governance board "add value" to the achievement of their *Health Links* goals & objectives?**

If these are indeed the five learning disabilities of the health sector, then the prudent response would be:

1. **First, drive out fear. Develop the internal capacity to transform. Become a safe, supportive, collaborative environment. Invest in just-in-time capacity-building for transformation. Become a learning organization.**

2. **Abandon the "structural quick-fixes" and tap into the collective intelligence of the system and fully engaging the patient/family perspective to the redesign of services.**

3. **Let go of "silo perspectives", and focus on the patient/client's whole journey across the continuum and develop a *System Balanced Scorecard*. Align economic incentives to reward quality outcomes and patient satisfaction rates.**

4. **Shift from "provider-focused" system design to a "patient/client-focused design" – and liberate front-line workers to engage in patient experience design -- with *Storyboarding* methodologies.**

5. **Fewer isn't better! But how governance is practiced needs to evolve to embrace a "larger accountability" for integration across the delivery system – not just governance for their silo. Governance transformation is essential. Click on Governance Matters.**

6. **Develop a *Health Links System Scorecard* with *CEO & Managerial Accountability Agreements* that are designed to achieve the results sought at the unit/department/organization & system levels.**

7. **Trust in the wisdom of people!**

FORWARD THIS BLOG TO COLLEAGUES WHO MAY BE INTERESTED IN ADDRESSING THE LEARNING CHALLENGES FACING HEALTH LINKS.