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HEALTHCARE SYSTEM TRANSFORMATION: From *Caterpillar* To *Butterfly*

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CATERPILLAR STAGE	BUTTERFLY STAGE
Acute care is the “hub of the system”.	Primary health is the “hub of the system”.
The delivery system is designed to meet the needs of healthcare providers.	The delivery system is designed to be customer-driven – while incorporating the needs of all care-givers along the continuum.
The systems, structures and processes have evolved overtime and have been cobbled together with unaligned assumptions in each silo. Lack of alignment and perverse incentives produce chaos in the system.	Systems, structures and processes are aligned and intentionally designed to achieve the outcomes required. Organizational alignment produces synergy within organizations and across the delivery system.
System is fragmented. Patient fend for her or himself, moving from silo to silo.	System is seamless. Coordinates needs of complex patients, using case managers for those that are especially difficult.
Sickness-focused. Episodic/Individual.	Health status & outcomes-focused. Systemic/ Population based.
The system is designed to provide care and services to individuals (a diabetic, for example),	The system is designed to meet the needs of defined populations (diabetics, for example) while retaining responsiveness to individual needs.
Designed to facilitate freedom, independence and autonomy of professionals.	Designed to facilitate the best combination of independent and interdependent professionals.
Systems, structures and processes are designed to control and regulate the people working in the system.	Structures, systems and processes are designed to facilitate collaboration, co-ordination and teamwork.
Hierarchical, command & control systems/structures/processes/culture creates toxic work environments.	Systems, structures and processes are designed to achieve the right balance of empowerment and accountability. High staff satisfaction rates.
“Accountability” means blame. Blame causes cover-up. Constant cover-ups means we don’t address design flaws in our systems, structures and processes.	“Accountability for Outcomes” is clear for every manager and Medical Chief. “Learning from our best mistakes” means continuous improvement.
Systems, structures and processes are designed to find out “who is to blame?”	Systems, structures and processes are designed to provide the support people need to achieve the outcomes for which they are accountable.
Information is centralized and hierarchical. Physician is supreme source of knowledge and dictator of therapy.	Information is dispersed. All caregivers and patients have direct access. Physician is integrator and facilitator of choices.
Medical record is fragmented and idiosyncratic to a particular silo. Individual caregivers work off entirely unconnected, often contradictory scripts.	Medical record is electronic and instantly updated and available for all relevant caregivers, all caregivers read from precisely the same script.
Tight centralized control and influence over the delivery system by unaccountable public servants.	Assumption that people are competent when accountabilities are clear and the supports required are in place.

Assumption that performance problems result from lazy, unmotivated and uncaring people that need to be carefully monitored and controlled. More and better regulations and processes are the answer.	Knowledge that poorly designed systems, structures and processes leave people feeling powerless and uncaring. 93% of time performance issues are system design issues. System redesign is the answer.
Designed to encourage political behaviour/ power games.	Designed to produce collaborative behaviour and teamwork.
Behaviours characterized by fear and anxiety. Little trust.	Behaviours characterized by creativity and innovation. Lots of trust – and a real sense of purpose.
Bosses are “in control” of “sub-ordinates”.	Leaders are in stewardship (“in service”) to those around them.
Solutions to problems translates to retraining or censoring people.	Solutions to problems translates to redesigning systems and providing people with the learning support they need.
The system requires compliance from people.	The system seeks commitment from people.
Goal is to maximize resources for your silo.	Goal is to allocate resources appropriately within the system.
Huge resources are consumed in reimbursing inefficient systems. 30% of all work is unnecessary rework.	Huge resources are freed up for innovation and quality improvement. People & resources are leveraged.
Traditional budgeting processes are political, inflexible, linear and absorb up to 30% of senior executive’s time, and 20% of middle managers efforts.	Strategic budgeting allocates resources based on evidence to achieve the outcomes and targets set by management and approved by the Board. Management time on the budget process cut by 50%.
Resources are allocated centrally -- based on politics in silos.	Evidence-based allocation of resources. Strategic budgeting to achieve outcomes.
Assumption: “First, do no harm.” Provider intentions impeccable.	Assumption: Humans are inherently fallible. Harm occurs despite providers’ best intentions.
Reality: Human error generates harm with threat of punishment as a deterrent.	Reality: System accepts human error as inevitable. Designs error proofing.
Mistakes are inevitable, but to be avoided; move on quickly if they occur. These are “undiscussables”.	Mistakes are our most valuable source of learning. Learning from our “best mistakes”.
Hospital accidents are common. Medical error, death and injury headlines are regular, predictable occurrences.	Hospital accidents are rare, with medical error death equivalent to airline and nuclear power plant performance.
Complexity makes it easy to do things wrong, hard to do things right (Institute of Medicine).	Well-designed workplace systems, structures and processes make it easy to do things right and hard to do things wrong.
Ultimate definition of quality endlessly debated, thus avoiding adequate measurement, management and improvement.	Consensus exists regarding a variety of key measures including access to care, clinical outcomes, functionality, satisfaction and value received.
Quality can be improved by responding to each event and dealing with the “problem people”. There is a silo for quality.	Quality is achieved by designing error proofing at the interface of people and processes. Everyone is in charge of quality.
Quality capability is seen almost solely in terms of professional skills – with virtual blindness to the importance of support systems.	Understands that carefully designed quality infrastructure is absolutely essential to reduce risk and optimize skills of professionals.

Quality improvement efforts are undertaken by silos in charge of quality monitoring.	Quality emanates from the careful design of clinical and operating processes and the coordinated skills of caregivers, patients and community stakeholders.
When major TQM/CQI efforts are undertaken with vigor, the existing system can reach 3 to 4 Sigma on quality. (3.5% to 7.5% error rates)	Transformed organizations, systems, people can reach 6 Sigma and beyond – to the next stage of healthcare system design.
Dominant thinking style is left brain/manufacturing model (<i>re-engineering/lean thinking</i>) which fails most of the time in complex adaptive systems. In 30% of cases, real improvements are produced with lean/re-engineering.	Whole-brain thinking (right & left brain) applied to complex, adaptive, human systems (i.e. <i>Patient Experience Design Storyboard</i>). Patient-centred care is better, and often up to 30% cheaper/more efficient.
Patients flounder as they crisscross the delivery system with "gaps" in services and very poor linkages.	Case managers and health coaches in CCACs and primary care settings provide system navigation that makes the system seem "seamless".
The "one-size-fits-all" belief system results in a common curriculum provided by one centralized provider. (i.e. a belief that no matter where a group or community is at, they should go through a curriculum that is designed perfectly for 20% of the system).	Knowledge of complex, adaptive systems means skills development programs are custom-designed to meet the unique needs of each group (i.e. "meet the learners where they are at"). Customized learning vs. "one-size-fits-all" curriculum.
CEOs manage an organization within a network of healthcare services. Managers in silos talk past each other. Despite the rhetoric of co-operation, the rewards and incentives for "winners" and "losers" -- are for those who play politics.	CEOs participate in facilitating a network of healthcare delivery organizations and provide strategic management and leadership to their own organizations. Silo managers integrate their planning and system design efforts. They are rewarded for achieving the goals in the <i>Integrated Health Service Plan</i> , and for excellence in silo management.
Governance represents the self-interests of the organization.	Governance represents the "owners": the citizens/ community.
The system is designed to be complicated.	The system's complexities and self-organizing potential is realized in a natural <i>complex adaptive system</i> .
The LHINs are empowered to create an <i>Integrated Health Service Plan</i> for their area, but have no authority or flexibility to implement their community's vision of the future.	Power and authority to allocate resources across the system under the existing LHIN Act is finally enacted as "devolution". Local communities, rather than Queen's Park, determine the allocation of resources.
LHINs are tiny offices with crushing workloads in danger of being an "unnecessary layer of bureaucracy" -- because the plan for <i>devolution of authority</i> has not yet happened. The work done by Queen's Park public servants has not been shifted to local communities, as per the intent of the legislation.	With devolved authority, after they have allocated the resources, LHINs need to further devolve authority to local <i>Health Links</i> so they can self-organize and integrate clinical services at a sub-LHIN level.
Senior managers "control" middle managers -- who, in turn, "command" the front-line caregivers.	Senior managers "empower" middle managers to "liberate" the front-line caregivers and facilitate their collective intelligence.
Health professions do things "to" and "for" "their" patients.	Health professions do things "with" patients in <i>collaborative partnerships</i> .
Healthcare executive and providers feel somewhat stressed & anxious.	People feel liberated & excited.

FORWARD THIS BLOG TO PEOPLE YOU THINK WOULD BENEFIT FROM EXPLORING THE WHOLE MEANING OF "TRANSFORMATION".

