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HOW TO STOP BLAMING:
Six Principles For Accountability Design

Ted Ball

"Accountability" is a word that is loaded with meanings that strike fear in the heart and soul of our health system's leaders and followers. That's because it has come to mean: "Who is to blame?"; and, "How should they be punished?"

E-health, Ornge and other scandals has everyone focused on blame-avoidance, blame-sifting, gaming, cover-ups, in-fighting, defensive behaviors, anti-leaning dynamics and the cause of even further dysfunction in a system already diagnosed as among the "least healthy work environments in the country."

The question is: how has the system responded to the rigid rules and controls that have been imposed from the top? Did it improve the system, or did it produce gaming and compliance role-playing? Have system leaders just blindly gone along with this whole "blame culture" that has been nurtured by Queen's Park to deflect blame from the inner circle of connected operators? Are there any leaders who are prepared to speak-the-truth, or is everyone afraid of some unknown and unspeakable horror? Is anyone prepared for true accountability?

Accountability is very different than blaming -- which means "to find fault with, to censure, revile, reproach". Blaming is an emotional process that seeks to discredit the blamed.

Marilyn Paul, a scholar in the field of organizational accountability says that a blaming culture causes organizations to become dysfunctional because "where inquiry tends to cease, and the desire to understand the whole problem diminishes." Paul says that "accountability creates conditions for ongoing constructive conversations in which our awareness of current reality is sharpened, and in which we work to seek root causes, understand the system better, and identify new actions."

She lists the true qualities of accountability as: "respect, trust, inquiry, moderation, curiosity and mutuality".

If we accepted this best practice notion of "mutuality", it would require a significant paradigm shift for a healthcare system that is currently rooted in hierarchical, command-and-control systems, structures and processes. Unfortunately, while we talk about following best practices, we don't -- including on this key topic of "*accountability*".

Marilyn Paul says that "holding people accountable should only be done in the context of clearly defined outcomes. Outcomes must be understood and adjusted regularly to reflect new realities. Not only must everyone understand what is expected of them and why, they must also have the necessary resources, conditions and skills to achieve the outcomes for which they are being held accountable."

Governance Boards need to ask: are you following best practices when you "hold the CEO accountable"? The MOHLTC needs to test the design of the current *Performance Agreement Process* with each LHIN against the six principles for accountability design.

At the operational level, governance and managerial leaders need to ensure that there is a best practice *Accountability Process* that is designed to mobilize the support required to make each person successful at achieving the outcomes embedded in three places: in their organization's *Balanced Scorecard*; in their *Health Link Business Plan;* and, in their LHIN's *Integrated Health Service Plan*.

From "best practices", here are the **SIX PRINCIPLES OF ACCOUNTABILITY**:

1. <u>You Can't Be Accountable For Anything Over Which You Have No Control</u>.

A best practice *Accountability Agreement* must be a "fair business bargain". It is a personal promise to achieve measurable results. But a person can't keep their promise if circumstances beyond their control change.

That makes sense, doesn't it? If a CEO is being held accountable by their Board for improving staff/physician moral, and their provincial government is engaged in highly emotional disputes with unions and physician organizations, how can the CEO be held accountable for the results that such an atmosphere will produce?

However, the CEO should certainly be accountable for demonstrating improved outcomes with their own organization's unions, staff and physicians that they are able to achieve from the processes that they put in place to achieve their measurable results locally.

If a manager is being held accountable for an outcome that can only be achieved if a certain barrier is removed – like the lack of a skills development program, or the lack of equipment or technology – and nobody removes the barrier, why should they be expected to be accountable?

If a *Health Link* lead is being "held accountable" for the outcomes promised in their **Health Link Partnership's Business Plan**, what happens if the cause of the sub-optimal performance is the lack of an integrated set of accountabilities among the other partners? How can they possibly deliver on their promise -- if they are not given the level of support from their partners that they require to succeed?

Best practice *Accountability Agreements* list the "supports required" to achieve the outcomes for which a person is willingly accountable. If they don't get the support they need, they can't be held accountable. It's that simple.

That's where this concept of "mutual accountabilities" comes into play.

At the operating level, a manager with an *Accountability Agreement* must be able to hold his or her boss accountable for providing the supports they mutually agree are required to successfully achieve their outcomes. At the LHIN-level, a *Health Service Provider* must be able to hold the LHIN accountable for the supports they require to succeed. Same at the *Health Link* level.

An *Accountability Agreement* is therefore a tool for people to mobilize the support they need to make them successful. It's a manager's, or an organization's <u>best</u> <u>friend</u>, not their <u>worst</u> <u>enemy</u>!

Between the LHINs and each of the agencies and institutions they fund, there also needs to be an explicit and "fair business bargain" designed as an *Accountability Agreement*.

What are the high-level outcomes -- results -- that the province and a local LHIN will hold a *Health Service Provider* Board accountable for, and, what "supports required" can a HSP Board hold their LHIN, and the Ministry of Health, accountable for providing? This is the best practice principle of *mutual accountabilities*.

While many would accept that such thinking is perfectly reasonable and fair, our traditional cultures in hospitals, CCACs, community health and support agencies, and the MOHLTC are still very much stuck in the "blame-game". Indeed, it is ingrained in our culture – how we think and behave.

Nobody ever went after the people who benefitted from past scandals. Indeed, most are still around and thriving. But in the midst of the scandals, Queen's Park proclaimed that the problems were not caused by an inner-circle of connected friends, but by a lack of a rigorous RFP system.

So instead of going after members of the inner-circle, the government wagged its finger, warning all HSPs to rigorously follow the newly-created rules, templates and processes which will enable the system to pinpoint who we should all blame and shame. This is a worst-practice design flaw that leads to severe dysfunction.

When we redesign accountability to fit with best practices, we'll end the "blame-game" – and, we will shift our culture towards the way true *learning organizations* think and behave.

In an environment that is so much about "control" and "risk management", the people who reach the top positions tend to be people who thrive in command-and-control environments. This is in stark contrast to environments that are all about "creativity" and "innovation". The top bosses in such organizations model the behaviors of innovative and creative managers.

While there are pockets of innovation everywhere across our healthcare delivery system (perhaps 20% to 30%), most HSPs (70% to 80%) are zealously compliant, and very fearful of authority. They focus mostly on "risk management" and "blame-avoidance", not "creativity", "innovation", "learning", and "continuous improvement".

If we spent as much time, energy and creativity on quality, safety and the patient experience, as we do on blame-avoidance, we would have a much better system.

Unfortunately, the MOHLTC has simply ignored the first principle of accountability in the design of their *Performance Agreements* with each of the fourteen LHINs. Today, the Ministry holds each LHIN accountable for outcomes over which they have absolutely no control.

Despite this "worst practice" behavior by the MOHLTC, the fourteen LHINs simply accept this unfair/worst practice as part of their lot in life. The LHINs who just "sign off" on their agreement, and simply set out to manage the government relationship, behave well. The LHINs that are frightened by their *Performance Agreement*, usually pass on their fear to their HSPs -- with equally unfair *Accountability Agreements*. This is the "abuse syndrome".

Rather than focusing on making real improvements, people under pressure tend to "game the numbers". Indeed, "gaming the numbers" is a very common *defensive routine* in blame-oriented environments.

The second key principle for best practice approaches to accountability:

2. <u>Accountability For Outcomes Means That Activities/Efforts And Processes Are Not Enough</u>.

Think of the mindset shift required here. Our health care system is characterized by a complex set of rigid bureaucratic processes designed in separate Ministry and government silos holding very different assumptions about reality, and about "what works".

Unfortunately, bureaucratic processes create jobs with turf boundaries to protect – at the operating level of the system, and, between the public servants and the organizations that receive funding. It also creates turf boundaries between service providers and the separate silos within the Ministry of Health.

The truth is, our fragmented health care system is the product of the individual self-interests of the isolated silos within our Ministry of Health. Fragmentation is actually designed into the DNA of the system. Overseeing all the Ministry silos over the past year is the newly-formed **Transformation Secretariat** that has a mandate to create 80 local integrated healthcare delivery systems across our fourteen LHINs.

While each *Health Link* must have an operational business plan, there are currently no plans for how <u>governance</u> and <u>accountability</u> will work in the transformed system. Whoops! That seems to be a fundamental design flaw.

While there is lots of talk about "transformation", the actual focus of our healthcare system today -- in the post E-health/Ornge era -- is on the rules, regulations and bureaucratic processes developed in the top-heavy silos at Queen's Park.

Best practices would suggest that "holding people accountable" should only be done in the context of clearly defined outcomes or results. These outcomes must be understood and adjusted regularly to reflect new realities as they emerge in a constantly changing and chaotic environment.

Not only must everyone understand what is expected of them and why, they must also have the necessary resources, conditions and skills to achieve the outcomes for which they are being held accountable. Is that not a reasonable and "*fair business bargain*?"

In a best practice accountability process, no one is given points for "following the process". The only thing that counts is getting the results. If the process design does not produce the results required, we need to change the process. Better yet, we need to design processes that are focused on achieving the results that are required – right from the start!

So let's start by honestly reflecting on the *unintended consequences* of the way we currently define and practice accountability in the healthcare system – and in the public sector generally. Is the accountability process really designed to achieve the outcomes that we all want to achieve, or,

are the MOHLTC processes just simply designed to exert "control" by the people with authority, and to ensure that blame can be placed elsewhere?

At the <u>operating level</u> of our health care services delivery system, we need to ask ourselves: **what are we in management and governance going to do to provide the practical supports required to make our people successful?** At the <u>LHIN-level</u>, and *<u>Health Link</u> governance-level*, the focused question is: **how can you ensure that individual *Health Service Providers*, and the local *Health Link* partnerships are successful?**

In my view, a system that is focused on "accountability for *outcomes*" (rather than MOHLTC's focus on *process*) would have the best chance of finally shifting our traditional pattern of spending more and more resources to produce poorer results. This needs to be a "*fair business bargain*".

The third principle:

3. <u>Accountability For Results Requires Real Empowerment And Room For Personal Discretion And Judgment</u>.

This principle would require another paradigm shift for the health sector: the principle is about the reality of balancing <u>empowerment</u> and <u>accountability</u>. Not the empty rhetoric that has contributed to the growing cynicism of our front-line health care providers -- but real empowerment, and accountability.

While the health care sector is clearly part of the knowledge economy, many of us continue to live with industrial-age assumptions about the "need for command and control", and the need for micro-management by Queen's Park. These are the folks who think "fewer is better", rather than adopting the "benefits of bio-diversity" in healthy *complex adaptive systems*.

The assumption in other modern knowledge-based industries that rely on skilled professionals is that the solutions to their most complex and perplexing problems are within the hearts and minds of the people who work in the system.

Smart organizations that are thriving in the knowledge economy invest between 1% and 5% of their payroll budgets on developing the skills of their people to work in high performance teams solving organizational problems and dilemmas by tapping into the collective intelligence of the people in their system.

Is our health care system now prepared to invest in our own IQ -- at the service delivery level, with intact teams who are "learning by doing" on transformation projects in their organization, as well as across the continuum-of-care among the *Health Link* partners?

One of the more interesting shifts that has taken place in the system over the past eight years is the "role of the CEO". While we were not too good at holding bad CEOs accountable we provided an environment where CEOs were liberated to be innovative.

Not anymore. To be innovative in a totally risk-averse environment is just stupid. So there are very few examples of true innovation from CEOs anymore. Maybe 10% -15% are "leading-

edge" -- half of what it used to be. If this is to change, the risk-averse blame environment has to change.

Everyone acknowledges that the post-scandal rules have gone "way overboard", and need to be brought into balance. We need to rid ourselves of rules and processes that scream: "**No innovation!**"

To restore a sense of "safety", the existing culture must change.

Are we prepared – at the governmental, Board and managerial levels to stop blaming and replace the rhetoric about being "learning organizations" and "best practices", with the reality of learning organizations and following "best practices" – by having a real balance of empowerment and accountability, and by investing in the skills of our people?

The fourth best practice principle on accountability design is:

4. <u>**Accountability Must Be Dynamic: Outcomes And Targets Change As Circumstances Change**</u>.

While most people would agree that this seems perfectly reasonable, the existing rigid bureaucratic culture of health care – from the Premier on down to the front-line care provider – is about "inflexibility", and "rigid rules" and "approved templates".

In the existing system, we are given every incentive to focus primarily on the <u>process</u>, rather than the <u>outcomes</u>. We tell our people that they need to be innovative, and that we should "learn from our best mistakes", and then maintain the same old systems, structures and process that account for 93% of the reasons why our results are sub-optimal! Compliance is the outcome from this system based on fear.

We also need to be flexible as we learn and improve. *Health Links* need to be designed with "**Shared Accountabilities**" to promote better communication and teamwork between the various *Health Service Providers*.

Without a flexible learning approach, people will feel fearful, fearful of being blamed.

The emphasis in governmental communications has been to make a big fuss over the "early adopters" -- special people who have been admitted to some sort of special inner circle. All talk of "accountability for outcomes" is avoided in an environment that has been made fearful by the same people who now speak glowingly about the "early adopters".

Deming told us: "first, drive out fear". Yet fear and anxiety are the dominant emotions that are driving our health care system today. Best practice *Accountability Agreements* are flexible. When circumstances change, accountabilities change. The focus is on what needs to be done to ensure that a person is successful.

That is how *Learning Organizations* function. The bosses are "in service to", rather than "in control of" those who work for them. As circumstances change, sometimes it is possible to achieve gains that are double the original target. Sometimes the circumstances that emerge require downsizing the target, or even shifting the goal altogether.

The fifth key principle for accountability system design is:

5. <u>Accountability And Stewardship For The Organization Belongs To Every Employee</u>.

Management guru **Tom Peters** has said that health care systems, structures and processes are the most complex organizational designs ever conceived by humans. But most of our core design assumptions are very much rooted in the old industrial model.

Re-engineering and *lean thinking* are two techniques borrowed from the manufacturing sector, rather than designed for a complex adaptive system like healthcare.

Systems thinking, chaos theory and quantum physics have all contributed greatly to our emerging understanding of the health care sector as a *complex adaptive system*. Each part of the system impacts on the performance of the other parts of the system. We know that.

Despite the fact that all parts of the health care system are inter-connected, we've organized ourselves into rigid silos and departments which we attempt to "manage" through traditional bureaucratic control mechanisms -- where we solve issues within each silo -- often without any apparent concern about its impact on the other parts of the system.

Best practice accountability processes include integrating the agreements cross-functionally -- across the organization, and, in a *Health Link*, across the healthcare delivery system. That way, people will truly understand how their actions impact on others; and why we need to ensure that we are working synergistically together within our organizations, and with all parts of the system.

With the introduction of *Health Links* as local integrated delivery systems at a sub-LHIN level, we have created another important set of accountabilities for the outcomes promised in each ***Health Link Partnership's Approved Business Plan***.

The sixth and final principle for designing accountability systems is:

6. <u>Accountability Is Meaningless Without Fair And Appropriate Consequences</u>.

For all the fear and anxiety that our existing hierarchical, command-and-control accountability processes produce in people, the truth is that there really isn't much of a focus on the actual consequences -- just the "threat" that maybe something bad could happen.

In their book, ***Accountability: Getting a Grip on Results*** authors Klatt, Murphy and Irvine point out that "accountability is not about assigning after-the-fact blame. Rather, it's about providing before the fact incentive for success, and room for decision-making, risk-taking and growth."

They state that "consequences may be positive or negative, but either way they need to be fair. They are not punishing or under-handed. Finding out what went wrong in a situation is essential for preventing the recurrence of problems."

But, for the most part, there are not many real "consequences". Just fear. Indeed, our healthcare system is being run by very high-priced managers, a critical mass of whom are primarily motivated by <u>fear</u>.

However, the health system will never successfully transform unless it moves past the fear-based, rules-driven, process-oriented bureaucratic mindset and, instead, embraces self-organization; collective intelligence; and, an appropriate balance between "risk management", and, creating an "innovative environment".

In a best practice accountability development process at the *Organizational-Level*, managers throughout an organization need to think through the outcomes in their organization's that they should be accountable for; the supports they need to be successful; and, what the consequences will be on their organization, their unit and themselves if they fail -- or, if they surpass the targets agreed to.

At the *LHIN-Level*, each HSP CEO needs to determine what part of the region's **Integrated Health Service Plan** their organization ought to be accountable to the LHIN for achieving. So, in addition to being accountable to their Board for their organizational outcomes, CEOs would also be accountable to their Board for IHSP outcomes as well. At the *Health Link-Level*, the accountable "lead CEO" needs **Shared Accountability Agreements** that enable each of the partners -- at the CEO level -- to understand what part of "the whole" they are accountable for achieving.

When these processes are truly designed and aligned with a learning and continuous improvement focus, they work. They don't work in bureaucratic, anti-learning and blame-avoidance environments.

That's why Boards and CEOs need to rethink how they practice accountability. This is a key leverage point which can cause the redesign of the delivery system. Boards and CEOs need to be aligned on both the "**outcomes**" and "**supports required**" for a "**fair business bargain**" between the Board and the CEO.

FORWARD THIS BLOG TO COLLEAGUES WHO YOU THINK MIGHT WANT A BEST PRACTICE ACCOUNTABILITY SYSTEM THAT MOBILIZES THE SUPPORT THEY NEED IN ORDER TO SUCCESSFULLY ACHIEVE THE OUTCOMES FOR WHICH THEY ARE ACCOUNTABLE.