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Aligning CEO Accountability Agreements With Collaborative Governance Concepts And Practices

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At the bottom of this blog is a chart that sets out the design of accountability in the LHIN/Health Link health service delivery system model for **Collaborative Governance**.

In the *Collaborative Governance Model*, health service providers (HSPs) shift from their silos into a systems approach to governance and accountability.

From the perspective of a health service provider organization, the accountability system includes up to three components:

- **The Strategic Balanced Scorecard** -- the four-box framework that sets out the organization's Board-Approved strategy -- including the methodology for tracking progress.

- **The Service Accountability Agreement With The LHIN** -- that sets out the organization's expected outcomes and alignment with the ***Integrated Health Service Plan*** which -- if best practices were followed -- reflects a "fair business bargain" agreed to by the LHIN and HSP. The *Service Accountability Agreement* will also reflect the *Accountability Agreement between the LHIN and the MOHLTC*; and, where appropriate,

- **The Health Link Business Plans** contain the newest set of accountabilities that Boards of organizations that have joined a *Health Link* must add to the other two sets of accountabilities. While the lead partner in the *Health Link* is accountable to the LHIN, each partner's board, and their CEO, are accountable for achieving their part of the agreed-upon outcomes.

The chart at the end of this blog also outlines how formal **Accountability Agreements** between Boards and their CEOs (as well as Chief-of-Staffs in hospitals) reflect the input from those three sources: the internal organizational scorecard; the agreed-upon *Health Link* outcomes; and, the outcomes required in their *Service Accountability Agreement* with the LHIN and the local ***Integrated Health Services Plan***.

It shows how the *CEO's Accountability Agreement* (and the *Chief-of-Staff's Agreement*) drive both the *Managerial Accountability Agreements,* and the *Medical Chiefs' Agreement* in hospitals. Best practices suggests that everyone's accountabilities -- and the "supports they require in order to be successful" -- are explicit, fair and balanced.

The *Balance Governance Scorecard's* four-box framework can provide a method to check on the degree of alignment that there is in your system of cascading accountabilities.

The chart outlines the accountability architecture, from the perspective of a single HSP. From a "system perspective", we need each of the HSP's governance boards to hold their CEO's accountable for each of these three perspectives.

They are no longer just a silo board, they need to think and act like a "system board" on behalf of the whole community.

The key assumption of the **Collaborative Governance** model is that Boards exist to represent the interests of the "owners" of the organization -- not the narrow interests of the organization itself.

So, in addition to holding the CEO accountable for the outcomes in the Board's approved organizational scorecard, a best practice *Collaborative Governance Board* would also monitor progress on the LHIN's service agreement -- as well as the appropriate components of the local ***Integrated Health Services Plan (IHSP);*** and, the agreed-upon business plan outcomes from their *Health Link.*

That's the basic architecture of the **Collaborative Governance Model**.

For the most part, the people currently talking up the concept of "*Collaborative Governance*" really only mean that collaboration is a "good thing". It's a nice value, rather than an aligned pragmatic accountability system design for governance. In this simple worldview, collaboration is "good" and, as such, ought to be practiced.

But the concept of "***Collaborative Governance***" must become more than just a "good intention" and a "nice value", it must be intentionally designed and aligned to actually work to create collaboration at the CEO/Management/and at clinical levels -- where integration really counts.

Collaborative Governance needs to be intentionally designed to be an antidote to "silo governance". It enables silos to be part of the network system. It is intended as a force for integration -- if the Boards of *Health Links* partners would meet together periodically to ask the "wicked" and "probing questions" on behalf of the community: the "owner" of the entire healthcare services delivery system.

When HSPs were just silos, governance boards only held their CEO's accountable for outcomes in their silo. Today, a major feature of ***Collaborative Governance*** is that while Boards exist to ensure good management in their silo, as *Health Link Partners*, and as members in a common LHIN, they are equally and mutually accountable for improved outcomes in their local healthcare services delivery system as well.

So in the future, Boards would hold their CEO's accountable for both system-level, and silo-level outcomes. That's the key leverage point for *Collaborative Governance*: the integration of system & silo accountabilities. It's the traction that makes integration

actually occur at the *Health Link* level without setting up yet another "super-board" to govern the whole local system. Nevertheless, *Collaborative Governance* needs to be much more than just a "good intention".

The "lead" *Health Link* partner organization has been entrusted with one million dollars of taxpayers' funding to support the development of the partners' agreed-upon action plan. Some of the more strategic CEO-led *Health Links* (vs. the more operational ones), will be developing *Health Link Balanced Scorecards* that spell out the "cause-and-effect linkages" between the *Customer/Patient/Client* outcomes; the *Financial* outcomes, the *Process* outcomes, and the *Learning & Growth* outcomes in their scorecard.

As everyone will discover, when you've seen one *Health Link*, you've seen one *Health Link*. They are a real mix of relationships. Nevertheless, leadership surveys @ **TedBall.com** demonstrate a very respectable amount of optimism that *Health Links* will in fact succeed in their mission to transform their local delivery systems.

While concerns have been raised that some *Health Links* see themselves as a pilot project for the Top 5%, rather than a structure to achieve better integration of services for the whole community -- based on the "lessons learned" from the "Top 5% Group", who consume 66% of all our resources.

For organizational structures to succeed, they need to be designed and aligned to succeed.

However, for whatever reason, Queen's Park has failed to be very clear about the governance of *Health Links*, or about how accountability would work. Why? They believe that saying nothing about governance and accountability means they are promoting a "low rules" environment, and that people should feel free to innovate.

So, without a macro-framework for alignment, it will now be up to the 80 individual *Health Links* to design and align themselves to work as an integrated health services delivery system. *Collaborative Governance* provides a framework and practices to enable alignment within each *Health Link.*

The advent of *Health Links* as formal partnerships -- with formal accountabilities -- ought to trigger the governance boards of the *Health Link Partners* to get together -- perhaps a couple of times per year -- to review the progress being made together by "the partners" in the network.

By bringing the ***Health Links Partners Governance Boards*** together to review their local delivery system's progress; and to explore how the partners could transform the patient experience as they travel across the continuum-of-care; communities, through these boards, could be able to hold "*stewardship*" for the local health services delivery system's transformation journey.

As "stewards" for the well-being of their community, our governance Boards need to stretch their minds ahead to 2015 and beyond. They need to understand that there will in fact be significantly fewer resources available for healthcare services immediately after

the election. Some organizations could face 10% cuts in their budget, while others will be required to manage rapid growth and expansion.

There will also be a pressing need to re-allocate resources within the existing healthcare delivery system to meet the emerging needs of each unique community. Who is going to do that job?

Governing boards would need to acknowledge that their CEOs manage in toxic, blame-oriented regulatory environments driven by fear and anxiety that starts at Queen's Park and spreads throughout the healthcare services delivery system. Boards need to explicitly liberate their CEOs to be innovative and creative as healthcare system executives, and as the organization's strategic and operational leader accountable for silo and system outcomes approved by the Board.

The beliefs and convictions of Ontario's health sector leadership was captured in the recent health issues survey @ **TedBall.com** during March Break.

On the question of "**Devolution Of Authority**" (for allocating resources) to the LHINs, 30% of respondents said they were "very supportive"; another 21% were "supportive"; and a further 25% said they had "some support, with adjustments". That's 76% of health system leaders who want devolution. That's a significant stance that should not be ignored.

Only 13% of respondents were "opposed to the devolution of authority" to the LHINs.

With the arrival of a new Deputy Minister in June, and the expected report of the Legislative Committee studying the original LHIN legislation, there is an opportunity to tag the LHINs with the task of re-allocating fewer resources across their delivery system using provincial standards and their ***Integrated Health Service Plan*** as guides.

I very much doubt that the next government really wants to put Queen's Park in charge of downsizing budgets at the local level -- or in charge of re-allocating resources from acute care to community care, based on evidence and population need. That's the point at which politicians say: shouldn't the decision about the allocation of resources be a local decision, rather than a centralized bureaucratic decision?

The emerging challenge for *Health Link Partner Boards* and their CEOs, is: how quickly they can prepare for major transformational change over the next year or more -- while funding still remains somewhat stable -- as long as we are in "pre-election mode".

While the next election could actually be as far away as a year from now -- and perhaps even to the end of the legislated mandate in 2015, people who have been "putting things off until after the election", should be asking themselves: why are you waiting? Are you a political candidate, or a healthcare leader?

So, now would also be a good time for engaging in **Health Link Governance Partners** to engage in conversations about *Collaborative Governance* design -- before the financial

crunch comes after the election. Smart people, smart communities will be getting their ducks in a row now.

Unfortunately, many LHINs and *Health Links* may actually wait until their community is in a horrible crisis before moving to action. Some will hold true "stewardship" for their community, and take action much earlier. Today, perhaps 20% to 30% of our healthcare delivery system has actually achieved a state of "readiness for transformation".

There are a number of LHINs that are currently already engaging their HSP governance boards about governance, and about the concept of **Collaborative Governance**. But given that 70% of all major large-scale change efforts fail, it is very possible that only 30% of our *Health Links* will actually succeed in the end. That may be the case in some LHINs.

There are mixed reports on the behaviors and operating assumptions of our 14 LHINs. Respondents to our recent March Break **Health Leaders' Survey** had a distinct pattern.

40% said they had "little" to "no confidence" that LHINs would contribute to the success of the *Health Link Program*. That is a significant level of negative judgment about our existing LHINs, and their capacity to support transformation.

32% of Ontario healthcare leaders said they have "some confidence" that LHINs will help the *Health Links* initiative to succeed. 28% said they had "high" to "great" confidence that these local integrated health systems would succeed. That's 60% who have some degree of confidence that LHINs would help the *Health Links* succeed. Form a change management perspective, that's a solid critical mass going forward.

But if *Health Links* are to become the "transformational" vehicle that Queen's Park claim they are, the partner CEOs and senior managers need to be liberated by the governors to develop the strategy and a plan for aligning the structures, culture and skills of the partnering organizations to create a better more seamless experience for patients.

If every Board told their CEO that among their highest priority is the creation of a "seamless experience" as patients and their families move across the continuum-of-care in their community, we would achieve the integrated system taxpayers are demanding. The foes of local governance say that these silo-boards are in fact urging their CEOs to build a self-serving empire at each organization.

That could be true in 10% to 15% of "old-school cheerleader boards".

Today, in addition to each Board holding their CEO's accountable for system and *Health Link* outcomes, *Collaborative Governance* design could also include an aligned structure for regular quarterly meetings of *Health Link* Board Chairs/Vice Chairs in order to review the overall *Health Link Scorecard*, and to engage in *generative dialogues* on high-level strategic directions for the **Health Links Partnership**.

Notice I'm not advocating for a new layer of *Health Link System Governance*. **Collaborative Governance** is about the self-organizing capabilities of systems. It is not about new structures. It's about new conversations, and new behaviors.

Of the three governance modes of *Strategic/Fiduciary* and *Generative*, the *Collaborative Governance Partners' Council* needs to focus primarily on being "**generative**".

On behalf of the "owners" of our healthcare delivery system, they should invest perhaps four days per year asking "wicked" and "probing" questions that will help management uncover the strategic directions required to achieve the vision for a more integrated delivery system, that improves the patient experience, and achieves the goal of improved health status of the population served.

Health Links need to become learning communities, and the governance boards need to play a role in facilitating learning, in their organizations, and across the sector.

The challenge: Queen's Park seems to be totally perplexed by governance and best practice governance concepts -- including their own incredible track record of actually implementing "worst practice" governance models at the *Family Health Team* level. In addition, a number of key people in the Queen's Park inner-circle of policy influencers are "anti-governance". This is the "*Fewer Boards are Better*" camp.

The "fewer boards are better" advocates apparently do not accept the research from *Canadian Patient Safety Institute* (CPSI), and from *Institute For Health Improvement* (IHI), that suggest that properly trained governance boards can actually add significant value towards improving health quality, patient safety and the patient experience.

The anti-governance advocates don't acknowledge these points. They simply say that silo-governance causes system fragmentation. They say the solution is to just "get rid of them".

As always, there is some degree of truth in the anti-governance group's charges. Some governance boards -- particularly our Health Science Centre Boards, and sometimes boards of smaller hospitals -- do push their CEOs to be silo-centric, rather than system-centric.

All the Minister of Health, (or even the LHINs) need to do is "call them out on it", when Boards are being silo-centric.

So far, this anti-governance sentiment has only manifested itself as neglect from Queen's Park. The problem is, if *Health Links* fail because there was not a best practices approach to governance and accountability, who will be accountable? Would that be the Minister's, or the MOHLTC's responsibility to ensure that the program they designed actually works?

The answer is: it's both.

While these are still early days, we are now entering into our second year with the *Health Links* program. What are we learning? What's working? What's not?

The best current examples of emerging *Collaborative Governance* in Ontario is at the *North Simcoe Muskoka LHIN* -- led by Board Chair, **Bob Morton**; and at the SELHIN, led by Board Chair, **Donna Segal**. People should access their slide deck presentations from their upcoming April 28th OHA Workshop presentations to understand their respective approaches to ***Collaborative Governance***.

While these slide-decks outline the logic of the approaches being taken by the NSM LHIN and by SE LHIN, the glue that actually holds their process together is trust, ownership and commitment. Trust enables true collaboration, and, with practice, synergy.

In the *Collaborative Governance Model*, if Board Chairs, Vice-Chairs and Committee Chairs of *Health Link* partner boards were to meet three or four times per year as the HSP governors, they could monitor the systems' evolving progress, and explore potential *leveraged actions* that would propel the whole system forward -- the wonderful world of continuous improvement and strategic learning.

We have yet to get accountability design right in our healthcare system.

So, in this "low rules" environment -- where government has no clear views on governance and accountability for *Health Links* -- health system leaders should take some time to think about it: how could your organization better integrate the multiple outcomes for your organization -- and for the larger system at the LHIN and *Health Link* levels?

Think about it as you review the chart here: **Collaborative Governance: Accountability System Alignment**.

Collaborative Governance Accountability System Alignment

SERVICE ACCOUNTABILITY AGREEMENTS

- Sets out "high-level" financial & customer outcomes expected for money provided

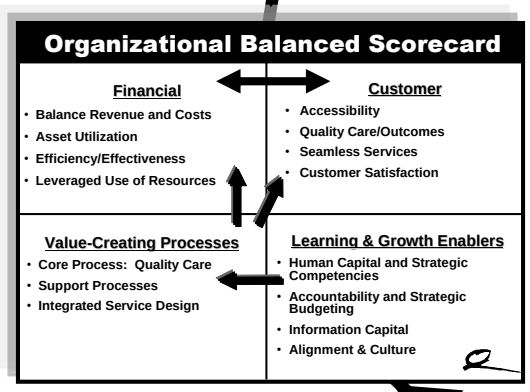
STRATEGIC BALANCED SCORECARD

- describes strategy, measures & targets
- guides execution
- information on performance

Service Accountability Agreement with the LHIN

BALANCED GOVERNANCE SCORECARD

- states the financial & customer outcomes
- defines the strategic contribution of the board
- helps manage the performance of board/committees
- clarifies the strategic information the board needs



Dialogue & Continuous Dynamic Evaluation & Learning

Accountability Agreements For CEO & Chief-of-Staff

- **Managerial Accountability Agreements**
- **Medical Chiefs' Agreements**

Health Links Business Plan Accountability to the LHIN

HEALTH LINKS PARTNERSHIP

- Lead partner accountability to the LHIN

ACCOUNTABILITY AGREEMENTS

- sets out what parts of the scorecard each individual is accountable for achieving & the supports they need to be successful.

FORWARD THIS BLOG TO COLLEAGUES INTERESTED IN THE ART & SCIENCE OF ACCOUNTABILITY ALIGNMENT, AND THE NEED FOR DESIGNING COLLABORATIVE GOVERNANCE FOR HEALTH LINKS AND FOR LHINS.