

DESIGNING INTEGRATED HEALTHCARE SERVICE DELIVERY SYSTEMS

By Ted Ball

Quantum Transformation
Technologies

The major challenge facing the Ontario healthcare system's leadership over the next two to three years will be the implementation of the key components of the *Made-in-Ontario Model* of health service delivery. Healthcare leaders who thought their job was just to “govern” or “manage” their silo, will now discover that their talents/knowledge/insights are really needed to help design functional meaning into the way the delivery system will operate in the future. So we need our governance and managerial leaders to become “system designers” and “system architects.” The challenge for the LHINs and for the service provider organizations is: how to design a high-quality, affordable delivery system that is focused on the best interests of the patients/customers and clients — who are also the funders and owners of the system.

The problem is that most health system leaders at the governance and managerial levels view themselves as “governors” or “managers” — not as “system architects” or “system designers” who need to focus on the public interest — as well as their organization's interest.

This is a very different way of thinking about a service delivery system that has traditionally been designed by politics, not evidence about “what works.”

Deming (the father of the discipline of quality management) said that after a lifetime of learning about organizational and whole system change, he realized that 93% of all the problems he encountered in organizations were due to poor design — while 7% of the time the problem was people-related.

Deming said that half the time the issue was a “people problem,” the root issues were actually things like inadequate skills and training.

But despite the fact that only 3.5% of problems are about “bad behavior,” the healthcare sector's culture tends to blame people: “those CEOs,” those “LHIN people,” “the doctors,” “the unions,” “the government,” etc.

This background paper will attempt to provoke your thinking about complex system design — and what that might mean at the provincial, local and organizational levels — when we finally abandon politics and embrace systems thinking and performance metrics as the way to design our health service delivery system.

At the core of this paper is a best practice systems thinking-based organizational design tool that provides a framework for exploring the key leverage points of system design. The paper will attempt to provoke your thinking about what needs to be done to enable the health-care system to transform itself over the next two to three years.

At the risk of turning off readers with management science mumbo-jumbo, the paper also makes references to a number of best practice tools and processes for strategy execution and performance measurement — without which the path ahead will be chaotic and fraught with misunderstandings.

The purpose of the paper is to provide some context to the emerging environment in which organizations and delivery systems will be designed and transformed, and to explore some of the “lessons learned” and best practices that are emerging in the field of system design that will provide some helpful guidance to those who will be engaged in designing the “*Made-in-Ontario Model*.”

CURRENT REALITIES

The good news is that there are a critical mass of healthcare organizations that are already well down the path of transformation and performance improvement. So there is already some momentum in the delivery system for positive customer-driven changes.

But in complex adaptive systems, the moment change begins to happen, resistance to change provides the countervailing force. Nevertheless, I believe that the current financial crisis is about to provide the “tipping point” for more rapid change in Ontario’s healthcare delivery system.

Historically, we have never succeeded in incrementally “buying” health reform — even with the 32% increase in provincial healthcare spending over the last five years. Wages were improved, services were not — except for some important improvements in wait-times for some surgical procedures.

But today Ontario is no longer fiscally capable of pumping more and more money into the healthcare delivery system. Indeed, while predicting can be a “mug’s game,” prudent strategists must be able to plan ahead under several different scenarios and assumptions.

A safe assumption on provincial funding is that Ontario’s budget this year will exceed \$100 billion (including bailouts for General Motors and Chrysler) with a deficit of up to \$18 billion over the next two years.

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But while the medium-term scenario may be bleak, the short-term scenario is actually a little better.

As Ontario becomes a “have-not” province this year, we qualify for \$350 million more than we did under the old *Canada Health Transfer* formula. This just-in-time funding will help stabilize the system in the short term.

However, while the government may indeed come up with their promised 2.1% overall healthcare budget increase this year, given the free-fall in provincial revenues, and the depth of the recession, I think it would be prudent to expect them to hold the line at 0% increases for the healthcare system in 2010-2011 — which, given cost pressures, would actually amount to an overall cut of about 4% for the sector.

That does not mean a four percent cut for everyone.

Within each local delivery system, as a result of the new LHIN resource allocation process, health service organizations will be expanding and contracting beginning in 2010-2011 — based on their performance, and based on evidence.

I may be wrong on my specific numbers — but not in the overall direction. The truth is: Ontario simply cannot afford to waste this crisis. This is perhaps our best opportunity for a long overdue transformation of the delivery system — now made possible by our current and expanding financial crisis.

JOBS vs. WASTE

My best guess is that the scale of our economic problems will require the McGuinty Government to take action on runaway health sector spending over the next three years. But I believe the government will likely move in increments — allowing the system to prepare for an intelligent redesign, rather than a frenzy of program cuts and staff firings.

In the Harris era, re-engineering methodologies and old-fashioned management practices led to the firing of over

5,000 nurses. The assumption was: if 70% of the costs of the system are wages, then we need to fire people in order to balance the budgets.

But this was profoundly misguided because the firing of staff actually leads to a lowering of the health status of the population, as well as loss of capacity in the healthcare system.

The most important *social determinants of health* are *food, shelter, and economic security*. So laying off healthcare workers doesn't save taxpayers money. In fact, it costs us money in the medium and longer term. Throwing fifty-year old nurses on the scrap heap is a lose/lose/lose proposition.

It is also unacceptable. These experienced and knowledgeable professionals have provided twenty-five years of dedicated and caring services to our families and neighbors. We owe them — and we need them.

So, where do we get the money to reform and improve our healthcare services — while keeping all the current staff employed? The challenge ahead is to eliminate waste in the system — estimated to be at 30% of total costs — and redeploy these resources to where the evidence says we will get a higher return-on-investment.

Of course, in the future, when LHINs allocate resources based on performance and evidence, some organizations will shrink and some will expand. So, what will happen then?

Rather than having healthcare workers as employees of an institution or agency, maybe we ought to consider making them employees of a local system — so that people can be redeployed across the system, rather than losing their job because they are trapped in an organizational silo.

Holding on to old paradigms and structures will result in harm to our front-line healthcare workers — so union leaders and employers need to get flexible and creative to ensure that nobody will lose their job as the system is transformed over the next two to three years.

I certainly recognize that these suggestions would require a great deal of dialogue and planning. But our system leaders are, for the most part, a pretty smart and competent group.

Ontario is lucky. Former Minister of Health George Smitherman put in place the tools and structures to transform the healthcare delivery system, and his successor, the Hon. David Caplan, fully intends to implement the provincial reform agenda during the government's second term.

Mr. Caplan has told healthcare service providers that they can still count on the government's promised 2.1% budget increase next year — even with the collapse in provincial revenues. Given the stability that would be created by this measure, the new Minister will no doubt be counting on the leadership of the delivery system to fully implement the "*Made-in-Ontario Model*" over the next two to three years.

The government will need to demonstrate to Ontarians that they are making measurable progress at creating a more customer-focused delivery system with high quality services that are effective at improving the health status of the population.

Their re-election campaign is in just three years. So change is going to happen. It has to. The status quo simply cannot survive.

But where are we going? If change is really coming this time, what will it look like? How will it be better than our existing healthcare delivery system?

THE VISION THING

At the risk of causing you to roll your eyes over the "*Vision Thing*," the truth is that, as architects, our system leaders really must be guided by a *clear vision* of what it is that we are seeking to design — at the provincial, local and service delivery levels.

Peter Senge in *The Fifth Discipline* said "a shared vision is not an idea. It is rather, a force in people's hearts, a force of impressive power. It may be inspired by an idea but once it goes further — if it is compelling enough to acquire the support of more than one person — then it is no longer an abstraction. It is palpable. People begin to see it as if it exists. Few, if any forces in human affairs are as powerful as a shared vision."

But do we really have a coherent and compelling "vision" of the future system? Are managers, Board members and front-line staff aligned on where their local system is

going? Do they have a vision and strategy for how their organization “fits” with the larger system?

In his HBR essay on “Why Transformation Efforts Fail” John Kotter points out that without a vision “transformation efforts can easily dissolve into a list of confusing and incompatible projects that take the organization in the wrong direction or nowhere at all.” In most failed transformations, you will find lots of plans, directives and frantic sub-projects, but no vision.

Managers and governance leaders at the network level need to clarify what their vision means for the evolution of their local service delivery system over the next several years.

From now on, LHINs will be held accountable for improvements to the health status of the population they serve.

After all, what is the point of spending \$40 billion annually on *healthcare*, if we are just getting sicker and sicker? Still, here we are, three years into the new delivery system, and only a few people are even thinking about how to shift the system from its traditional focus on “sick care” to reflect the evidence from health promotion, illness prevention and environmental health.

I include *environmental health* measures here because even as most healthcare sector leaders are thinking through the compelling rationale for shifting resources into illness prevention and health promotion, our citizens — our funders and our clients — are increasingly concerned about the impact of environmental issues on their health status, on their own use of the healthcare system, and, on the system’s capacity to adequately respond to society’s evolving needs.

As recently as January 30th, 2009, the *Toronto Star* published a story about a new report by the Toronto Public Health Unit entitled, “*Air Pollution Burden of Illness From Traffic in Toronto*” that estimates that air pollution now causes *1,700 premature deaths* and *6,000 hospitalizations* each year in Toronto. Similar figures were released two years ago, and then a couple of years before that. The problem is growing, not going away.

The Obama-Age is about “connecting the dots.” People grasp the need for integrated measures that are effective at disease prevention. They know that it would be more

prudent to address air pollution than to watch premature death rates and hospitalizations climb indefinitely.

Our citizens want measures that will improve their health — and, they also love their doctors, hospitals and community services.

“From now on, LHINs will be held accountable for improvements to the health status of the population they serve.”

The vision of a system in which health promotion and disease prevention are at the “hub” is commonly called a “**Second Curve Delivery System**.” This truly is a major shift from our current *First Curve Delivery System*, which places hospitals at the hub.

The evidence for why we should do this has been accumulating for decades, and it’s overwhelming. But the problem is that it’s easier said than done because a lot of people feel uneasy about change. For many of these folks, resistance is due to the fact that they don’t really know how to make change happen. And for others, it’s based in a sense that they can’t “win” in this process.

People and organizations who feel threatened will, of course, prevent change from happening.

So let’s explore how system change can become clear and exciting, and how it can produce wins for everyone — including the acute care sector. There is compelling evidence to suggest that building a more effective delivery system with primary care at the centre will include a better acute care system too.

ORGANIZING FOR TRANSFORMATIONAL CHANGE

How do we get the right balance in our independent and interdependent delivery system?

I would suggest that the three most *leveraged actions* (maximum benefit for minimum effort) that Health Service Provider Boards could take to achieve a balance are:

- Reward senior management behaviors that support collaboration and system transformation instead of “silo-maximization;”
- Hold the CEOs accountable for playing full tilt with their system partners on local network re-design issues; and,

- Hold managers accountable for improvements and innovations in their own organization's performance in the context of their **Integrated Health Service Plan**.

At the Operational Level, where services are delivered to real people — hospitals, CCACs, community agencies, Family Health Teams, Community Health Clinics and Public Health Units — managers, staff and Boards of service provider organizations all need to “refresh” their vision with careful attention to strategy implementation, in ways that reflect today's financial realities — and the organization's current performance results.

Service provider organizations also need to develop *Managerial Accountability Agreements* that link the agreements between the Board and CEO, and between the Board and the LHIN.

For LHINs, *leveraged actions* to create momentum and balance could include:

- Building a *LHIN-Level Scorecard and Strategy Map* by working with providers to determine the best indicators that will measure the successful implementation of the goals of their community's updated or “refreshed” three-year-old *Integrated Health Service Plan*;
- Incorporate these agreed-upon indicators into the *Service Accountability Agreements* with each of the Service Provider Boards in their network; and,
- Build highly collaborative and respectful relationships at the staff level with senior managers across their network of service delivery organizations — because, in the end, it is all about *relationships, relationships, relationships*.

These efforts need to be conducted as team-building and trust-building processes that model and practice “collaboration.”

The MOHLTC of course plays a critical role in modeling *stewardship* by no longer attempting to be “in control.” At the same time, the provincial government needs to provide the high-level strategic imperatives for the system.

Queen's Park is deeply concerned about patient flow in the delivery system. On any given day there are more than

3,000 frail, elderly patients in hospitals known as ALC, or *Alternative Level of Care* patients. These patients now take 19 percent of all active care beds — up 10 percent in the past year.

“70% of all major change efforts fail. That means that there is a 30% chance that the ‘Made-in-Ontario Model’ is going to be successfully implemented”

The province also intends to set targets for ER wait times and to take additional measures to move frail, elderly patients into community care settings.

Today, the government's three top *strategic imperatives* (i.e. things we must get done) are:

- Improving access to emergency department care — by reducing the amount of time that patients spend in the emergency department waiting;
- Reducing the amount of time that patients spend in alternate level of care beds; and,

- Improving access to integrated diabetes care — by supporting the roll-out of MOHLTC's diabetes strategy.

These top priorities are to be integrated with the LHINs own unique IHSP through the *Service Accountability Agreements* with health service providers.

The “Owners,” who are the citizens of Ontario, are really counting on their communities' senior managers and governors — and their provincial government — to create a better, more customer-driven healthcare service delivery system. They are counting on their local health sector leaders to stop competing — and start collaborating on the new system design.

As we now enter the *Strategy Execution Phase* of provincial health reform, service delivery network partners at the governance and management levels need to develop a real commitment to the changes they agree they should make over the next one, two and three years. If there isn't a real commitment, and a rigorous process for strategy execution, the system simply will *not* transform — however logical the motivation for change.

The “lesson learned” from past efforts at organizational and whole system transformation is that 70% of all major change efforts fail. That means that there is a 30% chance that the “*Made-in-Ontario Model*” is going to be successfully implemented.

Those are still good chances. The delivery system can be transformed — if we do it right. We don't have to repeat each of the failed mistakes of past attempts to reform the system.

COLLECTIVE INTELLIGENCE & SYSTEM WISDOM

The unique service delivery model that Ontario created four years ago was designed with the understanding that the knowledge about how to design a better system is in the system itself — not in a LHIN Office, or at Queen's Park.



This view accords with many system design experts. Margaret Wheatley, for example, in her best-selling book, *Finding Our Way: Leadership For An Uncertain Time*, advises that, “when a system is failing, or performing poorly ... the solution is always to bring the system together so that it can learn more about itself from itself.” She notes that “the value of this practice was quite evident at the beginning of the customer service revolution, when talking to customers and dealing with the information they provided became a potent force for stimulating the organization to new levels of *quality* and *service*.”

So the task at hand is to extract and codify the wisdom in our service delivery organizations — so that they can get to work redesigning and transforming the system step-by-step.

At the organizational level, there is a great deal of wisdom at the front-line. People in the delivery system know what's wrong, and how to make things better — if they have the tools and the training.

At the community level, LHINs are best positioned to be the “facilitators” of the collective intelligence of service provider leaders in their network. They can draw out and systematize the insights, knowledge, experience and wisdom so it can inform system design and organizational practice.

To do this, they need to act in *stewardship*, rather than staking out political territory as the “system manager” who is “in charge” of the delivery system. Power dynamics in a fragmented political system are “normal.”

Everyone is counting on our healthcare system governors and managers to submerge their egos and narrow self-

interests to provide their own best *leadership wisdom* during the transformation journey ahead.

The formula: **Wisdom = Knowledge + Experience + Reflection (- Ego)**. Keeping in mind that “ego” is as often organizational as individual.

Everyone is also really counting on the service delivery partners to fulfill their part of the bargain — which is to actually become “a local system.” That's the “interdependent” part of the “independent & interdependent system design.”

In this paradigm — call it the “*LHINs Are Us Model*” — the actual organization called “the LHIN” is just 9 Board members and 20 staff in stewardship to the system and the powerful vision of the high-quality patient-centered health system that our political leaders say they are creating for us.

The LHINs are essential to facilitate local system planning and, of course, to allocate resources based on evidence and performance. They've got the mandate and they've got the money. The “*Made-in-Ontario Model*” simply can't work without LHINs. So, we cannot allow any LHIN to fail. If they fail, we all fail. The LHINs, after all, *are us!*

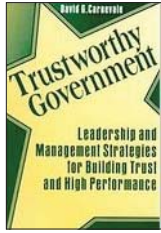
TRUST AND THE WIN/WIN MINDSET

A recent *Toronto Sun* article cast the LHINs' mission and purpose as “a way for politicians to distance themselves from hospital closures,” and referring to Board members as “unelected groups that never have to explain their decisions to irate voters.” This is not very helpful to the cause of health reform. More drama and politics. More fragmentation and confrontation and lose/lose/lose scenarios.

By contrast, LHIN leaders and provincial leaders need to ensure that they continue to engage one another, and the managerial and governance leaders in the delivery system, as true partners, not as anxiety-ridden officials focused on the old “blame-and-blame-avoidance dance.”

In other words, they need to build trust.

In *Trustworthy Government*, David Carnevale writes that many people go to work each day “with guarded, suspicious and cynical attitudes ... these emotions corrode relationships and destroy the possibility of high performance ...” By contrast, “trust is an integrative mechanism —



the cohesion that makes it possible for organizations to accomplish extraordinary things.”

But the truth is that most people in the delivery system don't feel safe. They are fearful. Indeed, in the

January 12th, 2009 *Hospital Service Accountability Agreement Update*, KPMG reported that only four of 14 LHINs say that there is a “trusting relationship” among the LHINs and the hospitals in their networks. And in many organizations, that lack of trust goes all the way down the line. The result? Fear and anxiety cause higher and higher error rates.

If this reality isn't addressed quickly, health system transformation will fail. These last three or four years will have been a lot of very expensive busy work going nowhere. In the end, we will have only inserted an additional layer of bureaucracy (the LHINs) on the same old delivery system.

Same old, same old. Have you seen this picture before?

If we really want to succeed this time, we must build and restore trust. One thing each of us controls is our own attitude. We need to become far less judgmental and negative in our attitudes towards others in the delivery system.

For example, while in the past it may have been politically acceptable to bad-mouth hospital CEOs — and perhaps even to characterize them in cynical ways — if we are ever to successfully transform our delivery system, the truth is, we need to draw on the considerable managerial talents and skills of our hospital CEOs.

Trust issues also have to do with many service providers' fears that they are going to be micro-managed by LHINs, rather than facilitated; that they are going to be bossed around, rather than supported and linked together.

LHINs are concerned that they may be micro-managed from Queen's Park — not the devolution of authority that has been mandated; not the liberation to solve the unique challenges of their community that was promised.

Another major issue that I flagged earlier: the shift in emphasis to health promotion and primary care is often

thought about and presented as a “loss” for the hospitals — instead of a golden opportunity to hone and take acute care to new levels of excellence.

With the “loss” mindset, it would be normal to expect hospitals to rise to their own defense by marshalling their considerable managerial and political skills to oppose what seem like threatening changes. But if this happens, we can expect power struggles, politics, competition and profound system stagnation — in other words, huge roadblocks to implementing the government's reform agenda.

The truth is that we need to draw on the talents and skills of our hospital CEOs. We need them to help Ontario build the healthcare delivery system that each community requires and wants. And we

need them to tackle with enthusiasm the wonderful new opportunities for innovative ways to improve acute care and integrate it with the rest of the delivery system.

In LHINs where there are strained relationships from the Start-Up Phase, the highest priority ought to be: *building trust*. We also need to provide hospital CEOs and other leaders with *aligned incentives* to help their community build a more effective health services delivery system.

If hospital Boards are still rewarding their CEOs for achieving higher growth and bigger budgets for their silos, rather than focusing on the interests of the “owners” (citizens-clients), refining and innovating with respect to acute care and disease management, and helping the system to develop — they are, in effect, derailing system change. They really need to rethink what they should be holding their CEOs accountable for achieving in accordance with the new “*Made-in-Ontario Model*” — which balances independent service providers who are operating in an *interdependent* system.

Getting the right mix of incentives, rewards and pay-at-risk for CEOs, Executive Directors and Chiefs-of-Staff will be a key leveraged action (“highest return-on-investment”) for Boards who are looking for better results.

These *pay-for-performance* formulas need to reflect the whole picture: the organization's Board-approved strategy; the *Service Accountability Agreement*; and each person's own unique challenges and circumstances in their role.

“Getting the right mix of incentives, rewards and pay-at-risk for CEO's, Executive Directors and Chiefs-of-Staff will be a key leveraged action for Boards.”

PRIMARY CARE & DISEASE MANAGEMENT

Redesigning the continuum-of-care around the core business of primary health presents challenges that should be relished by innovative leaders across the delivery system.

Making the mind see primary health as the “core business” of our healthcare delivery system provides an abundance of innovative possibilities. What one begins to see is that the value chain takes on a new configuration in the service offering along the entire continuum-of-care. In particular, there are tremendous opportunities — and needs — for filling in the gaps in our existing services.

One major gap is *Chronic Disease Management*. One third of our youth and adults have chronic health conditions such as diabetes, heart disease, cancer and arthritis.

These chronic diseases generate: 67% of all visits to community nurses; 51% of all visits to family doctors; 55% of all visits to specialists and 72% of nights spent in hospitals.

As the “*Made-in-Ontario Model*” is shaped and sculpted based on this type of evidence, you begin to get a better sense of the future system that needs to be created. So, where will evidence-based decision-making shift resources to?

I think more investments can be expected in disease management programs and prevention protocols, fewer in acute care for episodic recurrences. There will be more incentives and processes to manage demand; fewer emergency and walk-in visits will occur for minor ailments.

More concern and attention will be paid to case management. Investments will be made on the Emergency Room/ALC problems; likewise the enhanced support for community-based mental health services and for the roll-out of MOHLTC’s diabetes strategy.

A much more rigorous focus will be placed on quality and safety (the world of 9-Sigma achieved by the airline industry) and real progress will be made on implementing an e-health strategy.

We’ll also see continuing expansion of Community Health Clinics and Family Health Teams; and, the achievement

of significant cost savings from “*Back Office Integration Projects*” that are now being organized across the province with support from the *Ministry of Finance* — who are keen to see a more leveraged use of resources and less “waste” in the health sector.

“Chronic diseases generate: 67% of all visits to community nurses; 51% of all visits to family doctors; 55% of all visits to specialists and 72% of nights spent in hospitals.”

However, in addition to all these changes, perhaps the most significant shift in the delivery system that will be required over the next two to three years is to move towards *Illness Prevention Strategies*.

In his vision for *Medicare in the 21st Century*, Tommy Douglas said, “only through the practice of preventive medicine will we keep the costs from becoming so excessive that the public will decide that Medicare is not in the best interests of the people

of the country.”

We even had a blueprint in the mid-’70s to implement Douglas’ strategy called the *Lalonde Report*. But the destructive pull of interest group politics and a lack of political will have kept us in the *First Curve Delivery System* for much longer than most public systems on the planet. These have cost us dearly in every way. Our fiscal challenges demand that we put an end to them.

Based on the *World Health Organization* and the Canadian Medical Association’s definitions of **primary health care**, the following definition was developed by the PCCCAR Sub-committee on Primary Health Care:

“Primary health care consists of a first-contact assessment of a person and the provision of coordinated care for a wide range of health concerns within a sustained relationship. It combines a focus on individuals and families with a focus on the health of a defined population within a community.”

“Primary health care is delivered by a variety of health professionals and providers working collaboratively with the consumer to maintain health, support wellness and treat illness. Full participation of consumers and accountability to consumers and to the community for high quality and comprehensive services are essential features of primary health care.”

Outside of the capital “H” healthcare system box, are several other policy levers that can in fact prevent sickness. Many of these levers are in the social services and education sectors. Others are in the environmental and financial portfolios.

In Ontario, for example, poverty-induced expenditures related to healthcare have an annual cost of \$2.9 billion. By investing \$1.4 billion in poverty over the next four years, the McGuinty Government hopes to reduce poverty — and at the same time make a dent in healthcare costs. But the \$1.4 billion could be just a start, there may be more in the Provincial Budget in March, 2009.

This is a good example of “out-of-the-silo,” “Beyond One-Ministry” thinking. Reduce poverty, save health system costs, benefit all taxpayers, benefit all citizens, and, do “what’s right.”

So how do we encourage this type of systems thinking across the whole delivery system? To change the core business of a system — and to learn how to “think differently” — involves a change in the key *assumptions* underlying the decisions which are made day-to-day in the system.

SECOND CURVE DESIGN ASSUMPTIONS

Unless current *assumptions* are surfaced and tested, they will hang on and become barriers to the development of the new system. In the case of our healthcare system, changing the core business to primary health and health promotion will require the surfacing and testing of current assumptions, and their replacement with assumptions which are based on evidence and are valid and appropriate in today’s evolving fiscal environment.

An *assumption* is a belief that is rarely questioned — even though it drives decision-making.

For over four decades, our Canadian health care system has been driven by the twin assumptions that “health” is synonymous with “health care”; and that health care is synonymous with physician and, especially, hospital services. This core belief has fostered another key assumption: **acute care is the hub of the system.**

Several years ago, Dr. Martin Merry and I wrote an article on “*Designing & Creating ‘Second Curve’ Healthcare Systems*” that makes **primary care the hub of the system.** When you review the assumption shifts between the *First Curve* and *Second Curve* systems on the next two pages, you might think about how you would alter — or add to — the assumption shifts that you believe are necessary for our healthcare system to transform. By reviewing, comparing and reflecting on the *First* and

Second Curve system design assumptions, you will begin to get a better picture of the system that is struggling to emerge.

You will also see that parts of the *Second Curve* system are *already* emerging. But to ensure that the *Second Curve* system emerges complete and robust, we still need to step back and get to the 5,000-foot level to see how more of the unfolding system can be allowed to emerge — and what parts need to be designed and redesigned to achieve the outcomes and results required.

How do we do that?

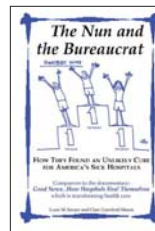
SYSTEMS THINKING

Systems thinkers see an institution like a hospital, or a complex network of organizations, not as the sum of its parts, but as the *product of its*

interactions.

In the companion piece written for the documentary “*How Hospitals Heal Themselves*,” the authors point out, “a system is not measured merely by what people are doing individually, but by how well they are *working together* — interacting and interfacing. It is the quality of their interactions that makes an organization greater — or lesser — than the sum of its parts.”

Designing a complex adaptive system to meet community needs can be viewed as a fairly logical process. But our habit of fragmenting everything into its component parts is a difficult one to break, reinforced as it has been by fragmented funding silos.



In *The Nun and The Bureaucrat*, Savary and Crawford-Mason trace the successful transformation of two integrated health systems in the United States. They point out that “unlike the limited individualistic, single-focused, pragmatic, direct cause-and-effect approach of the scientific method, the systems mindset is about relatedness, interdependencies and deep-seated causes.”

They say that instead of focusing on actions, systems thinking enables us to focus on the *interactions* — what happens between individuals and between organizations, sectors, teams, groups, and departments.

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FIRST CURVE – CURRENT REALITIES

SECOND CURVE – EMERGING VISION

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.	Knowledge that poorly designed systems, structures and processes leave people feeling powerless and uncaring. 93% of time performance issues are system design issues.
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.	Solution to problems translates to redesigning systems and providing people with the learning support they need.

A S S U M P T I O N S & B E L I E F S

FIRST CURVE – CURRENT REALITIES

SECOND CURVE – EMERGING VISION

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.
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 a 3rd curve of healthcare system design. (3.4 defects per million and better)
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 are for "winners" and "losers" and 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 integration and for excellence in 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 authors say that “in most of today’s hospitals, administrators continue, often fruitlessly, to apply traditional management tools that are no longer adequate to control the tumultuous complexity and contemporary chaos overpowering their facilities.”

“Almost all of those no-longer-useful management tools were based on linear reasoning and single-event thinking — a mindset designed for running an organization during a much simpler era than ours.”

“Everyone is familiar with typical methods of traditional system management by objectives, putting out ‘fires’ as they occur, making little fixes here and there whenever a problem emerged, adding more security, duplicating services, doubling and tripling inspection personnel, putting up posters, hiring flavour-of-the-month consultants, buying the latest equipment, giving motivational exhortations, passing the buck, offering incentives — or threats, and blaming.”

The list of those we blame is quite large. It includes politicians, public servants, government regulations, labor unions, the CEOs, the managers, the doctors, the health-care self-interest groups, unrealistic public expectations, etc., etc.

System designers and architects need to focus on the winning performers.

When you shift the focus from the “bad guys” to the “*good guys*,” the list of innovative leaders across Ontario — in our hospitals, in CCACs and in the community — is extensive. Many of these organizations have applied a combination of different ways of solving their internal system design problems.

These organizations — the top 25% of performers — are achieving ever-improving results in their performance because they practice and operate as true “*Learning Organizations*.”

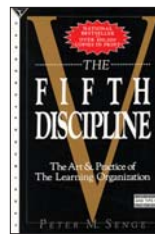
That is:

- They invest in the skills of their people to transform their organization;
- They shift from command-and-control to stewardship, facilitation and team learning;

“If we don’t understand systems dynamics, or how to find the key leverage points within systems, we will forever reproduce flawed systems that don’t do what we need and want them to do.”

- They have a common language and framework for developing and managing strategy;
- They have ongoing internal processes that engage the right people in developing and learning from their strategy;
- They link their strategy and operations with a rigorous strategy management system;
- They measure results, and learn from their “best mistakes;”
- They are learning how to produce real bottom-line improvements in their results on key performance indicators;
- They have a linked system of *Accountability Agreements* that align everything together;
- They are deeply committed to supporting their people to be successful at achieving the outcomes for which they are accountable; and,
- They have *pay-for-performance* incentives for managers.

While there are many useful modern management tools available for strategy development and execution — and for system design and organizational alignment — all of these tools are rooted in a deep understanding of how complex human systems actually work.



Systems thinking is the discipline that enables people to “see the whole picture.” It is an essential framework and tool for system redesign. If we don’t understand systems dynamics, or how to find the key leverage points within systems, we will forever reproduce flawed systems that don’t do what we need and want them to do.

There are a variety of systems thinking-based tools for complex system design that can be used to bring people together to analyze the organization’s design and to determine how it can be better aligned to achieve the outcomes that need to be achieved.

But *alignment* — arguably the most important overall objective and process that permits other features of system redesign to succeed — is more complex than just getting people to see eye-to-eye.

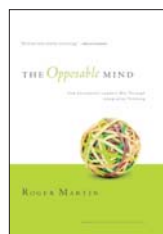
ALIGNING STRUCTURE, CULTURE & SKILLS WITH STRATEGY

While there are many fancy words and tools that describe the problems found in complex adaptive systems, those organizations that have actually managed to improve upon their performance did so because they applied systems thinking skills and used the collective intelligence of their people to liberate the creative capacity of their organization to solve problems.

A key example of this is the issue of *organizational alignment*: a concept that is not well understood in the public sector — which tends to compartmentalize functions in silos designed to be isolated from one another, and yet, nevertheless, impact significantly on one another.

As a noun, *alignment* refers to the degree of integration of an organization's (or local service delivery system's) core systems, structures, processes, and skills; as well as the degree of connectedness of people to the organization's (or system's) strategy. As a verb, *aligning* is a force — like magnetism. It is what happens to scattered iron filings when you pass a magnet over them.

Over the past 20 years the science of organizational alignment has advanced considerably. While there are perhaps a half a dozen good system alignment models based on systems theory, the two most common in Canada are the *Star Model* and the *Strategic Alignment Model*.

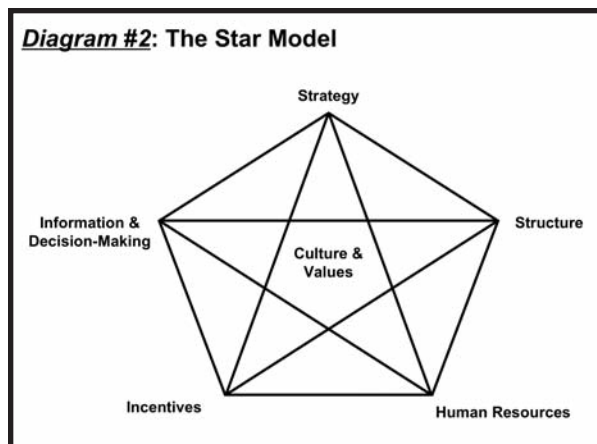


The *Star Model* is the product of the thinking of Roger Martin, the Dean of the Rotman School of Management and author of *The Opposable Mind*; and, Brian Golden — who holds the Sandra Rotman Chair in Health Sector Strategy at the University of Toronto.

While the *Star Model* outlined by Golden and Martin in their essay, “Aligning the Stars: Using Systems Thinking to Design Canadian Healthcare” (*Healthcare Quarterly*, 2004) has the science of alignment down pat, I think that the tetrahedron shape of the *Strategic Alignment Model* (on page 14) more clearly demonstrates visually, how Strategy needs to drive Structure, Culture and Skills.

If you follow the thinking in each model, they both focus on the key leverage points of complex system design. Both the *Star Model* and the *Tetrahedron Model* are strategy-focused integrative thinking tools.

As Golden and Martin say: “Strategy must be seen as dominant — with the other sub-systems designed, to the extent possible, to support the implementation of strategy.”



Historically, the healthcare services delivery system has been misaligned and provider-focused. This is why it produces sub-optimal results on many of the measurement indicators that matter most to patients and taxpayers.

But the traditional response to poor performance has been to reshuffle the internal organizational boxes, rather than align all of the integrated components that would achieve the results required. If we are to stop repeating the same mistakes of the past, leaders need to master the art and science of system alignment and organizational design.

The *Strategic Alignment Model* (in the shape of a tetrahedron) is presented in *Diagram #3* on the next page. While the *Balanced Scorecard* is a best practice systems process for strategy implementation, there will not be a successful transformation until — and unless — there is organizational and system alignment.

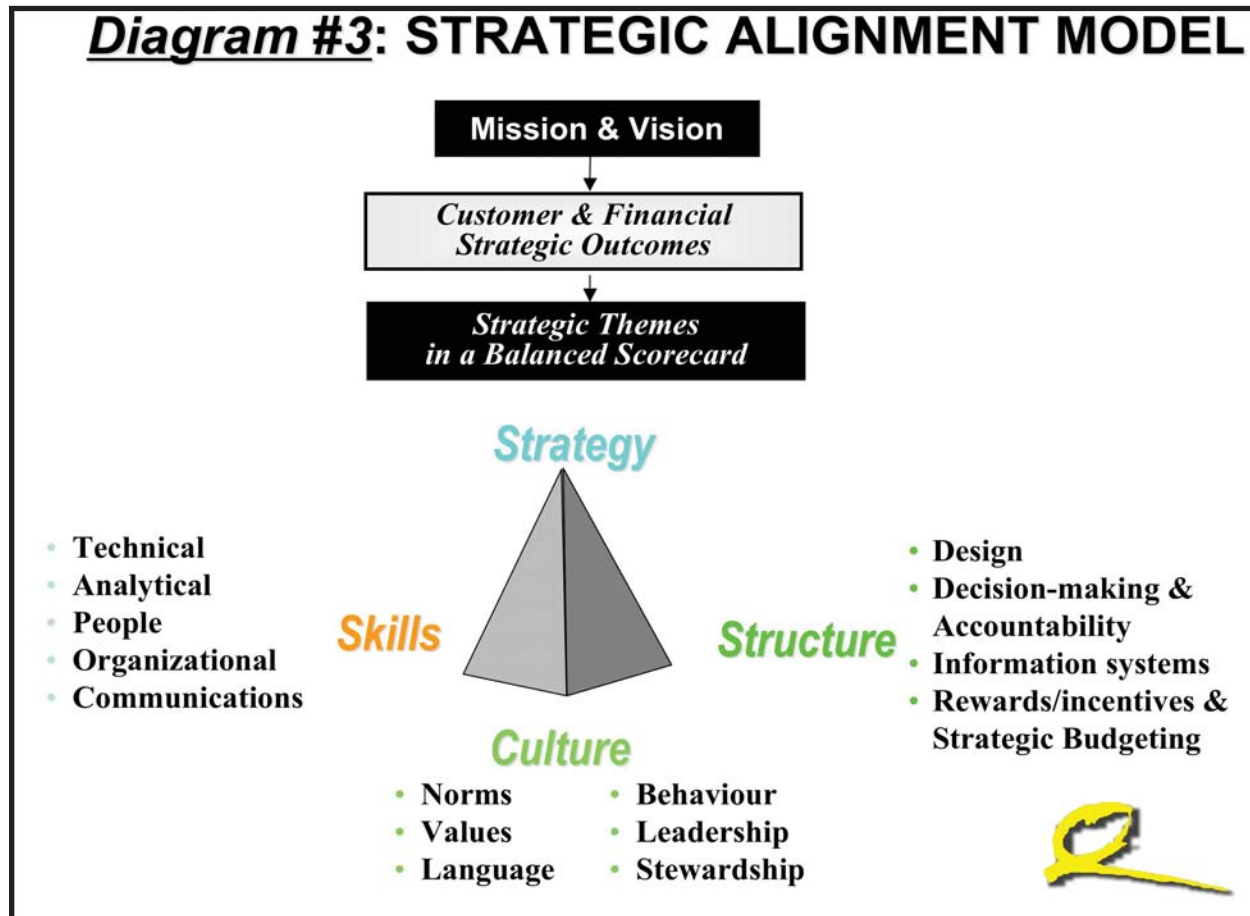
The message of this systems thinking-based tool for organizational design is that to achieve its mission & vision, an organization or system must align the components of their *structure*, *culture* and *skills* to the *strategies* put in place to realize those outcomes.

Strategy is the set of actions taken to achieve the results required to achieve the organization's mission & vision.

As a diagnostic tool, the tetrahedron can help an organization — or a local delivery system — to identify where there is poor *alignment* that can be altered and re-designed to improve performance.

The *Star* and *Strategic Alignment Models* provide people with a *common language* and common set of *frameworks* that will enable service provider partners to talk about, plan for, and actually implement change together, rather than talk past one another.

Diagram #3: STRATEGIC ALIGNMENT MODEL



Both the *Star* and *Alignment Models* can be used to generate learning dialogues among cross-functional groups that can facilitate an *integrative mindset shift*: from seeing isolated aspects of their organization, to seeing the critical importance of the *relationships* and *dynamics* at play within the organization — and within the larger delivery system.

Organizational and system design processes that are driven by strategy can take time. The problem is boards of governors, funders, taxpayers and healthcare workers will become increasingly more anxious and grumpy if they don't see some progress soon.

People do want the improved system sooner. Taxpayers are telling pollsters that they want the system they have already paid for — and they want it now.

FASTER CHANGE

The pace of change during the strategy execution and implementation phase of the “*Made-in-Ontario*” system will be picking up considerably over the coming year

or two because of three highly leveraged *macro system design changes* that have now combined to create what change management scholars call a “*Burning Platform*” for change.

These are:

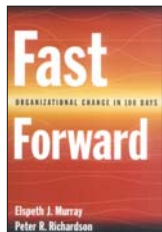
- A couple of thousand health service provider organizations are about to negotiate **Service Accountability Agreements** with their LHIN. This is intended to be a “fair business bargain” that will set out agreed-upon bottom-line outcomes for which the organization's Board will be accountable — in return for their organization's annual budget allocation;
- The introduction of **Managerial-Level Accountability Agreements** — tied to each organization's strategy — and to their **Service Accountability Agreement** with their LHIN; and,
- A new **Annual Resource Allocation** (and reallocation) **Process** that will be based on evidence and performance outcomes that will define what a “patient-focused system” means.

Our healthcare system will undergo significant changes over the next two to three years as a direct consequence of these three macro system design changes. What the details of those changes will be over the next several years is yet to be worked out in each community — in alignment with their own *Integrated Health Service Plan*, and, aligned with the higher level provincial strategic directions and strategic imperatives.

If the managerial and governance leadership of a delivery system are currently experiencing this environment as “an exciting opportunity to create a really great system,” then positive change will no doubt occur over the next few years.

However, if people are experiencing their current environment as “threatening,” they will be guarded and risk-averse. Fear and anxiety will be very present — and bottom-line results will not flow in such a stressful environment. As successful change practitioners say: “its about relationships, relationships, relationships.” People must be made to feel safe. As Deming said: *First, drive out fear!* Change management practitioners also provide wisdom like: “*slowing down, in order to speed up*”; “*slow is better*,” etc.

However, best practices also suggests that at a critical stage of the strategy development process, a much more rapid pace of change will be required to mobilize and align the organization and system.



In their book, *Fast Forward: Organizational Change In 100 Days*, two Queen’s University change management scholars provide readers with some best practice frameworks, models and “*Winning Conditions*” for rapid implementation of organizational change.

Murray and Richardson’s research on change management provides healthcare leaders with some guidance on how organizations can build speed and momentum in their change process.

Organizations that have developed the strategic capacity for change, but are caught in slow motion incremental change processes, need to develop their internal capacity for highly targeted rapid change initiatives that will improve their performance on specific indicators.

“Organizations that have developed the strategic capacity for change, but are caught in slow motion incremental change processes, need to develop their internal capacity for highly targeted rapid change initiatives that will improve their performance on specific indicators.”

So, can healthcare organizations go fast and slow at the same time?

While the urgent culture of the health sector isn’t significantly different than the culture of an emergency department, the fact is that while we can take some rapid leveraged actions that will demonstrate progress, the path towards healthcare transformation is not a short one. It is in fact a learning journey with many stops, side road options and obstacles.

Change managers sometimes call this “*the crab-walk*”: three steps forward, one step back, scuttle to the left ...

To traverse this path effectively and efficiently, healthcare leaders do not have the luxury of sitting around the campfire thinking about change theory. Instead, they sometimes need to take some well-managed sprints towards the vision by engaging their staff directly in the change process in focused and productive ways. These methods carry names like: *Six-Sigma*, *Lean Thinking*, *GE Workouts*, *Kaizen*, *Rapid*

Action Teams, etc.

These adult learning methodologies for *Rapid-Cycle Change* in the healthcare sector can be used strategically to create a sustainable surge in quality; the elimination of waste; dramatic improvements in efficiency; speedier cycle times; higher customer satisfaction rates; etc.

The “lessons learned” from the failures of mass classroom training for TQM/CQI fifteen years ago was that these are ineffective learning approaches. Adults “*learn-by-doing*” on a “*just-in-time*” basis in their actual work world — working on real problems that matter.

Studies by the American Quality Foundation suggest that “efforts to indoctrinate employees on quality improvement theory and tools are not likely to yield results without greater attention to the psychological triggers for motivating behaviour change.”

Approaches that are proving effective tend to combine *Rapid Action Teams* and *Kaizen Events* to focus on some key strategic metrics by engaging staff teams working in 60- and 90-day cycles to achieve measurable improvements.

While traditional management thinking supports incrementalism, the big “lesson learned” from regular cycles of rapid change is that these produce a more centered, calmer and more energized and satisfied workforce. “Early wins” and “celebrating progress” creates positive energy and confidence-building momentum for change within organizations and systems.

Hence, the emphasis needs to be on *staff engagement*, not on learning complex theories about lean thinking and black belt six-sigma tools.

BEST PRACTICES

Finally, let’s talk about the issue of why we don’t adapt to best practices very easily.

In Canada, our healthcare delivery system is down several quarts of what leading change management experts call “*Replication Competency*” — which is, “*the capability to identify, implement and institutionalize best practices.*”

A *best practice* can be defined as “the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people.”

The measuring stick for *replication effectiveness* is the cycle-time to proficiency in deploying new practices and methods that have proven to work in certain circumstances. The lack of these capacities in the healthcare sector has cost taxpayers hundreds of millions of dollars, and, cost Canadians thousands of lives.

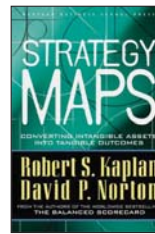
For example, breakthrough innovations — like adapting the *Pilot’s CheckList* for surgical teams — which recently demonstrated a 40% decrease in preventable deaths — won’t be fully implemented for another two or three years — if we simply follow our “normal” patterns and practices.

This is the case throughout the system. While parts of the delivery system know how to eliminate waste, improve quality, speed-up cycle time, etc., most organizations don’t change their practices. They are stuck in an old world, potentially harming people and wasting money.

How can best practices and “lessons learned” be replicated and adapted at much faster rates?

Locally, LHINs could potentially have a *stewardship* role in helping health service providers to share best prac-

tices. Service providers could learn from one another — about saving money and saving lives; about strategy mapping; or, implementing best practices, etc.



Many providers in each of the 14 networks already have best practice *Balanced Scorecards* and *Strategy Maps*. These system-thinking tools from Kaplan and Norton provide proven frameworks for communicating and executing strategy — while also allowing the strategy to evolve in response to changes in the internal and external environments.

These proven tools, processes and practices will enable communities and organizations to create their own solutions together. To succeed in such an environment, you have to be open to learning, open to other perspectives, and open to doing things differently.

CREATING YOUR OWN SOLUTIONS

Learning how to *speed up the pace of change* to create sustainable surges in performance ... using best practice system design tools like the *Star Model* and the *Strategic Alignment Model* to “test for alignment” ... applying best practice strategy execution tools like Kaplan/ Norton’s *Strategy Map* and *Scorecards* ... using the lenses of the First and Second Curve Health System Designs to renew or generate a *Shared Vision* for the future ... *using evidence* to determine the design of the system ...

These are the integrated set of complex challenges that this report has asked you to think about. The mind really boggles with the complexities of the challenges facing our health system leaders today.

That’s why these systems thinking tools are so helpful. They provide best practice frameworks that enable each individual organization (or network of organizations) to design and implement solutions that address their unique circumstances.

While the tasks ahead can appear to be overwhelming in complexity, they don’t have to be. But the consequences of failing to fundamentally redesign the delivery system over the next three years would be tragic.

If our governance Boards, LHINs, senior managers and public servants at Queen’s Park fail at implementing the McGuinty Government’s customer-focused health system design, a vacuum will be created — and, there will be other system designs offered for consideration.

The *Canadian Medical Association*, for example, has just launched a major new campaign to advocate for a health system designed to reduce waiting lists and improve quality by blending private medicine with universal access in order to enhance physician incomes and to transform many doctors into enterprise business people.

What we know from public opinion polling is that there are two alternatives that are completely unacceptable to Canadians. The first is the status quo, and the second is the CMA Model for enhancing the role of the private sector and vastly increasing the percentage of GNP that Canada would invest in medical care.

And what we know from best practices and jurisdictional comparisons is that the CMA model won't work. As someone said, "they want the Swedish health system, with the American tax model." That's the alternative model.

So, we really have to succeed. We must discover how to implement the "*Made-in-Ontario Model*" in a "win/win" fashion. It can be done.

The task ahead will be very challenging. No question. This is very hard work. What our leaders need to have is empathy — and what they need to be is supportive, encouraging and hopeful.

What we know is that difficult, complex, high-stakes challenges that are "hard work," won't get done ...

Unless its fun ... unless there is a safe/supportive environment ... which fosters creativity and innovation ... which celebrates and rewards success ... and makes people feel that they are doing something that matters — something that adds "real value" to the community and to the world.

Being in service to the system as "*system designers*" and "*system architects*" is very definitely: "something that matters," and, "something that adds value to the community and to the world."

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