DISRUPTIVE INNOVATION: Patient/Family-Focused Care

By Ted Ball

Quantum Transformation Technologies

Disruptive innovations cause fundamental paradigm shifts in the way we think and behave in complex adaptive human systems. Instead of tinkering on the edges with simple structural reforms as we have been doing in Ontario, redesigning our core healthcare delivery system processes at the service delivery level—with a strategic focus on patient/family care—will create the fundamental shifts that will be required for us to save Medicare, if we embrace it fully within the next two to five years. Are we capable of such change? Do we have the political will to make it happen? Do we have the tools to build such a system? Will the government actually fund such a strategy? Are our governance Boards, CEOs and LHINs ready to become catalysts for the patient/family-focused care revolution that taxpayers and voters want?

All this sounds like big changes ahead. But humans don't like change. In fact, change management scholars tell us that nine of out ten humans would rather die, than change.

If we are really compelled to change, we will choose incremental shallow changes that enable us to maintain the "illusion of control"—and the comforting delusion that we could always go back to the old ways of doing things—if the little changes don't work out.

When deep, fundamental, transformational changes that are irreversible occur, people undergo a complete paradigm shift in how they think and behave. The system evolves through the occasional disruptive innovation when everything changes, and there is no going back to the "good old days."

So how are we ever to successfully transform our health-care delivery system? When are we going to stop tinkering on the margins of structure, and get on with the real reforms that Ontarians want?

Using innovation management models previously applied to other industries, Clayton M. Christensen, a Harvard business professor, argues in his recent book, ***The Innovator's Prescription***, that the concepts behind "disruptive innovation can reinvent healthcare."

The term '*disruptive innovation,*' which he introduced in 2003, refers to "an unexpected new offering that turns the market on its head."

The internet and the personal computer are examples of disruptive innovations. They changed everything—and there is no going back to the old ways of doing things.

Disruptive innovators in healthcare aim to shape a new system that places patients and their families at the centre of the delivery system and provides health-care consumers with a high-quality continuum of services that are delivered seamlessly.

Mr. Christensen argues that by putting the financial interests of hospitals and doctors at the centre, the current system gives routine illnesses with proven therapies the same intensive and costly specialized care that more complicated cases require.

The *New York Times* (February 1st, 2009) suggests that "by creating a continuum of care that follows patients wherever they go within an integrated system, care providers can stay on top of what preventive measures and therapies are most effective."

Princeton economist, Uwe Reinhardt, says that in such systems "tests aren't needlessly duplicated, competing medications aren't prescribed by different doctors, and

everyone knows what therapies a patient has received."

In Canada, the push for the disruptive innovation of patient/family-centred care is coming from consumer groups and think tanks—as well as from some of our leading-edge CEOs who are currently applying Lean Thinking and Kaizen to their redesign efforts.

For years health system critics have suggested that patients/families/citizens/taxpayers have not had a very significant influence on health system reform efforts. Rather, these have been driven by influence, authority and span-of-control issues for service provider managers and public servants. These issues are of great concern to health system insiders, but of little concern to patients and the larger public—who are actually the "owners" of our health-care delivery system.

Patients and their families simply want access to seamless, patient-focused care; and taxpayers/citizens want access to the high-quality healthcare system that they have already paid for in their taxes and in their health premium payments.

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Nevertheless, despite years of government-led health system reform initiatives, the core healthcare changes that matter most to patients and their families never seem to actually happen. That's because as we tinker with the little organizational boxes, we simply create the countervailing forces to undo each successive structural reform.

Structural Fixes

For the past thirty years, the Province of Ontario—under governments formed by all three political parties—has stuck steadfastly to shallow, incremental "structural fixes" that have always failed to achieve the promised improvements.

"Structural fixes" have included *District Health Councils*—who were to serve as the "eyes & ears" of the Minister of Health on the planning of local healthcare delivery systems; the provincial strategy for *Merging of Hospitals*—recommended by the Harris Government's Health Services Restructuring Commission; the McGuinty Government's *Local Health Integration Networks*—which were to operate as crown agencies allocating resources to health service providers in fourteen regions based on performance, instead of from a remote bureaucracy at Queen's Park; and, the last big structural fix: the *Merger of 42 CCACs* into fourteen—in order to fit into the boundaries of each local health network.

In the politically-charged environment of the health sector, powerful vested interest groups like the Ontario Hospital Association, the Ontario Medical Association and The Ministry of Health & Long-Term Care (which mostly operates as The Ministry of Doctors and Hospitals) have been on a continuous campaign to maintain or expand their power within the system.

While each will claim to be advocating for the patient, they are not. Hence the name "self-interest group."

While citizen community Boards of Governance of health service provider institutions and agencies were supposed to represent the interests of the "owners" (the citizens of the community/province), historically very few have taken a strong pro-patient/family perspective. Until very recently, most did not even hold their CEO accountable for continuous improvement on the key performance measures for clinical quality and patient satisfaction.

The truth is, the voice of the patient/customer/client/resident/etc. is very faint in our system. Very faint.

While healthcare governance best practices suggests that 25 percent of every Board meeting should be devoted to dialogues about quality and patient stories (good & bad), very few Boards have such a disciplined customer focus.

While healthcare professionals are sincerely convinced that they are "people-centred" and "patient-focused," health-care consumers tell stories that clearly communicate that for many people, the "patient experience" is too often a bad experience, or a poor one.

NRC Picker's patient satisfaction scores across the province demonstrate the extent of dissatisfaction among patients and their families—and indeed, among healthcare service providers as well.

The truth is, our delivery system has not been designed with the customer experience in mind. While there is a lot of rhetoric about "patient-focused care," it is mostly optics and public relations.

Politics and power drive the system and the fact is: consumers have no power.

Governance Boards at the local level, and policy-makers at Queen's Park, are often perplexed by the subtle dynamics of interest group politics that drive key decisions—decisions that are based on power, rather than evidence or a customer-focus.

All of the shallow structural changes that have emerged from successive governments over the past thirty years have really only been about the narrow interests of service providers and public servants.

Each of the past "structural-quick-fixes" have failed because they avoided the fundamental leverage points of meaningful system design—and instead focused on the optical illusions about where "control" and "power" are located in the system.

As *District Health Councils* gained the ear of Ministers of Health, vested interest groups—including the MOHLTC's own bureaucracy—created a countervailing force that ensured that DHCs were never allowed to be successful.

Hospital mergers and mergers of CCACs were supposed to result in (a) lower costs; and (b) improved quality—another set of "structural interventions" that didn't work out. Promises of savings worth tens of millions and hundreds of millions of dollars were never realized. Promises of improved quality never materialized.

While *Local Health Integration Networks* were to have power and authority over the allocation of resources based on performance contracts with the LHIN, once again the countervailing forces within the MOHLTC, and within a segment of the CEO community, have created a set of dynamics where it appears unlikely that LHINs will succeed in their role before the next election in October, 2011.

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They could, and they still might succeed—if the government makes their success a priority in the final 14 months of their mandate. But healthcare reformers who were hoping that the system will pull together to make the "*Made-in-Ontario*" model work need some reality therapy: "on our present course, it ain't gonna happen."

Therefore, take heed: those healthcare delivery organizations who want to see our healthcare system survive the current economic meltdown, need to shift their own organizational focus as quickly as possible to what healthcare consumer groups call "*Patient/Family-Focused Care*," or "*People-Centred Care*."

The paradox is that healthcare providers report that they enjoy working more in patient-focused delivery system designs, than in provider-driven system designs. But resistance to change within the delivery system is very high.

Capacity For Transformation

Change management scholars tell us that at this point, perhaps thirty percent of health service provider organizations will be willing and able to embrace methodologies, techniques and tools that will produce such a fundamental shift. It all depends on leadership at the governance and managerial levels.

We already see the "innovators" and the "early adopters" within the health service delivery system engaging in redesign exercises driven by Lean Thinking, Kaizen, Experience Design, and advanced forms of TQM/CQI, like agile care.

At **North York General Hospital**, for example, the Board and management developed a major strategic focus on quality in both the Board's *Balanced Governance Scorecard* and in the organization's *Strategy Map* and *Strategic Balanced Scorecard*.

NYGH's Board Chair, the late Gordon Cheesborough, and *Governance Renewal Task Force* Chair, Dunbar Russel, placed a high priority on the *Board's Quality Committee* that worked in partnership with CEO Bonnie Adamson and V.P. Susan Kwolek to engage in an unrelenting learning journey on how to improve quality and increase patient/family satisfaction.

When this hospital invested in developing their internal capacity to transform themselves, they were able to produce significant results by:

- Having a passionate commitment to patient-focused care at the governance, management, staff and physician leadership levels.
- Building the internal capacity of front-line managers to lead and manage a strategic & cultural transformation;
- Engaging over 150 managers, medical chiefs, directors and team leaders in building the organization's *Strategy Map* and *Scorecard*;
- Developing the internal systems, structures and processes to actually implement strategy—by creating an *Office of Strategy Management & Strategic Learning*;
- Tapping into the collective intelligence of front-line workers—what NYGH's CEO, Bonnie Adamson, calls "*thinking differently*;"
- Ensuring a customer-focus lens/mindset; and,
- Using Lean Thinking, collective intelligence and Kaizen methods to redesign both core and support systems, structures and processes.

One example of the impact of all this at NYGH: a team of front-line care providers and physicians redesigned the 169-step process for moving a patient from the Emergency Department, to a bed—to just 10-steps, thereby reducing wait times for patients.

How? By asking: **"If you were a patient, would you pay money for this step?"**

NYGH also partnered with the Central CCAC in a *Flo Collaborative* project to design dramatic customer-focused improvements between the hospital and the community.

Under the leadership of CEO Janet Davidson, **Trillium Health Centre** has also been making significant improvements in their performance: reducing ALC occupancy by 61%; achieving a 67% reduction in the use of urinary catheters that did not have an evidence-based indication.

Trillium Health Centre has recently introduced ""safety crosses" that are used to provide visual impact to quality improvement and safety initiatives. As a result, pressure ulcer rates in acute care have decreased from 17.9% to 12.7% over a very brief period.

Other examples of patient-focused quality improvement success stories in Ontario:

- ☑ **Orillia Soldiers Memorial's** Emergency Department patients waiting for initial physician assessment has decreased by 50%.
- ☑ **Queensway Carleton Hospital's** redesign of patient flow for hip and knee replacements has reduced the determination of the need for surgery or other intervention from three-plus months, to two to three weeks—and actual hospital stay for the surgery has been reduced from 5 days to 3 days. The total Joint Assessment Model has now been adopted LHIN-wide.
- ☑ **Sault Ste. Marie Group Health Centre** redesigned their congestive heart failure discharge program and reduced the number of readmissions by 43%.
- ☑ **Thunder Bay Regional Health Sciences Centre** has reduced bed empty time by 25% (four hours to three), by implementing lean process redesign; and,
- ☑ **The Ottawa Heart Institute** decreased heart failure 30-day readmission rate from 54% to 14.8%.

While there are many other success stories like these, perhaps 60% to 70% of the healthcare delivery system is still stuck at the moment. Health reform is not easy if we continue to govern and manage the system as we currently do.

But it can be much better. Organizations have within them the knowledge and wisdom about how to dramatically improve services and quality. Add the critical perspectives of patients and their families, and you've got the "whole picture."

The Consumer Revolution

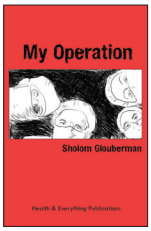
In the recent U.K. report, ***Human Factor: How Transforming Healthcare to Involve the Public can Save Lives & Save Money***, researchers Bunt and Harris tell us that "the people who use services, and the staff who deliver services, generally have deep knowledge and understanding about how to make them better."

The authors proclaim that "in the most basic sense '*patient-centred care*' means taking more account of the users of services. There is extensive evidence that this delivers improvements in care delivery, increases in health literacy, and provides valuable feedback and assistance in setting priorities."

Despite this, in Canada, we still don't really pay much attention to the patient or their families. "Patient-Centred Care" isn't a strategy, it's a slogan.

While traditional vested interest groups continue to have extraordinary influence over government, new consumer/public interest groups are now emerging to break the log-jam.

Sholom Glouberman, President of the newly-formed *Patients' Association of Canada (PAC)*, has written a new book entitled ***My Operation*** (available later this fall at admin@adppa.org).



"Organizations have within them the knowledge and wisdom about how to dramatically improve services and quality."

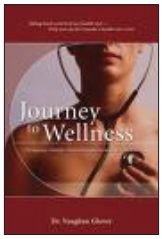
Sholom says that he is optimistic that most healthcare delivery organizations really do want to put the patient and their families at the centre of their service system designs. "They just need encouragement and support to do it," he says.

The PAC's mission is to promote increased patient engagement with healthcare organizations to enhance the voice of the patient. They will be organizing training programs specifically designed to improve the capacity of patients and their caregivers to interact with healthcare professionals. They also intend to develop courses to enable patients to function more effectively and to provide staff and administrators with "the patient perspective."

The Patients' Association of Canada isn't the only consumer group to emerge recently. Another is the Canadian Association for People-Centred Care.

Dr. Vaughan Glover is a co-founder of the Canadian Association for People-Centred Health—a grassroots organization dedicated to finding ways to make our healthcare system more responsive to patients and their families.

In his book, ***Journey to Wellness: Designing a People-Centred Health System*** (available at www.capah.ca), Dr. Glover says that the issues in a people-centred system are "whether I feel valued, whether I am listened to, whether my needs are met, whether I was presented with all the options for care, and whether I received high-quality service."



He says "the principle of individuality creates an interesting problem: a patient-centred system must be inclusive enough to support 34 million personalized health systems that are unique to each Canadian and ultimately managed by him or her." He says that "health is a personally defined balance of mental, physical, spiritual and emotional well-being."

The *People-Centred Model for Health Care* is a vision for a Canadian healthcare system that puts the individual at the centre—supported by the care provider or coach, many kinds of support groups, and innovative policies and legislation.

This new health consumers' advocacy group says that "a people-centred model must be implemented in such a way that the patient should always be able to influence their own health and healthcare. This includes selecting the most appropriate provider or coach, the type of service, and how, when, where, and why to use and pay for a particular form of support."

Glover says that "getting all parts of the healthcare system to understand and acknowledge this point may be the greatest hurdle to overcome."

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The *Canadian Association for People-Centred Health* acknowledges that they are pressing for reforms that deal directly with provider power and money.

They quote the 1999 ***Health Services Restructuring Commission Report*** that found that 69% of the billings of general and family physicians were for service fees that were within the licensed scope of practice of nurse practioners and other lower-cost healthcare professionals.

Their *People-Centred Model*, places the informed patient at the centre—with access to coaches and support groups, supported by legislation and a system that is managed to be patient/family-centred.

While the direction of change in this model is clear, it shifts the focus from the structural issues raised by the existence of the LHINs, to the fundamental issues that go to the heart of purpose: *Why does the healthcare system exist?*

What is its mission, its purpose for existing? If the answer is: "to serve the patients/families/clients/residents," then it is important to know what "*patient-centred care*" really means?

What Does Patient-Centred Care Really Mean?

There are many definitions for PCC that are offered. NRC Picker, (the company specializing in tracking patient experiences) suggests seven components of patient-centred care:

1. ***Respect for patient's values, preferences and expressed needs.*** This dimension is best expressed through the phrase, "***Through the Patient's Eyes***" and the book of the same title. It leads to shared responsibility and decision-making.
2. ***Coordination and integration of care.*** This dimension addresses team medicine and giving patients support as they move through different care settings for prevention as well as treatment.
3. ***Information, communication and education.*** This includes advances in information and social technologies that support patients and providers, as well as the cultural shifts needed for healthy relationships.
4. ***Physical comfort.*** This dimension addresses individual, institutional and system design (i.e. pain management, hospital design, and type and accessibility of services).
5. ***Emotional support.*** Empathy and emotional well-being are as important as evidence-based medicine in a holistic approach.
6. ***Involvement of family and friends.*** Care giving includes more than patients and health professionals so that the larger community of caregivers are considered.
7. ***Transition and continuity.*** Delivery systems provide for caring hand-offs between different providers and phases of care.

In their newly released 2010-2013 strategic plan, *The Change Foundation*, a healthcare think tank that is always ahead of the curve, has declared that their central theme for the next three years will be the "patient/customer/client experience."

It is important to notice the language shift from "patient/family-centred care," to "people-centred care," and to "individual and caregiver experience."

Cathy Fooks, the President and CEO of *The Change Foundation* says of her organization's new strategic plan that "we spent of lot of time on the wording and settled on the 'individual and caregiver experience,' rather than the 'patient experience'."

She says that "patient groups we dealt with expressed a preference for not being called a patient, so we altered our language." By including the "caregiver" in the experience, *The Change Foundation* clearly understands that there is a strong correlation between staff/physician satisfaction rates, and patient/family satisfaction rates.

Language is important. The words we use are our "mental models" that create meaning for us. In the 1990s, management language that referred to patients as "customers" was often rejected by many front-line healthcare workers who held beliefs that calling their patients "customers," was an American business concept that had no place in the Canadian healthcare system.

Former Chair of the *Ontario Healthcare Restructuring Commission*, Duncan Sinclair, says that it is important to think about what words to use: "I like to remember the old adage that more important than the patient, is the person—a prospective patient seeking to avoid becoming the real thing."

"Yes, language and mental models are important," says *Patients' Association of Canada* President, Sholom Glouberman. "When the staff at a nursing home shifted their language from 'residents' to 'tenants', the nature of the relationship changed. The so-called "residents" had more authority when they became paying 'tenants,'" he says. "That's what patients need: more authority over their experience as patients."

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Are healthcare service providers willing and able to really become patient-focused, or are provider interests and interest group power still going to drive the evolution of the delivery system?

The Change Foundation's new strategy, ***Hearing the Stories/Changing the Story*** points out that "research shows that a high-performing health system understands, measures and responds to patient experience. Our report, ***Who is the Puzzle Maker?***, reveals a rallying cry from patients and care-givers—calling for a healthcare system that is less fragmented, easier to navigate, and more user-friendly."

The Foundation says that "for Ontario's quality improvement agenda to advance, we need to learn how best to incorporate people's lived experience and their views directly into improvement methodologies."

At the ***2010 Meeting of the Minds Conference: Redesigning Health Services with Patients Top of Mind***, Change Foundation Board Chair, Scott Dudgeon declared that "a high-performing health system understands, measures and responds to the patient experience. That should be front and centre in any healthcare reform—not just symbolically, but substantively."

Dudgeon says "too often, patients' perspectives and their experiences get overlooked, crowded out by other interests and imperatives. Instead of being shuffled back and forth, people need to be connected to quality care and support wherever they are, clear about whom to turn to, and talk to, assured of what comes next."

"That's why *The Change Foundation* has set its sights on improving people's experiences as they move through Ontario's healthcare system," Dudgeon told the thinkers' conference.

In their new strategy paper, the Foundation says that "we know that successful businesses are those which are truly customer-focused—viewing a dissatisfied customer as evidence of their own failures. But in our healthcare system, such is not the case. Instead, people try to wend their way through a maze of services during difficult times in their lives."

The Foundation observes that "in the absence of a system that anticipates and adequately meets their needs, they are turning to each other for help—often through social media networking sites, and other communities of practice. They are sharing information and trying to manage their own healthcare, rather than leave it to luck."

In 2008 The Foundation conducted a series of focus groups to get a better understanding of the patient experience. As part of their work on patient/caregiver perspectives on navigating health services in Ontario, health policy expert Steven Lewis identified the following eleven elements that define "patient-centred care." These include:

- ☑ **Comprehensive Care**—all of their needs, not just some, should be addressed.
- ☑ **Coordination of Care**—someone is in charge, there is someone to go to who knows you and will help you navigate the system.
- ☑ **Timelines**—they should get care when they need it and where a sequence of services is required, the intervals should be short.
- ☑ **Functioning e-Health**—provide information once, ensure that it is accessible to those who need it, give patients access to the records and the opportunity to add.

- ☑ **Clear and Reliable Communication**—listen, explain, clarify, ensure that the provider team members are on the same page, consistency of messages, access to phone or internet consultations.
- ☑ **Convenience**—minimize the need to go to different physical locations for services; open access, same-day scheduling; no unnecessary barriers or steps to getting to the right provider.
- ☑ **Respect**—for their time, intelligence; for the validity of their stories; for their feedback about quality and effectiveness; for their environment and family caregiving partners.
- ☑ **Empathy and Understanding**—for their circumstances, fears, hopes, psychological state.
- ☑ **Time**—to express needs and be heard effectively.
- ☑ **Continuity and Stability**—to know and be known, minimize the number of different care providers.
- ☑ **Fairness**—amount and timeliness of service commensurate with need.

So why is there such resistance to patient-centred care paradigms—even when patient-centred designs are cheaper and better?

Patient-Centred Design Is Cheaper

Today, according to the ***Euro-Canadian Consumer Health Index*** (2009) Canada ranks last out of 32 countries on "value-for-money" criteria.

In his paper on ***Patient-Centred Care*** prepared for the Saskatchewan Government, Steven Lewis says "there is a growing body of evaluative research on the impact of patient-centred care. Just to cite findings from the hospital sector, a patient-centred approach reduces length-of-stay, reduces costs; facilitates team work that challenges the division of labour; improves safety; increases employee retention rates; and, improves self-care."

Despite evidence demonstrating up to 30% waste in our healthcare delivery system in Canada, and despite the evidence that the realities of the U.S. economy means that we could be heading for a double-dip recession, policy-makers and senior health-care executives continue to behave like the future will be much like the past.

Today in the U.K., economic realities are leading to a dramatic wake-up call for the National Health Service.

With the urgent imperative to save between £15 billion to £20 billion over the next two years in the U.K.'s National Health Service, NESTA, the public services innovation lab, has just released their discussion paper, *The Human Factor* in which they outline their "lessons learned" through healthcare innovation projects that have demonstrated "radical new ways of innovating that give genuine power to front-line staff, patients and public."

They say: "patient-centred designs will unlock the savings we need—and improve the nation's health."

This recent U.K. report points out that "at a time when resources are scarce, leading companies are discovering that so-called 'user' and 'open' innovation can develop better products and services at less cost than traditional closed innovation processes. This means innovating in more collaborative ways—including drawing on the innovations developed by their customers."

"Prudent organizations will realize that they can become more efficient, save money—and provide better care—by shifting to patient-focused care designs now."

In the U.K., they believe they can save £20 billion by 2014 by implementing these patient-focused approaches more widely.

"These projected savings reflect a relatively modest 10 per cent reduction in the cost of treating long-term conditions—achieved through a mixture of redesigning care with user involvement and more effective prevention," says NESTA researchers Laura Bunt and Michael Harris.

Most healthcare organizations breathed a sigh of relief in the last provincial budget because predictions (like mine) of a 0% budget increase didn't happen.

Instead, despite tough economic realities, the budget increase was a generous 1.5%.

While Canada has experienced some recent short-term improvements in our economic performance due to the stimulus spending strategy, the reality is that our biggest economic partner, the United States, is in trouble.

Those of us who think we are "economic realists" believe that by the Spring of 2012, the provincial healthcare budget will be reduced significantly. I believe there will be no choice—given the uphill challenges that will be facing the North American economy, and the fact that healthcare spending simply cannot be allowed to carve into social services, justice, education, day care, poverty reduction and environmental budgets.

Prudent organizations will realize that they can become more efficient, save money—and provide better care—by shifting to patient-focused care designs now, rather than waiting for what I am forecasting as a budget crisis in the Spring of 2012.

Patient-Centred Design Is Better

Sometimes the health sector can appear to be a bit smug and paternalistic about consumer empowerment, but the revolution has arrived—and there is no going back to the "good old days."

In their July 2nd, 2010 lead editorial, the ***Globe & Mail*** suggested that "a stronger customer service mentality may both improve health and address the political obstacles to better healthcare systems. Patients will still be patients. But if they are regarded with more respect, empowered with information about their own care, and treated by professionals armed with good information, their care will be better."

"Today, Canada's healthcare system ranks last out of 32 countries on 'value-for-money.'"

However, the importance of a "***Customer Service Mentality***" has still not caught on in Canada as our healthcare delivery system continues to decline.

In June 2010 the *Commonwealth Fund* released their latest comparison of seven health systems. Next to the United States, Canada was rated the second-worst healthcare system. We were last for overall quality, effective care and timelines for access; and, we scored second-last on efficiency.

This new study—which ought to be a wake-up call to Canadian healthcare leaders—says that our health system is characterized by "long waits; poor management of chronic conditions like diabetes; poor coordination of care; and, failure to involve patients in decisions about their care."

While Canadians have poured billions of extra dollars into our delivery system in order to "fix it for a generation," as former Prime Minister Paul Martin promised, the fact is that "more money" in a poorly designed and wasteful system has not been the answer.

While saving money is now an important motivator in the U.K., in the United States, healthcare customers are becoming much more demanding. They want an integrated service delivery system that is designed to meet their individual needs.

A number of leading-edge organizations are now embracing the discipline of *experience design*. Art Frohwerk, a systems engineer and human factors expert, who once headed up the Show/Ride Engineering at *Disney Imagineering* has devoted the last 20 years of his life adapting *experience design methods* to the patient/caregiver/family experience in the United States.

Experience design incorporates many disciplines including the best of TQM/CQI/Lean Thinking/Strategy Mapping/Scorecarding/Kaizen/Emotional Intelligence and the collective intelligence of patients, nurses, doctors, families, staff and even Board members. Experience design fundamentals include: being relevant, engaging, flow and adapting (as set out in **Figure #1**).

Redesigning systems, structures and processes from the perspective of the patient is an example of *disruptive innovation*. Imagine if a hospital or a community service was configured within a framework that viewed the patient as a "whole person"—rather than as something to be fixed.

Frohwerk, the leading developer of *experience design methodologies*, says: "using the tools of experience design not only helps us have a shared focus on the patient, but causes us to visualize how we can each contribute in often little ways. Then, it's like *Appreciative Inquiry*—folks go back to work and just start doing better things."

In such a place, care would be personal and proactive—anticipating the patient's needs, reducing risk, improving efficiency—all with the empathic intention to improve healing, in body, mind and spirit.

With such care, the patient would understand the purposes and procedures of treatment. This understanding would reduce anxiety, fear and uncertainty. Importantly, it would increase self-confidence, and promote patient compliance with the healing process.

Experience Design Fundamentals

Be Relevant:
Learn. Understand to be person-centered. Anticipate and act on the needs and concerns of patients, their families and associations. Become proactive throughout the whole process.

Engage:
Trigger intended awareness through behaviours, physical elements, and impressions. Provide more than what is expected. Create desired memories. Eliminate the negatives.

Flow:
Connect all the elements in a predictable way. Link the patient to the care team, to the next procedure, to information, service, time, and place so that the patient never becomes "lost" or fearful.

Adapt:
Share learnings easily. Innovate regularly. Continually improve and sustain. Evolve based on all kinds of learning.

Figure #1

In such a place, the inherent need for teamwork with a shared focus and with better connected processes, would improve the experience of nurses, doctors, other health professionals, technicians and administrative staff—as well as patients and their families. Such improvements would in turn produce the results that every healthy organization needs: greater job satisfaction, and higher staff retention rates.

Organized by the principles and insights of *experience design*, such a healthcare service delivery organization would more readily meet its financial objectives—because relevant processes are cheaper to run, and lead directly to improved predictability and higher loyalty.

Storyboarding

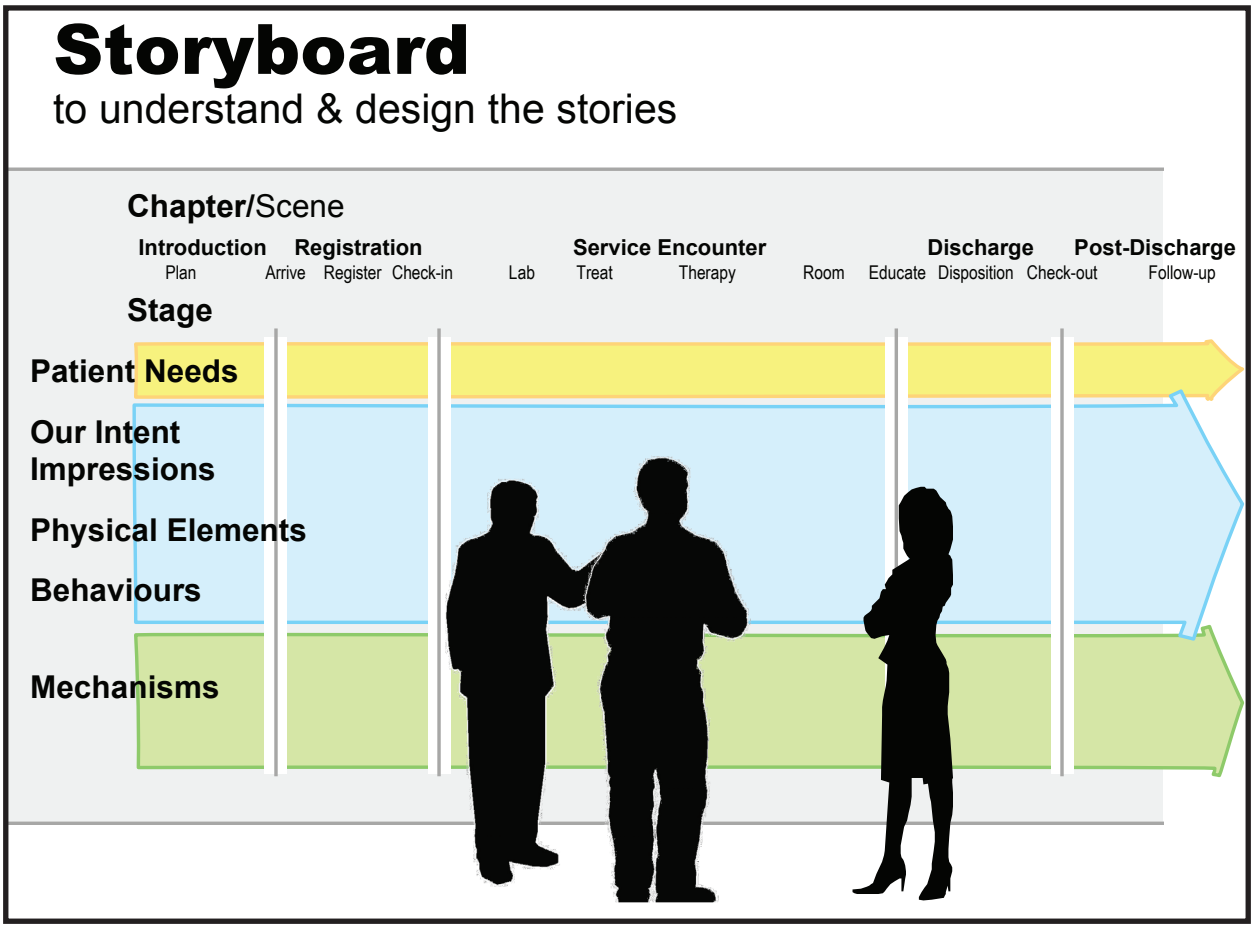
Frohwerk's world-leading experience design methodologies include the *Storyboard* and the *Master Process* which he first developed 20 years ago while leading teams designing the way to deliver new levels of guest experience at new Disney attractions.

The *Experience Design Storyboard* is a unique tool with the ability to create insight and organize ideas and information in a way that process design, and lean thinking alone cannot. It's used by teams of healthcare service providers, patients and families to set the stage for seamless processes, integrated systems, appropriate roles, useful measures and strategy implementation.

Experience Design Storyboarding combines the leading-edge disciplines of visualization, storytelling, process workflow, experience design, system design, scorecarding, lean thinking, Kaizen, and addresses emotional, social, and spiritual issues as well. The deliverable is an imaginative, graphical representation of the activities, issues and mechanisms, at an "altitude" that enables broad, yet specific patient/family-focused issues to be addressed.

The process of *Storyboarding* for design is much more than just brainstorming, telling stories, sending out surveys, or hosting focus groups to ask what an experience should be. It creates a setting to bring customers, leadership, and cross-sections of staff together in different forums to discover, invent and test the "story" of the patient experience.

A critical insight is that our patient/family experiences are made up of a continuum of events—some positive, some negative. One of the first tasks in the storyboarding process is to *find and eliminate the negative*, those things that get in the way of the *positive experiences* (see **Figures #2 and #3**).



Frohwerk says that "it is a demanding, insightful, and comprehensive task to design a care system so that everything is focused on the systems of patient healing. It entails some paradigm shifts. It requires bold leadership and institutional commitment."

He says that "most organizations might need to prepare their culture, processes, personnel and operations for the self-examination that *experience design* requires. They need to build it into their strategy, bring it alive, off the paper and into new rituals. Leaders need to be ready to commit themselves to the vision they articulate and to provide active, positive, and sustained support for its implementation throughout their organization."

Before leaping to experience design, or lean thinking, or Kaizen, organizations need strategic alignment and the skills and processes for strategy execution.

Strategy Execution

The "patient experience" is only one part of "patient-centred care." Aligning each of the components requires a rigorous approach to implementing a patient-centred strategy.

Changing a healthcare service provider organization and shifting the healthcare delivery system from a provider-focus, to a patient-focus requires a major behaviour change within the healthcare delivery system. To change our behaviour, we need to change how we think about our realities.

The scale of these changes requires much more than good will and exhortations from our leaders. It requires a strategic focus and a disciplined process for redesigning the patient experience and aligning the core systems, structures and processes to be patient-centred.

Transforming a system with ingrained behaviours and traditional "ways-of-doing-things" will not be easy.

Health system design expert Steven Lewis points out that "the way patients and providers (and the system as a whole) interact is a product of history, circumstance, psychology, social norms, identities, and other factors that together define the nature of the relationship."

What are the ingrained habits of behaviour that need to be overcome?

In his paper "***Making Patient-Centred Care Real: The Road To Implementation***," Lewis says that while the theory of patient-centred care is straightforward implementation is not.

He sets out the following challenges for those who want to shift to patient-centred care. He says:

Eliminate Negative Experiences

Ignoring me
- ❑ Treating me as a non-person or inanimate object
- ❑ Leaving me uninformed (& "out of the communication loop")
- ❑ Talking about me to others as if I were not there

Being rude to me
- ❑ Putting your personal issues before mine
- ❑ Acting hopelessly busy
- ❑ Engaging in off-stage behaviors on stage
- ❑ Leaving me waiting without explanation
- ❑ Rushing or being impatient with me

Scaring me
- ❑ Being insensitive in delivering distressing news
- ❑ Reciting horror stories of other patients with similar problems
- ❑ Criticizing my physician(s) or other health care team members

Abandoning me
- ❑ Leaving me wondering
- ❑ "Entrusting me" to someone else without explanation
- ❑ Giving up on me
- ❑ Allowing me to become lost (e.g. in the hospital, healthcare system)

Distressing me
- ❑ Making it hard for me to find my way around the hospital
- ❑ Creating unpleasant sights, sounds, smells, touches & tastes
- ❑ Putting me in unnecessarily humiliating or intrusive situations
- ❑ Confusing me during the discharge process

Figure #2

Create Positive Experiences

Recognize me as a person by:
- ❑ Treating me with respect
- ❑ Acknowledging my hopes, dreams, life accomplishments & interests
- ❑ Understanding my doubts, concerns, & fears

Listen to me/talk to me by:
- ❑ Taking the time to hear what I have to say
- ❑ Using my personal information to demonstrate awareness & understanding
- ❑ Engaging me in two way conversation (including the use of my native language when it differs from English)
- ❑ Sharing & explaining information with me on a timely basis

Make me feel safe by:
- ❑ Being confident & calm even under the most difficult of circumstances
- ❑ Anticipating my needs
- ❑ Educating me & my family so we can be part of the healing process (through information in hospital & home)
- ❑ Consistently doing what you say you will do

Handle me with care by:
- ❑ Treating me with compassion, love & patience
- ❑ Providing me with delicious, nutritional food, keeping me & my room clean & comfortable
- ❑ Responding when you are needed
- ❑ Reducing noise, unnecessary light & unpleasant smells
- ❑ Using the power of human touch, music & other therapies

Keep me connected by
- ❑ Ensuring teamwork between me, my physicians, my nurses & other involved in my care
- ❑ Helping me to be in the right place, at the right time, with the right people, for the right treatment at all times
- ❑ Assisting me in navigating the healthcare system

Figure #3

- ☑ On many levels the nature of the relationships is inherently unequal. Patients are by definition dependent on their providers for help (otherwise they wouldn't need to see them) and providers have more knowledge (most of the time).
- ☑ Much of the time, patients are in some degree of pain, discomfort, or anxiety. They are not at their peak; they are vulnerable. In such circumstances, they often have reduced capacity to assert themselves and take control of their care.
- ☑ Status and other hierarchies come into play. Often providers are more highly educated than patients, particularly older generations. There is a tendency to defer to credentials and the other attributes of status that accrues to providers, notably but not exclusively doctors.
- ☑ Providers—again, physicians in particular—are not inculcated with a culture of service. They see patients as fundamentally different from customers. They view their own time as a precious commodity (which it is) and organize their practices around its most efficient deployment. Their basic question is not, "what does the patient need to have a good experience," but rather, "what do I need to do to cope with demands."
- ☑ It is difficult to imagine a system fundamentally different from the one we know. Our behaviour is conditioned by our expectations, which are conditioned by how things are and have been. It is even more difficult to change when one does not know what is possible.
- ☑ There are risks (real or perceived) inherent in trying to change power relationships and models of communication and behaviour. Alienating a provider on whom one depends is obviously problematic. Where the relationship is intermittent, it may not be worth risking even if there is some dissatisfaction with what one has.

Varda Burstyn, a long time writer on health policy and environmental health, works with the ***Environmental Health Association of Ontario***. EHAO addresses the needs of over 217,000 Ontarians with chemical and environmental sensitivities. She says that Steven Lewis has surfaced the real issue of power imbalance. "I agree that many healthcare providers, and physicians above all, don't relate to their patients as 'customers' to be served."

Burstyn feels that patients are at considerable risk because of issues of power imbalance, and suffer in a number of serious ways as a result. "Many physicians—and these are the standard setters for others in the system—are often open about their impatience if a patient doesn't fit neatly in a pre-existing time slot, or diagnosis, or responds slowly to treatment. Neither family physicians nor specialists coordinate the complex care of patients, which creates terrible problems. And if patients question their decisions or ask for more assistance, physicians sometimes punish them, even if they do this unconsciously, because these patients don't fit in with the physicians' expectations and their demands."

Burstyn stresses that these power imbalances make it nearly impossible for patients to have an impact on their caregivers on a one-to-one basis. "With little choice in physicians, many patients don't have the power to leave, and far too many often have to put up with behaviour that ranges from indifferent and cold, to downright abusive, not to mention, on occasion, incompetent."

"Storyboarding creates a setting to bring customers, leadership and cross-sections of staff together in different forums to discover, invent and test the 'story' of the patient experience."

"Health care providers don't set out to be poor caregivers," Burstyn notes, "and despite all obstacles, there are some wonderful providers working out there. But those who are not delivering quality care—doctors, nurses, administrators—actually believe they do a good job and care a lot, even when their behaviour doesn't always indicate such values. They mistake their own unconscious perception of their self-interest for the public good. And crucially, the economic structures and existing professional organizations support them in these attitudes—these are perverse but powerful incentives that re-enforce bad behaviour. We pay dearly for this, both in individual and societal health."

So, how do we go about actually implementing the sorts of changes that will produce a fundamental transformation of both the patient experience and the caregiver experience?

After 30 years as a strategy coach to Ministers of Health and to CEOs, I think it is fair to say that in the healthcare sector, we're addicted to strategy development processes—while ignoring the art and discipline of strategy execution.

While most healthcare organizations have a "strategy," very few have the developed capability for actually executing their strategy, measuring the results, and holding people accountable for agreed-upon outcomes.

Henry Mintzberg tells us that only about 10% of organizations ever actually execute their strategy. At the 2003 ***Health Care Summit***, organized by the ***Balanced Scorecard Collaborative***, research was presented (see **Figure #4**) that outlined the classic barriers to strategy execution.

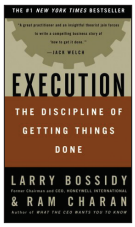
These included the ***Vision Barrier*** (because only 5% of the

workforce understands the strategy); the ***People Barrier*** (because only 25% of managers have incentives linked to strategy); the ***Management Barrier*** (because 86% of executive teams spend less than one hour per month discussing strategy); and the ***Resource Barrier*** (because 60% of organizations don't link budgets to their strategy).

Healthcare organizations that took leveraged actions to overcome each of these barriers and took a highly disciplined approach to implementing strategy have been able to produce significantly improved results on each of their key performance indicators—because they actually executed their strategy.

Bossidy and Charan, in their book ***Execution: The Discipline of Getting Things Done***, describe execution as "a systemic process of rigorously discussing hows and what questioning, tenaciously following through, and ensuring accountability."

"It includes making assumptions about the external environment, assessing the organization's capabilities, linking strategy to operations and the people who are going to implement the strategy, synchronizing those people with their various disciplines, and linking rewards to outcomes."



It also includes mechanisms for changing assumptions as the environment change and for upgrading the organizations capabilities to meet the challenges of an ambitious strategy. Execution is about implementation of strategy.

Implementing deep irreversible strategic change is the challenge that must be addressed by healthcare managers. After 15 years working with leading-edge balanced scorecard practioners in the United States and Canada, Ken Moore of Quantum Innovations of Austin Texas developed the ***Strategy Management System***.

As set out in **Figure #5**, the ***Strategy Management System*** links the two ovals of strategy formulation and strategy execution into an integrated learning system which enables healthcare strategy teams to "learn-by-doing."

What the ***Strategy Management System*** provides is a proven best practice framework and process that enables change to become sustainable, while continuously evolving to reflect an organization's and a system's unfolding realities.

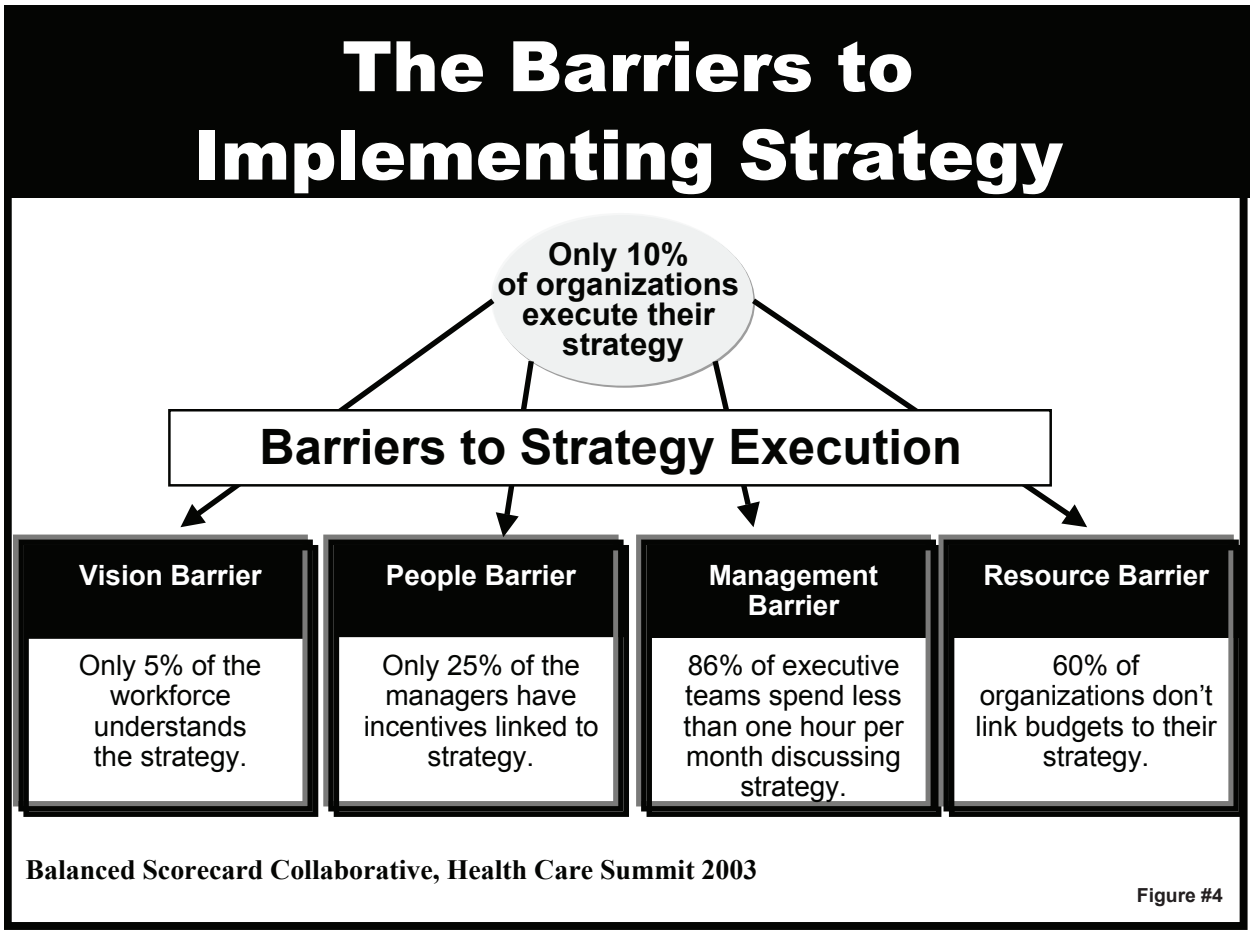


Figure #4

In his July/August 2010 ***Harvard Business Review*** article, entitled "***The Execution Trap***," Roger Martin, the Dean of the *Rotman School of Management* argues that "strategy development and strategy execution have to be connected right from the beginning."

He says "the idea that we have to choose between a mediocre, well-executed strategy and a brilliant, poorly executed one is deeply flawed—a narrow unhelpful concept replete with unintended negative consequences."

To avoid the execution trap that Roger Martin talks about, a number of healthcare organizations are creating an *Office of Strategy Management*. Perhaps the most evolved version of this innovation is at *Canadian Blood Services*. Similar offices have been created at *North York General Hospital*, *Sick Kids*, *York Central Hospital*, *Trillium Health Care* and at the *South East CCAC*.

While we need new skills, frameworks and processes to enable the transformation, we really can't do it without political and governance leadership at the top.

Provincial & Local Leadership Required

Every Minister of Health has one or two themes or subjects that characterize their tenure. Smitherman created the LHINs, Caplan championed mental health and now Deb Matthews has stepped forward with her ***Excellent Care for All Act*** and proclaimed healthcare quality and patient-centred care as her priorities.

The Act is certainly a good start—but "where's the beef?"

The missing piece in Minister Matthews' new quality/patient agenda is: financial incentives for performance improvement.

We know that patient-centred care is better and cheaper — but will good results actually be rewarded?

The most leveraged action the province could take to implement their quality agenda is to direct their crown agencies, the *Local Health Integration Networks*, to allocate significant resources next year based on each health service provider's performance on key indicators for patient/family satisfaction rates and quality-of-care performance—as well as staff/physician satisfaction rates.

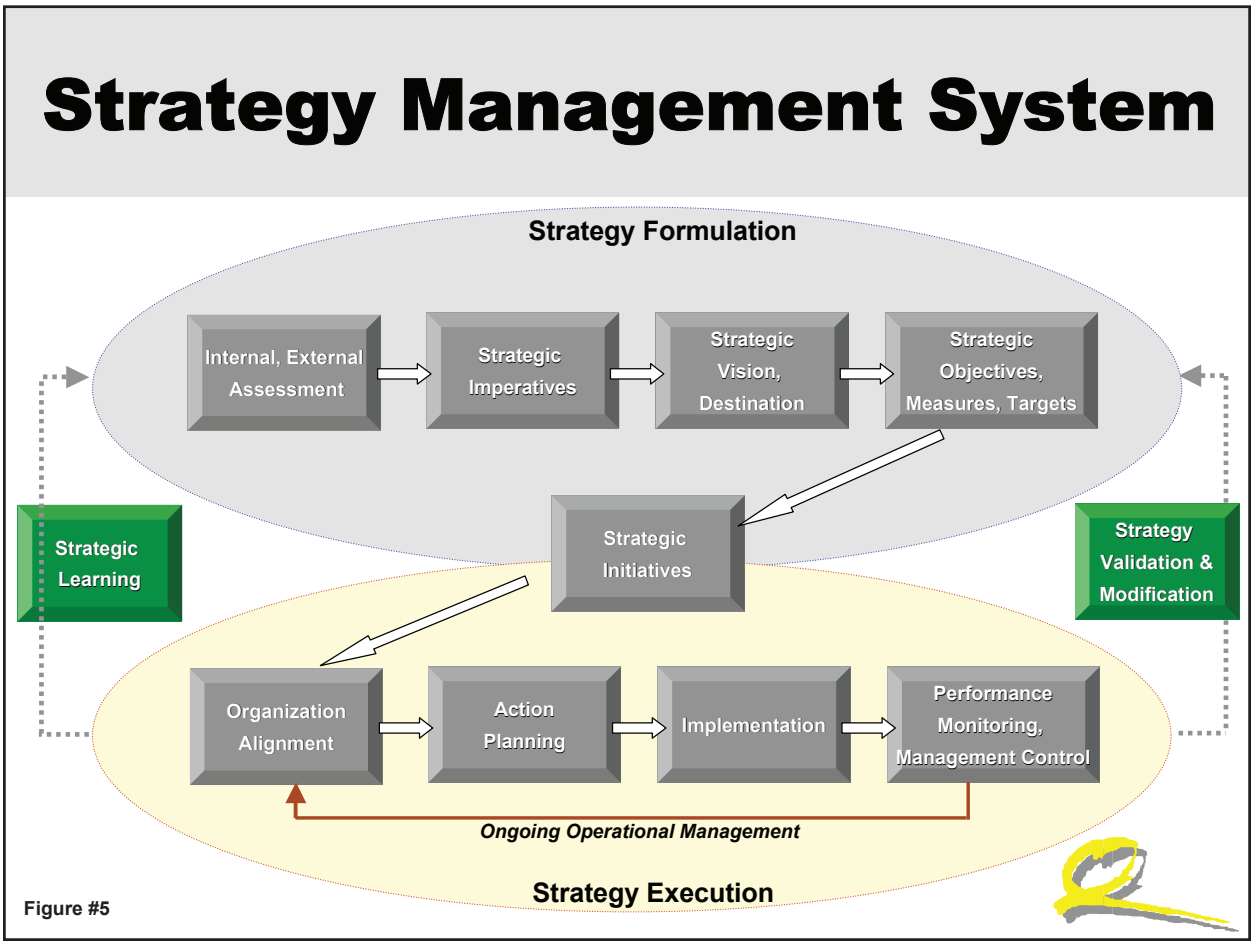


Figure #5

Proposals to align the economic incentives to reward customer service have been around for awhile. A decade ago, Duncan Sinclair, head of the *Health Services Restructuring Commission*, recommended a primary care system for Ontario in which 30% of the capitation payment would be held back if patients were not satisfied with the services provided by their primary care team.

So when will Ontario finally take action on aligning economic incentives with the desire for a more customer-focused approach to healthcare delivery?

"The Hon. Deb Matthews is poised to play her role as a 'champion' for patients and taxpayers."

While the *Ontario Health Quality Council* has been given a mandate to engage in public consultations and to provide recommendations to the provincial government concerning funding for performance improvement outcomes, there is an urgent need to introduce *indirect market forces* now—so that there will be some improvements to the system before the next election.

"Indirect market forces" would have LHINs provide substantial rewards to those health service providers who have good results on their patient/family/people-focus, and quality-of-care outcomes. The strategy is to empower LHINs to allocate resources based on consumer/patient evaluations.

Today LHINs are feeling more optimistic about the future because of the positive relationships that are developing with the new Deputy Minister, Saäd Rafi; and between the Minister and the LHINs. A key strategic issue is: how can Queen's Park be "in service" to the delivery system (vs. "in charge"), as it transforms?

Change management scholars point out that when the first 30% of a system is being rewarded for the desired behaviours, the 30% of organizations who are "on the fence" will quickly join the early adopters. At that stage, 60% of the system will be "on board"—which is usually enough momentum to sweep the final 40% into the new paradigm.

That's how change works in large complex adaptive human systems—in successive waves and iterations towards the vision.

However, organizational transformation to a patient/family/people-centred delivery system is about making deep fundamental change. Such change only occurs when there is strong provincial, local and organizational leadership.

The Minister, the Hon. Deb Matthews, is poised to play her role as a "champion" for patients and taxpayers—but are our leaders at the local level ready to play their vital role in the transformation of the system?

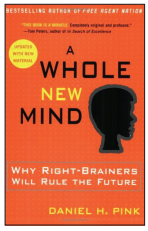
Governance Boards and senior management teams don't have to wait until the Minister brings more clarity to the economics of patient-centred care. If Boards of Governors truly exist to represent the "interests of the owners," they should be requiring their CEOs to demonstrate continuous improvements to their patient/client satisfaction rates right now.

Indeed, Boards should consider progress on their organization's annual *Quality Improvement Plan* with the same priority accorded to having a balanced budget.

At the managerial level, leaders need to be prepared to let go of the "illusion of control" and be prepared to master learning organization tools and practices—including the empowerment of staff and customers.

Physician brainpower also needs to be incorporated with the collective intelligence of all providers. But there are very few physician leaders that have emerged as collaborative team players. Where there isn't a collaborative mindset among physicians, progress is very slow.

Second Curve Leaders



As our First Curve CEOs retire over the next two to five years, they will be replaced with a very different breed of leader. Gone is the age of "left-brain" dominance. In his book, ***A Whole New Mind: Why Right-Brainers Will Rule The Future***, Daniel H. Pink proclaims "the future belongs to a different kind of person, with a different kind of mind: designers , inventors, teachers, storytellers, big picture thinkers—creative and empathic 'right brain' thinkers whose abilities mark the fault line between who gets ahead and who doesn't."

Pink says we are moving from an economy and society built on the logical, linear, computerlike capabilities of the *Information Age*, to an economy and society build on the inventive, empathic, big-picture capabilities of what's rising in its place: the *Conceptual Age*. While there is indeed a need for a re-balancing of left & right brain capabilities, healthcare leaders of the future will need both.

What about the shift for front-line care providers as we move form the First Curve to Second Curve system?

In their book, ***First Break All The Rules: What The World's Greatest Managers Do Differently***, Buckingham and Coffman talk about their research identifying one hundred excellent nurses, and one hundred average nurses.

They say "among the many talents common to great nurses

was one called '*patient response.*' Great nurses *need* to care. They cannot not care. Their filter sifts through life and automatically highlights opportunities to care. But if the caring itself is a need, the *joy* of caring comes when the patient starts to respond. Each little increment of improvement is fuel for them. It is their psychological payoff.

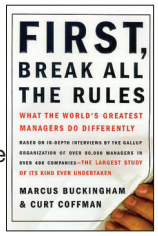
This love of seeing the patient respond is the talent that prevents great nurses from feeling beaten down by the sadness and suffering inherent in their role. It is the talent that enables them to find strength and satisfaction in their work."

The authors point out that despite the knowledge and insights of great nurses, most hospitals do not incorporate their wisdom in the design of their systems, structures and processes. As a consequence, "the hospital sector is now struggling more than ever with patient dissatisfaction, nurse morale, and rising costs."

In the *First Curve* healthcare system, there has been a competition for nurses. In the *Second Curve* healthcare system, there will be a competition for great nurses, great doctors and great staff. Why? Because good staff will be attracted to organizations that produce good results—and because higher patient/family satisfaction rates will be rewarded economically.

"Leadership at the provincial and local levels is essential if we are to achieve the deep changes that are required by the shift to a *Second Curve Patient-Centred System*."

While resistance to change has always worked in the healthcare sector, there is something different this time as we move inevitability from what has been called the "***First Curve***" health system design, to a "***Second Curve***" health system design.



In the first curve, organizational designs are rooted in the craft stage of system development and reflect early stage industrial designs. Today, we are teetering on the brink of a *Second Curve* paradigm of development—a more evolved set of system, organizational and process designs that are required to satisfy the increasing demands of funders, service providers, and, above all, customers in the knowledge economy.

While many healthcare leaders are aware of the burning platform we are on, I believe the cutbacks that will be required in the Spring of 2012 will be the drop-kick that finally propels us into a transformed system. Organizations that are prepared for the second curve system will increasingly thrive, those who are stuck in first curve, will continue to struggle.

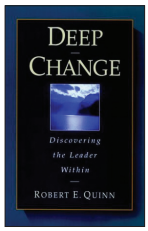
But our healthcare system needs leadership to get to the *Second Curve*.

Leadership at the provincial and local levels—from the Minister, to LHINs, to community governance Boards, to CEOs and their management teams—is essential if we are to achieve the deep changes that are required by the shift to a *Second Curve Patient-Centred System*.

Deep Change

Beyond the simple structural reforms of the past is the impending disruptive innovation of patient/family-focused care—a transformation that will produce deep, sustainable change in our healthcare delivery system.

In his book, ***Deep Change: Discovering the Leader Within***, Robert Quinn distinguishes deep change from incremental change—the type of change we usually talk about.



Quinn describes "*incremental change*" as the typical result of rational analysis and planning. There is a desired goal, and specific steps to reach that goal. Incremental change is usually limited in scope and is reversible. As it does not disrupt our past patterns, we can return to the old way if the change does not work out. Therefore, during incremental change we feel that we are "in control."

In contrast, "*deep change*" requires new ways of thinking and behaving. It is change that is major in scope, discontinuous with the past, and generally irreversible. The deep change effort distorts existing patterns of action and involves taking risks. Deep change requires people to be working to surrender the "*illusion of control*."

So what will happen when LHINs actually allocate more resources to health service organizations that are patient/customer/people-focused; and fewer resources (i.e. budget cuts) to organizations that don't have good data on their key performance indicators?

When our provincial and local LHIN leaders make the math on such a direction very clear, I believe that the system will shift overnight. CEOs, senior managers and community boards of governance who understand the emerging incentives will drive the patient/family-focus revolution.

Publicly, citizens and the media will observe the unfolding reports of budget increases and budget decreases for local service providers that are based on performance measures that reflect the opinions & evaluations of consumers.

If this is an open, fair and transparent process that rewards

healthcare service provider organizations for "good performance," and punishes "poor performance," I believe that the public will be very supportive of this type of process and outcome.

I also have faith that local community governance Boards will seize the opportunity to lead their organizations into what Dr. Vaughan Glover calls "*people-centred care*."

Once the disruptive innovation of patient-centred care takes hold, it will never return to the "good old ways of doing healthcare;" and we will have a better, less expensive healthcare delivery system.

"It's economic incentives that will finally shift behaviour in the healthcare delivery system," says *Ontario Environmental Health Association* spokesperson Varda Burstyn. "The sooner the LHINs become an effective surrogate for patients/customers/clients/etc., the better for everyone."

Until then, Sholom Glouberman of the *Patients' Association of Canada* warns: "patients don't want to be another 'flavour-of-the-month' that gets added to the list of other managerial fads. Patients and their families want real and meaningful change this time."

TED BALL is a Second Curve transformation strategy coach and learning facilitator for healthcare orgranizations that have decided to develop their internal capacity to transform themselves. If you want more information on patient-centred design, storyboarding and Second Curve health systems, contact: **ball@quantumtransformationtechnologies.net**