As the McGuinty government heads full-steam into the 2nd year of its second 4-year mandate, it must set a prudent course of action that will produce some real improvements to the healthcare system that patients and their families can actually “experience.” Any hope of a third term for the provincial Liberals will rely, in part, on Health Minister David Caplan making some very meaningful and measurable progress on the healthcare file over the next two to three years. In their first term, under Minister Smitherman’s stewardship, some significant progress was made on establishing a customer-focused health reform agenda with the structures and processes to implement it. But taxpayers also had to invest an additional $10 billion over the past five years — basically just to maintain the status quo, with some incremental improvements in some selected service areas.

The questions are: can we really keep doing this? Is the existing system even sustainable? How will the system actually change in the next few years?

You will want to know: how can your organization thrive in the emerging system? Should you be counting on bail-outs, or, is your future success largely dependent upon your own innovative capabilities? And, what is your organization doing to improve performance?

In Ontario, governments from all three political parties have tried over the years to “buy improvements” to the healthcare delivery system. Over the past four years, for example, we increased service volumes in hospitals to reduce selected wait-times for surgeries.

While such resource-driven strategies work in the short-term, longer-term structural changes designed by front-line health service providers are required to address the underlying root causes of sub-optimal performance.

The problem with a strategy that relies so heavily on increased spending for short-term improvements is that you have to keep spending more and more money.

But it would appear that we may have finally hit the wall. There may not be any more money — beyond the extra $10 billion that taxpayers have just invested in their healthcare delivery system over the past five years.

Health system leaders who believe there will be “another bail-out” need a reality check. As we hit the brick wall on finances, we need to remember that Ontario already has a $162 billion dollar debt that costs taxpayers $25 million a day — just to meet the interest charges on the money we owe — which amounts to $12,664 for each person in the province.
Taxpayers really can’t afford to spend even more money on healthcare.

Paradoxically, if the provincial government was to invest another dime in our healthcare system, it would have to come at the expense of the health status of our population. In other words, any further investments in our healthcare budget would make our society sicker.

Why? Because, in a shrinking economy, increased spending on healthcare services must come at the expense of children’s services, education, the provincial poverty agenda, climate change, pollution abatement, etc.

In a larger economic context, Ontario has been experiencing significant job losses in the wealth-generating manufacturing sector — while continuing to expand the cost of the public sector, mostly on our healthcare system.

While much of the increased spending has been a federal flow-through, the money is running out.

In 2003, Prime Minister Paul Martin agreed to provide $36 billion over 5 years to the provinces — so that they could “fix their healthcare systems.” In 2004, under significant political pressure, he added another $42 billion over 10 years.

The Premiers said at the time that this would mean that the healthcare system would be: “fixed for a generation.”

Canadians fully supported increased spending on healthcare. They love their health system. But taxpayers want “value-for-money” from their investments. So far, most of the new money has been spent on improved compensation for people working in the system, rather than actual service improvements for patients and their families.

Canadian healthcare consumers want to know: what’s in this for us?

A new study called Euro-Canada Health Care Index compared Canadian and 29 European countries’ healthcare systems — from a consumer perspective.

While Austria scored highest (806 points out of 1,000), Canada placed 23rd out of 30 with a score of 550. However, when compared from a return-on-investment from a taxpayers’ perspective, Canada ranks last.

Even worse, when focusing on patients’ rights and patient-focused care, Canada tied with Poland, just ahead of last place Latvia. So while Canada has been spending as much or more than the Europeans, we have not bought a better system for taxpayers and healthcare consumers.

“More money” for health service providers has also not resulted in happier doctors, nurses and other health professionals. Indeed, health professionals are as critical of the performance flaws in the system as the general public.

Many experience their work environments as “toxic.” Getting more money to take home has not made them feel more fulfilled or satisfied.

Indeed, a new study by Kyle Killian of York University informs us that healthcare professionals who deal with tragedy and trauma every day can suffer from “compassion fatigue” and exhibit “symptoms of post-traumatic stress disorder, burn-out and emotional exhaustion.”

Providing healthcare workers with more wage increases does not address the stresses in their workplace, and it does not address the concerns of patients and their families.

Today taxpayers want the customer-focused system that they were promised — and they want it now.

In a stagnating economy, when we are already spending 50 cents of every provincial tax dollar on healthcare, cries for “more money” from the traditional healthcare vested interest groups will not be very well received by taxpayers.

It is doubtful that the Minister of Finance is even in a position to bail out the healthcare sector as the provincial economy sputters on the brink of a recession. I believe we may have encountered the “perfect storm”: increasing demands for fundamental customer-focused health reform — and no “new money” available to buy it anymore.

The reality is that if the provincial government was serious about improving the “health status of the population,” they would make poverty and the determinants of health their top priorities.

But do health system leaders truly understand that “more money” is: (a) not the answer; and, (b) not even possible?
EXPECTATIONS & WASTE

Historically, when the province has been hit by economic downturns, the physicians' lobby (the OMA) and the hospitals' lobby (the OHA) have usually blustered forward demanding ever "more funding" anyway.

But today's leadership of Ontario's most powerful lobbies seems more realistic than in the past — or, at least they are not publically demanding more money.

In the hospital sector, the Change Foundation and the OHA's Health Care Leadership Development Institute are emerging to provide practical support, research and training for the next generation of healthcare leaders who need to learn how to transform and modernize the system and their organizations.

It has been estimated that about a third of our hospital CEOs are currently mobilizing their organizations to execute their strategies in alignment with the evolving system.

While a majority of senior hospital executives have up to ten years of service left, the reality is that as much as 40% of the CEOs and other senior executives will retire in the next five years.

The skills required by the next generation of leaders will revolve around achieving measurable improvements in customer-service, quality care and efficiency measures — without any additional taxpayers’ money.

So, let’s assume that the government will in fact “hold the line” on overall hospital and physician spending over the next two to three years — while allowing for the reallocation of resources within the system for circumstances like population increases (as in Barrie and the 905-area), and for other compelling cost pressures.

While allowing for these types of legitimate exceptions, overall growth of the healthcare budget will most likely only be tied to inflation. But it could be 0%!

Given that many organizations are experiencing increased costs of 3% to 4%, it is possible that such circumstances (i.e. 0% to 2% increases in 2009) could result in actual bottom-line budget cuts for healthcare organizations.

That means if an organization wants to thrive and grow in the next several years, it must find ways — within their own organization, and within the system — to reallocate resources.

Instead of getting billions of additional tax dollars to maintain the status quo, in the future, “growth money,” and “new investments” to meet emerging community needs will need to come from the non-leveraged activities in the system — estimated to be as high as 30% of the total provincial healthcare budget of $40 billion.

Often senior healthcare executives will challenge this “30% waste” figure. If we found all this waste, it would provide $12 billion in “new funding.” Just 10% would provide an extra $4 billion. Even if we just got 5% of the estimated waste, we would be able to eliminate the Health Premium Tax — and save every taxpayer $900 per year, or $4,500 over the next five years: almost enough to pay a year’s tuition at university!

Patients and taxpayers — who are also the “owners” of our healthcare delivery system — want high quality, effective and efficient care. They don’t want to pay for waste.

So, where is all this waste?

Some of the most common forms that waste takes in healthcare organizations and systems include: unnecessary medical interventions; unnecessary tests; repeating medical histories and symptoms for each provider; utilizing higher levels of acuity that are not necessary; gathering useless information, duplication of efforts, repetition of services, rework, quick-fixes—that-fail, endless waiting, mis-scheduling, focusing on public relations and “looking good” vs “performing well”; “feeding the Minister’s briefing book”; and engaging in small "p" politics. Healthcare providers are also being shaped by the plethora of perverse incentives that continue to reward waste and inefficiency — and often punishing heroic attempts at “good management.” When are we going to change this?

The fact is, we need to become smarter at how we design, govern and manage our healthcare delivery system. In places like Saskatchewan, Nova Scotia and Manitoba — where they don’t have a lot of money — they have had to be smart.

Ontario has never really had to be smart — because we’ve had money! Or, at least we did in the olden days.
THE BURNING PLATFORM: Leap Or Die

Today, we have the following combination of circumstances:

- A couple of thousand service provider organizations are about to enter into 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 define what a “patient-focused system” means.

These three highly leveraged macro system design changes have now combined to create what change management scholars refer to as a “burning platform” for change.

Any organizations that struggle to stay on the burning platform (i.e. maintain the status quo) are doomed to failure. That is simply not a prudent survival strategy — when past performance and evidence on effectiveness will be the driving factors in the LHIN’s resource allocation process from here on.

In a transformed healthcare system, local governance boards will be shifting from representing their “silo”, to representing the “owners” of their organization: the people of their community. That means that their emerging role will be to “hold management accountable” for achieving bottom-line results that are in the best interests of the clients/patients/residents/customers/taxpayers (i.e. the “owners” of the system).

So, in order to survive — and hopefully thrive — an organization must mobilize everyone to achieve the improved performance results for which they will be held accountable by their own Board, and by the LHIN’s Board.

Rather than react to these forces as threats, successful organizations will respond to them as opportunities to create the future that they want.

The most successful organizations use best practice learning organization tools and practices for executing strategy — learning from the results — and learning how to constantly adjust and recalibrate their strategy to respond to their own “lessons learned”; and, to evolving “best practices” in health system transformation.

If healthcare organizations are going to thrive in the emerging environment, they need to take six leveraged actions (see Figure #1).

1. The Board, management, staff and key stakeholders need to have a powerful vision of their organization (within their local delivery system) and become deeply committed to executing a strategy which will enable them to achieve their vision. At the network level, system partners need to share a health services delivery system vision at the local level.

2. As a true learning organization, build the capacity of leaders throughout the organization to work collaboratively together to continuously improve on each of your key performance indicators that you have embedded in a best practice Balanced Scorecard that undergoes continuous improvements in highly participative processes. At the LHIN-level, each network needs a Strategy Map and Scorecard.

3. Before entering into a Service Accountability Agreement with your LHIN, undergo a “strategy refresh” — utilizing a best practice Balanced Scorecard framework and applying a rigorous methodology for strategy implementation, learning, strategy recalibration and “accountability for outcomes.”

4. Create an aligned set of Accountability Agreements that includes: the Service Accountability Agreement with the LHIN; the CEO/COS’s Accountability Agreements; and, the Managerial and Medical Chiefs’ Accountability Agreements.

5. Create an Office of Strategy Management (accountable to the CEO) to co-ordinate strategy execution efforts, provide business intelligence insights on performance issues and monitor and support the integration of Accountability Agreements.

6. Introduce a best practice Pay-For-Performance System for managers that is linked to the Board’s and organization’s key scorecard metrics and personal Accountability Agreements.

Figure #1:

To successfully take these six leveraged actions, you really need to have everyone in your organization — and in your delivery system — deeply committed to implementing the changes that will be required over the next two to three years.
This is where most organizations fail: their commitment to fundamental change has not been achieved; and, they do not share a common language or use common frameworks for developing and executing change.

Think about it: is your organization really ready to transform? Are you and your network partners ready for the fundamental changes that will be required over the next few years?

**FUNDAMENTAL CHANGE IS NOW REQUIRED**

Until the health sector learns more about what the new Minister of Health thinks about his government’s health reform model, there will be speculation that he might choose to invest his tenure at the health ministry altering the “Made-in-Ontario Model.”

Should there be fewer LHINs? Bigger LHINs? Transforming the LHIN offices back into local ministry offices that are controlled by Queen’s Park?

Prudent leaders will realize that Minister Caplan will more likely spend his time at health actually implementing the reforms that have been promised by the Liberals in their first term. Given that the next election is in October 2011, Mr. Caplan has only three years left to make an impact. Not much time.

Shifting LHINs into Regional Health Authorities, or, re-empowering the MOHLTC to micro-manage the delivery system is not the “Made-in-Ontario Model” that has been promised. So, assuming that the government stays on course, what type of change should healthcare organizations start preparing for as the “Made-in-Ontario Model” is implemented over the next two to three years?

While new skills for strategy execution are essential — so are basic old-fashioned change management skills. The fact is that our healthcare organizations are profoundly human organizations — and humans are emotional beings who really hate to change. Because fundamental change is required, healthcare leaders need to practice and model change management themselves.

In the 80’s and 90’s, change management literature highlighted the differences between four types of organizational and whole system change types: Developmental; Transitional; Reactive/Transformational; and, Conscious/Transformational Change.

**Developmental Change** is the improvement of a skill, method, performance standard or condition that does not measure up. These are improvements to existing operations. The new state is a prescribed enhancement of the old state, rather than a radical transformation.

The change is incremental, often structural, sometimes requiring new skills. Program Management structures and TQM/CQI Skills Training are examples of “developmental change” in the 90’s. While the objectives of these change initiatives are essential, the track record indicates a 70% failure rate for these types of change initiatives.

More recently, Ontario’s health system has been experiencing what change management scholars call “Transitional Change.”

**Transitional Change** is more complex than developmental change. Rather than simply improving “what is,” transitional change replaces what is with something completely different. Translational change requires the dismantling of the old state, and the conscious design of a new state.

-Figure # 2:

Large-scale change initiatives fail 70% of the time.”

Figure # 2: Four Types of Change

**DEVELOPMENTAL CHANGE**

 Improvement of what is: New state is a prescribed enhancement of the old state.

**TRANSITIONAL CHANGE**

 Design and implementation of a new state, requires dismantling of the old state and management of the transition process.

**REACTIVE TRANSFORMATIONAL CHANGE**

 Old state is forced to die. New state is unknown. It emerges through trial and error application of current management trends. New state requires fundamental shift in mindset, organizing principles, behavior and/or culture.

**CONSCIOUS TRANSFORMATIONAL CHANGE**

 Death of old state is required and supported. The new state is initially unknown. The principles driving the change are understood and become the design criteria for the new state and course correction. Whole system participates. New state evolves as new information is generated, and learning and course correction occurs.
Forty-two CCACs becoming fourteen CCACs is an example of “transitional change.” These changes have consumed these organizations — often painfully — for three or four years now.

While the evidence on “mergers” suggests an 80% failure rate in the corporate sector, it is difficult to calculate how well the CCAC sector and the Harris-era hospital mergers have actually fared in Ontario. Did these top-down structural changes ever deliver on the promised financial savings and the improved quality and service outcomes?

“Tinkering with structures” has been the most common approach to health reform for the past twenty years in Ontario. The various structural solutions that have been imposed over the years has certainly kept everyone very busy. But each structural change has failed to deliver on its promises.

So, before anyone begins to entertain the next series of “structural quick-fixes”, what did we learn from the “fixes” of the past? Did we improve the performance of the system — from either a patient or taxpayer perspective? Did satisfaction rates improve for patients and healthcare professionals? What measurable outcomes/results were actually achieved?

Now is really the perfect time to generate and reflect on our “lessons learned” from these various structural changes — and plan accordingly, going forward. We don’t need to keep repeating the mistakes of the past. We need to learn from our “best mistakes.”

Transformation coaches say: “Plan to plan, or plan to fail.” This adage continues to ring true in our current circumstances.

As the McGuinty Government executes their health strategy in their second term, the “Made-in-Ontario Model” actually requires what change management scholars call: “transformational change.”

Transformational Change involves a radical shift from one state of being to another — where the new state is uncertain until it actually emerges. While the primary motivation for developmental change is improvement, transformational change is required when survival is at stake. In 2009, for the first time, LHINs will have Service Accountability Agreements in place with each of the health service provider Boards in their network.

In the near future, Boards of healthcare service providers will be “held accountable” for certain outcomes (measurable results) that the organization needs to monitor because: survival (or at least their economic well-being) could be at risk — if they don’t produce reasonable, agreed-upon outcomes on an annual basis.

That’s what the new system will do. It will allocate resources based on outcome evidence and performance data. So, if organizations don’t perform well, there could be serious financial consequences.

The McGuinty government is now introducing meaningful market forces into the delivery system. From here on, patient satisfaction and quality-of-services will be as important as a balanced budget.

The fact is: these aligned measures and incentives will drive major transformational changes to our existing system over the next three years. To survive or thrive in such an environment, organizations will respond with what change management scholars call “Reactive”, or “Conscious Transformational Change Strategies.”

**REACTIVE CHANGE**

Today, Ontario is mostly experiencing Reactive/Transformational Change Strategies — because neither the LHINs, nor healthcare service providers, have a coherent or “shared” vision of the future.

If you step on the accelerator of an unaligned vehicle, it will shudder and shake, disrupting everyone. That’s what’s still happening in the delivery system at the moment.

Today, health service providers across the system — and even within organizations — lack a common language and common framework for talking about, planning for, or executing aligned strategic change. Without alignment on a LHIN-Level Scorecard — and a network-level Strategy Map — system change will be experienced as chaotic and threatening. Trust will certainly not be present, and, in such environments, there will be very little sense of a “community of partners” capable of collaborating to build a better system for their community.
Under such conditions, it is normal for people to squabble and behave badly. Without a true sense of community/ shared vision and trust, people will almost certainly get stuck — often painfully stuck. I keep a copy the May, 2005 issue of Fast Company on my desk to just to remind me that “9 out of 10 people would much rather die, than change.”

The fact is that people don’t like change — even when it means their very survival!

Fortunately, there are many first-rate talented organizations who are already dramatically improving patient care while providing higher quality and more efficient services — because they have developed leading-edge managerial and governance competencies for transformation.

A number of hospitals have fully embraced continuous quality improvement and patient safety practices and measures using lean thinking and best practice strategy execution and performance monitoring methods. North York General Hospital, Markham-Stouffville, Hotel Dieu-Grace in Windsor, UHN in Toronto and the London Health Science Centre/St. Joseph’s Health Care’s Transformational Change Project are just a few examples of how innovation leads to improved operational performance.

While being subjected to constant chaotic change, the CCAC sector has also managed to produce several examples of innovation and creativity. Indeed, many of our CCACs are behaving as “system integrators” at the local level: connecting hospitals, community services and primary care.

Some leading hospitals (and one CCAC) have created Offices of Strategy Management, applying a best practice methodology to facilitate strategy execution/strategy implementation. Bob Kaplan (of Kaplan & Norton fame) says that “the Canadian Blood Services has one of the best strategy execution capabilities built into their Office of Strategy Management that exists in the world.”

We have the capacity to change the system. The knowledge and know-how are in the hearts and minds of the people in the delivery system — but we need to get moving on it. We need to learn how to achieve results.

Today, at least 30% of Health Service Providers (HSP’s) are already in the midst of transforming — because they are continuously building their internal capacity to transform and integrate their own internal systems/structures and processes.

Indeed, significant parts of every local delivery system are already engaged in transforming themselves — organization by organization. Examples of innovative breakthroughs on performance are everywhere in our delivery system — but we don’t showcase or celebrate them enough.

“Examples of innovative breakthroughs on performance are everywhere in our delivery system — but we don’t showcase or celebrate them enough.”

So how can innovation and performance improvement efforts spread across our healthcare services delivery system? How can the healthcare organizations build the momentum required for creating a better performing delivery system?

The answer is: leadership & alignment.

The most advanced organizations are often headed up by leaders who are personally dedicated to continuous learning & improvement. Typically, these organizations are energized by empowered workers — and managed by aligned systems, structures, processes, incentives and people.

Organizations that are producing breakthrough results tend to have high levels of respect and trust. The Board and management are aligned and working synergistically together as a committed leadership team.

The challenge is that healthcare provider organizations are at very different stages of strategic development and with varying degrees of strategic capacity — across each of the sectors, within sectors, and within each local delivery network.

The leading organizations design and align themselves to achieve the results that they want to achieve — and that their Service Accountability Agreements will say they must achieve. They have built the internal capacity to transform themselves — rather than rely on “outside experts” to tell them what to do.

As you can see on the chart in Figure #3, the Reactive/Transformational Change process (which most healthcare organizations are experiencing today) can be very painful for people in the delivery system.

In threatening environments, senior executives and
<table>
<thead>
<tr>
<th>TYPE OF CHANGE</th>
<th>Degree of Pain Felt</th>
<th>Primary Motivation</th>
<th>Degree of Threat to Survival</th>
<th>Gap Between Current Reality and Emerging Vision</th>
<th>Clarity of Outcome</th>
<th>Impact on Mindset &amp; Paradigm</th>
<th>Focus of Change</th>
<th>Orientation</th>
<th>Method of Creating Solution</th>
<th>Level of Personal Development Required</th>
<th>How Change Occurs</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEVELOPMENTAL CHANGE</td>
<td>(1) Incremental improvements in specific parts of the organization.</td>
<td>(1)</td>
<td>(1)</td>
<td>(4) It is prescribed against a standard.</td>
<td>(1) Little, if any</td>
<td>Improvement of skills, knowledge, practice and performance.</td>
<td>To do better in a certain area; project oriented.</td>
<td>Expert-driven: Training</td>
<td>(1) Through training, skill development, communications, &amp; process improvement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSITIONAL CHANGE</td>
<td>(2) Fix a problem</td>
<td>(2)</td>
<td>(2)</td>
<td>(4) It is designed against criteria.</td>
<td>(1) Little, if any</td>
<td>Structures, practices and technology (not culture).</td>
<td>Project-oriented; largely oriented to structure, technology and practices.</td>
<td>Problem-solving; solutions created internally or externally.</td>
<td>(2) Organized process, and support structures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REACTIVE TRANSFORMATIONAL CHANGE</td>
<td>(3-4) Survival: &quot;Change or Die&quot;. Often driven by external environment. A race for compliance.</td>
<td>(3-4)</td>
<td>(3-4)</td>
<td>(1) It is not known, it emerges or is tried and corrected.</td>
<td>(2-3) Forced to shift; old mindset chipped away; change may be piecemeal.</td>
<td>Overhaul of structure, practices and culture; may be partial — not fully aligned.</td>
<td>Process-oriented within the parameters of the project; requires shift in mindset, behaviour and culture.</td>
<td>Emergent; trial and error based on tailoring current management trends and new practices.</td>
<td>(3-4) Leader-driven; emergent capacity-building process. Significantly more investments in human capability for transformation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DESIGNED AND CONSCIOUS TRANSFORMATIONAL CHANGE</td>
<td>(1-4) Excellence. A powerful shared vision to be &quot;the best&quot;. Accelerated change. Become a Learning Organization.</td>
<td>(1-4)</td>
<td>(1-4)</td>
<td>(2) Outcomes are listed on a Balanced Scorecard; outcomes emerge through trial and error and continuous course correction.</td>
<td>(4) Transformational Thinking &amp; Skills. Lean thinking &amp; the ability to surface &amp; test assumptions. Being system thinkers, and providing stewardship &amp; adaptive leadership.</td>
<td>Transformation of people &amp; processes. Align strategy, structure, culture and skills to the shared vision of the organization or system.</td>
<td>People and process orientation; requires shift in mindset/behaviour and culture. Becoming a Learning Organization. System &amp; Lean Thinking.</td>
<td>Developmental facilitation and capacity-building for transformation. Highly-participative strategy development &amp; implementation. Integration of silos. Accountability Agreements linked to Balanced Scorecard for the organization and system.</td>
<td>(1-4) Principle-driven, co-created emergent process. Senior &amp; middle managers build capacity for transformation across the organization and system. Focus on strategy execution.</td>
<td></td>
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Adapted from: Anderson & Marquart, OD Practitioner, 1989

(Scale: 1 low, 4 high)
volunteer governance leaders will retreat to their silos and go back to the “way we’ve always done things.”

Physicians, nurses, managers, technicians and front-line service providers experience this period as highly “threatening” and “unstable.” In such environments, patients are at risk.

Today, patients and their families are increasingly reporting that they are experiencing their healthcare system as “bureaucratic”, “confusing”, “unfriendly”, “difficult to navigate,” and “unresponsive.”

If we are going to actually succeed in transforming the delivery system, we need leadership at all levels to move towards strategy execution — implementing the “Made-in-Ontario Model.”

Government leaders at Queen’s Park — and in their crown agencies (the LHINs) — need to create an environment where innovation, risk-taking, and “accountability for outcomes” co-exist. The system needs coaching and support to achieve the outcomes for which people will be accountable.

This is not about some theoretical change management construct. This is about “being human in the midst of system chaos.” It’s not fun to work in an environment were everyone is anxious about being blamed. Emotionally, people are fearful and prone to mistakes — not a good thing in a system where 1 in every 13 patients is already being harmed. As we know, there are an estimated 25,000 preventable deaths in the Canadian hospital system annually.

The reality is that more and more chaos in the delivery system will result in ever-increasing preventable deaths and patient harm. It is essential that our system leaders address these realities up front. We need our leaders to resist being trapped forever in “crisis management.” Instead, they need to focus on working more collaboratively together, to prevent the causes of the crisis.

Leaders must become more strategy-focused. They must learn how to engage the wisdom of our front-line healthcare providers in the redesign of our delivery system.

At the provincial-level, the LHIN-level, and at the delivery system’s governance and managerial levels, our health sector leaders urgently need to provide a calm confidence, a sense of optimism, an openness to learning — and genuine support for innovation and fundamental change.

Fear and anxiety must be replaced by creativity and innovation as dominant forces and “feelings” in the system. Shifting from a “blame culture” to an “accountability culture” is essential for success.

LHIN leaders at the governance and staff levels also need to build trust and confidence between themselves and the governance and managerial leaders throughout their network. As we know from experience, “blaming”, “threatening” and “top-down micro-management” are not effective strategies that work. Indeed, such behaviors usually make things much worse. There is still some uncertainty over what the system actually values, and what it does not value — what it will reward, and what it will not reward. If there have been points of stress over the past three years, leaders need to be wise enough to “forgive and forget.” They need to build solid, trusting relationships across the system and within each organization.

“The most leveraged action that system-level leaders can take is to recognize and reward those organizations, and those individuals, who are already on a ‘transformation path.'”

The most leveraged action that our system-level leaders (Minister/senior ministry officials/LHIN boards and staff) can take is to recognize and reward those organizations and those individuals, who are already on a “transformation path” — and are already demonstrating improvements in performance.

Service providers also need to learn how the incentives in the emerging system will be aligned with the government’s customer-focused strategy — and with their network-level strategy for service integration, as set out in their Integrated Health Services Plan. Health system leaders should assume that what is in their network’s IHSP will be key indicators of where the local delivery system is moving over the next two to three years.

They need to understand how they could actually “thrive” in the future delivery system — and they need to understand the risks of poor performance.

At the service delivery level — among senior managers and governors — there are a significant number of leaders who report that they are confused by the “mixed messages” about how the “Made-in-Ontario Model” is supposed to work in the emerging system.

Many local governance and managerial leaders are concerned that while they’ve been told to be more inno-
vative and customer-focused, they may not in fact be liberated to find innovative solutions. Rather, some are sensing the potential for an even higher level of micro-management in the emerging system than in the past. They could be right. They may be wrong.

So what is the reality of our “new” Ontario healthcare delivery system?

Does it function and operate in the same command and control style as before — or do we need to prepare for a different kind of system: a system in which independent service providers are liberated to deliver excellent services within an interdependent delivery system; a system that provides citizens with “high quality, effective care and a seamless customer experience”; and, finally, provides taxpayers with “value-for-money.”

I think that with reflection, it becomes clearer and clearer that the changes that are being made by the McGuinty government’s “Made-in-Ontario Model” are intended to go well beyond the Regional Health Authority Model that simply removes local community Boards and creates the “illusion of control” by local bureaucracies that micro-manage the delivery system from a central perch.

It may be true that many of our existing community governance boards don’t “add value” as representatives of the “owners.” But where community boards don’t exist, governance becomes increasingly about power politics — rather than about holding organizations “accountable for performance outcomes” that are patient/family/taxpayer-focused.

The Ontario Government’s strategy calls for a fundamental patient-focused/market-driven transformation of the entire delivery system — not more top-down, command-and-control bureaucratic decision-making structures.

The provincial strategy calls for community boards to represent the best interests of the “owners” — which isn’t always the same thing as the organization’s narrow self-interests. The Government wants community boards to become guardians for quality/safety/patient satisfaction and staff development. The provincial strategy is to align the incentives in the system and to introduce “accountability for outcomes” that are linked throughout the system.

While that may seem to be very clear to many, as cartoon character Pogo once said: “Some people won’t read the writing on the wall until their backs are against it.”

The problem is: forced change doesn’t work in complex adaptive systems — ever.

Systems thinking principles teach us that “when you push on a complex adaptive system, it pushes back much harder.” For Ontario to succeed, we must avoid “forced change.” Certain failure will occur if MOHLTC or LHINs were to adopt a threatening or authoritative approach to system transformation.

This is more than just a leadership “style” issue. These are core system design and culture issues that need to be addressed and clarified by the new Minister as we move through the Strategy Execution Phase of the government’s health system reform agenda.

Issues of equity, fairness and effectiveness can be expected to surface during this Reactive Transformational Change Phase. But smart people and systems will step back, calm down, catch their breath and notice that they aren’t going anywhere very fast — unless they focus on some agreed-upon organizational and system goals/objectives/targets.

Smart communities and organizations won’t wait until their “backs are against the wall.” They will get unstuck. They will become proactive — by intentionally choosing to shift to Conscious Transformational Change.

CONSCIOUS TRANSFORMATIONAL DESIGNED CHANGE

Change management scholars would describe the “Made-in-Ontario” model as the product of “conscious transformational change.” That’s because it requires an intentional mindset shift and a rigorous process for executing strategy.

We’ve never had a shortage of strategies in Ontario. We have simply avoided the Strategy Execution Phase — and developed yet another “grand strategy.”

The Ontario model isn’t simply about the optics of a couple of structural changes — the new model is designed to create a fundamental redesign of the delivery system’s DNA.

It is a system that supports both self-management and accountability — as well as independence & interdependence. It is a system design that balances empowerment and accountability and requires the right balance of leadership and management.
Change management practitioners call this the “Learning Organization Model.” Kaplan and Norton call it the “Strategy-Focused Organization” — which uses a best practice Balanced Scorecard to drive strategy execution.

Whatever you call it, successful implementation of this type of large-scale transformational change requires a certain type of leader. Such leaders need to be active learners seeking continuous improvement on the organization’s and delivery system’s key performance indicators.

**Conscious Transformational Change** requires increased investments in the learning and growth of staff. The 30% of organizations that actually succeeded in transforming into strategy-focused organizations where those who invested in the learning and development of their senior and middle managers.

Over the years many organizations have built the internal capacity of teams across their organization to lead and manage the transformation. Typically, these “human capital” investments range from 1% to 5% of an organization’s payroll budget.

“Conscious change” means deliberate, intentional, designed change. Organizations need to intentionally design and align their systems, structures and processes to achieve the results that are required. Balanced Scorecarding, Kaizen, Value-Stream Mapping, Lean Thinking, Work Process Design, Six-Sigma, TQM/CQI, Performance Measurement, Strategic Budgeting, Dynamic Evaluation, Accountability for Outcomes and learning through Story-Telling are all skills/tools/methods and processes that will be required to survive and thrive in the emerging change environment.

But what brings a human system together is a powerful “shared vision” of the future.

The fact is, unless each of the individual organizations within a complex system — like a LHIN — share and commit to a common vision, there is no “system.” They are merely a collection of individual component parts that exist side-by-side — with many different aims and purposes.

It would be like having all the Divisions of General Motors operating completely independent of one another — some even at cross-purposes.

**In complex-adaptive human systems**, the performance quality of the “whole system” is the product of how well all the parts actually work and “fit” together. If all the parts are designed to work together effectively and efficiently, a shared vision, and an agreed-upon system transformation strategy, are essential for success.

At the top governance and management levels, our leaders need to be aligned on where the system is going — and how they are going to get there.

Delivery systems need to create LHIN-Level Scorecards that are ultimately the product of the collective intelligence of service providers within each network. Scorecards and Strategy Maps will enable organizations within each local network to collaborate and implement the changes required to achieve better outcomes/results.

High-level guidance for redesigning our healthcare system is located in the Ontario Health System Strategy Map — which provides fourteen dimensions of performance (see Figure #4).

At the organizational level, in redesigning themselves to improve in each of these priority areas, healthcare organizations need to look at their functional design (what it does); their structural design (who does what); and work process designs (how work is done).

Evidence from healthcare delivery systems who have applied lean thinking/systems thinking/Kaizen/six-sigma and TQM/CQI methodologies demonstrate that it is possible to achieve 50% improvements in quality — and, up to 30% improvements in cost.

To achieve such dramatic gains, old ways of thinking about “managing” and “organizing” healthcare organizations are being abandoned. The successful ones have changed the way they think about their challenges.

After three years of experience as local health system partners within their LHIN, most local health system leaders are just now beginning to think more about the linkages across the continuum-of-care in their community.

**LEADERSHIP COMPETENCIES**

The scale of change required over the next one, two and three years requires a very different kind of leadership.
— at both the governance and managerial levels. But Ontario does not have a pipeline of talented leaders ready to take over this $40 billion-a-year enterprise.

Data from OHA’s Labour Market Survey indicates that only 36% of 375 respondents think their organization is “very good” or “excellent” at managing leadership talent. Three quarters say that potential leaders in their organization are not even identified in any systematic way.

However, if the health sector is to succeed, it urgently needs to develop the talent for success in the emerging environment of constant change and learning — where measurable bottom-line results are required.

This is beginning to happen across the sector with Trillium’s and Toronto East General’s “1001 Leaders Program”; with North York General Hospital, St. Joseph’s (London, Toronto and Hamilton), Hotel Dieu-Grace (Windsor), Markham-Stouffville Hospital, London Health Science Centre, Lakeridge Health System — as well as York Central Hospital and Queensway-Carleton’s capacity-building programs for senior/middle and front-line managers.

According to the OHA, in recent years, there has been a shift in healthcare towards the development of transformational leadership — rather than transactional leadership.

They suggest that the sector needs practical “how to” coaching support to develop their leadership capacity in areas such as “change management, systems thinking and interdisciplinary teams.” The association is deeply committed to helping its hospital members develop the leadership skills and competencies required for the future.

In Figure # 5 is a list of “Leadership Competencies” that Quantum and our partners believe are essential for leading and managing transformation in the emerging environment.

Leaders at the provincial, network, and organizational levels will also need skills for adaptive leadership and stewardship.

Adaptive leadership means raising tough questions, rather than providing answers; it means framing the issues in a way that encourages people to “think differently” — rather than laying out a map of the future. It means co-creating with people their new roles, power relationships, and behaviours — rather than orienting them in a new direction and giving them a big push.

If the government is to be successful at actually implementing their health reform agenda, they must mobilize the CEO/Ex.Dir. community behind them.

Successful transformation will only occur when our operational leaders are fully “on board” playing their essential role as adaptive leaders and as talented managers who can achieve the results required for success.

Government and LHINs need to approach the delivery system’s senior operational managers as the “potential solution”, rather than “the problem.” System leaders need to appeal to our experienced and talented operational managers to engage in real collaboration — not political games and dysfunctional dynamics.

In turn, MOHLTC — and all the stakeholders — need to be very supportive of LHINs. If they don’t succeed, the whole system fails.

The key question each stakeholder needs to answer is: How can you make the LHIN — and your community — successful?

Government needs to make it clear: the LHINs are empowered to implement the “Made-in-Ontario” model — and everyone needs to commit to their role in ensuring

1. Improve health system capacity & resources.
2. Increase availability and uptake of information & evidence for health system management.
3. Improve integration of health services providers, processes, and systems.
4. Increase productive use and appropriate distribution of resources across the system.
5. Improve access to appropriate health services.
7. Improve safety and effectiveness of health services.
8. Improve chronic disease management.
9. Improve healthy behaviors, health promotion and disease prevention.
10. Influence broader determinants of health.
11. Improve clinical and population health outcomes.
13. Increase sustainability of the health system.

Figure # 4:
the successful implementation of these customer-focused reforms.

While LHINs have the ultimate power of resource allocation, some may well be anxious about their “role” in the emerging system. Are they a “managerial authority” or “system facilitator”? Do they “manage” the delivery system, or, “reshape” it through the resource allocation process — and by monitoring performance on the outcomes/targets set out in the Service Accountability Agreements?

It is unlikely that the public would be happy if the next step in health reform was to increase the size of LHIN offices — so that they can “manage” their local system.

We already know that micro-managing the delivery system from Queen’s Park doesn’t work. Why would the Central Authority Micro-Management Model work any better at the LHIN-level? LHINs were never designed to be “local system managers,” that’s why they only have 20 staff and 9 Board members.

Their real power within the redesigned delivery system will be in the Resource Allocation Process. If they get this part right, their local healthcare delivery system will transform over the next two to three years.

But to be successful, change needs to start at the very top: with the role & function of the MOHLTC in the new “Made-in-Ontario” healthcare delivery system design.

The original strategy from Minister Smitherman was that the LHINs would not become “another layer of needless bureaucracy.” While most observers believed that the MOHLTC would be downsized after the LHINs were up and running, the government never did downsize the Ministry.

The transformation the MOHLTC and many other organizations are struggling with is “letting go” of the “illusion of control.” Indeed, some LHIN’s, (and some parts of the MOHLTC) continue to struggle with the new “Stewardship” role that Deputy Minister Ron Sapsford has mandated and nurtured within the Ministry and its local crown agencies.

In Peter Block’s book, Stewardship: Choosing Service Over Self-Interest, stewardship is defined as “the willingness to be accountable for the well-being of the larger community by operating ‘in service’, rather than ‘in control’.”

While the past twenty-five years of health reform efforts hasn’t produced many measurable improvements, we learned enough that we do know that certain leveraged actions will produce success.

LEVERAGED ACTIONS FOR SUCCESS

When organizations (and whole systems) get stuck at the strategy execution stage of transformation, they often decide to restructure in order to avoid real change. Rather than wasting the next three years engaging in endless tinkering with structure, healthcare leaders need to get on with implementing the “Made-in-Ontario Model.”

While tinkering with structure on its own can sometimes reap a few short-term benefits, most “restructuring exercises” only address the symptoms of dysfunction, not the root causes. We need fundamental change, not more time-consuming non-leveraged restructuring exercises about power and authority.

Experience with successful transformations at the organizational-level indicates that more effective interventions include:

☒ Engaging the Public in the early stages of health system planning and focus on becoming Customer/Patient-Driven.

Leadership Competencies Required For Transformation

• Dialogue/Team Learning & Collective Intelligence
• Primal Leadership & Emotional Intelligence
• Collaboration/Teamwork/Innovation
• Change Management/Adaptive Leadership
• Facilitation/Coaching/Re-framing
• Systems Thinking & Leveraged Thinking
• Lean Thinking/COQ & TQM/Kaizen Methodologies
• Balanced Scorecarding/Strategy Mapping/Performance Measurement & Accountability
• Organizational Alignment(Strategy/Structure/Culture/Skills) – and Strategic Budgeting
• Risk Management & Conflict Resolution
• Management/Leadership Balance for Transformational Change
• Stewardship/Talent Management

Figure #5:
- Investing 1% to 5% of payroll budget in the Learning & Growth of Managers — so that they can develop and execute strategies that are driven by the organization's and system's vision;

- Engaging management, physicians, board and staff in on-going Balanced Scorecard Development Dialogues that generate strategies that will align the organization to achieve improved performance;

- Focusing on Quality — which in the end, will also lead to cost savings through greater efficiencies;

- Linking Strategy to Operations — and Linking Managerial Accountability Agreements to the organization's strategic outcomes;

- Clarifying Decision Rights — so that everyone has a good idea of the decisions and actions for which they are responsible/accountable; and, that they understand how what they do contributes to the very purpose (mission) for why the organization exists;

- Aligning Structure/Culture/Skills to the strategic goals of the organization;

- Aligning the organization's budget to the strategy (only done by 40% of organizations);

- Developing Adaptive Leadership/Stewardship/Facilitation Skills within senior and middle managers — so they can lead and manage the organizational transformation and system integration projects;

- Shifting Organizational Culture from "command and control" to teamwork/collaboration/collective intelligence/emotional intelligence;

- Aligning incentives for managers for achieving bottom-line results (currently only done by 25% of Ontario hospitals);

- Renewing Governance in alignment with the reformed system — with major focus on quality customer/staff/stakeholder satisfaction;

- Generating succession plans and a talent management program for all key positions — aligned with the organization's strategic directions, as set out in their Balanced Scorecard;

- Creating an Office of Strategy Management that supports the CEO and managers as they execute strategy, measure results and provide general Business Intelligence reports that will enable learning and on-going strategy recalibration;

- Enabling managers and staff to get the information they need — so they can understand the bottom-line impact of their day-to-day choices;

- Enabling front-line managers to access the metrics they need to measure the key drivers of the strategy;

- Aligning Managerial Accountability Agreements that are linked to a Pay-For-Performance System — co-designed with a Board Committee and approved by the whole Board;

- Strategic Budgeting — linking strategic priorities with the resources required;

- Balancing the Budget; and, most importantly;

- Getting Improved Patient/Family/Staff/Physician Satisfaction Rates.

At the Local and Provincial System Levels, I believe that there are six essential leveraged actions required to succeed. These include:

- Making faster progress on Primary Care Reform to address the facts: 1 in 10 Ontarians do not have a regular medical doctor; and, 15% of Ontarians (with at least one chronic condition) have limited access to a primary care doctor.

- Designing a system for Chronic Disease Management — including testing, homecare, self-care support and education.

- Expanding the role of Case Management to improve coordination & communication among the organizational silos and healthcare providers (54% of Ontarians are not confident that patient care is properly co-ordinated: Change Foundation/Pollara).

- Facilitating the development of LHIN-Level Scorecards by tapping into the collective intelligence of the governance and managerial leaders within each LHIN — while being guided by the provincial Health System Strategy Map and Scorecard.
Providing resource allocation incentives to improve quality/safety/efficiency/appropriateness/effectiveness and financial outcomes.

Implementing an e-health strategy over the next 2-3 years

Embracing “The Stewardship Model” to support change by “letting go” of the need to maintain the “illusion of control.”

But I could be wrong. My purpose in this report on health system transformation has been to provoke your thinking.

So, what do you think we need to do to “fix” our existing system? How will your organization thrive in the future? What are you and your organization going to “do differently” over the next two years? How would you contribute to the success of your network’s transformation?

TED BALL is a partner in Quantum Transformation Technologies, an organization that participates in the creation of best practice tools/processes for strategy execution; performance evaluation/measurement and accountability system design. Quantum provides coaching & facilitation support for organizations that want to build their internal capacity to transform themselves.

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More On Transformation From Quantum

- Governance and Management Roles in Transforming and Integrating Independent Organizations within Interdependent Local Health Networks
- Best Practice Balanced Scorecards for Governance, Organizations and CEOs
- Leading an Organization through a Balanced Scorecard Transformation Process
- Skills, Structure and Culture Required for Successful Balanced Scorecarding
- Redefining Accountability in the Healthcare Sector
- Linking Board/CEO and Management Accountabilities
- Designing and Creating “Second Curve” Healthcare Systems

Essays on best practices for organizational transformation and balanced scorecards at:

www.leonardddomino.com
LEARNING ORGANIZATIONS
What Would It Be Like?

• People feel they’re doing something that matters — to them personally, and to the larger world.

• Every individual in the organization is somehow stretching, growing or enhancing their capacity to create.

• People are discovering that they are more intelligent together than they are apart. If you want something really creative done, you ask a team to do it — instead of sending one person off to do it on his or her own.

• The organization continually becomes more aware of its underlying knowledge base — particularly the store of tacit, unarticulated knowledge in the hearts and minds of people.

• Visions for the direction of the organization emerge from all levels. The responsibility of top management is to manage the process whereby new emerging visions become shared visions.

• Everyone is given the opportunity to learn what is going on at every level of the organization, so they can understand how their actions influence others.

• People feel free to inquire about each others’ (and their own) assumptions and biases. There are few (if any) sacred cows or undiscussable subjects.

• People begin to see themselves as part of a “system” — they learn more about how they impact on others and how others impact on them.

• People treat each other as colleagues. There’s a mutual respect and trust in the way they talk to each other, and work together, no matter what their positions may be.

• People feel free to try experiments, take risks, and openly assess the results. No one is harmed or in trouble for making a mistake.

— Peter Senge, *Fifth Discipline*