Governance and Management Roles in Transforming and Integrating Independent Organizations within Interdependent Local Health Networks

By Ted Ball, Dennis Pointer and Liz Verlaan-Cole

As Ontario's healthcare system undergoes a fundamental change over the next three years, the degree of success achieved will depend on how the role of local governance, the role of local management and the role of Local Health Integration Networks are designed. This article provokes the thinking of board members and CEOs of hospitals, CCACs, community agencies and clinics, primary care teams and public health units in the Ontario healthcare system.

The key questions are: Does everyone understand their role in an integrated system of services? Does everyone understand the service outcomes for which they will be accountable in the emerging system? and, Is everyone aligned on the change process that is meant to facilitate service integration at the customer level within each network?

Many change processes fail because roles, functions, responsibilities and accountabilities are ambiguous. So, does everyone in your community today have a common understanding of the respective missions/functions/roles of local governance and management, the Ministry of Health and Long Term Care and the Local Health Integration Networks?

Do the partners within your network hold a "shared vision" for the future healthcare delivery system that your community intends to create? Does each partner understand its unique purpose or *mission* within the network?

If there is clear alignment on your community's vision and the outcomes you are seeking, and on everyone's role in the emerging system, how can local board members contribute to the success of the change journey ahead? How can they make a positive contribution to their community's future?

The first questions that need to be addressed are: Who do board members actually "represent" in this process? What is their role? How is their role different from that of management? How is their role different from that of the provincial government? How is their role different from the Local Health Integration Networks (LHINs) being set up across Ontario?

Before you reflect on the roles and responsibilities of governance, you need to understand the *purpose* of a board member of a healthcare organization in Canada: best practices suggest that their purpose is *to represent the interests of the "owners."*

So, who are they?

The owners of our publicly funded healthcare organizations are the citizens of your community, the customers/patients that you serve and the taxpayers of Ontario and Canada. For some board members, this may entail a fundamental paradigm shift in thinking and behaving. In this model, the board's job isn't to represent the self-interests of the organization, but rather, to be in *stewardship* ("in service to") the larger community, and to the mission of the organization – through the CEO, its one employee.

Boards that engage in dialogues across the continuum of care usually discover that all board members of healthcare organizations within an area represent the very same "owners": that is, the people of their community.

Healthcare organizations within a delivery network are therefore not in competition with one another. At least, they shouldn't be.

Regular community dialogues with governance leaders engaged in creating LHINs should enable people to discover that they do in fact represent the same interests: the public interest!

Public sector healthcare governance boards have five key responsibilities:

- Specifying ends/results that their organization are to achieve – within the institution or agency, and within an integrated delivery system;

- Monitoring, evaluating and coaching the CEO – while holding him or her accountable for achieving the specific and measurable results set by the board (including outcomes listed in the Performance Agreement with MOHLTC);

- Ensuring the quality of care (clinical, quality, patient safety and service quality) provided;

- Ensuring the organization's financial performance and condition; and

- Ensuring the board's own effectiveness.

Here are some issues arising from each of these five responsibilities:

1. Defining Ends

In his September 9 St. Lawrence Market health system integration speech, Health and Long-Term Care Minister George Smitherman confirmed that within the government's vision for an integrated delivery system are independent governance boards for each of the institutions and agencies in the network.

Boards therefore still have overall accountability for the performance of their healthcare service delivery organization. In partnership with their management, boards must set high-level customer and financial outcomes – for which they hold the CEO and Chief of Staff accountable.

Through a best-practice *ends monitoring process,* boards need to engage in ongoing dialogues with management to establish the indicators, outcomes and targets that need to be achieved

within the organization and within the system over the short, medium and long term.

If board members are truly representing the "interests of the owners," then one of the key outcomes they should be seeking is system integration. The fact is that customers, citizens, patients, families and taxpayers all want a healthcare delivery system that provides a "seamless customer experience." How will your organization define the results you want from service integration?

Best practices would suggest that a balanced approach needs to be taken using a framework that includes customer, financial, process and learning-and-growth outcomes (the Harvard-based Balanced Scorecard).

It is through collaboration and sharing of evidence-based decision-making that the partners within a system will succeed. This is not the "regional authority" model – where a LHIN CEO and system board command and control the local partners.

If Local Health Integration Networks had been given the authority to simply impose integration plans and strategies, we know what the results would be: resistance. So, how could the partners within your LHIN happily develop a Local Health System Balanced Scorecard and begin to act on an integrated health system agenda?

Best practices suggest that the senior managers within a local delivery system need to collaborate to develop an Integrated Local Health System BSC – and then bring it back to their respective boards to determine the ends or outcomes that are required to fulfill each partner's unique mission.

Governance boards exist to ensure that the system is designed in the public interest – not the interests of providers, healthcare mandarins or powerful local institutional interests. Each board needs to determine its organization's integration priorities that reflect its unique circumstances – and for which it will hold its CEO accountable.

With this governance/managerial configuration, each of the independent boards within a network would hold their respective CEOs accountable for achieving "their part" of a system integration strategy – contained in an Integrated Health System Balanced Scorecard that they helped create.

In this best-practice model (IHS/BSC), collaboration is not something that is imposed by an external authority; it is willingly agreed to internally across the network – and within each organization. The system will integrate because everyone can clearly see the advantages of it – particularly the consumers of healthcare services and, indeed, the owners of the system.

With this governance and managerial architecture, independent organizations can determine how they will change their current operations to integrate services at the customer delivery level – and thereby create the interdependent system of services that consumers require, and that financial analyst's say will provide a more efficient use of public resources.

2. Monitor & Evaluate Executive Management Performance

Boards govern through (a) the policy development process, (b) the performance monitoring process and (c) the accountability process.

The question is: have boards done a good job of monitoring and evaluating the performance of their organizations? Have they provided their CEO and senior executives with feedback – from the owners' and customers' perspective? Have they been in stewardship to the customers who are served?

Best practices suggest that a board's job is to select the CEO and Chief of Staff and then hold them accountable for the results produced – through the BSC monitoring process. Their job is to ask probing questions of management on behalf of the organization's owners.

The purpose of a community governance board is to "push the envelope" on behalf of its community. Clearly, the board and the community want the CEO and the organization's staff to succeed. Indeed, the "owners" have no interest in "who is to blame." Their bottom line: they want access to the excellent healthcare system that they are now paying for in their taxes, and in their new health premiums.

"Accountability" must no longer be designed as a blame, shame and punish system – but as a methodology that is designed to mobilize the support required to make everyone successful at achieving agreed-upon outcomes. Success, not blame, is the goal. One of the keys to success is sustained learning and growth. In order to be in stewardship to the people served, the board needs to ensure learning and growth throughout the organization.

Best-practice boards of learning organizations allocate between 1% and 5% of their payroll budget for the *learning and growth* of their employees. While boards are advocates for their community, they also need to ensure that their staff have the supports they need to achieve the organizational and local health system outcomes for which they will be held accountable at the organizational level.

Rather than designing systems and processes to blame CEOs, best-practice approaches seek to support CEOs. In such models, boards clearly have a strong interest in having their CEO succeed – because when the CEO achieves all the outcomes required, then the organization will succeed at meeting the needs of the "owners." Boards also need to ensure that their CEO does not respond to the subtle and not so subtle efforts to create *"dual accountability"* – where they are accountable to both the board and to local public servants.

In their recent paper "Regionalization: Making Sense of the Canadian Experience," Steven Lewis and Denise Kouri point to the report of the Auditor General of British Columbia, which warned against the tendency in power-driven systems to shift from having CEOs accountable to their boards to having CEOs accountable to public servants. (See Figure 1.)

Boards need to ensure that there are systems, structures and processes in place that will facilitate *the right balance of empowerment and accountability* throughout their organization.

Through ongoing monitoring and evaluation processes, boards should explore the meaning of the results of

annual staff and physician culture surveys that demonstrate their organization's levels of job satisfaction and their internal capacity to transform. Boards also need to begin asking probing questions about alignment opportunities and HR issues to address the fact that the healthcare sector has become "the most toxic work environment in Canada." In the current system, there are people and processes that facilitate a powerful voice for CEOs, physicians, public servants, politicians and unions.

But who speaks for the healthcare consumer? Who speaks for the owners? How is your board doing at this function? How good have you been at "representing the public interest"? If you think you can improve, how will your board adjust your existing governance systems, structures and processes to reflect these essential requirements in the emerging system?

3. Measure Quality & Effectiveness

The "owners" of Ontario's healthcare system are deeply concerned about quality and effectiveness of care. Indeed, the public is increasingly alarmed at the existing data on quality, effectiveness and preventable deaths. While government officials dwell much more on the need for tighter financial controls, the owners are becoming increasingly alarmed about patient safety issues.

Best-practice governing boards need to engage in ongoing dialogues with their CEO, Chief of Staff, Senior Team and MAC on the quality outcomes and results being achieved on behalf of their "owners" and their "customers." Boards need to hold their CEO and Chief of Staff accountable for agreed-upon outcomes on

Figure 1. Governance Structure of Regionalization British Columbia

Governance Structure as Designed
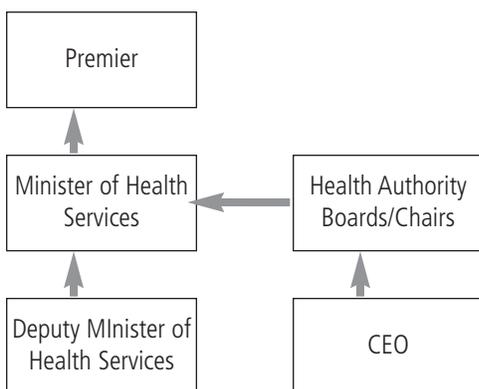
Governance Structure as Implemented
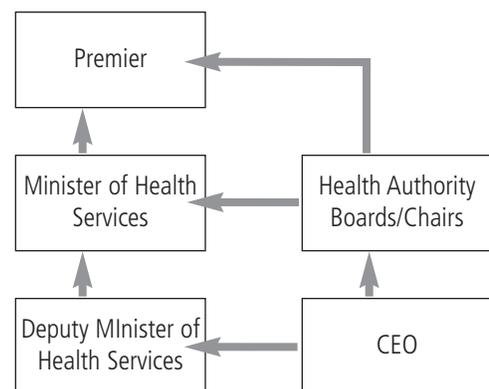
Source: Office of the Auditor General of British Columbia

quality, effectiveness and customer satisfaction indicators. Boards need to create a "safe environment" for the CEO and senior executives to be open to learning from others in the system. Boards should be constantly seeking and asking for the evidence upon which decisions are made – and about what others in the system have learned from their "best mistakes."

Today, Canadian hospitals have a preventable error rate that is double the rate in the United States. What is your organization's "fair share" of the 25,500 preventable hospital deaths in Canada each year? What are you doing to ensure quality and safety? The owners really want boards to pay much closer attention to these types of quality and safety issues in the future.

4. Ensure Financial Viability

While fully acknowledging the importance of a balanced budget, boards should be deeply skeptical of Performance Agreement designs that are mostly about financial controls and micro-management. This is the "worst practice" habit from the reengineering and restructuring era that we now know led to significant increases in morbidity and mortality in the U.S. hospital sector in the late 1980s and early 1990s. That's why the Balanced Scorecard was invented – to balance the bottom-line financials with the other essential perspectives for strategy implementation.

Boards can oversee the financial activities of their organization through the Balanced Scorecard Monitoring process – so they can ensure that there is a leveraged use of resources and a strategic budgeting process that is focused on achieving results.

Boards need to probe to see that budgeting within the organization is strategically focused on achieving the outcomes and results that have been set by the board in partnership with management. Does your current budget reflect your organization's mission and your board-approved strategy or ends policies?

Within local delivery systems, boards may require their CEOs to ensure that *supply chain management* methods are utilized within the network to ensure a leveraged use of public resources across the continuum of care.

However, boards that "sign off" on their Performance Agreement with the MOHLTC will want to be certain that the organization has sufficient resources to achieve all the outcomes that are being required by their Performance Agreement.

Boards would be well advised to work closely with their CEO on these Agreements – because they are the ones who will be held accountable to the board for keeping the board's agreement – with the government, or in the future, with the LHIN.

Boards should note how the current design of the Performance Agreement is in fact a "fixed performance contract." Board members and senior managers should take the time to learn about such structures. In their ground-breaking new book *Beyond Budgeting*, Jeremy Hope and Robin Fraser say that "fixed performance contracts cause managers to behave in dysfunctional ways at every stage in the budgeting process – particularly if they cannot meet these contracts. At best, this results in managing the numbers. At worst, it results in outright misrepresentation and fraud."

How will your board help your staff through this potential quagmire – if your existing Agreement with the government has inadvertently been designed to promote gaming and fraud?

5. Ensure Governance Effectiveness

Ontario has always been blessed with wonderful, high-calibre, competent board members.

But it doesn't matter how competent board members are individually if the macro governance processes are designed (however inadvertently) to be dysfunctional and dyslexic. That will then become the board's contribution to its organization – more confusion and ambiguity.

Best-practice governance renewal processes enable a board to design its own governance systems, structures and processes – as well as its own measurement system for governance effectiveness.

While there are a variety of methodologies for measuring board effectiveness today, an emerging best-practice approach is the Balanced Governance Scorecard – in which the top two quadrants for customers and finance are the same as their Organizational Scorecard. Boards then determine the internal support processes that they need, and the learning and growth that will be required for them to be effective at governance. (See Figure 2.)

Boards need to invest time and effort in making the adjustments required by the new Performance Agreement system, and by the introduction of Local Health Integration Networks.

Figure 2. Balanced Governance Scorecard

CUSTOMER	FINANCIAL
• Accessibility • Quality Care / Outcomes • Seamless Service • Customer Satisfaction	• Enhance Long-Term Value for Owners/ Customers • Balanced Budget • Leveraged Use of Resources
VALUE-ADDED PROCESSES	**LEARNING & GROWTH ENABLERS**
• Performance Oversight, Monitoring and Accountability Process • Strategic Budgeting Process • Quality Assurance Process • Compliance and Communication • Succession Planning	• Capacity-Building for Governance • Develop Coaching Skills • Invest in the Learning & Growth of Staff and Board • Performance Information System and IT Support

The fact is that the status quo will not exist three years from now. The system will change. The question is: to what extent have we created a "safe environment" in which local healthcare delivery partners will work collaboratively together on behalf of the customers, patients, community, taxpayers and owners?

Robert Fritz, author of *The Path of Least Resistance*, says that as complex adaptive systems undergo multiple change dynamics, the tension in the system will be rooted either in *creativity and innovation*, or in *fear and anxiety*. Where is the creative tension in your organization and within your local delivery system today? Are you currently experiencing creativity and innovation, or fear and anxiety? (See Figure 3.)

In this highly turbulent, fast-changing and often threatening environment, board members need to model how to determine and implement change – including introducing their own effectiveness measurement system.

Balanced Governance Scorecarding is a methodology that enables boards to evaluate their own effectiveness on the basis of the results being achieved. In the past, healthcare governing boards have not shared a *common language or common framework* for governing. Boards of hospitals, CCACs, public health units, community health centres, etc. have tended to "talk past each other."

This lack of connectedness at the top has been replicated throughout the delivery system where consumers get caught daily in the service gaps that exist throughout the system.

To achieve alignment within a Local Health Integration Network, independent community boards will need a common language or common framework to achieve system alignment, and to facilitate genuine interdependence.
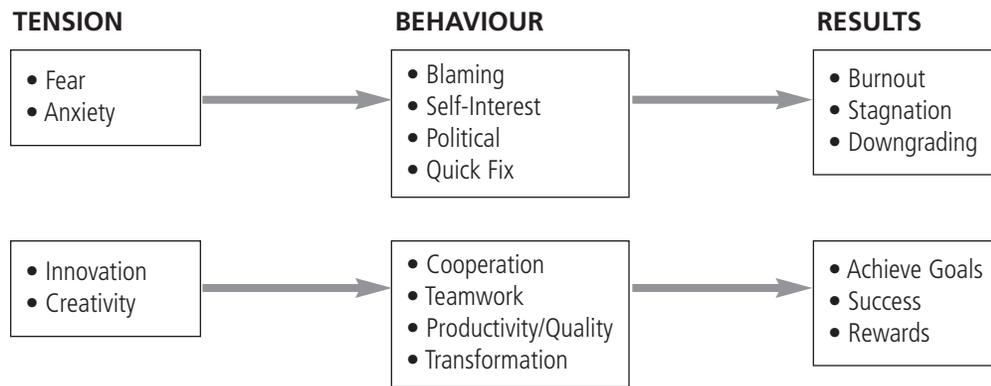
Systems can be independent and interdependent at the same time – if they use the same strategy implementation process. Health Minister Smitherman said last February that a Balanced Governance Scorecard provides such a common language and framework for building new synergistic relationships between the partners at the community level. It is a tool for silo partners to develop an implementation strategy for integrating the system across the entire continuum of care.

From Silos to Systems
The Ontario government's "made-in-Ontario solution" to health system integration is a design that leaves local governance and management in place in each network. The McGuinty government has officially rejected the "regional authority" model that would create a control structure for the delivery system at the operational level. Rather than the usual dynamics of resistance to an imposed authority, members of LHINs must therefore come together to design the delivery system collaboratively. Is that possible in your community?

Contemporary organizational science encourages us to understand the dynamics of healthcare systems through the lens of complex adaptive systems theory – and to reject the mental blinders that encourage us to respond with the usual structural quick-fixes-that-fail. (The pat-

Figure 3. Creative Tension: Where Is Your Community Today?

TENSION	BEHAVIOUR	RESULTS
• Fear • Anxiety	• Blaming • Self-Interest • Political • Quick Fix	• Burnout • Stagnation • Downgrading
• Innovation • Creativity	• Cooperation • Teamwork • Productivity/Quality • Transformation	• Achieve Goals • Success • Rewards

tern is so common in the healthcare system that it has become an archetype in the field of systems dynamics.)

Rather than a vehicle to mobilize local partners to implement common strategies for integration, LHINs may well be designed to be controlled from Queen's Park – at both the bureaucratic and the political levels. That's the BC model.

However, centralized political bureaucracies usually only want the "optical illusion of control" rather than real control and real accountability for the results that are produced.

Historically, Queen's Park's habit has been to design systems, structures and processes for blaming, rather than for real accountability. There are no *mutual accountabilities* for achieving the outcomes that MOHLTC says it wants achieved. What is the Ministry accountable for achieving? What are the mutual accountabilities that would ensure that the system achieves the outcomes set for 2007?

The problem is that such unbalanced and unreasonable system designs don't work. They always set off waves of defensive routines and power dynamics that waste time, energy and the creative capacity of the system's leadership.

However, the countervailing force in a system is at the centre. Centralized bureaucracies like the MOHLTC seek control, in part, because over the years the community partners have proven to be incapable of self-organizing in the public interest. Indeed, they are still being rewarded by the existing system for staying in their silos within the system. So, while the rhetoric about integration increases, the rewards and incentives are still vested in maintaining the silos – and their links back to the various fragmented MOHLTC departments and to the silo interest groups like the OHA, OMA, etc.

Indeed, centralized bureaucracies are severely threatened by local integration initiatives. They push for "cooperative partnerships" with Queen's Park to "run the system" and "call the shots" – even while decentralizing through the new local network structure.

To navigate a complex oscillating system, you need to be able to recognize and do something about the countervailing forces at play.

Do a reality check: are the healthcare organizations in your community stuck in the silos that Queen's Park continues to reinforce – while calling for integration? What is the true history of cooperation, collaboration and partnership in your community? Has your community learned any lessons from past failed attempts at system reform? How can you get the independent organizations in your local service delivery network to discover that they can also be interdependent at the customer level? How do you get people to give up personal power agendas and focus instead on the strategies required to achieve your community's vision?

What the Balanced Scorecard framework offers is a tool and strategy implementation process that can be used to organize complexity at the organizational, governance and system levels.

At the system level, healthcare organizations have often been trapped in senseless silo competitions between hospitals and between hospitals and community agencies within a community. Historically, the component parts of local delivery systems have been designed and controlled by centralized silos within the Ministry of Health. As a result, the component parts of the delivery system are usually engaged in a set of relational dynamics that systems thinkers call a "system archetype" – a repeating pattern of behaviours and thinking that always ends in failure.

Calendar

The archetype in this case is called "The Tragedy of the Commons," where the end result is: everybody loses!

Health Minister Smitherman's articulation of his government's vision for the Ontario healthcare system includes the statement: *"Our vision is to build a true system: one that's integrated and driven by one common cause – to deliver the highest quality outcomes for people."*

Figure 4 provides a template or framework for dialogue for an Integrated Health System Balanced Scorecard that is designed to achieve the high-level vision put forth by the Minister – as well as allowing for the more specific visions developed within each community network. While this approach empowers communities to design their local healthcare delivery system, we do not yet know if the MOHLTC will retain its fragmented silos at the Ministry. If it does, then the mixed design of "centralized control" and "community empowerment" would clearly work against each other.

The community dialogue template outlined below starts with the key questions: What outcomes or results do we want for our community and our customers? And, what outcomes must we achieve in the financial quadrant?

Then, to achieve these financial and customer outcomes, what are the value-creating processes that you would require to achieve your customer and financial outcomes?

And finally, the key question about what you need to do in order to succeed: What skills, competencies, information and learning and growth enablers do you need to change your processes so that they achieve your financial and customer outcomes?
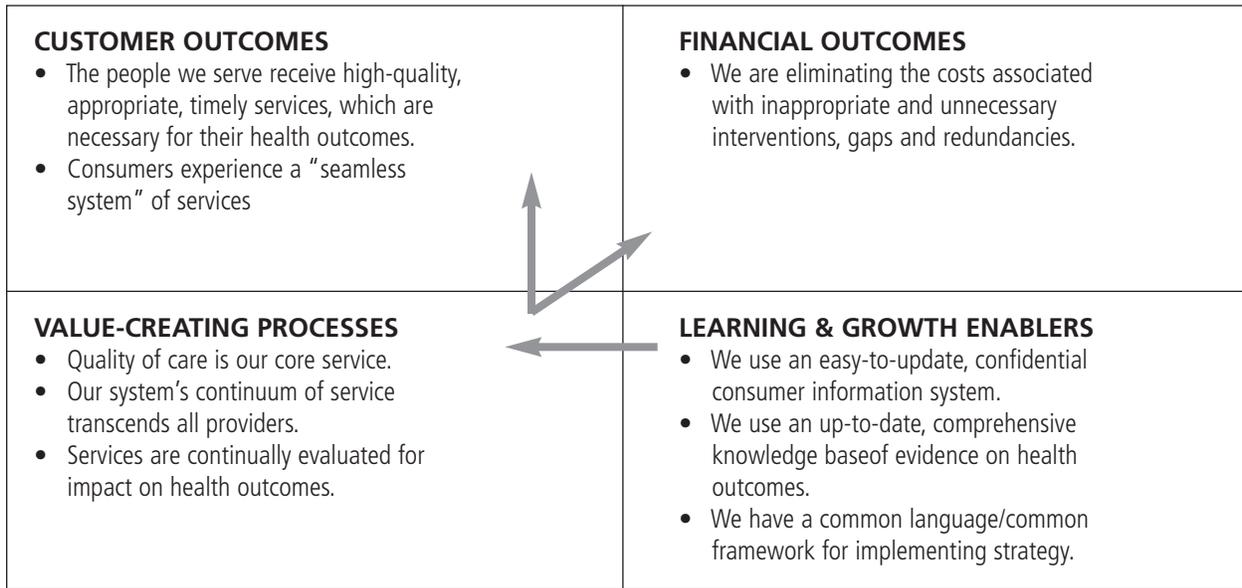
This is the best-practice learning process that needs to take place at the (a) work-unit (microsystem), (b) organizational and (c) delivery system levels. It is essential that board members and senior managers within the component parts of the delivery system are part of such a learning process.

As you begin the integration dialogue with your local system partners, you need to think about how you are going to improve your governance and managerial processes – so that they are aligned with the results being sought at both the provincial and local levels.

While the Pointer–Orlikoff Model (see Figure 5) provides a best-practice healthcare governance model, and while the Balanced Scorecard provides a best-practice framework for strategy implementation, these models must be adjusted to the emerging realities of each community's unique circumstances.

These are not easy, simple tasks. Sholom Glouberman and Brenda Zimmerman say they are not simply "complicated" issues requiring complicated solutions; rather, they are "complex" issues requiring complex responses (Romanow Commission, Discussion Paper No. 8).

Figure 4. Health System BSC – Continuum of Services

CUSTOMER OUTCOMES	FINANCIAL OUTCOMES
• The people we serve receive high-quality, appropriate, timely services, which are necessary for their health outcomes. • Consumers experience a "seamless system" of services	• We are eliminating the costs associated with inappropriate and unnecessary interventions, gaps and redundancies.
VALUE-CREATING PROCESSES	LEARNING & GROWTH ENABLERS
• Quality of care is our core service. • Our system's continuum of service transcends all providers. • Services are continually evaluated for impact on health outcomes.	• We use an easy-to-update, confidential consumer information system. • We use an up-to-date, comprehensive knowledge baseof evidence on health outcomes. • We have a common language/common framework for implementing strategy.

Board members need to understand that healthcare delivery systems – particularly the hospital components – are the most complex of organizational systems ever designed by humans. However, often lost in all this complexity is the most important – and yet simplest – design principle that we have: *our mission, or our purpose* for existing.

So, what is your organization's purpose within a network of local healthcare services across the entire continuum of care? What are the key relationships across the system that provide your customers and patients with the most value? Rather than design the delivery system with a provider-focus, governance boards and individual board members need to focus everyone on their purpose – starting with themselves.

So, why are board members part of this process? What is their unique role in the creation of LHINs? You need to remember: *governance boards exist to represent the "owners" – the citizens of your community, the customers and patients that you serve and the taxpayers of Ontario and Canada.*

As the LHINs are established across Ontario, it is essential that board members from the partnering organizations genuinely reflect the broader public interest – rather than the interests of their silos.

With their roots in a public interest perspective, and a knowledge of best-practice design principles, LHINs can be designed provincially and locally to achieve the outcomes that they are intended to achieve – that is, enhanced integration of services at the customer level through the willing and enthusiastic cooperation and collaboration of local delivery system partners.

Boards that take their mandate seriously, and are prepared to play full tilt at creating the future that their "owners" want, will want to think about how they will change – and what they will change in the modern integrated delivery system that you are about to build in partnership with your other network members.

What we know is this: there are no "one-size-fits-all" solutions to plug into your board, into your organization or into your local health services delivery system.

Figure 5. Indicators for Board Performance

Ends	The extent to which the vision is being fulfilled and key goals are being accomplished
Management	The extent to which the CEO's performance is in line with board expectations
Finances	The extent to which the organization's financial performance is in line with board-specified objectives and expectations
Quality	The extent to which quality of care (as defined by the board) meets standards
Self	The extent to which the board is fulfilling its responsibilities and executing its role

Source: The Pointer-Orlikoff Healthcare Governance Model

Figure 6. Managing Your Organization – Who Is Responsible for What?

BOARD'S ROLE	CEO'S ROLE
VISION • Continuously review, explore and refine the organization's vision to fulfill your mission. • Require highly participative processes for shared vision, strategy development and feedback.	SHARED VISION • Ensure teams and staff throughout the organization have ownership of the evolving vision and strategy. • Lead and manage transformation process.
APPROVE STRATEGIC DIRECTIONS • Long-term as well as short- and medium-term strategy and targets • Partnerships and system integration • Ensure strategy will fulfill mission.	DEFINE & COMMUNICATE STRATEGY • Identify financial and non-financial drivers. • Capacity-building for BSC input through cascading process • Partnership and system integration
OVERSEE FINANCIAL ACTIVITIES • Performance review/monitoring process • Fiscal policy/strategic budgeting • Ensure leveraged use of resources. • Approve major capital expenditures.	MANAGE FINANCIAL RESOURCES • Fiscal policy/strategic budgeting • Forecasting and strategic budgeting • Propose major capital expenditures. • Balance the budget.
COACH THE CEO/CHIEF OF STAFF & PARTNER WITH SENIOR MANAGEMENT • Decision support • Performance feedback/advice • Ask probing questions on behalf of "owners" and "customers." • Function as coach, guide, mentor.	ORGANIZATIONAL & PEOPLE ALIGNMENT • Workforce acquisition/retention and performance management • Alignment of processes, systems, structures, culture, skills to achieve strategy • Coach direct reports/model learning. • Provide right balance of leadership/management and empowerment/accountability.
SELECT & MOTIVATE EXECUTIVES • Executive performance and compensation • Succession planning/executive development • Invest in learning and growth of board and staff.	BUILD CAPACITY OF STAFF • Invest in learning and growth of staff. • Model learning. • Practise developmental facilitation and coaching.

This is how you can achieve "customization" within best-practice "standardized frameworks." So, how will this process unfold over the next few years?

Historically, health reform has been provider-centred and highly political – not because healthcare providers are inclined to be self-centred and manipulative, but because the change processes are actually designed to encourage everyone to behave that way. However, if reform is to succeed this time, it must be designed to achieve the right outcomes.

Edward Deming, the father of Total Quality Management, said that 93% of the problems in human organizations are caused by the design of the systems, structures and processes, and only 7% of the time is the problem people-centred.

The repeating pattern of failed healthcare reform in Ontario is that we always fail to deal with the key system and organizational design issues – and instead we blame people: the doctors, the boards, the CEOs, the restructuring commission, the unions, the public servants, the politicians, etc.

Instead of redesigning the system, we do structural quick-fixes like hospital mergers and other restructuring commission decisions that were unleveraged and non-strategic. The time now is to redesign the system.

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About the Authors

Ted Ball is a partner in Quantum Learning Systems. He is a leading expert in accountability systems design, cultural transformation, transformational leadership development and coaching. He can be reached at: **ball@quantumlearningsystems.net**.

Dennis D. Pointer is considered the world's leading expert in healthcare governance. Dr. Pointer is the author of 10 books, including *Board Work and Really Governing*. He can be reached at: **dennis.pointer@comcast.net**.

Liz Verlaan-Cole is a partner with Quantum Learning Systems. She can be reached at: **verlaan@quantumlearningsystems.net**.

Abstracts

Top 10 Patient Safety Myths

By Brian Shea

Many provider CIOs are re-evaluating their institutions' processes for ensuring patient safety. Some are seeking counsel to help break through the noise of the HIM marketplace. With that in mind, Cap Gemini Ernst & Young Health has compiled a list of the most dominant patient safety myths, along with tips on how healthcare leaders can counter them. **http://www.longwoods.com/hl/art.php?ID=137&view=1**

Current Strategies to Improve Patient Safety in Canada: An Overview of Federal and Provincial Initiatives

By Elizabeth Bonney and G. Ross Baker

This article provides an overview and examples of current initiatives based on reviews of documents and websites, interviews with key informants in several provinces and attendance at patient safety meetings in several cities. As we shall see, although several provinces are beginning to address patient safety issues, there remain important challenges of leadership, coordination and learning that are essential in gaining public confidence in the safety of our healthcare system. **http://www.longwoods.com/hl/art.php?view=1&ID=135**

Hospitals and Government: A Relationship That Needs to Work

By Bruce MacLellan

Effective government relations that create win–win situations begin with clear understanding of mutual objectives and concerns. The most obvious reason for this assertion is the simple fact that government is the main funding source for hospital operations. In addition, government health ministries set overall policy directions for the provision of health services, and hospitals are key implementers of such policies. Moreover, government influences the hospital's operating environment through legislation and regulations that affect governance, fundraising, human resources and other matters. **http://www.longwoods.com/hl/art.php?view=1&ID=85**

Healthcare Governance in Transition: From Hospital Boards to System Boards

By Fran Brunelle, Peggy Leatt and Sandra Leggat

Single hospital boards have been the selected method of governance since the first hospitals were built in this country in the 1600s. However, in recent years, governance of the Canadian healthcare system has undergone a radical transformation. Single hospital boards have almost disappeared. Instead, hospitals have been clustered together by governments into multiple-hospital consortia, or into regions, often with other non-hospital healthcare organizations that had previously enjoyed autonomous governance (e.g., boards of public health). **http://www.longwoods.com/hl/art.php?view=1&ID=53**

Private Financing: Is It the Solution for Canadian Hospitals?

By Michael O'Keefe

Canadian hospitals face unprecedented challenges in the 21st century. Capital reinvestment in hospital facilities, new technology and information systems have become critical priorities. At the same time, the traditional sources of capital funds – operating surpluses, donations and government funding – are under considerable stress. On top of all this, most provincial governments have recently initiated restructuring exercises that involve significant consolidation and capital investment in the hospital sector. **http://www.longwoods.com/hl/art.php?view=1&ID=54**

Newsworthy

FDA Scientists Pressured to Approve Drugs

According to a report in the *Washington Post*, 18% of the 360 FDA scientists that participated in a 2002 survey indicated they had been "pressured to approve or recommend approval for a [new drug application] despite reservations about the safety, efficacy, or quality of the drug." The *Post* reports that the results are significant because they appear to "support some portions" of FDA safety officer David Graham's "controversial" testimony that suggested the agency has trouble keeping certain unsafe drugs off the market and that dissenting scientists are sometimes pressured or intimidated. The survey, which was taken at the FDA's request, also revealed "underlying concerns and discord" in the agency, as more than 35% of scientists reported being only "somewhat confident" or "not confident at all" in the agency's decisions around drug safety, and 22% feeling similarly regarding decisions relating to drug effectiveness. (Source: *The Washington Post*, December 16, 2004)

Long Road to Patient Safety

According to the latest survey of over 1,000 U.S. hospitals conducted by the Leapfrog Group:

- 80% have implemented procedures to prevent wrong-site surgeries, and
- 70% require a pharmacist to review all medication orders before they are administered.

However:

- 70% do not have a formal protocol to assure adequate nursing staff.
- 70% do not have a policy to check with patients to see that they understand the risks of their procedures.
- 60% do not have procedures for preventing malnutrition in patients.
- 40% do not have policies requiring workers to wash hands with disinfectant before and after seeing a patient.

(Source: The Leapfrog Group, November 16, 2004)

Risk Management Shifting Focus

The hospital function of risk management is shifting from the traditional focus on potential professional malpractice claims and losses to include more proactive management of risk "from the storeroom to the boardroom." Case studies provide a more concrete view of what this means.

- At Stanford, led by a chief risk officer, senior managers identify and prioritize emerging areas of risk each year and then develop global plans for addressing the most pressing ones. The priorities can include employment practices, strategic operational risk, hazards, construction, regulatory, clinical trials and research, and business contracts.

- At SSM Health Care, a risk management committee meets regularly to consider concerns about emerging risks raised by representatives of the administrative, operational, and legal departments. In addition, a risk management review is conducted for every new service initiative.

- At Sutter Health, the board of the system's insurance company serves as the risk management committee.

- At Adventist Health, risk management analysis has been integrated as a formal step in strategic planning.

A number of these organizations have instituted a senior management position, the chief risk officer. Several of those have backgrounds in clinical care and additional degrees in law and finance or business. (Source: *Hospitals & Health Networks*, pp. 64–66, October 2004)

Accounting for Healthcare Spending

Healthcare spending for cancer, heart disease, hypertension, mental illness, and pulmonary conditions made up 31% of the overall increase in healthcare spending between 1987 and 2000, according to researchers at Emory University. For four of the 14 conditions studied, the majority of the cost increases was the result of increased treatment, not population growth or increased costs per visit. In another recent study by one of the Emory researchers, obesity accounted for 12% of the growth in healthcare spending between 1987 and 2001. (Source: *Modern Healthcare's Daily Dose*, October 25, 2004)