

# Systems Thinking in

# ACTION

## Finding the Right Leverage Point

You have had some success with visionary planning and now you intend to begin using "systems thinking" to help achieve your vision. In fact you have identified some major problems you believe can be resolved if you can find the right leverage point to change a system. But how do you know when you've found the right leverage point?

When your systems approach has *not* been effective, you will feel good for a while about the change you brought about. Then, over time, you will realize nothing has changed at all. When your approach *has* been effective and you've identified a true leverage point, the hue and cry from the whole organization will confuse and scare even the most stalwart "systems thinkers" in your institution.

That's the time to hang tough. You probably have hit upon an effective strategy for change.

At Griffin Health Services Corpo-

ration in Derby, Connecticut, our management team has been working for three years to bring about change using the principles of visionary planning and systems thinking. Griffin Health Services is a holding company with four subsidiaries: Griffin Hospital, a 262-bed community general hospital; Griffin Hospital Development Fund, responsible for all philanthropy; GH Ventures, a for-profit organization which provides a range of programs supporting Griffin Health Services; and Suburban Health Plan, a small health maintenance organization.

For us, visionary planning and its attendant development of a true organizational vision has been a rewarding experience. The systems thinking process, on the other hand, has been harder to take. When it is successful, the whole world will seem to be saying you have lost your mind.

As an internal instructor of a

systems thinking and visionary planning program developed by Innovation Associates, I have described these principles to nearly 500 individuals in workshops conducted over 18 months. Yet when "worse before better" behavior resulted from a systems change, even I had difficulty soothing my wounds with the knowledge that the system was just doing what a system does when an effective leverage point has been found.

The various stakeholders in your organization may expect management to keep the place running without a lot of controversy. If so, their expectations may not be met if change is produced by finding a leverage point that really changes a system. Long before the change has had an opportunity to move from "worse" to "better," large numbers of individuals will be saying to stop whatever it is you are doing.

Here are two examples of system interventions that have occurred at Griffin Hospital during the past two years. They demonstrate, respectively, ineffective and effective systems interventions at work.

### The system pushes back

To provide sufficient patient care in the face of a growing nursing shortage, we created a new level of health-care worker. In addition to previous nursing aide responsibilities, these new healthcare workers would be responsible for all personal patient care such as bathing, feeding, and keeping the room clean. Compensation was increased for the new responsibilities. Originally, currently employed nurses aides were trained to fill this new role. Later, we also hired individuals from outside the organization. The idea was to reapply our current manpower to provide more support to nursing and better coordinate inpatient activities.

Since the new workers would be

### How Systems Behave

Why, if you are doing the right thing, is implementing systems thinking so tough? Why all the aggravation and dissonance? A brief review of the principles of systems behavior can help answer these questions:

- **All systems resist attempts to change their behavior**, not just your staff, mid-level managers, or any other stakeholder who seems to be resisting change. The harder you push on a system to change it, the harder it resists change and pushes back.

- **Change can be accomplished by finding the right leverage point.**

- **The appropriate leverage point is far removed in time and space**

**from the problem or the symptoms of the problem.** Obvious leverage points tend never to be real leverage points.

- **When the appropriate leverage point is found, things tend to get worse before they get better.** Conversely, when a leverage point is not effective, things will get better in the short term but then decline over time.

- **An effective intervention may play itself out in a different arena than the one you intended.** The system you are seeking to change may actually have a totally different set of boundaries than you expected. In these cases, you may find that people and things you never intended to influence are acting strange, if not hostile.

taking over tray delivery and cleaning patient rooms, we expected that fewer employees would be needed in the dietary and housekeeping services. We also expected patients' satisfaction to improve because of the greater personal attention being paid to them.

After a appropriate training, we initiated the program. There were some complaints by those who previously had been aides. But for the most part, the program was received well by nurses, physicians, and patients.

A year later patient satisfaction is not higher, the program has not significantly reduced the dietary and housekeeping staff, and most nurses are no longer supportive of the program. What we have accomplished, it seems, is to increase the pay of nurses aides and change their title; but they continue to do basically what they did before.

We missed the leverage point, and the system pushed back. Probably, we chose a point that was too close to the problem, rather than taking the time (which we felt we didn't have) to look for the right leverage point: a clear case of the "better before worse" phenomenon.

#### **No pain, no gain**

To stem a chronic decline in medical-surgical admissions, the hospital board of trustees adopted several strategies to encourage an increase in the medical staff size and range of services. They included: establishing recruitment targets; eliminating the policy of setting maximum numbers for each specialty—a practice that had restricted individuals from joining the staff in the past; and appointing an acting chairperson from outside the staff to encourage and assist in the recruitment effort.

Each of these steps elicited expressions of dissatisfaction from various members of the medical staff. However, each decision had near-unanimous support of trustees, including the physician representatives.

Things got interesting when, mid-year into the effort, we were able to pinpoint which physicians had admissions significantly below those of the previous year, and the amount of

revenue we had lost because of this volume decline.

We reported this information to the hospital and holding company governing boards and the medical staff in a newsletter. Coincidentally, the release of the information came shortly before

meant that our analysis of physical activity did not depend on our ability to recall what happened months earlier.

2. The dissemination of this information, through a newly initiated newsletter, to the full medical staff and to the boards of Griffin Health Services

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we reduced our full-time equivalent employees by about 30 because of the reduction in medical-surgical inpatient admissions.

For almost the next six months, a few members of the medical staff made a concerted effort to question the competence, honesty, and motivation of senior management. Every conceivable arena was utilized to question previous operating decisions, capital allocations, and even the very process of utilizing visionary planning.

Board members began to be apprehensive about the previous strategic direction the organization had taken and established special *ad hoc* methods to review the overall organization's direction and strategy. To some degree the evaluation continues.

Yet the commitment by a majority of stakeholders in the organization to expand the size, scope, and choice of healthcare to the community has become the highest priority. And it has made all parties willing, even eager, to support our strategies. For example, by year end we had increased the size and scope of our medical staff by adding 25 young physicians.

Things did get worse before they got better. And, for a while, all stakeholders in the organization felt worse. I believe that the leverage point that worked was a combination of two new means of communication:

1. The capability to report physician activity on an almost real-time basis. In the past, physician activity profiles were not available until about three months following the close of a fiscal year. Having current data


and its subsidiaries. Having new real-time information and the willingness to act on it changed the system in a dramatic fashion.

#### **Information intervention**

Management expected the policies adopted by the board would bring about controversy. In reality, it was management's ability to describe factually, rather than anecdotally, to the full medical staff and the boards what was happening in real time that created the controversy. But it also committed the whole organization to address the issue immediately.

It is my view that without the "information intervention," the policies we adopted would not have led to significant additions to the medical staff.

Prior to all of these recent activities, we had tried to make our board members aware of systems thinking and the behavior of systems. However, during a "crisis" these lessons can be forgotten.

What we discovered is that all those who will be affected by a successful systems intervention must understand the principles of systems behavior and must have an opportunity to work with examples from other fields or from past organizational changes. This preparation can reverse the natural inclination to stop the intervention once problems arise and turn off the heat. 

*Jerold A. Sinnamon is executive vice president of Griffin Health Services Corporation. This article was condensed from the Healthcare Forum Journal March/April 1990.*