BIG CHANGES AHEAD:

New Patient-Centred Incentives and Merger Strategies Will Shift Health Services

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Health system transformation has finally begun.

After more than 25 years of advocacy on the part of health system reformers, our provincial government is finally aligning the economic incentives in our healthcare delivery system to reward organizations that provide good quality "patient-centred care".

As a result, there is an excellent chance that the "patient-centred" buzz-words will no longer be a meaningless slogan -- but a reliable recipe for strategically earning money in our evolving healthcare system. Health Minister **Deb Matthews** says of this new era of health reform: "We have to shift spending to where we get the highest value." She says, "Our funding models need to be updated to accelerate the transition from a provider-centred funding model, towards a patient-centred funding model."

Yes, that's what she said. So big change is on the way for healthcare service providers -- fundamental transformational change. What's happening?

Ontario's new funding formulas for hospitals will reduce the lump sum global budget from 100% to 30% -- with the remaining 70% dependent upon performance outcomes that are focused on patients, quality, safety and other key factors.

These patient-based payments will increase with the complexity of care required. Hospitals will be paid "fixed fees" for the number of patients that they treat for selected procedures – like hips and knees. This will be an evolving learning process as the system alignment process unfolds and as we learn more about evolving best practices for patient-centred care.

In the future, the increasing emphasis on hospital funding will be on the so-called "*Clinical Quality Groupings*" -- the first three to be funded are cataracts, joints, and chronic kidney disease. The hospital sector is very much focused on how they can make

money in the new funding system. Today a great deal of brainpower is being devoted to discovering how hospitals can adapt and adjust to these changing circumstances.

We know these new incentives for the hospitals -- and soon the community sector -- will drive behavior in directions aligned to the vision for a more patient-focused system. The *C.D. Howe Institute* says that under the new HBAM funding system, "citizens will become choosing customers, not simply powerless patients."

Maybe. What we know is that competitive instincts in managers often produce "gaming behaviors" in their organizations. *C.D. Howe* warns against "upcoding" practices which enable hospitals to characterize patient needs as being much more dire than they are -- and therefore more financially rewarding. What starts out to be well-intended, can sometimes become the very opposite of the original intent.

Health Minister Matthews says that LHINs will be playing an increasing role in determining the allocation of resources within their community. That would be a positive step …but we'll see what happens. Normally Queen's Park sidelines any efforts to actually "devolve power and authority" to local regions -- because public servants would lose their power and control from the centre. However, by hanging onto the status quo, the system never changes.

Health reformers believe our very best hope is to move to a more devolved decision-making system -- shifting spending authority to the LHINs -- whose role over the next three or four years will be to facilitate the redesign of their local healthcare system, in partnership with healthcare service providers – while using their power to allocate resources to shape the emerging local healthcare delivery system, where decisions are based on evidence, not politics and power.

Will our LHINs be up to that task of facilitating the transformation of their local delivery system over the next three/four years? That depends.

Let's see if LHINs actually get the resources and support they will require to develop their internal capacity to allocate resources in ways that would enable them to achieve the vision that they have developed for their commuity. Will LHINs get the supports they need to get healthcare service providers to engage in effective planning for patient-centred care -- and be evaluated on such planning themselves? Again, we'll see what happens in the unfolding dynamic between MOHLTC and the *Local Health Integration Networks*.

Power struggles between the forces for "centralized control" and "local empowerment" are not likely to make "patient-centred care" their central purpose for the structure they want to create. "Who has power", rather than "what are we creating", tends to be the central focus of these age-old battles about decentralized vs. centralized control.

While *strategic financial incentives* are just now becoming key driving forces in the design of our future healthcare system in Ontario, even more important than money is the "attitude" and "spirit" under which the transformation of our healthcare system occurs. This is called "*Leadership Style*" and reflects how the leaders are "being".

So what outcomes does the style of our macro system leaders at Queen's Park, and in the LHINs produce in our healthcare system? What in fact is the "psychic environment" in which our healthcare service delivery system managers are operating? Are operational leaders treated with respect and included? Are our leaders focused on innovation and creativity -- or are they just focused on following the rules and staying out of trouble?

The fact is government officials have been traumatized by the e-health and Ornge scandals that they have experienced as participants. Today they are risk averse and deeply worried about being blamed when things go wrong. Indeed, this is a "blame/blame-avoidance" environment.

So, how the regulator (MOHLTC), and funders (the LHINs) behave will be the critical component for a successful transformation of our healthcare system. What is the "tone" that these leaders are setting? Are they open to learning, or are they closed? Are they threatening and blame-oriented, or are they operating in "stewardship" to the system partners? Is there the right balance of empowerment and accountability? Or, is there disrespect and bullying? How do these leaders make us feel – confident and capable, or uncertain and anxious?

If the transformation is poorly led in a "command and control" style, and micro-managed through regulations by the various hierarchies at the provincial, local and organizational levels; it will fail…badly. No question.

Is it possible to succeed? Yes. But traditional bureaucratic command and control paradigms have to shift. Letting go of the "*illusion of control*" will be the critical success factor in a successful health system transformation in Ontario. But will our hierarchies actually "let go" of their long-standing need to maintain this "*illusion of control"* that they have constructed? We will see.

Our health system hierarchies include Queen's Park (the *regulators*); the LHINs (the *funders*); as well as the CEOs (*management*); and, the Boards of health service delivery organizations (*governance*). Each of these hierarchies has experienced a certain degree of chaos that has resulted in "sub-optimal performance" in the recent past.

Evidence from change management tells us that 70% of all major transformation efforts fail. Only 30% succeed. Past efforts at large-scale change have focused on "technocratic methods": *Downsizing; Reengineering; TQM/CQI; Program Management; Horizontal Integration* (i.e. hospital mergers & downsizing from 42 CCACs to 14); and, *"structural fixes*" that included DHC's, local offices and LHINs.

Instead of being methods and structure-focused, we need to focus on the outcomes/results -- from a patient/client perspective – and have these perspectives drive fundamental change in our healthcare services delivery system.

But is there a *shared vision* for what this looks like? Do we all have a common understanding of what the Minister means when she invites us all to join her in becoming **"obsessed with being patient-centred"**? It seems to me that the first essential step is alignment on the vision for our healthcare service delivery system – from a patient/client/customer perspective.

When we are aligned on a vision for a patient-focused system, the second essential success factor is a transformation support system that is both top-down, as well as a bottom-up process that will enable everyone to learn how to transform the way we do our work. Successful system transformation will depend on the delivery system's ability to learn, adapt, adjust and innovate – as the system transforms over the next three or four years.

Learning, adapting, adjusting and innovating are not activities that easily lend themselves to lots of bureaucratic rules and regulations. So how do we spark innovation in the system; and, how do we mobilize the collective intelligence of the system to generate innovative solutions if Queen's Park is risk averse and over-controlling?

On the other hand, if the transformation of the system is shepherded competently and wisely by the regulators at Queen's Park, and, by the funders at the LHIN level, we could in fact produce a surge in performance over the next two or three years that can be accomplished by the "bottom-up" combination of the empowerment of front-line healthcare providers; and, by the proven techniques of patient experience design that uses patients and front-line service providers to drive the design of service delivery at the patient/client/customer level.

With these types of best practice approaches that are designed to mobilize an aligned network of health service providers within an organization, and within a community, we could indeed do "*more, better, for less*" over the next two or three years.

But do each of our hierarchies have the wisdom to 'let go' of the paradigms that currently entrap our existing healthcare services delivery system – or, will they continue to hang onto the "illusion of control", and, all too often, the endless pursuit of personal, silo and organizational power and gain? We are about to see how the future unfolds -- as the full implications of the provincial budget becomes more apparent over the next several months to both health service providers and to MOHLTC officials.

In the face of our emerging budget realities, if we have any chance of successfully transforming our health system, it is essential that we mobilize the considerable managerial and leadership talent that we have in our healthcare delivery system -- rather than continue the orgy of insults heaped upon all hospital CEOs. The fact is we need their support and their talent -- along with the leaders in our CCACs, the community sector, etc – if we are to successfully manage the transformation of our healthcare delivery system over the next few years.

But our health system operational leaders also need to get a grip on reality: it is not going to be easy redefining the role of those on the front lines of health service delivery – as the system transformation is enabled by transferring power and authority to the perimeter. This is the true meaning of the ubiquitous buzzword "*empowerment*" -- and it is not done at the flip of a switch. It is a developmental learning journey requiring *adaptive leadership* skills.

While it is fashionable for senior healthcare executives and policy wonks to talk enthusiastically about "*empowerment*" and "*patient-centred care*", the fact is that pushing power and decision-making down into the ranks is normally a very difficult and complex process – because it involves nothing less than the dismantling of the long-standing barrier between those who think, plan and conceive – and those who execute and do -- between those who have things done to them (patients, for example), and those who engage in deciding what to do (healthcare decision-makers and professional service providers, for example).

So these are some of the big paradigm-shifting changes that I am talking about. That's what "transformational" means. And let's remember: change management scholars tell us that *90 percent of people would rather die, than change!* How can our leaders work intelligently with the human factor as our system transforms?

The barriers to change are built into the very design of our existing industrial-age health system structures, processes and funding models. In addition, a lot of people who occupy positions in the hierarchy of our healthcare system have an enormous stake in a system that has been built on the "illusion-of-control". So, will our leaders actually change the way they think and behave as our system transforms? Will they "model" the change themselves?

Being willing to surrender the "*illusion of control*" is often a first step to experiencing personal change for leaders who want to play a meaningful role in the transformation of our health system, and of their organizations. "**Transformation**" means big change – as in a caterpillar becoming a butterfly.

In the industrial age, Henry Ford transferred the traditional military structure to industrial manufacturing with the invention of the assembly line. While the factory model has been imposed on the healthcare delivery system, this tragically flawed system design ignores the reality in the healthcare sector that every single patient/customer is different, and does reflect the true real-world realities of a "*complex adaptive system*" like healthcare.

So, rather than going back to the simple structural "quick-fixes" (like, for example, the idea that we should simply reduce the number of governance boards and CEOs through mergers of small agencies by an arbitrary number) -- healthcare service providers, with facilitative support from their LHIN, could actually redesign the whole healthcare services delivery system -- from the patient/client perspective -- not from the perspective of provider interests, and not from the perspective of "turf" battles between providers.

If LHINs were to approach the subject of *integration* from a narrow "turf perspective", significant disruption would produce a number of, as we say in healthcare: "*sub-optimal unintended consequences*". The fact is, we have seen this movie before a couple of times: Past experience teaches us that merger efforts usually result in the entire delivery systems' leadership becoming entrapped for several years in quagmires of local political campaigns to save a service provider organization that – in the end – will result in everyone losing. We don't want the LHINs placed in a position where nobody wins the public relations war.

Lose. Lose. Lose.

That can't be allowed to happen! We need our LHINs to succeed -- if our communities are to successfully transform their health services. But they won't – not without additional resources and adequate supports to do the new job that they have been given.

To be clear: their mandate isn't to manage a local health system, their job is to work collaboratively with the service providers to design and fund the evolution of a patient-centred health services delivery system (including primary care) that meets the unique needs of their community – within the funds available. We don't want LHINs to learn how to "manage the existing broken service delivery system", we need them to "learn how to design the future system" that is based on evidence.

So, the most leveraged learning challenge ahead here is **Local Health Services System Design**. LHINs -- in partnership with service providers -- need to learn how to design local delivery systems that will work in their unique circumstances. And they have to do all this, while being "patient-focused", and driven by evidence about "what works best".

This means developing the capacity to think differently about our circumstances. Rather than linear thinking and fragmented thinking, we need systems thinking and integrative thinking.

We should be prepared, for example, to change roles and functions within the delivery system -- rather than hold a rigid assumption that, for some reason, "fewer boards are better". Rather than such limited thinking about the total number of healthcare service providers, we need to think instead about function; about roles; about system linkages; about the design of hand-off processes across the continuum of care and, most importantly, we need to learn how to drive all our thinking from a "*patient perspective*".

If the role of governance in a transformed system were at a higher altitude and focused on quality, safety and the patient/client experience -- along with financial accountability and system integration – wouldn't there be real value in keeping governance at each service provider? If, by contrast, their role is to continue to represent the narrow self-interests of their organization, that would be counter-productive if our goal is to create a "seamless system" of care for patients and their families within their local communities.

Where did we ever get the idea that fewer providers is somehow better for meeting community needs? Did we save money or improve quality following the last few rounds of hospital and CCAC mergers? Since no such evidence exists from past health sector mergers, why is there an aggressive agenda to non-strategically reduce the number service providers?

Our healthcare system is in fact a complex adaptive organism. In nature, *interdependent bio-diversity* is what leads to innovation, growth and success in a healthy vibrant eco-culture. Having fewer players in the current system will certainly never yield the scale of

the financial savings that are required by the healthcare system today. More importantly, the process to achieve "***Mergers of Munchkins***" will exhaust everyone's political capital – as well as their creative energy. So why are we about to do it?

Potential tactics for enhanced integration of services from a "patient perspective", range from the redesign of work processes at the hand-off points; to the alignment of the structures, cultures and skills of the delivery system partners within a community; to back-office integration; to full-scale mergers of organizations – whichever option is in the best interest of the patients.

We need to be strategic and focused as we implement patient-centred care strategies using incentives, and when appropriate, mergers of health service providers.