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Will The *Integrated Funding Model* Produce Vertically Integrated Delivery Systems -- Or Simply Invite More Micro-Management Of Pilot Projects From Queen's Park?

By Ted Ball

This week is the deadline for submitting proposals for the next generation of *Healthcare Reform In Ontario* -- another controlled "innovation" designed by the risk-averse, command and control culture and mindset at our Health Ministry.

Having reviewed the *Integrated Funding Models Program* that is being directed and managed by Queen's Park, what stood out for me is that this effort does not actually seek to create a vertically integrated delivery system, but rather, micro-manage a small, limited and specific pilot project on "bundled payments" with as little risk and innovation as possible over the next three years of careful study -- just as the government is seeking re-election.

The program appears to be an initial splash in what MOHLTC calls their "First Wave" of proposals that are focused on "patients that receive hospital care, and require care in the home for a short-stay". We don't know anything at this point about how many other "waves" are planned for their stormy sea of transformation experiments and pilot projects that they will safely micro-manage from Bay Street in Toronto.

The serious question that *Health Service Providers* at the governance and senior management levels need to ask themselves is: given your existing accountabilities for the outcomes in your *Performance Agreement* with the LHIN, and, for your own Board-approved set of organizational outcomes, why would you agree to be micro-managed by Queen's Park for three years -- just to test some funding models," in successive waves" that you don't know anything about -- all for a total of $175,000, and bragging rights?

"Lessons learned" from past macro-system design failures would suggest that Queen's Park should only set high-level goals, objectives and strategic directions, rather than determining the "how" and micro-managing it while holding the HSPs accountable for results.

The MOHLTC -- through the LHINs -- would be well-advised to simply set the high-level goals and objectives that reflect both the provincial/local planning priorities/strategic directions -- and then liberate LHINs and HSPs to achieve the high-level outcomes. The knowledge of "*what is wrong, and how to fix it*" is at the frontline of the service system, not at Queen's Park. Furthermore, it should be understood that top-down project management tools and practices are

not a replacement for strategic thinking rooted in reality, and, collaborative local decision-making.

There clearly has not been many "lessons learned" from the past about the need to "balance local realities", with the need for some legitimate "provincial standards". Instead, the MOHLTC says they intend to drive this bundled payments program with "a real-time, centrally-conducted provincial evaluation that will determine the impact of the project".

However, instead of this constant pendulum swing from the "*Low Rules/everyone should do their own thing*"; to rigid templates with controls seeking to make everybody the same, we really need more balanced approaches that work in the real-world of healthcare service delivery. Queen's Park simply does not get "system alignment" and "system design". They only get "press releases", and "project management controls".

Under my desk, and in a locker room at the back of the office, are boxes of what I call my "*Issues Files*". So, on the weekend I pulled out the box of papers from the '90s on "***Designing Integrated Delivery Systems***". What a rich treasure of "lessons learned" from the past!

In the '90s, we had people like: my mentor, **Herbert Wong,** of *Quantum Solutions* of Austin Texas, who was creating systems thinking-based design tools for designing and aligning complex adaptive systems; **Stephen Shortell**, who analyzed and described the major benefits of the *Integration Delivery System (IDS) Model;* **Margaret Wheatley,** who wrote about the "self-organizing capabilities of human systems"; and, **Peter Senge,** who taught systems thinking, team learning and collective intelligence.

When *Quantum Solutions* was purchased by *H.C.A. Columbia*, and provided a billion dollar learning budget, Herbert Wong and his team of transformation coaches (who had already developed proven/leading-edge design tools for complex adaptive systems) invented two additional powerful **Simulation Learning Workshops** for up to 60 people at a time. In their *Integrated Delivery System Workshop*, the participants played three rounds of a game over two days -- where, with the "whole system" in the room, each round turns out to be a year-in-the-life of an *Integrated Delivery System* in the start-up stage. Wow! What a brain-enema. Systems thinking in action! The "connections" popped out.

I remember interviewing physicians after the workshop in Nashville Tennessee. They said the *Integrated Delivery System* simulation learning game let them tap into their collective intelligence to see how all the pieces of the puzzle will be changing together over time. Their take-away: the *capitation payment* model, rather than *fee-for-service*, is the most appropriate way forward for physicians in the future.

Physicians, nurses, administrators, and patients emerged from these intense paradigm-shifting learning experiences with a real sense of the challenges ahead -- and an understanding about

some of the potential solutions available to achieve the results. The Simulation Learning Game was an essential component of *H.C.A. Columbia's* efforts to meet the needs of their customers/clients who told them: *they wanted a seamless experience as they moved across the continuum-of-care services* provided by their company.

At the *Transformation Capacity-Building Division* of H.C.A. Columbia, the old Quantum Team provided systems thinking workshops and introduced best practice design tools like the *Strategic Alignment Model* to regional teams across the U.S. who had the responsibility to design their local healthcare service delivery system to achieve the patient-centred outcomes that their customers wanted over the course of their journey across the range of services available.

While I was never comfortable with the *H.C.A. Columbia's* focus on "making money", I loved their riveted attention on "serving their patients and customers". They were also strategically brilliant. For example, they did not want an "*H.C.A. Columbia IDS Design*". Each community -- twenty-three of them -- were told to apply the systems thinking system design frameworks to their unique circumstances, and design a "local delivery system" that would produce the required results.

All the company's head office wanted at the strategic level was -- collaboration, synergy and the seamless patient experience -- as the deliverable that each division was accountable for achieving, at the operating level. What each territory did to achieve the same result, was left up to the local players -- another valuable lesson for the "*same-size-fits-all*" template building industry @ Queen's Park.

Only in America, you say? As I plough through my box of papers, workbooks, essays and reports on *Integrated Delivery Systems,* I found a 25-year old paper by *Leatt, Pink and Guerriere* untitled "***Towards a Canadian Model of Integrated Healthcare",*** where they built upon the building blocks for integrated delivery systems that *Shortell et al.* had written about; and that *Herbert Wong* was already building -- in response to customer demands for more integrated, seamless and co-ordinated healthcare services.

The Leatt paper asks: **How will patients know when an integrated health system exists?** Their answer was, when they:

- Do not have to repeat their health history for each provider encounter;
- Do not have to undergo the same test multiple times for different providers;
- Are not the medium for informing their physician that they have been hospitalized or undergone diagnostic or treatment procedures; been prescribed drugs by another physician; not filled a previous prescription; or been referred to a health agency for follow-up care;
- Do not have to wait at one level of care because of incapacity at another level of care;
- Have 24 hour access to a primary care provider;

- Have easy-to-understand information about quality-of-;care and clinical outcomes in order to make informed choices about providers and treatment options;
- Can make an appointment for a visit to a physician, a diagnostic test or treatment with one phone call;
- Have a wide choice of primary care providers who are able to give them the time they need; and,
- With chronic disease -- are routinely contacted to have tests that identify problems, before they occur; provided with education about their disease process; and, provided with in-home assistance and training in self-care to maximize their autonomy.

Sounds good, but in the scary, scary world of blame and blame-avoidance dynamics of Queen's Park, survival is often sought with "low-risk projects" done in tiny, digestible bites stretched out over the life of the government. So, instead of telling the system that they would like to reconfigure the service delivery system into "Patient First", seamless, *Vertically Integrated Delivery Systems* -- and trust the system to do it; they instead will be engage in enormous efforts to template and micro-manage everything -- in the belief that, without their essential involvement, control and guidance, the poor dumb health system would be lost.

But that is not true. The system is actually smart… but very poorly-led by risk averse public servants.

For example, the Minister's *Patient First Agenda* has now just become a three-year test of various funding approaches to *bundled payments*, and then, I guess an election -- where the government will no doubt promise to create a *Patient First Health System*. Or, did the Minister say he was doing that now? Hello?

FORWARD THIS BLOG TO PEOPLE WHO WANT AN *INTEGRATED DELIVERY SYSTEM*, BUT MAY WANT TO REFLECT ON THE BENEFITS AND COSTS OF MICRO-MANAGEMENT FROM QUEEN'S PARK.