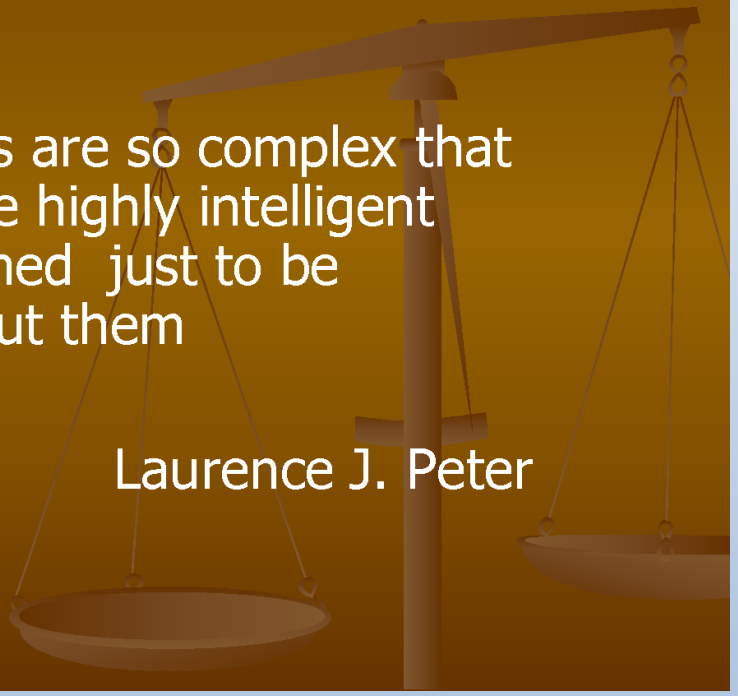
Health and Alliances

WHY

Wicked Problems



Some problems are so complex that you have to be highly intelligent and well informed just to be undecided about them

Laurence J. Peter

Not an unusual problem

- ‘Wicked problems’.
  - Policy analysis in which nature of the challenge may be complex, individual solutions are not clearly right or wrong, and there are disputed definitions of public good.
  - Complex systems: piloting solutions change the context.
- Common pooled resource problem:
  - Tragedy of the commons. Economics and political science. Classic application to environmental problems, but wider applicability. Ordinary market mechanisms may not work well, or may be more costly.
  - Dysfunction can result in short term horizons and resource depletion.
  - Some communities can develop institutions which work, others struggle.

What are we dealing with in health?

- Service integration issues:
  - Decisions over how best to use a limited amount of resource;
  - Different professional and community groups have different interests and priorities which often need to be reconciled;
  - Organisations have interests in their own viability and influence;
  - Information is often unclear, only available in the longer term, or incomplete for the system as a whole;
  - Easy to get trapped into short term adversarial positions in a zero sum game.

"Problem solvers dealing with a wicked issue are held liable for the consequences of any actions"

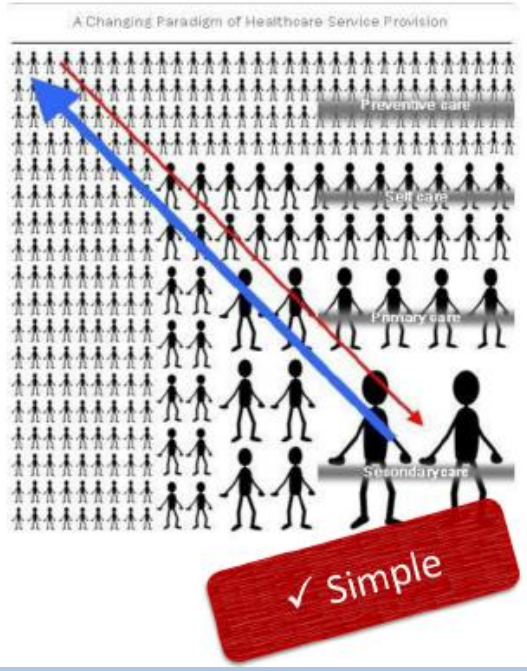
What does the DHB want to do?

- Improve the health and wellbeing of its population
- By…
  - doing more of the right things
  - and less of the wrong things

✓ Simple

What does improving the health of the population mean?

- People take greater responsibility for their health.
- People are supported to stay well in their homes and communities.
- People receive timely and appropriate complex care.



The Funder's Dilemma

How you fund can have more impact on health service delivery than how much you fund !

There are many funding mechanisms in use but there is weak and/or contradictory evidence to support any of them !

All funding mechanisms are hampered by information asymmetry.

And we work in a complex , adaptive system

The Role of Funding Mechanisms

- Can act as a barrier to change
  - "you get what you pay for"
- Rarely drive the right change
  - Can create perverse incentives
  - Can lead to unintended consequences

- Need to be used to support/embed change
- Need to be openly and transparently applied
- Need to be as simple as possible

  - And can we buy outcomes ?

Outcomes

- 5-10 years
- Change in the health status of the population
- Specific

- People take greater responsibility for their health.
- People are supported to stay well in their homes and communities.
- People receive timely and appropriate complex care.

OUTCOMES

e.g. ⇩ smoking rates
⇩ obesity rates

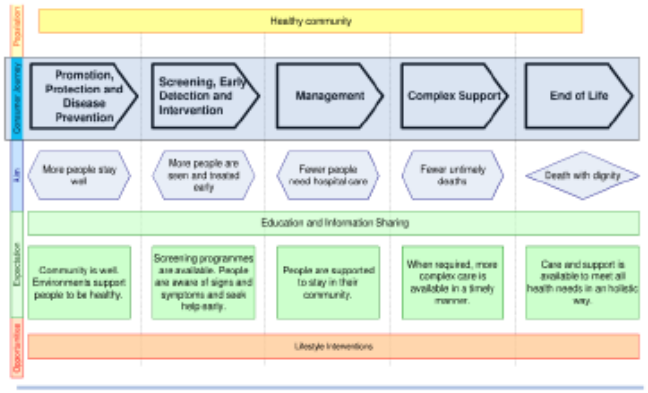
e.g. ⇩ ED attendances
⇩ ARC (vs HBS)

e.g. ⇩ % people acutely readmitted to hospital
⇩ 30 day mortality rate

✓ Simple

What services (outputs) do we deliver to make these impacts in achieving these outcomes?

Patient-Centred Model of Care



- Prevention Services
- Early Detection and Management
- Intensive Assessment and Treatment
- Rehabilitation and Support

✓ Simple

So where do we go wrong?

OUTPUTS

Issues of scope

- Sheer diversity of outputs
- Over 500 service lines within our provider arms *(not even including our mental health services)*
- 1,400 contracts (many for multiple services) with community and primary providers
- How do we measure them all?
- How do we fund in the right way?

How do we get the right resources to the right place??

And then how do we improve ?

Complex /chaotic systems cannot be managed in the sense of standing outside them and manipulating some of the elements towards a precise outcome .

- ***Command and control is out.***
- ***Observation, negotiation and facilitation are the tools required."***

"Complexity and Healthcare Organisation: A view from the Street" 2004, David Kernick Editor.

WHAT WE WERE DOING WASN’T WORKING !

Alliances

- An attempt to draw upon existing approaches to these complex problems;
- Models exist in a number of commercial contexts: construction, IT, transport…
- Fundamentally a mechanism to support stable and enduring consensus decision making.
- And in health…
    - Empower clinical leadership

This is not a new idea

“ Healthcare alliances are increasingly being examined as a potential solution for problems of fragmentation that undermine coordination across the continuum of care and contribute to poor-quality care.”

Hearld et al; Barriers and Strategies to Align Stakeholders in Healthcare Alliances : Am J Manag Care 2012: S148-S155

Ostrom: how successful groups work

- Derived from empirical studies:
  - Boundaries between groups are clear;
  - Rules governing use of collective goods reflect local needs;
  - Individuals affected by rules can participate in changing them;
  - External authorities respect the rights of community to devise their own rules;
  - Community members monitor participants' behaviours;
  - There is a graduated system of sanctions;
  - There is access to low-cost conflict resolution mechanisms;
  - Where resources are parts of larger systems, activities are organised in multiple layers of nested enterprises.

- *Healthcare is a system*
- *Seek to understand variation in the system*
- *Use data in a dynamic and systematic process of continual improvement*
- *Create an environment of trust , relationships interdependence and shared purpose*

Based on

Deming's System of Profound Knowledge

New Approach – An Alliance

- Establishes a clear decision-making framework that identifies the roles of the various parties
- Combines it with a relationship based contract with process mechanisms that support service development and innovation.
- Creates a high trust, low bureaucracy environment
- With high quality and accountability.
- Dependent on shared values, agreed outcomes and principles and open, transparent processes and information sharing.

Decision-Making Framework

Allocative Efficiency

"Buying the right thing"

We discuss, Funder decides.

Provider decides.

Funder decides.

Technical Efficiency

"Doing things the right way"

We discuss, Provider decides.

Why an 'alliance' Agreement Approach

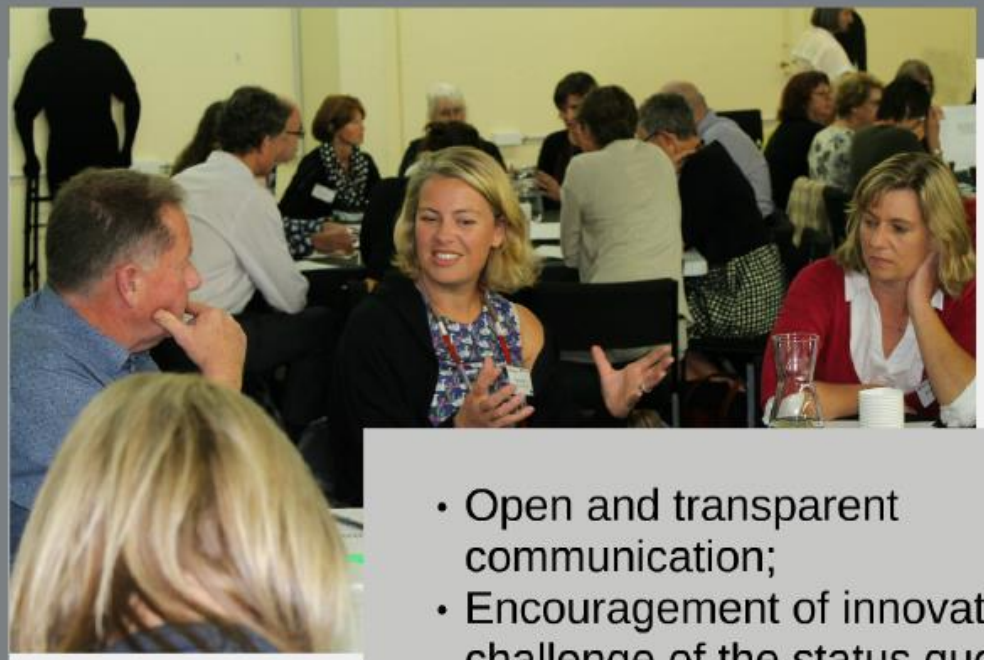
Address the limitations of standard contracts

- Incentives are poorly aligned
- Risk is poorly allocated
- Competitive processes undermine collaboration
- Innovation is not well supported within the contract
- Clinical leadership is not explicitly supported
- Resource intensive in unproductive activity

Enables a system to adapt , change and evolve

Alliancing Principles

- Accountability;
- Collective responsibility for all decisions and outcomes;
- Co-operative resolution of disagreements;
- Consensus, principle-based decision-making on all key project issues;
- Decisions on 'Best for person-Best for System' basis;
- Best use of resources in all activities;



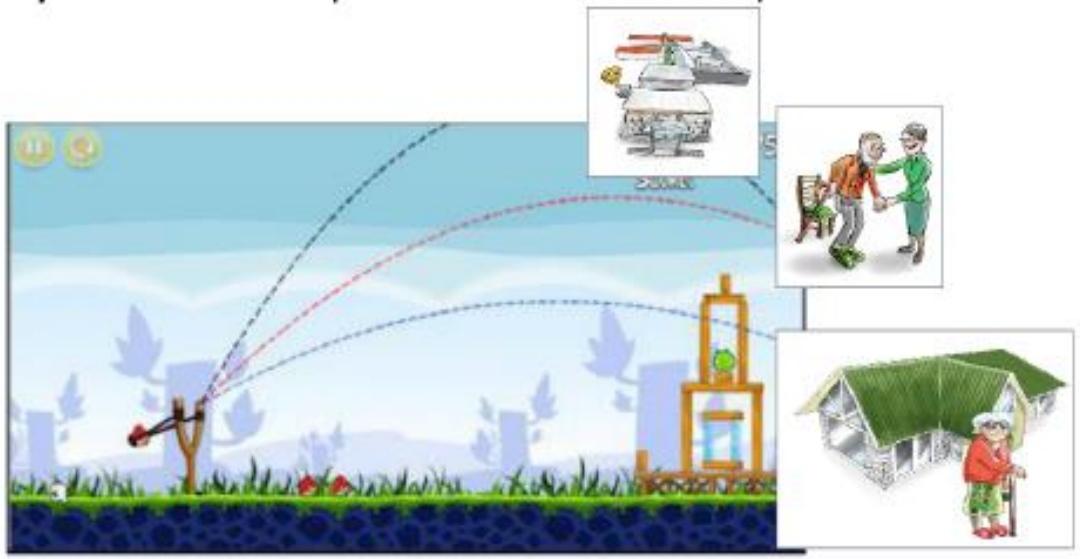
- Open and transparent communication;
- Encouragement of innovation and challenge of the status quo;
- Collective sharing and management
- risks and benefits;
- Win/win or lose/lose

We either all fail or all succeed

An alliancing framework encourages the idea of a healthcare **team** providing wrap-around, person-centred support

What does this mean in practical terms?

- Alliancing allows us to alter the trajectory of demand by investing across the system (for example, investing in supports in the community that reduce hospital and ARC admissions)



FOR EXAMPLE:

In Canterbury community service providers have worked together in an alliancing approach to provide flexible, integrated and responsive community services that help people to live safely within their own homes and communities.

Making an alliance work

- Some kind of structure, programme office coordination;
- Need to give genuine devolution of decision rights to service level alliances;
- Participants need to see early gains: create momentum;
- Other investment: Time to make it work. Commitment seen in terms of people time;
- Need to be clear about what success looks like and how going to monitor making a difference.
  - Monitoring and evaluation should be proportionate

Alliance charter

- Agreement to agree:
  - The scope, activities and objectives of the alliance;
  - How decision rights will be allocated across different parties, and how the process for joint decisionmaking will work;
  - Principles for working together;
  - The roles and responsibilities of an alliance leadership team;
  - Arrangements for joining and leaving the alliance; and
  - Dispute resolution.

Alignment is Key

- Market context was one of the most important factors differentiating alliances.

- More highly aligned alliances
  - had more extensive histories of collaboration,
  - established more credibility in the local community,
  - were more effective at balancing collaborative initiatives against competitive interests.
  - took more active approaches to build consensus among stakeholders regarding alliance initiatives,
  - successfully utilised small decision-making bodies to foster this consensus.

- Leadership credibility, leadership stability, and trust were important facilitators of alignment for all alliances, regardless of the level of alignment.
- These factors intersect and overlap in a multitude of ways to influence stakeholder alignment.

Hearld et al; Barriers and Strategies to Align Stakeholders in Healthcare Alliances : Am J Manag Care 2012: S148-S155

The role of the DHB

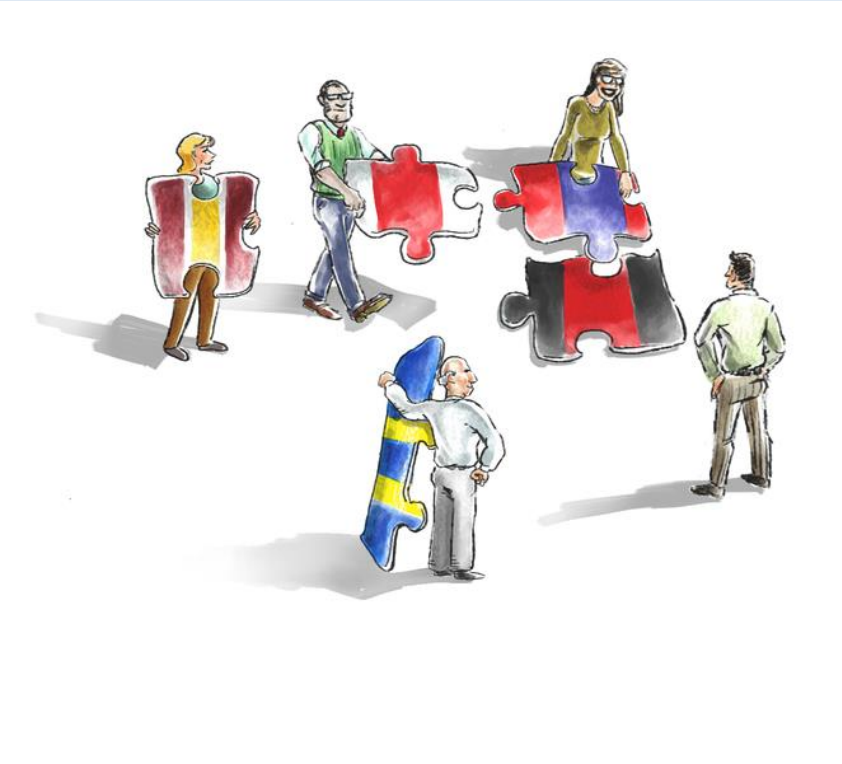
- Statutory accountability for coverage of health services in a district: cannot contract out of this.
- Funder (mostly).
- DHBs contract for services in accordance with the decisions made by the alliance.
- DHBs responsible for maintaining commercial transparency of procurement.
- DHBs can choose not to respect alliance decisions, but the threshold for doing so would have to be very high.

The Next Horizon

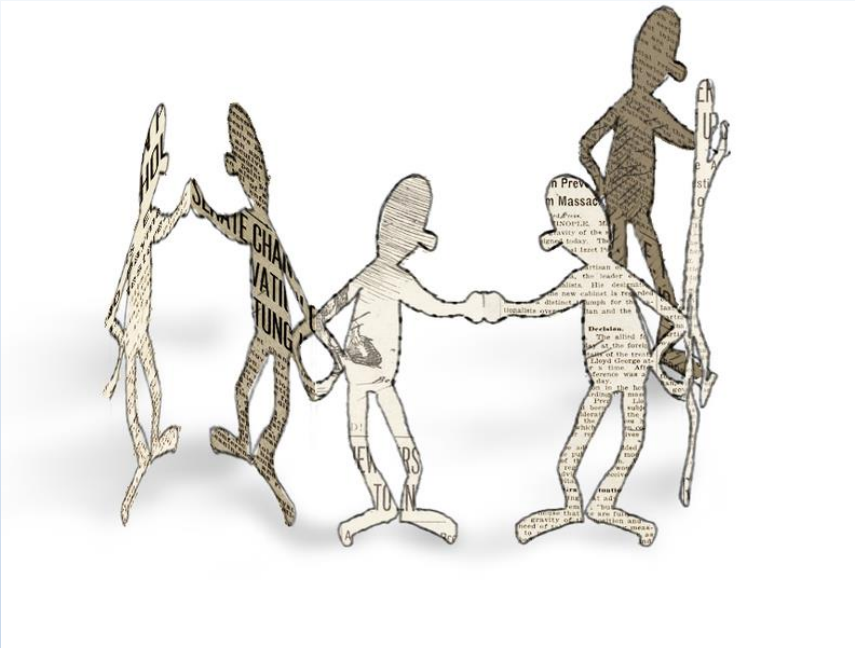
Integrating Health and Social Services

The Potential of Collective Impact

Investing in collective impact



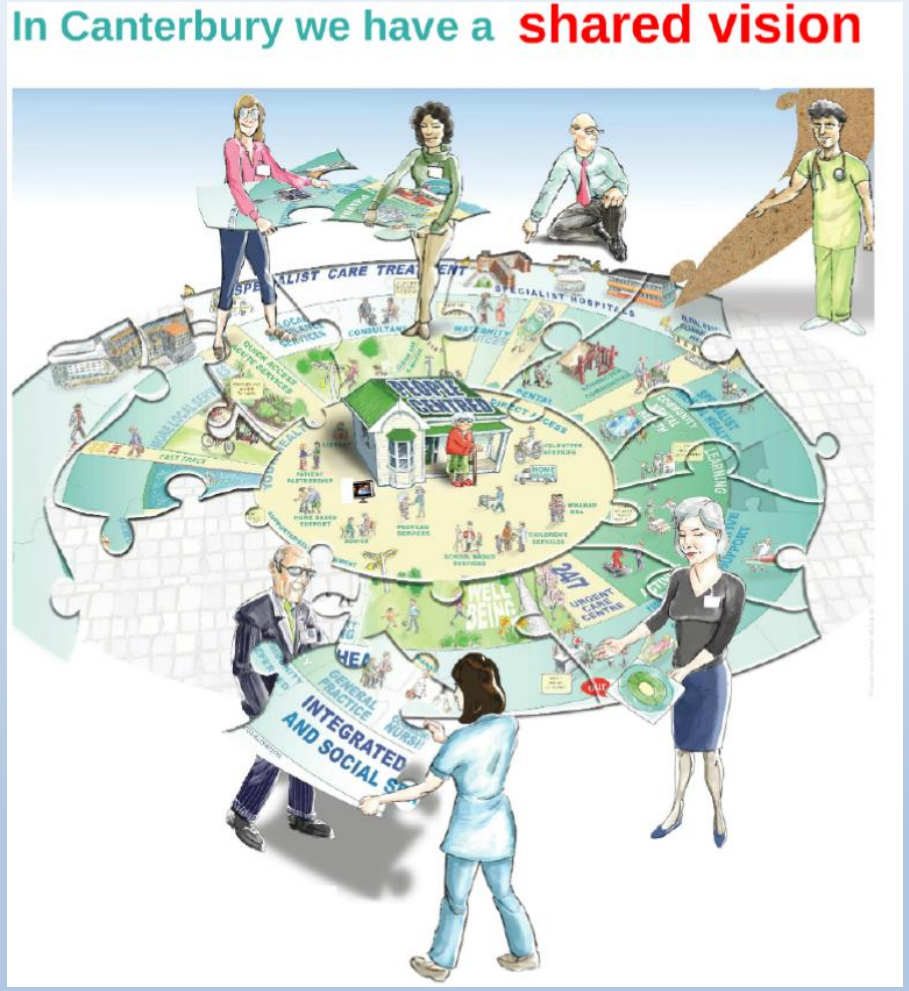
Shared systemic understanding, collective problem solving and impact

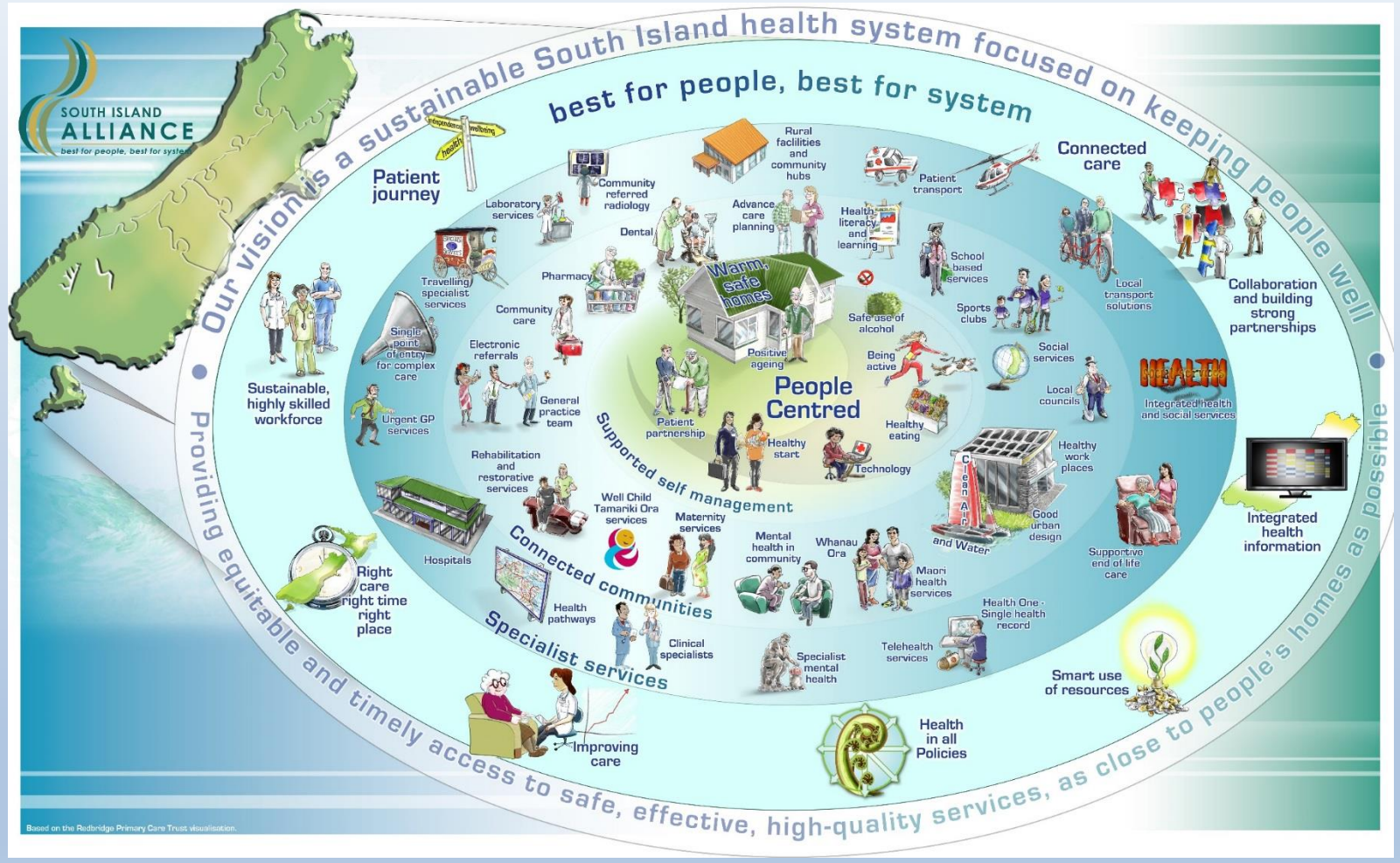


COLLECTIVE OWNERSHIP

Build trust, relationships and shared collective decision making of those affected by and working within the system. A community of common ownership, dialogue and interests who co-design and are stewards of the system

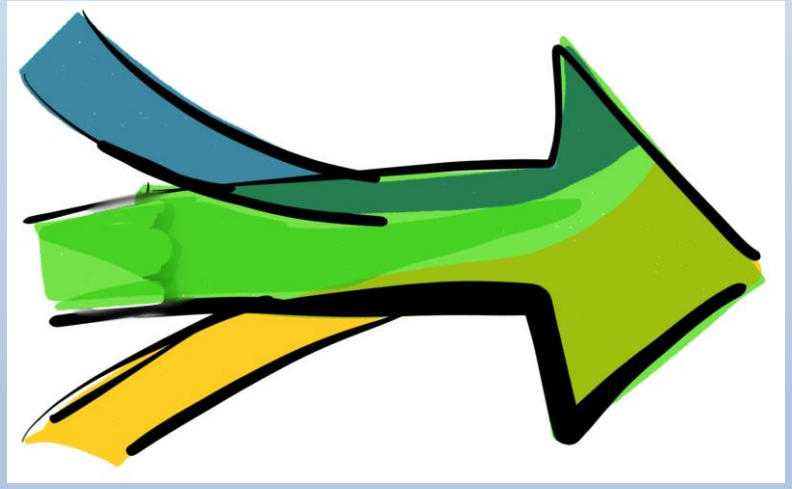
- We work in trusted way. Bringing people together.
- Coordinated networks across the hierarchy
- Flexible and dynamic




SOUTH ISLAND
ALLIANCE
best for people, best for system
Our vision is a sustainable South Island health system focused on keeping people well
best for people, best for system
Providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible
Patient journey
Connected care
Collaboration and building strong partnerships
Sustainable, highly skilled workforce
People Centred
Supported self management
Connected communities
Specialist services
Right care right time right place
Improving care
Health in all Policies
Smart use of resources
Integrated health information
Warm, Safe Homes
Rural facilities and community hubs
Patient transport
Community referred radiology
Laboratory services
Dental
Advance care planning
Health literacy and learning
School based services
Local transport solutions
Travelling specialist services
Pharmacy
Community care
Single point of entry for complex care
Electronic referrals
General practice team
Urgent GP services
Safe use of alcohol
Sports clubs
Social services
Local councils
Being active
Positive ageing
Patient partnership
Healthy start
Healthy eating
Technology
Integrated health and social services
Healthy work places
Good urban design
Clean Air and Water
Supportive end of life care
Rehabilitation and restorative services
Hospitals
Well Child Tamariki Ora services
Maternity services
Mental health in community
Whanau Ora
Maori health services
Health pathways
Clinical specialists
Specialist mental health
Telehealth services
Health One - Single health record
Based on the Redbridge Primary Care Trust visualisation.

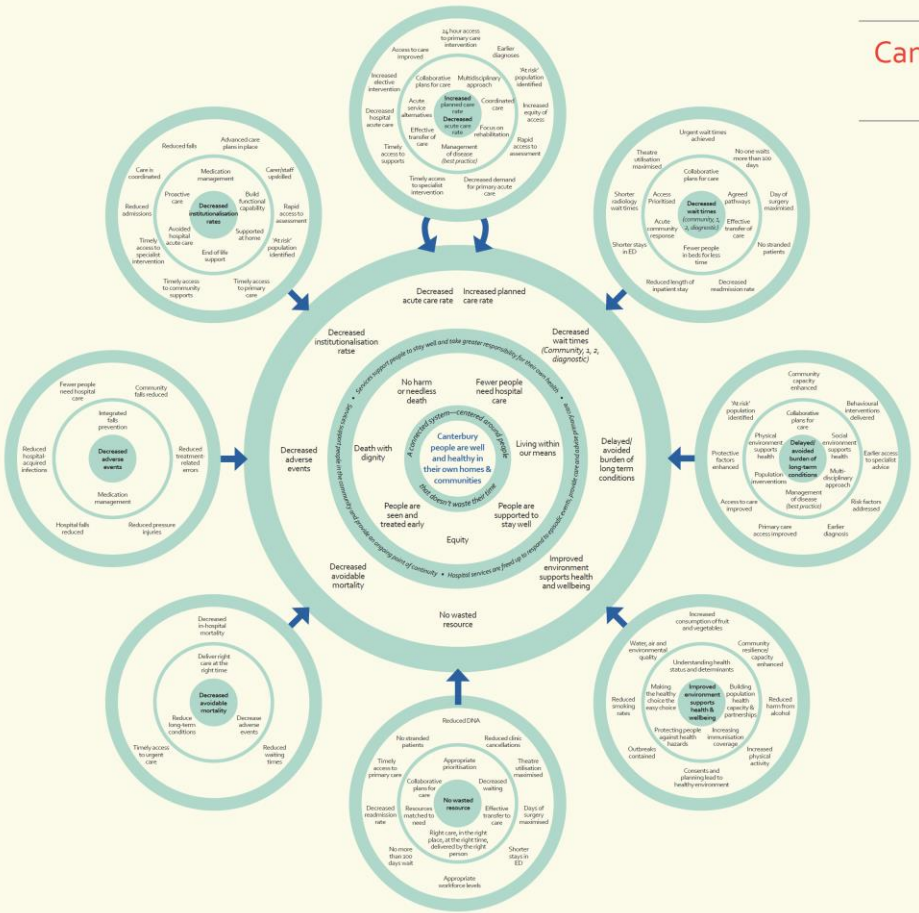
SHARED ORIENTATION

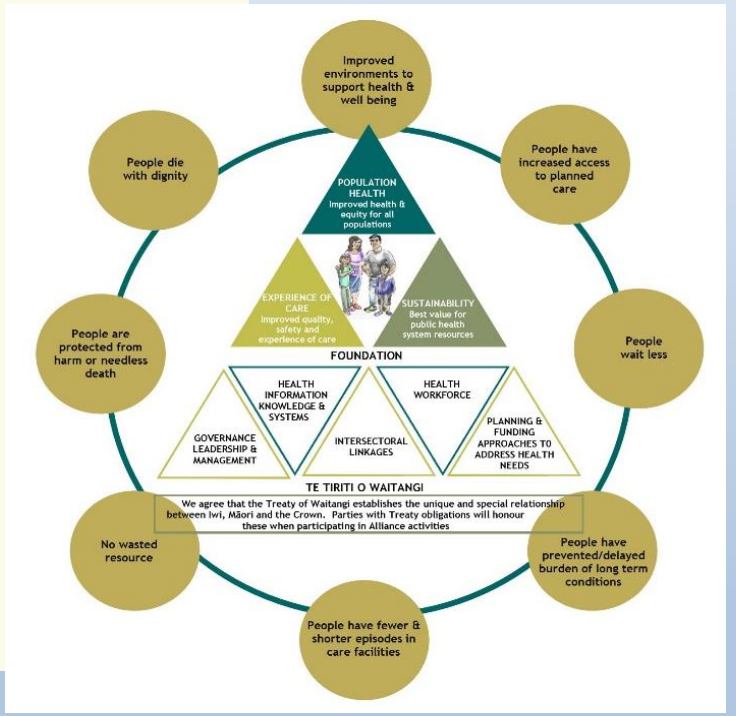
Shared measurable objectives, direction and attribution. Understanding that we all contribute in a complex system .
Mobilized towards common outcome and articulate your part in shared contribution to achieve those outcomes.
Aim for global system maxima. Not local efficiency. Balancing the needs of the person with the needs of the population.



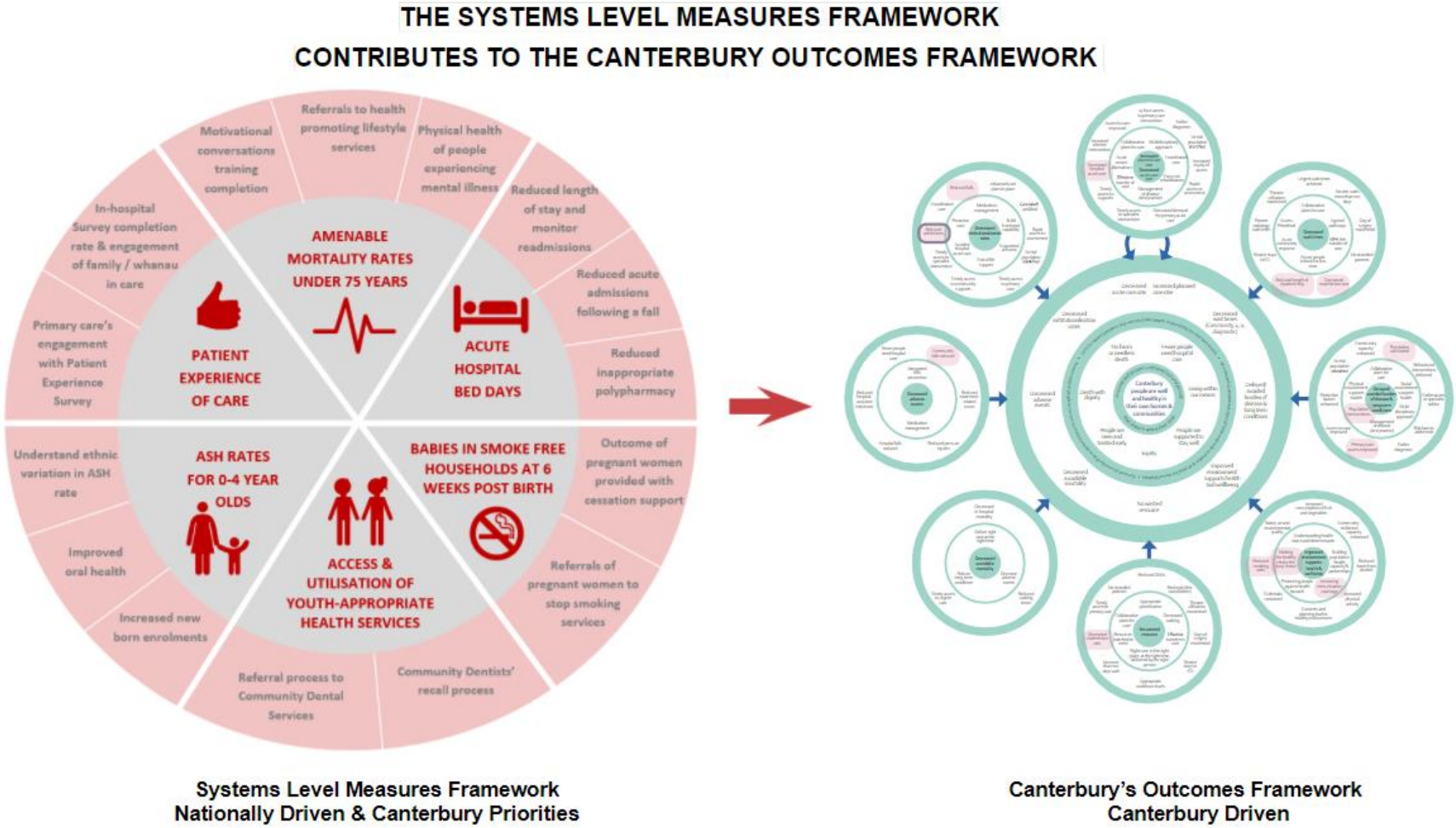
Canterbury Health System Outcomes Framework

June 2014





System level measures aligned to our Outcomes Framework



COLLECTIVE (RE)INVESTMENT

Enabling local system design and reinvestment. 'Budget' holding is for a defined population and the system and the longer run, not individual service groups or organisations.

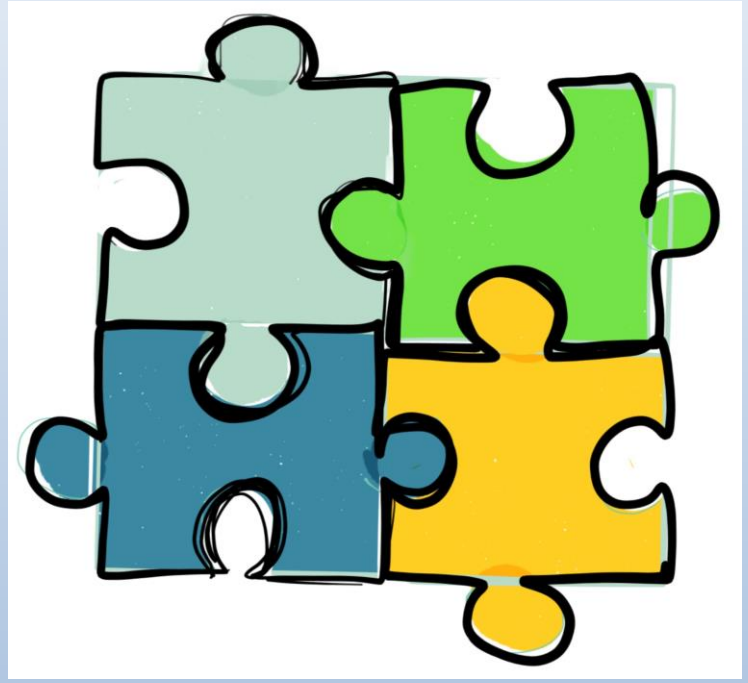
Funding models need to simple and allocative

CO-OWNED COORDINATION

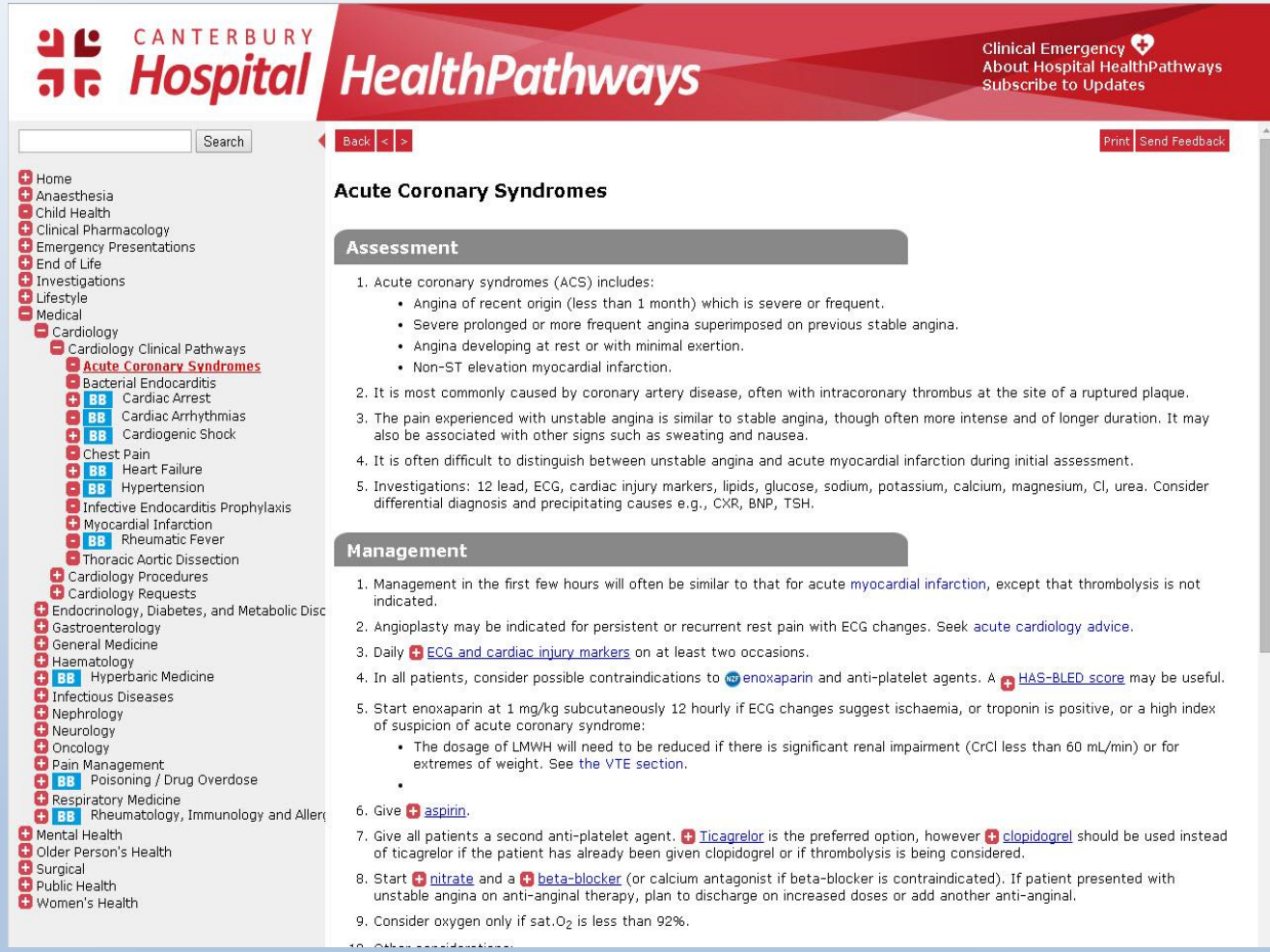
System level agility and coordination is obtained through shared communication about how to navigate the system.

This helps turn globally good practice into localized practice.

Agile because practice is based on information that can change

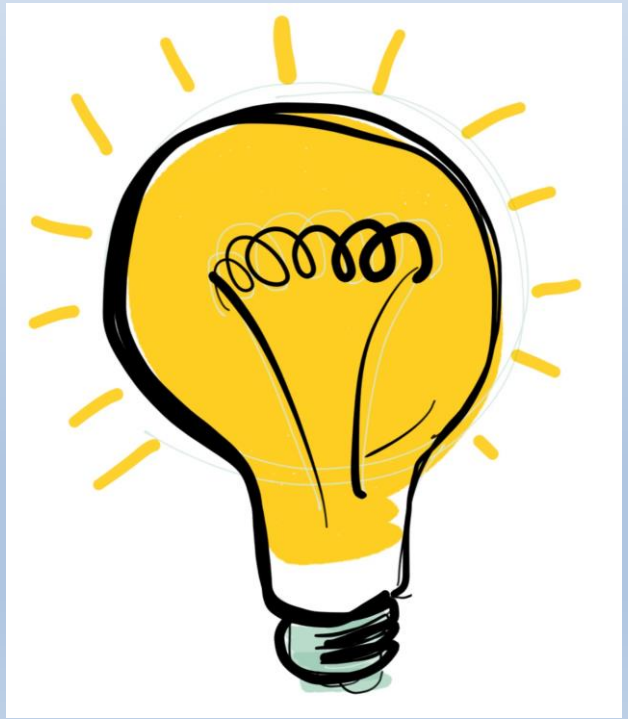


- 'This is how we do it around here'.
- Co-designed by people inside system
- Essentially Captured agreement
- My part in pathway.
- 2-way communication; “Send feedback”
- Everyone always knows they are current.
- High reliability organization; adaptive in crisis. Changed how system worked on back of earth quake.
- Education Canterbury; help teachers understand get support for kids

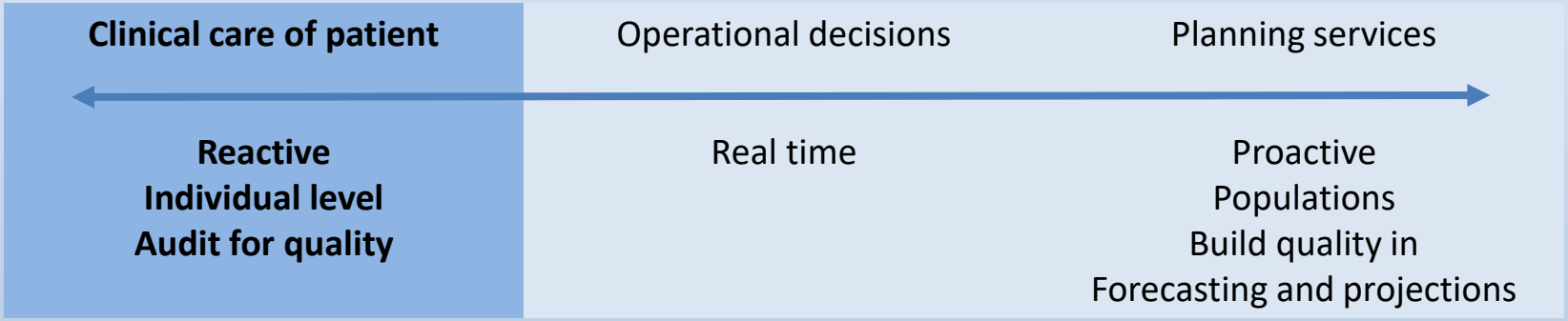


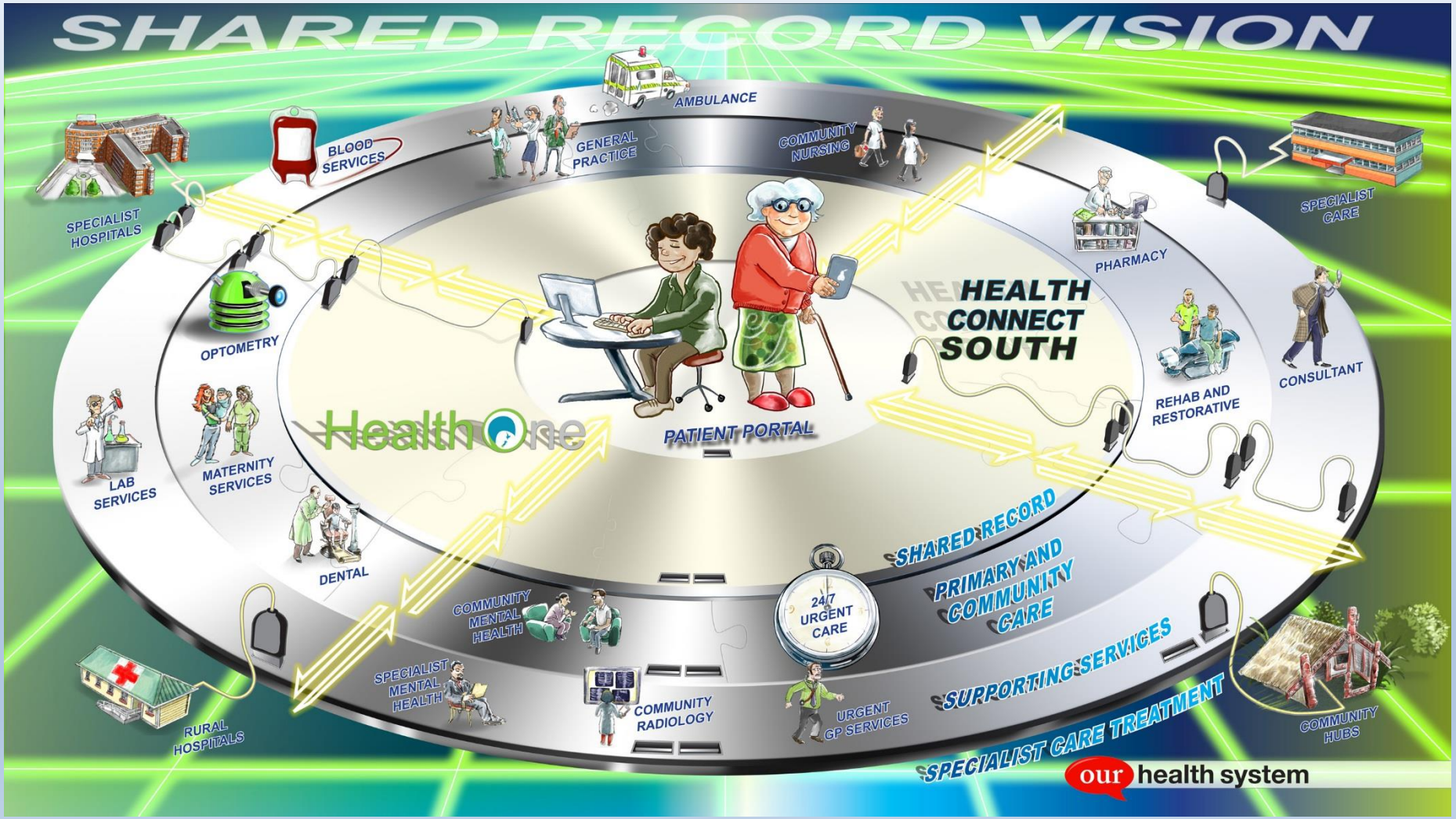
SHARED INSIGHT AND LEARNING

Feedback. Shared insight of the system provides real time feedback about how the parts of the system work together to produce a result. There is real time operational visibility of the system, analytical insight and an insight liaison service (interpretive and educational)

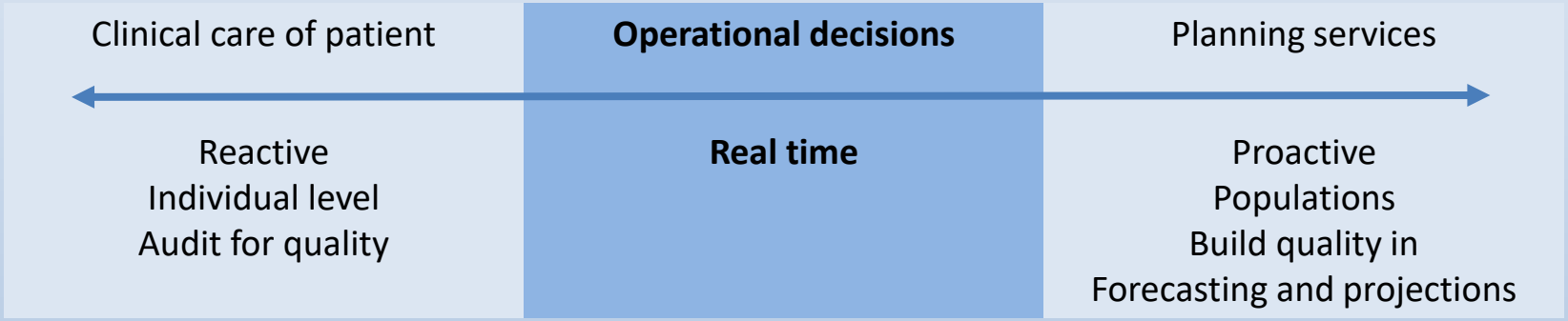


The Role of Data

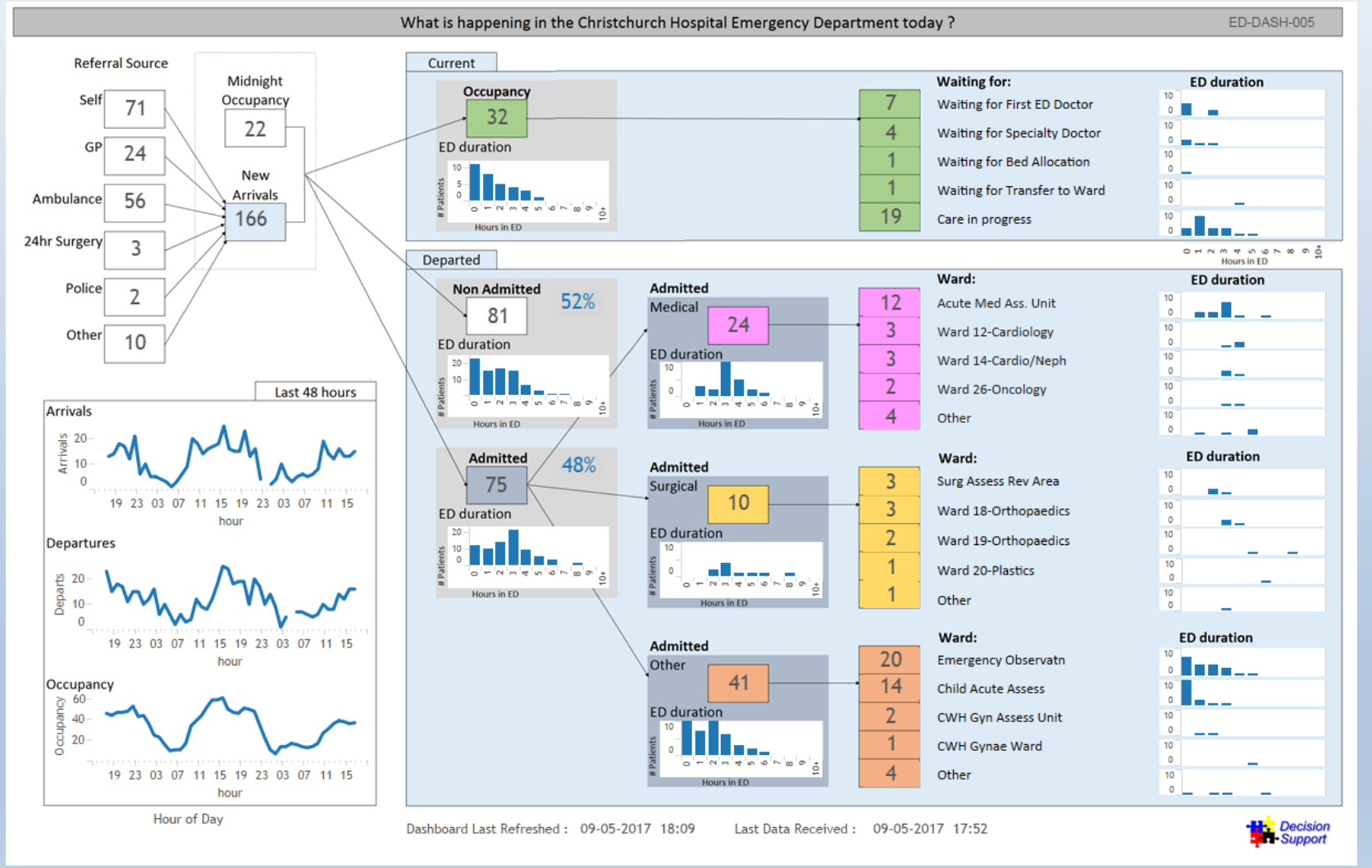



SHARED RECORD VISION
AMBULANCE
BLOOD SERVICES
GENERAL PRACTICE
COMMUNITY NURSING
SPECIALIST HOSPITALS
SPECIALIST CARE
PHARMACY
HEALTH CONNECT SOUTH
OPTOMETRY
CONSULTANT
REHAB AND RESTORATIVE
HealthOne
PATIENT PORTAL
LAB SERVICES
MATERNITY SERVICES
DENTAL
SHARED RECORD
PRIMARY AND COMMUNITY CARE
24/7 URGENT CARE
COMMUNITY MENTAL HEALTH
SUPPORTING SERVICES
SPECIALIST MENTAL HEALTH
COMMUNITY RADIOLOGY
URGENT GP SERVICES
RURAL HOSPITALS
COMMUNITY HUBS
SPECIALIST CARE TREATMENT
our health system

Data Use


Clinical care of patient
Operational decisions
Planning services
Reactive
Individual level
Audit for quality
Real time
Proactive
Populations
Build quality in
Forecasting and projections

15 minute updates (react quickly)



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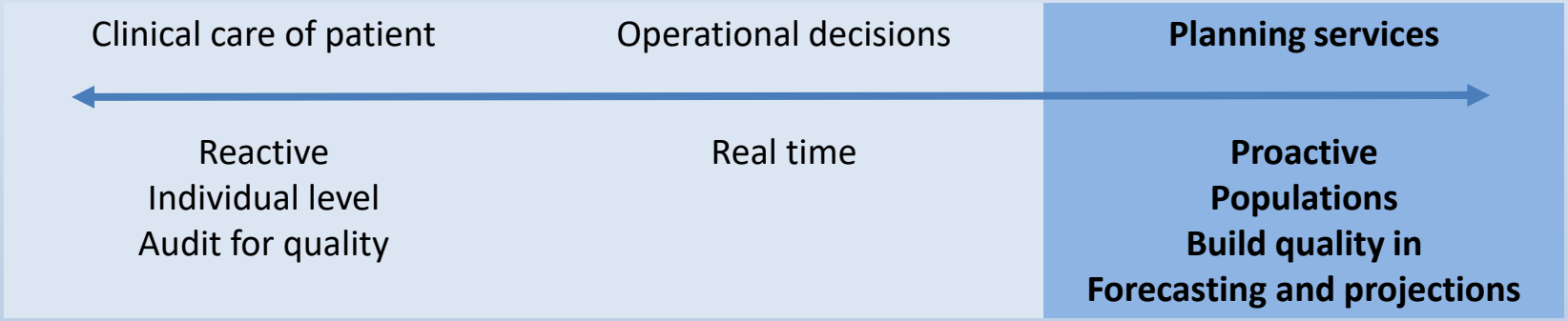
Clinical care of patient
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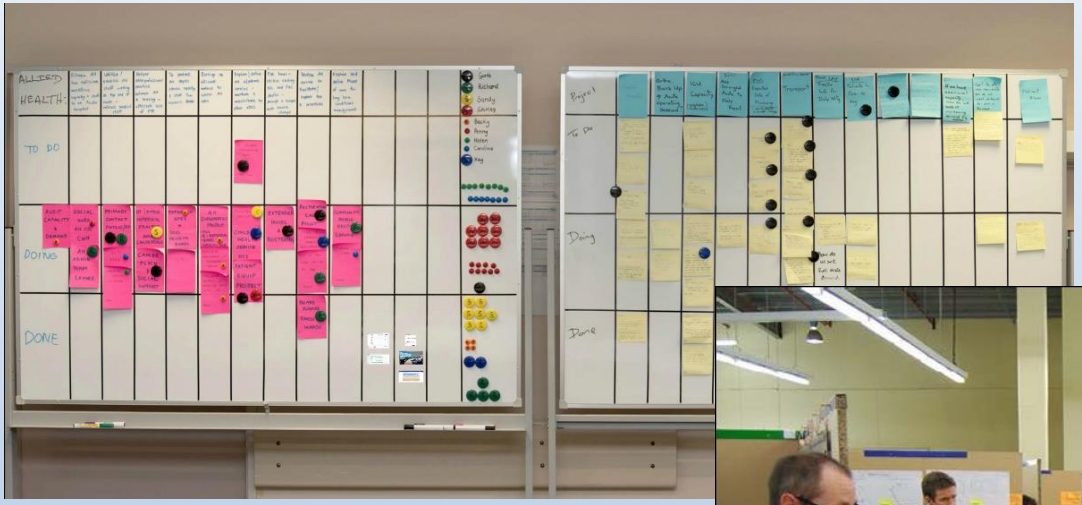
Getting the right people in the room

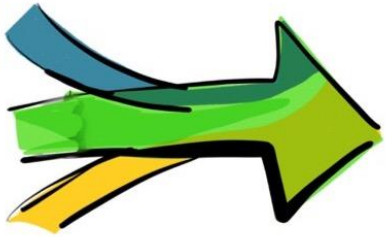


Data-informed conversations – redesigning pathways and interventions

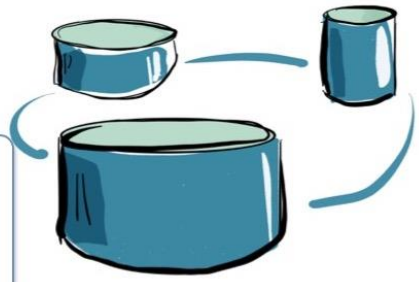
COLLECTIVE OWNERSHIP

COLLECTIVE (RE)INVESTMENT

SHARED ORIENTATION



HIGH TRUST DATA INTEGRATION



SHARED INSIGHT AND LEARNING

CO-OWNED COORDINATION

DATA IS COLLECTED TO MEASURE OUTCOMES and ENGAGE IN SERVICE IMPROVEMENT...

which ends information asymmetry

...so we're all on the same page...

...allowing us to respond nimbly to changes in demand as circumstances change...

...and allowing us to plan for what we want to do together in the future

Alliances

- There is no panacea – Alliances are not an easy way out;
- But a better opportunity to work in a complex system than transactional alternatives.
- Genuine localisation and devolution of decision making is everything.

We built a integrated system based on trust and a shared vision