Health Care Policy & the Bloomington School of Institutional Analysis: Opportunities and Challenges of a Regional Approach to Reform

Michael D. McGinnis

Visiting Faculty, Dartmouth Center for Health Care Delivery Science and Dartmouth Institute for Health Policy and Clinical Practice, Professor, Political Science and Senior Research Fellow, Ostrom Workshop, Indiana University, Bloomington, Core Faculty, ReThink Health, Rippel Foundation

Comments Welcomed mcginnis@indiana.edu
Topics

- **Linking Health Care and Commons Research**
  - For more details on this topic, see “Caring for the Health Commons: What It Is and Who’s Responsible for It” [http://php.indiana.edu/~mcginnis/chi.pdf](http://php.indiana.edu/~mcginnis/chi.pdf)

- **Implications of the Bloomington School of Institutional Analysis**
  - Health
  - Health Care
  - Health Policy

- **Alternative Models of Health Stewardship**

- **Alternative Visions**
Linking Health Care & Commons Research

- Don Berwick – a tragedy of the commons in health care?

- Dartmouth Atlas – why regional variation?

- Any relevance of Design Principles to “positive deviants” with multi-stakeholder coordination? – Case study of Grand Junction, CO

- Action-research with ReThink Health team/alliance (http://www.rethinkhealth.org/): Upper Valley, NH/VT
How Will We Do That?
Participating Hospital Referral Regions

Standardized Medicare payments per enrollee (2007):
- $9,300 to 15,750 (55)
- 8,600 to < 9,300 (65)
- 7,900 to < 8,600 (56)
- 7,200 to < 7,900 (62)
- 5,279 to < 7,200 (68)
- Not Populated

How Will We Do That? Building Low-Cost, High-Quality Health Care Regions in America (May 2010)
www.IHL.org
Why Institutional Analysis?

- Might help unite currently separate discourses in disciplines studying public health, health care, health policy
- **Help us understand why system is so Fragmented?**
  - Insurance coverage segments population in strange ways
  - Diverse professions, little training in teamwork
  - Many different kinds of hospitals, clinics, physician associations, hybrid consolidations
  - Wide regional variation in cost and utilization of care, and in health outcomes
  - Many different governmental agencies involved, but no policy network for health sector as a whole?
  - No obvious convener for comprehensive planning
- **IAD framework** should be relevant to all these areas
Bloomington School of Institutional Analysis

- Vincent and Elinor Ostrom established the Workshop in Political Theory and Policy Analysis, at Indiana University in 1973, and worked there until 2012.
- The Ostrom Workshop is an inter-disciplinary research and teaching center where faculty, students, and visiting scholars and practitioners focus on understanding how self-governing groups work to solve their own collective problems and realize their shared aspirations.
- The “Bloomington School” encompasses their work and that of a large number of their students, collaborators, and colleagues.
- Unusual emphasis on informal institutions, integration of multiple methods of multi-disciplinary analysis, and on both analytical rigor and policy relevance.
- Series of studies on police, metropolitan systems, development assistance, resource management, constitutional order, and other topics as they emerge (including my research on health, health care, and health policy in the U.S.).
Institutional Analysis and Development (IAD) Framework

- **Institutions** are rules, norms, and other shared understandings that constrain and enable collective action; **analysis** breaks institutions up into their component parts, **development** shows how they change.

- IAD emerged during long Workshop discussions and collaborations, intended and used to facilitate communication across disciplines.

- Has become the centerpiece of one of the most influential approaches to the study of public policy in political science and political economy.

- Locates **action situations** (choice processes at **inter-locking levels of analysis**: operational, collective, and constitutional) within **institutional context** set by nature of goods/biophysical conditions, attributes of the community, and rules-in-use, with these contextual factors **endogenously determined** by other action situations, especially processes of **evaluation and learning**.
How Is IAD Appropriate for this Project?

• IAD highlights the configural nature of relationships, since the effects of specific changes are filtered through complex institutional systems.
  – A key unanswered question is how much value is added (to the now standard repertoire of realized or proposed program improvements) by coordination among regional stakeholders.
  – An open question: can IAD handle the requisite level of complexity in health care?

• IAD forces policy analysts to dig deeper into the underlying nature of the problem.
  – If you change one aspect of a system in hopes of realizing an improvement, you need to learn what deeper forces led to that aspect being in place. Unless you also make changes at deeper levels that divert those forces into supportive results, the status quo will reassert itself, and sabotage your intervention.
  – Many good ideas have been tried in health policy, but what’s missing is a more comprehensive program of mutually supporting changes at all levels of analysis.

• IAD is especially effective when applied to situations in which individuals and groups are able to change the conditions under which they interact.
  – This is the crux of the ReThink Health initiative, that local leaders can, collectively, make and sustain the changes needed for a fundamental transformation to a “healthy” and sustainable system of health care in the U.S.
Implications of Bloomington School of Institutional Analysis

Health
Co-Production

Health Care
Sustainability of Micro-Commons

Health Policy
Regional Stewardship
1. HEALTH

• Dominance of social & behavioral determinants of health outcomes
  • Yet little professional contact between public health officials and care providers
  • Reform efforts focus on system of care ("downstream")
• We have built a very expensive system of “illness care”
  • Over-utilization is rampant (supply-induced demand)
  • Should focus instead on preventive care
• Ostrom Workshop adopted an early emphasis on Co-production and active engagement of citizens
  • Patients need to be more than passive consumers
  • Shared decision-making leads to less utilization
2. HEALTH CARE

Sources of Fragmentation in U.S. health care

• Federalism
  • State Insurance regulation, lots of federal regulation and programs.
  • Some local officials manage community hospitals or clinics.
  • Government programs & technology link local, state, national, global.

• Health care is local and personal
  • Patients typically go to doctors and hospitals close to home or work.
  • Providers interact with others in that community and neighboring regions.

• Challenges and conditions vary in a big country.
  • Diverse challenges set by demographic and economic conditions
  • Many regional “healthsheds” cross state borders, vary widely
  • But clinicians are suspicious of regional variation, tend to see as mistakes, as deviation from “best practices”

• Professional training and innovations in technology and institutional design
Fragmentation as Basis for Transformation?

- **Fragmentation** is evidence of lots of collective action.
- Each community has experience with many programs for
  - Clinical care,
  - Insurance coverage,
  - Quality Improvement,
  - Health promotion
- A micro-commons designates a **program** (i.e., resources and procedures) developed and operated jointly by different types of health care professionals and other stakeholders.
  - Each program established for a specific purpose, has rules on access to prevent overuse and degradation.
  - Each is a form of common property (and thus a subject of both cooperation and conflict).
- The health care system as a whole consists of the macro-level aggregation of all these programs, and other relevant resources.
Important Examples of Micro-Commons in Grand Junction

• **B4 Babies and Beyond** (pre-natal and infant care)
• **Marillac Clinic** (for uninsured patients)
• **PCP** (Primary Care Physician) recruitment
• **Financial Pool** to equalize reimbursement across insurance categories
• **Monitor** physician performance to reward excellence and encourage improvement
• **Quality Health Partners**: Health Information Technology
Sustainability of Micro-Commons

• **Micro-commons are not automatically sustainable**
  - Requires careful attention and hard work

• **Is sustainability even a concern here? YES!!**
  - The underlying problem is unlikely to be eliminated.
  - Solutions to new challenges build on past successes.

• As instances of common property, **Ostrom’s design principles** are, at least potentially, relevant as foundation for sustainable operation
  - Need a careful translation of context and interpretation from natural resources to health care context
## Translation of Terms to a Health Micro-Commons

<table>
<thead>
<tr>
<th>Natural Resources</th>
<th>Health Micro-Commons</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR = Common Pool Resource <em>(Example: population of fish)</em></td>
<td>Program <em>(Health Promotion or Quality Improvement)</em></td>
</tr>
<tr>
<td><strong>Resource Unit</strong> <em>(example: a fish once it has been caught)</em></td>
<td>Episode of care for an individual</td>
</tr>
<tr>
<td>** Appropriation** <em>(extraction of resource unit from resource pool)</em></td>
<td>Benefits received from program</td>
</tr>
<tr>
<td><strong>Actors</strong>: Appropriators and Providers may be from same group</td>
<td>Individuals appropriate resource units &amp; providers are stakeholder organizations</td>
</tr>
<tr>
<td><strong>Provision</strong>: replenish resource or construct and maintain infrastructure</td>
<td>Providers make different contributions to program</td>
</tr>
<tr>
<td><strong>Appropriation Rules</strong> may restrict time, place, quantity, and technology of resource extraction</td>
<td>Rules define eligibility for beneficiaries</td>
</tr>
<tr>
<td><strong>Provision Rules</strong> specify contributions to replenishment of resource or maintenance of infrastructure</td>
<td>Rules specify which providers are responsible for which services</td>
</tr>
<tr>
<td><strong>Rule-making activities</strong> by community or by user group</td>
<td>Contracts among providers to deliver services, and insurance coverage to individual or groups</td>
</tr>
<tr>
<td><strong>Higher level public authorities</strong> may restrict ability of local users to set or enforce own rules</td>
<td>Programs and regulations set by local, state, and national authorities, and by certification organizations</td>
</tr>
<tr>
<td><strong>Tragedy of the Commons</strong>: degradation or destruction of the resource</td>
<td>Demand for the program’s services tends to overwhelm supply capacity</td>
</tr>
</tbody>
</table>
| **Goal of Sustainability** *(ensure future access to resource)* | Financial viability (avoid dependence on grants) 
Initial problem is not likely to be eliminated |
| **Common property** *(joint ownership)* | Jointly operated program |
### Conditions Facilitating Sustainability in Resource Commons

<table>
<thead>
<tr>
<th>Design Principles</th>
<th>Facilitating Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Boundaries</td>
<td>Boundaries (on a group’s access to resources) set by history of inter-group competition</td>
</tr>
<tr>
<td><em>Long-Term Horizon</em></td>
<td>Long-term concern implied by users’ dependence on access to resource</td>
</tr>
<tr>
<td>Wide Participation</td>
<td>Close-knit community insures regular opportunities for communication</td>
</tr>
<tr>
<td><em>Trusted Leaders</em></td>
<td>Leaders likely to be well-known as members of community</td>
</tr>
<tr>
<td>Recognized Autonomy</td>
<td>Autonomy may be recognized by default (esp. for remote regions)</td>
</tr>
<tr>
<td>Congruence to Conditions &amp; Values</td>
<td>Local knowledge based on traditions that worked, and reciprocity is critical for survival</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Monitoring easy if users remain close to the action and are highly motivated</td>
</tr>
<tr>
<td>Graduated Sanctions</td>
<td>Social sanctions can be powerful, and are often finely nuanced</td>
</tr>
<tr>
<td>Dispute Resolution</td>
<td>If resolved via traditional methods, disputes can reinforce community ties</td>
</tr>
<tr>
<td>Nested Enterprises</td>
<td>Nested enterprises accumulate over time, cover a wide range of situations</td>
</tr>
</tbody>
</table>

*Principles not included in Ostrom’s original list, but implicit in her analysis.

These same 10 Design Principles are relevant to health care micro-commons, with some modifications.
## Responses to Sustainability Challenges (Grand Junction)

<table>
<thead>
<tr>
<th>DPs</th>
<th>Challenges to Sustainability</th>
<th>Responses from GJ Micro-Commons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Boundaries</td>
<td>Providers may participate in many programs; beneficiaries may qualify for several programs.</td>
<td>Financial pool established by Rocky and Mesa Co. Professional Independent Physicians Association (MCPIPA)</td>
</tr>
<tr>
<td><em>Long-Term Horizon</em></td>
<td>Long term commitment may be lacking if successful program reduces the problem</td>
<td>B4 Babies reduced infant mortality rates and achieved significant cost reductions; Multiple efforts to recruit PCPs.</td>
</tr>
<tr>
<td>Wide Participation</td>
<td>If program implementation doesn’t require close consultation, providers may not feel like a team; Beneficiaries may be passive recipients.</td>
<td>Equalization of payment across insurance categories, coupled with incentive plans, nurtured a sense of community among providers.</td>
</tr>
<tr>
<td><em>Trusted Leaders</em></td>
<td>Program leaders may not benefit professionally from program success.</td>
<td>Long tradition of collaborative leaders</td>
</tr>
<tr>
<td>Recognized Autonomy</td>
<td>Not clear who has authority to initiate new programs.</td>
<td>Long tradition of setting up multi-stakeholder cooperation; no challenges from within region?</td>
</tr>
<tr>
<td>Congruence to Conditions &amp; Values</td>
<td>Demand for programs may exceed supply; Information-sharing difficult across organizations.</td>
<td>Exempted physicians close to retirement from required participation in QHP HIT</td>
</tr>
<tr>
<td>Responsible Monitoring</td>
<td>Program-specific reporting often lacks comparative context; Consumer opinions are difficult to measure.</td>
<td>Performance data used for bonuses; Consumer use of comparative data.</td>
</tr>
<tr>
<td>Graduated Sanctions</td>
<td>Sanctions for low contributions may be toothless, if program is not central to core mission.</td>
<td>Informal sanctions , especially on new physicians.</td>
</tr>
<tr>
<td>Dispute Resolution</td>
<td>Program contracts may not specify procedures to resolve disputes.</td>
<td>Informal</td>
</tr>
<tr>
<td>Nested Enterprises</td>
<td>Each program may have multiple moving parts; coordination an on-going challenge.</td>
<td>Tradition of discussing programs openly.</td>
</tr>
</tbody>
</table>
In a regional system of the delivery of health care, many micro-commons operate simultaneously

- Each program was established for specific reason, but may later experience mission drift
- Some programs complement or reinforce each other,
- Other programs compete for funding, or undermine each other’s effectiveness
- Many gaps will remain uncovered, since they lack some ingredients for getting a program started
- Funding agencies and government programs change priorities often, and often capriciously

If, as is usual, no one is in charge at this level, we should expect to see only more fragmentation.
3. HEALTH POLICY

- **Health policy** tends to be seen as something that happens *TO* citizens and providers, and not something under their control – remarkable lack of efficacy
- I see major relevance of public administration literature: public officials embedded within cross-sector networks
- Core problem: **missing institutions** !!
  - No one’s in charge, at any level
  - Spillovers from other policy sectors, and many effects of health on other sectors; no mechanism to deal with this
  - Spotty record of entrepreneurship, falls well short of a full-fledged “ecosystem of innovation”
  - Even an ecosystem often needs some kind of governance
Why We Call it Stewardship

• To me this is a problem of governance, but I’m been advised to avoid that word (because it’s too close to government)
• Stewardship more appealing, but not ideal either;
  • Governance: my definition: the processes through which collective decisions are made, implemented, interpreted, and reformed for some group – processes that are shaped not only by formal government officials but also by private individuals, corporations, and a diverse array of professional associations, community-based organizations, and voluntary/non-profit/non-governmental organizations.
  • Stewardship: “the conducting, supervising, or managing of something; especially: the careful and responsible management of something entrusted to one's care.” (Merriam-Webster on-line dictionary). Tends to be most easily understood by religious groups or by environmentalists.
• Example of effective stewardship (or good governance?): Grand Junction, CO
Mesa County Health Leadership Consortium

Health Plan
- Rocky Mountain Health Plans

Physicians
- Mesa County Independent Physicians Association
- Primary Care Partners

Hospitals
- Family Health West
- Community Hospital
- St. Mary's Hospital & Regional Medical Center

Hospice
- Hospice & Palliative Care of Western Colorado

Home Health
- Home Care of the Grand Valley

Public Health
- Mesa County Health Department

Behavioral Health
- Colorado West, Inc.

Health IT
- Quality Health Network

Underserved Populations
- Mesa County Human Services
- Marillac Clinic
- Hilltop Community Resources
- Mesa Developmental Services

Business
- Grand Junction Area Chamber of Commerce
- City of Grand Junction
What Do They Talk About In MCLHC Meetings?

- **Issues related to existing programs** that they run collaboratively;
- **Tensions & Externalities**: The costs that one program has imposed on others, and how those costs might be reduced;
- **Gaps** in coverage that remain in their system, and potential new programs to fill those gaps;
- **Opportunities** for external funding of new programs (and the risks of undermining existing programs);
- **Learning** from the experience of colleagues in other regions or areas of work;
- **Reminders of shared vision and overall strategy**;
- **And lots of good-natured banter.**

My conclusion: The MCHLC is a fine example of **good governance** in practice, even though the MCHLC is definitely **NOT** an official **government** body.
The Grand Junction “Model”
Or Path to Regional Stewardship

Step 1: They assigned priorities to some programs (see earlier slide) and made top priority programs sustainable.

Step 2: They slowly expanded the coverage of these programs, added new programs, and built habits of regular consultation and collaboration

• Share plans & listen to concerns of other stakeholders
• Align organizational goals to community interests
• Build capacity to cope with remaining gaps, in ways that do not result in increased competitive pressures

They built a system of shared stewardship.

Took a long time to establish -- not widely replicable.

• Geographic isolation, sense of community, major providers are nonprofits, dominant payer also nonprofit (Rocky)
Alternative Models of Health Stewardship

Stakeholder Groups and Other Actors

Principles of Design – Commons Theory

Exploring Other Paths to Regional Stewardship
The “Usual Suspects” for Participation in a Regional Stewardship Team

1. Physicians and other healthcare professionals
2. Administrators of medical facilities (hospitals, clinics, etc.)
3. Insurers (commercial and non-profit)
4. Employers (health-related and other)
5. Local government officials (esp. public health officials)
6. Community Service Organizations (public & non-profits)
7. Professional Associations (health-related or other)
8. Individual Citizens (often as groups with specific characteristics)

Note: This is a highly simplified classification of the relevant actors.
Who Else Might Want to be Involved (And Who Can Make Important Contributions)?

- Schools, libraries, and educators
- Social workers and therapists
- Exercise and recreational facilities
- Food producers, merchants, and cooperatives
- Local cooperatives and other community enterprises
- Groceries and pharmacies
- Senior citizens (including retired professionals and community leaders)
- Friends and families of patients (including those living elsewhere)
- External investors (especially in social impact bond markets)
- Information technology experts
# Translation of Commons Theory to Regional Health Commons

<table>
<thead>
<tr>
<th>Natural Resources</th>
<th>Regional Health Commons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPR = Common Pool Resource</strong> (Example: population of fish)</td>
<td>Overall stock of physical, financial, human, and social capital in region</td>
</tr>
<tr>
<td><strong>Resource Unit</strong> (example: a fish once it has been caught)</td>
<td>Costs of care for individuals in an identifiable population segment</td>
</tr>
<tr>
<td><strong>Appropriation</strong> (extraction of resource unit from resource pool)</td>
<td>Utilization, total health care costs</td>
</tr>
<tr>
<td><strong>Actors</strong>: Appropriators and Providers may be from same group</td>
<td>Stewardship Team acting on behalf of population as a whole</td>
</tr>
<tr>
<td><strong>Provision</strong>: replenish resource or construct and maintain infrastructure</td>
<td>Providers may establish an innovation fund, and agree to reinvest savings</td>
</tr>
<tr>
<td><strong>Appropriation Rules</strong> may restrict time, place, quantity, and technology of resource extraction</td>
<td>Rules may limit construction of new facilities that duplicate existing services</td>
</tr>
<tr>
<td><strong>Provision Rules</strong> specify contributions to replenishment of resource or maintenance of infrastructure</td>
<td>Limitations on how parties can spend savings from programs, or what initiatives they should undertake</td>
</tr>
<tr>
<td><strong>Rule-making activities</strong> by community or by user group</td>
<td>Stewardship team sets priorities for program support and gaps that need filling.</td>
</tr>
<tr>
<td><strong>Higher level public authorities</strong> may restrict ability of local users to set or enforce own rules</td>
<td>Anti-trust regulations and other restraints on cross-stakeholder collaboration</td>
</tr>
<tr>
<td><strong>Tragedy of the Commons</strong>: degradation or destruction of the resource</td>
<td>Rising health care costs reduce overall economic productivity</td>
</tr>
<tr>
<td><strong>Goal of Sustainability</strong> (ensure future access to resource)</td>
<td><strong>Quintuple Aim</strong>: Triple Aim (better health, high-quality care at lower costs), plus Equity and Productivity</td>
</tr>
<tr>
<td><strong>Common property</strong> (joint ownership)</td>
<td>Stewardship of regional resources</td>
</tr>
</tbody>
</table>
# A Strategy for Shared Stewardship of a Health Commons

<table>
<thead>
<tr>
<th>Design Principles</th>
<th>Guidelines for Stewardship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Boundaries</td>
<td>Think Systemically</td>
</tr>
<tr>
<td>*Long-Term Horizon</td>
<td>Align Plans to Community Values</td>
</tr>
<tr>
<td>Wide Participation</td>
<td>Build Momentum</td>
</tr>
<tr>
<td>*Trusted Leaders</td>
<td>Find a Trusted Convener</td>
</tr>
<tr>
<td>Recognized Autonomy</td>
<td>Establish Shared Priorities</td>
</tr>
<tr>
<td>Congruence to Conditions &amp; Values</td>
<td>Recognize Inequities</td>
</tr>
<tr>
<td>Responsible Monitoring</td>
<td>Gather and Share Information</td>
</tr>
<tr>
<td>Graduated Sanctions</td>
<td>Hold Each Other Accountable</td>
</tr>
<tr>
<td>Dispute Resolution</td>
<td>Address Disputes Honestly</td>
</tr>
<tr>
<td>Nested Enterprises</td>
<td>Nurture Innovation</td>
</tr>
</tbody>
</table>
# Two Contexts for Sustainable Stewardship

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Informal (Grand Junction)</th>
<th>More Formal Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Think Systematically</strong></td>
<td>Physical barriers helped create sense of shared community, collective self-reliance west of the Rockies; Rocky and MCPIPA built pool for equal reimbursement</td>
<td>Recognizing systemic dynamics is more important than drawing artificially clear geographic boundaries; Recruit new partners when needed</td>
</tr>
<tr>
<td><strong>Align Plans to Community Values</strong></td>
<td>Strong sense of community; Public health concerns becoming more central</td>
<td>Community values need to be clearly articulated, and shared priorities defined and followed</td>
</tr>
<tr>
<td><strong>Build Momentum</strong></td>
<td>Monthly MCHLC meetings with explicit agendas, notes; Open discussion of plans and initiatives and unmet needs</td>
<td>Set norms of open discussion, safe harbor; May define complex voting rules</td>
</tr>
<tr>
<td><strong>Find a Trusted Convener</strong></td>
<td>Initial leadership from physicians, Rocky (insurance plan) serves as MCHLC convener (and in dominant position local market)</td>
<td>Convener &amp; sponsors need moral authority, with details depending on local context; Public health should play important role</td>
</tr>
<tr>
<td><strong>Establish Shared Priorities</strong></td>
<td>Set priorities on B4Babies, primary care, QHN, etc. FTC consent decree in 1988 (but still source of sensitivity)</td>
<td>Priorities can be community “game plan” or more formal statement of priority programs; Anti-trust remains sensitive issue</td>
</tr>
<tr>
<td><strong>Recognize Inequities</strong></td>
<td>Limit number of facilities to efficiencies of scale; Allowed older physicians to opt out of HIT upgrades</td>
<td>Confront negative externalities explicitly; Capture &amp; reinvest savings may be effective tool (if targets are clearly stated and measurable)</td>
</tr>
<tr>
<td><strong>Gather &amp; Share Information</strong></td>
<td>Locally developed system for patient health information Peer evaluation for physicians Local clinician training</td>
<td>Track changes in community needs &amp; capabilities; Embed measurement in all programs</td>
</tr>
<tr>
<td><strong>Hold Each Other Accountable</strong></td>
<td>Informal (esp. lack of patient referral); Common pool for quality performance incentives</td>
<td>Formal specification may be problematic, but informal norms can be powerful</td>
</tr>
<tr>
<td><strong>Address Disputes Honestly</strong></td>
<td>Informal committee of local physicians and other healthcare professionals resolve disputes</td>
<td>Mediation options may need to be specified</td>
</tr>
<tr>
<td><strong>Nurture Innovation</strong></td>
<td>Shared funding for Marillac Clinic, hospice Reward primary care physicians for hospital visits</td>
<td>Build and sustain effective micro-commons, Monitor regional consequences and fill gaps</td>
</tr>
</tbody>
</table>
Design principles/guidelines for stewardship need to be grounded in and supported by enabling conditions at several levels:

- Characteristics of **individual leaders**: collaborative, innovative, systems thinking
- Processes within **leadership teams** (openness of communication, shared understanding) and
- **Stakeholders** with interests aligned to community values
- Enabling conditions at regional and national levels, esp. **sufficient resources** and **room for local autonomy**
Institutional Diversity in (More-or-Less) Integrated Regional Systems of Health Care Delivery

- No regular discussions among all key stakeholders (Bloomington, IN)
- Informal consortium of community leaders (Grand Junction, CO)
- Bottom-up initiatives building towards broader discussions (South Carolina RTH group)
- Regular meetings sponsored by a non-profit organization (Network of Regional Health Improvement Collaboratives)
- Multi-Stakeholder Cooperative (Health Partners, MN)
- Accountable Care Community (Akron, Whatcom County)
- Fully integrated system (Kaiser Permanente, Geisinger)
- Association of Diverse Collaboratives (High Value Health Collaborative)
<table>
<thead>
<tr>
<th>Model and Illustrative Example</th>
<th>Who are members (and are Citizen Groups, Public Health, Education, typically included)?</th>
<th>How governing bodies are composed</th>
<th>Scope of authority to allocate resources</th>
<th>Decision making process</th>
<th>Degree of formality, legal status, constraints</th>
<th>Financial process</th>
<th>Can it cross state lines?</th>
<th>Expandability</th>
<th>Anti-trust implications</th>
<th>Implications for care integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC: Accountable Care Community, (example Akron, Ohio)</td>
<td>partnership of community health programs, Public Health is key partner; education and social services, business leaders</td>
<td>ABIA founding partner structure: PH, providers, community organizations</td>
<td>Full range of health care and health promotion; priority setting, integrating initiatives (voluntary by partners)</td>
<td>ABIA builds operational infrastructure to enable targeted multi-party interventions</td>
<td>Coalition</td>
<td>Varies. Outside grants to initiatives; some experiments with PPPM payment</td>
<td>Yes</td>
<td>Easy</td>
<td>None obvious. Consumers are included in decision making</td>
<td>Critical focus of model</td>
</tr>
<tr>
<td>MSC: Multi-Stakeholder Cooperative; (example Health Partners, MN)</td>
<td>Consumer groups, providers, insurers, and other relevant groups; Employers, &amp; schools should be easy to include</td>
<td>Representatives of each stakeholder group</td>
<td>Depends on state regulation; could be very broad</td>
<td>Complex voting rules are typical</td>
<td>Varies by state regulation of coops</td>
<td>* Savings can be distributed to members</td>
<td>Possibly, depends on state laws</td>
<td>May require complex renegotiation</td>
<td>Unclear, should be OK if consumers included</td>
<td>Depends on priorities of MSC</td>
</tr>
<tr>
<td>501(c)3 Non-Profit Organization (Example: Network of Regional Health Improvement Collaboratives)</td>
<td>Donors, volunteers, staff, recipients of services Very easy to include all kinds of groups</td>
<td>Board of Directors (as mandated by state laws)</td>
<td>Can award funds to applicants</td>
<td>Board and Staff</td>
<td>Highly regulated</td>
<td>Members pay yearly dues, but should be tax-deductible</td>
<td>Yes, this should be easy</td>
<td>Easy</td>
<td>None</td>
<td>Indirect, only through grant recipients</td>
</tr>
<tr>
<td>Informal collaboration (example: Grand Junction, CO)</td>
<td>Individual leaders as informal representatives of key stakeholder organizations</td>
<td>Mesa Co. Health Leadership Consortium</td>
<td>No direct authority, encourage members to follow “game plan”</td>
<td>Consensus, some voting</td>
<td>Very informal, weak legal status</td>
<td>^ No direct control over any budget</td>
<td>Easy (if near state border!)</td>
<td>Difficult, need common sense of belonging</td>
<td>Sensitive issue, so they avoid too much detail in agreements</td>
<td>Indirect, through many specific programs</td>
</tr>
</tbody>
</table>
To be effective, in any setting, stewards need to

1. meet regularly,
2. set priorities,
3. allocate resources to keep achieving these priorities, and
4. monitor effects on the region as a whole.

And a shared vision can be a critical foundation
Alternative Visions:
Patient-Centered Care
Progressive Contact
Polycentric Care
Patient-Centered Care

• Critical to Patient-Centered Medical Home
  • **PCMH**: “a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.” [http://www.pcpcc.net/about/medical-home](http://www.pcpcc.net/about/medical-home)
    • But individual patients are always in social contexts
    • Some information is too technical, and clinical coordination is beyond their control
    • Patients often need advocate or translator

• **Accountable Care Organizations** take to higher level
  • **ACO**: “Accountable care organizations are networks of providers with unified governance that assume risk for the quality and total cost of the care they deliver.” (Burns and Pauly, *Health Affairs*, Nov. 2012)
    • But governance requires community-level perspective
Progressive Contact (an Upper Valley possibility)

System of options across entire continuum of care

- **When healthy**: easy access to health information & preventive health (workplace, pharmacies, schools, etc.)
- **When need 1st contact**: 24/7 access (virtual & urgent care)
- **Primary care options**: physicians, PCMH teams, nurse practitioners, iphone doctors
- **Acute care**: comparative data, shared decision-making
- **Chronic care**: multiple clinics, in-home monitoring
- **Palliative care**: nursing homes, hospice, home care
- **Community discussion and stewardship**: public forums, web portals, and leadership meetings

Combines virtual and personal contact in each context
Involves many others beyond usual suspects
Polycentric Care (my favorite!)

- System of health care governance is fragmented, and plenty of institutional diversity, but it is NOT a fully polycentric system
  - Efficiencies of scale not fully realized, many missing institutions
  - Too little coordination of programs to be a polycentric system
  - Lots of cost-shifting, not acceptable on normative grounds
- “A polycentric organization has been defined as a pattern of organization where many independent elements are capable of mutual adjustment for ordering their relationships with one another within a general system of rules.” (V. Ostrom 1972, in McGinnis 1999b, p. 73; emphasis added)
- “The efficiency of any particular polycentric system would depend upon ... (1) the correspondence of different units of government to the scales of effects for diverse public goods; (2) the development of cooperative arrangements among government units to undertake joint activities of mutual benefit; and (3) the availability of other decision-making arrangements for processing and resolving conflicts among units of government.” (V. Ostrom 1972, in McGinnis 1999b, p. 53, emphasis added)
Challenges of Realizing Polycentric Care

• Information and time requirements
• Coordination costs
• How can partisan entanglement be reduced, given
  • Medicare benefits are big contributor to federal deficit
  • Medicaid is key contributor to state financial problems
  • State insurance exchanges, but will lack of full adoption lead to national exchange?
• Need an inspiring public articulation of normative basis
  • Combination of choice, individual responsibility, local autonomy, equity, free enterprise, professional ethics, innovation, and basic human decency.
• Improve sense of efficacy
Our main lesson is this:

Healthcare professionals and community leaders CAN and SHOULD assert ownership of their health commons at the regional level.
Many important decisions ARE made in local settings:

1. **Recruitment** of professionals in different specializations;
2. Corporate decisions to **build new facilities or to consolidate**;
3. Negotiations among hospitals, physician groups, and insurance plans regarding **reimbursement**;
4. Procedures established within hospitals or physician groups (regarding **quality control**, reducing medical errors, hospitalists, etc.);
5. **Communication among different types of medical professionals**
6. Interactions between individual **patients and clinicians** (especially regarding referrals to specialists or testing facilities);
7. Interactions between **patients and employers** or government agencies offering health insurance coverage or wellness plans;
8. **Sharing of values, goals, plans, and information among providers and with public**
9. Location of parks, bike paths, food stores, and other aspects of the “**built environment**” that affect personal choices for healthy behavior;
10. **Personal choices between healthy and unhealthy behaviors.**