

# TRANSFORMING HEALTH CARE DELIVERY:

## Why It Matters and What It Will Take

### INTRODUCTION

While extending coverage to millions of uninsured Americans remains an essential policy objective, improving patient care so as to achieve better outcomes at a lower cost is no less critical. Problems such as inadequate coordination and communication among providers, misaligned incentives, and poor information management all have a negative impact on the health of patients and can drive up spending on health care unnecessarily. Many of these problems stem from fragmentation, lack of integration, and a focus on particular services rather than the holistic needs of patients, which characterize care in our health system today. Making the needed improvements will require nothing less than a transformation in how patient care is delivered.

Transforming health care delivery so as to better meet the needs of patients will require changes to strengthen delivery of care for patients who already have good access to services, as well as changes to improve care for patients who find it harder to get the care they need. In both cases, policymakers and health care experts are eyeing new and emerging models of health care delivery as potentially better positioned to meet the challenges of growing complexity in health care and the expectations of actively engaged patients. Such innovations include development of cross-specialty teams and networks of providers that are accountable for the full range of services used by their patients or for specific episodes of care. At the same time, primary care practitioners, working independently or in teams, are starting to take on new roles and responsibilities in managing patient care and serving as a health resource hub for their patients.

Of course, changes in how the provision of health care is structured and organized are desirable to the extent that they ultimately have a positive impact on patient and population health. And there is much promising innovation in this direction as well, exemplified by current efforts to reduce avoidable hospital readmissions, improve transitions between health and long-term care settings, increase patient safety, and help patients make informed and evidence-based decisions about the treatments that are right for them. These efforts happen when health care providers have both the incentives and the means to implement innovations that enhance quality and reduce costs.

### WHAT CONSTITUTES AN EFFECTIVE AND EFFICIENT HEALTH CARE DELIVERY SYSTEM?

Leaders in health care have widely endorsed the “triple aim” of improving health, improving health care, and reducing cost. The fact that there is considerable progress to be made on all of these fronts is underscored by findings from studies comparing U.S. health care system performance to that of other nations. Such studies consistently show that the United States leads in terms of costliness (by a wide margin) but lags on health outcomes like life expectancy and infant mortality, and has a mixed performance in terms of quality of care.

The problem cuts across all elements of the health care system. At present, the structures and processes that make up U.S. health care delivery are not functioning optimally. They do not work consistently well for those who are “in the system” – insured and with good access to care – in that they produce care that is too costly and that too often yields suboptimal outcomes. And they are not working well for those who are uninsured or otherwise face financial, geographic, or other barriers to access, as evidenced by significant service use differentials and disparities in outcomes.

But knowing what we lack is not the same as knowing what we need. How would we know an effective and efficient health care delivery system if we saw one? Experts have described some general characteristics, recognizing that specific details will vary across communities. For instance, The Commonwealth Fund Commission on a High Performance Health System identified a number of attributes of a well-organized

system of health care delivery that aims to furnish the full spectrum of needed care for patients in a given geographic area:

- Patients' clinical information is available to providers at the point of care and to patients through electronic health record systems.
- Patient care is coordinated across providers, and transitions to different care settings are actively managed.
- Providers are accountable to each other, review each other's work, and collaborate reliably to deliver care that is of high quality and value.
- Patients have easy access to appropriate and culturally competent care and information, including after hours.
- There is clear accountability for the total care of patients.
- The system is continuously innovating and learning how to improve quality, value, and the patients' experience (Shih et al. 2008).

While these attributes are not common features of existing health care delivery systems generally, the commission's report observed that this wish list is not out of reach; delivery systems in some communities already have many or even all of these attributes. Experimentation with new structural models of health care delivery (for example, accountable care organizations, patient-centered medical homes, health homes, coordinated care organizations), as well as variants on existing models, provide opportunities to test whether particular structures are better equipped to operate or serve as part of well-organized systems of health care delivery.

## **BUILDING BLOCKS AND TOOLS: WHAT WILL IT TAKE TO TRANSFORM HEALTH CARE?**

The goal of transformation is to move from where we are to where we want to be in terms of having effective and efficient delivery systems to meet health needs across communities. Much of the change needs to happen locally, with assistance and investment in key system-wide areas at the state and national levels. Coordination and open communication across levels are essential. Areas requiring and benefiting from attention include both infrastructure and incentives.

- **Workforce** – Human resources are the most important component of the health care delivery infrastructure. While the U.S. health care workforce is well-educated and well-trained, there is relatively little national attention to workforce strategy and few policy levers outside of payment by which to spur desired changes. It is not clear that resources are always deployed in ways conducive to establishing effective and patient-oriented health care delivery systems. Notably, the system offers far greater financial rewards to those physicians who hone relatively narrow specialties instead of a general practice focusing on primary care and prevention. Further, medical education and training programs have not traditionally emphasized the teamwork approach that is increasingly recognized as a critical feature of effective health care delivery. It is difficult to retool practice and sustain change if practitioners are unprepared to practice in new ways. Also, the use of the broader range of health care professionals and the scopes of their practice vary significantly across states and communities, suggesting that there is untapped potential to deliver care more efficiently without compromising effectiveness.
- **Health Information Technology (HIT)** – After decades of paying lip service to the need to integrate automated information management and communications technology into health care delivery, remarkable progress on this front has been made quite recently. Information technology provides the capacity to access patients' clinical information in the course of a treatment episode, to make relevant and up-to-date evidence and protocols more readily available, to share information across providers, to facilitate patients' self-management and shared decisionmaking, to extend care to patients living in areas with limited local provider availability, and to engage in real-time monitoring of quality and safety. Thus, strengthening the

infrastructure and fostering its use continue to be among the most essential goals of delivery system transformation in the short term.

- ▶ ***Patient-Centered Outcomes Research*** – Information and evidence from research on effective health care delivery, in terms of both treatments and models, are another essential part of the health care delivery infrastructure. Recent investments in developing the information base have resulted from debates that highlight the large gaps in knowledge needed to deliver care effectively and to arm patients with the ability to participate in informed and shared care decisionmaking. Such investments are also critical to achieving a better balance between the promotion of beneficial innovation and the pressures to rapidly diffuse unproven technologies that serve as a driver of rapid escalation in health care costs. Ultimately, information on relative effectiveness could be combined with estimates of the relative costs of alternative treatment paths to enable patients to consider value as a factor in decisionmaking.
- ▶ ***Quality Improvement*** – A focus on quality of care, particularly when it is accompanied by investments in the quality measurement and improvement infrastructure, can create incentives for health care delivery reforms. An early and ongoing focus on patient safety issues, such as medication errors, has expanded to include national attention to problems such as avoidable hospital readmissions, inadequate management of chronic conditions, and poor transitions across health and long-term care delivery settings. Furnishing providers with data on relative performance across quality metrics can and does spur innovation in approaches to deliver health care that can provide models for others seeking to improve.
- ▶ ***Provider Payment and Other Misaligned Incentives*** – Misalignment of financial and other incentives is perhaps the largest obstacle to be surmounted in reforming health care delivery. Too often, provider payment systems unintentionally reward duplication of services, use of services that may not be clinically necessary or appropriate, and other cost-escalating activities, while failing to create incentives and compensate providers for their contributions to desired outcomes (including disease prevention) and their care decisions to appropriately use fewer and less intensive services. Incentives to develop delivery innovations for better management of high-cost patients so as to achieve desired outcomes are countered by the reality that such patients serve as an important source of provider revenue. Experts agree that the fee-for-service payment system needs to evolve and give way to more sophisticated arrangements that offer global or bundled payments that are tied to acceptance of responsibility for care episodes and outcomes. Experimentation with alternative payment arrangements is one of the most important areas of ongoing reform.

Provider payment is not the only area in which misaligned incentives pose obstacles to health care delivery reform. Throughout the health system there are tensions and conflicts of interest that can create barriers to change. While the burden of high and rising health care costs affects everyone, the health sector is also a thriving economic sector that serves as a job creator and center for lucrative opportunities that have played a vital role in the nation's economy. Deep-seated cultural, financial, and institutional vested interests constitute hurdles to recognize and overcome. Addressing these challenges will require leadership, creativity, and sustained commitment.

## WHAT IS HAPPENING IN FEDERAL AND STATE POLICY TO AID IN TRANSFORMING DELIVERY?

In addition to its provisions to expand health insurance coverage, the Patient Protection and Affordable Care Act of 2010 (ACA) included a focus on delivery system transformation. The law created the Center for Medicare and Medicaid Innovation, charged with supporting development and overseeing testing of new payment and delivery models, including ones for the supply of clinical services, integrated care, and community health. The ACA also created the Patient-Centered Outcomes Research Institute, charged with promoting the development and use of evidence on which treatments work best for patients under different circumstances. The ACA itself was built on a foundation laid through provisions of 2009 legislation enacted as an economic stimulus, which funded investment in HIT and outcomes research.

While events in 2012, notably the results of the Supreme Court decision expected in June and the

November election, will have seminal implications for the ways in which health reform unfolds, the value of innovation in health care delivery is widely recognized and activities focused on transforming health care continue to gain momentum. The new Center for Medicare and Medicaid Innovation has launched programs such as the Innovation Advisors Program, which supports local experts on innovation who engage in demonstration and diffusion of model activities, and the Partnership for Patients, a program for hospitals engaged in improving quality and safety through reduction of readmissions, hospital-acquired infections, and other aims.

Meanwhile, there is also a great deal of activity under way in the states, the locus of regulatory authority over health care delivery and the administrators of state Medicaid and Children's Health Insurance Programs. In Massachusetts, where near-universal coverage has already been achieved, delivery system transformation is an important current focus of attention. An agreement announced in December 2011 will provide the state with \$120 million annually in new federal funds to align safety net hospitals and primary care providers in integrated delivery systems that could be paid on a global basis and with quality- and efficiency-based incentives (Massachusetts Office of the Governor 2011). In Oregon, there is an effort under way to reorganize care for state residents who rely on the Oregon Health Plan, the state's Medicaid program, around new coordinated care organizations. These are locally-based teams charged with reducing barriers to both services and health. They are prospectively subject to global payments encompassing health, dental, and mental health services and including incentives for population health improvement. Legislation to put this model in place was introduced in the Oregon Legislature in early 2012 (Oregon Health Policy Board 2012).

### **HOW ARE HEALTH CARE PROVIDERS, HEALTH PLANS, AND LOCAL STAKEHOLDERS WORKING TO TRANSFORM HEALTH DELIVERY?**

Inspired and empowered by changes in policy and demand from purchasers and consumers, today's health care landscape features many examples of health care providers and health plans stepping forward to remodel aspects of health care delivery. For example, provider networks encompassing hospitals and physician practices have become more tightly integrated in communities like Cleveland, using tools such as electronic medical records, hospital network expansion, and direct employment of physicians as part of efforts to exert greater influence on the delivery of services (Katz et al. 2010). Such integration allows for potentially cost-saving, bundled payments for episodes of care involving multiple providers; in fact, the Cleveland Clinic entered into an agreement with Lowe's Companies, Inc. to furnish cardiac care to the company's employees at a discounted and inclusive price. At the same time, provider integration also has the potential to drive up costs by reducing the ability of health plans to negotiate lower rates.

In some communities, unaffiliated providers are working together with other stakeholders to develop and implement plans for transforming local health care. The Michigan Primary Care Consortium, for example, includes providers, insurers, employers, consumer groups, and others collaborating to strengthen the state's system of primary care. Since its founding in 2006, the consortium has worked on initiatives such as increasing the use of HIT and changing primary care practices into so-called patient-centered medical homes that will be accountable for delivery of preventive care and effective chronic care treatment.

Health plans are also seeking to adopt or create incentives for new methods of health care delivery. Plans like Kaiser Permanente's Foundation Health Plans are equipped to implement changes directly, in that they are tightly managed and involve exclusive arrangements with providers. Plans with looser and less exclusive networks sometimes work to influence delivery practices by changing payment incentives as part of efforts to spur desired changes, such as quality improvement initiatives, or investments in information management infrastructure.

### **WHAT IS THE ROLE FOR PHILANTHROPY?**

When it comes to transforming health care delivery, there are many opportunities for philanthropic organizations operating in the health arena. Whether a foundation aims to reduce the number of deaths from breast cancer, ensure an effective local safety net for underserved community residents, or assist patients in

becoming better advocates for their own health, a more functional, effective, and efficient system of care is essential to make the kind of progress that is needed.

Foundations are taking stock of developments at the national and state level and are posing questions about whether and how to get involved in health care delivery transformation. A number of foundations and grantmakers have invested in this area for years; others are just beginning to explore their options. Some such efforts reflect the particular priorities and circumstances of the local community or state in which the foundation operates, while others have been launched as part of work intended to support implementation of health reform. Activities undertaken include public education campaigns, partnerships with government authorities, advocacy, policy research, and convening activities (GIH 2010). Specific initiatives include development and evaluation of new delivery and payment models, as well as work to address particular aspects of health care delivery or its components (for example, workforce issues, primary care, hospital readmissions, transitions across settings, HIT). Consistent with a rationale of focusing attention where need is greatest, a number of foundations have placed a priority on work to strengthen the safety net and to improve care for vulnerable populations, such as those with chronic conditions requiring coordinated, patient-centered health care, to achieve good outcomes.

Being maximally effective in efforts to achieve change in health care delivery may require foundations to develop new partnerships, including those with private-sector actors with whom they have not worked before. Another promising path lies in support for regional coalitions that feature a standing infrastructure and multistakeholder commitments. Foundations will also benefit from sharing information about successful ventures and collective work to identify the most promising areas for grantmaking. With contributions from all those with a stake in improvement, it should be possible to muster a veritable army of successful innovation developers and diffusers.

## CONCLUSION

Transforming health care delivery is arguably the single greatest current challenge in health care policy and practice today – more technically difficult, albeit less politically controversial, than is coverage expansion. There is no single change in policy or practice that will suffice; instead, the problem must be addressed through a range of concurrent, sequential, and mutually reinforcing changes. Moving the fragmented and isolated actors that collectively constitute our health care delivery system in a direction that fosters more cohesive and coordinated activity focused around the needs and demands of patients is akin to steering a rudderless ship. But there is a compass that can help us hold the course. By creating an environment in which common goals for more effective health care are defined, innovation is encouraged, and local successes are diffused and emulated, ongoing evolution of health care delivery can be seen as a positive outcome in its own right.

## REFERENCES

Grantmakers In Health, *Implementing Health Care Reform: Funders and Advocates Respond to the Challenge* (Washington, DC: August 2010).

Katz, Aaron, Amelia M. Bond, Emily R. Carrier, et al., *Cleveland Hospital Systems Expand Despite Weak Economy*, Community Report No. 2, (Washington, DC: Center for Studying Health System Change, September 2010).

Massachusetts Office of the Governor, *Governor Patrick Announces \$26.75 Billion Medicaid Waiver Agreement*, press release, December 21, 2011.

Oregon Health Policy Board, “Coordinated Care Organizations,” <<http://health.oregon.gov/OHA/OHPB/health-reform/ccos.shtml>>, accessed December 2011.

Shih, Anthony, Karen Davis, Stephen Schoenbaum, et al., *Organizing the U.S. Health Care Delivery System for High Performance* (New York, NY: The Commonwealth Fund, August 2008).

## RECOMMENDED READING AND RESOURCES

Berwick, Donald M., “[Launching Accountable Care Organizations – The Proposed Rule for the Medicare Shared Savings Program](#),” *The New England Journal of Medicine* 364:e32, April 21, 2011.

In his perspective article, former Centers for Medicare and Medicaid Services Administrator Donald Berwick explains the objective of introducing accountable care organizations to Medicare as one of a number of complementary initiatives intended to bring an end to the era of fragmented care delivery.

Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, March 2001.

In this seminal resource, the nation’s top experts in health care quality and health care delivery make recommendations for fundamental changes in health care to bridge the gap between the care we now have and the care we could have.

Riley, Pamela, and Cara Demody, “[Achieving Equity in the Health System: The Commonwealth Fund’s Vulnerable Populations Program](#),” The Commonwealth Fund Blog, January 31, 2012.

This blog post makes the case for needed innovation in health care delivery to transform the safety net into a high-performance health system for vulnerable populations.

Shih, Anthony, “[Making Sense of Multiple Delivery System Reform Efforts](#),” The Commonwealth Fund Blog, November 17, 2011.

In his brief blog commentary, Commonwealth Fund Executive Vice President Anthony Shih makes the case that a wide range of delivery system reforms will collectively move us toward the goal of a more organized and effective health care delivery system.

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The following is an illustrative list of Grantmakers In Health Funding Partners that have been working on issues related to transforming the health care delivery system.

Aetna Foundation, Inc.  
[www.aetna.com/foundation](http://www.aetna.com/foundation)

Alliance Healthcare Foundation  
[www.alliancehf.org](http://www.alliancehf.org)

Archstone Foundation  
[www.archstone.org](http://www.archstone.org)

The Atlantic Philanthropies, Inc.  
[www.atlanticphilanthropies.org](http://www.atlanticphilanthropies.org)

BHHS Legacy Foundation  
[www.bhhslegacy.org](http://www.bhhslegacy.org)

Blue Cross and Blue Shield of Florida Foundation  
[www.bluefoundationfl.com](http://www.bluefoundationfl.com)

Blue Cross Blue Shield of Massachusetts Foundation  
[www.bluecrossfoundation.org](http://www.bluecrossfoundation.org)

Blue Cross Blue Shield of Michigan Foundation  
[www.bcbsm.com/foundation](http://www.bcbsm.com/foundation)

Blue Shield of California Foundation  
[www.blueshieldcafoundation.org](http://www.blueshieldcafoundation.org)

California HealthCare Foundation  
[www.chcf.org](http://www.chcf.org)

The California Wellness Foundation  
[www.calwellness.org](http://www.calwellness.org)

Children’s Fund of Connecticut  
[www.childrensfundofct.org](http://www.childrensfundofct.org)

The Colorado Health Foundation  
[www.coloradohealth.org](http://www.coloradohealth.org)

The Colorado Trust  
[www.coloradotruster.org](http://www.coloradotruster.org)

The Commonwealth Fund  
[www.cmwf.org](http://www.cmwf.org)

Community Health Foundation of Western and Central New York [www.chfwcnny.org](http://www.chfwcnny.org)

Community Memorial Foundation  
[www.cmfdn.org](http://www.cmfdn.org)

Connecticut Health Foundation  
[www.cthealth.org](http://www.cthealth.org)

Consumer Health Foundation  
[www.consumerhealthfdn.org](http://www.consumerhealthfdn.org)

Endowment for Health  
[www.endowmentforhealth.org](http://www.endowmentforhealth.org)

Foundation for a Healthy Kentucky  
[www.healthy-ky.org](http://www.healthy-ky.org)

Foundation for Community Health  
[www.fchealth.org](http://www.fchealth.org)

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The George Gund Foundation  
[www.gundfdn.org](http://www.gundfdn.org)

The John A. Hartford Foundation, Inc.  
[www.jhartfound.org](http://www.jhartfound.org)

Harvard Pilgrim Health Care Foundation  
[www.harvardpilgrim.org/foundation](http://www.harvardpilgrim.org/foundation)

The Health Foundation of Greater Cincinnati  
[www.healthfoundation.org](http://www.healthfoundation.org)

Health Care Foundation of Greater Kansas City  
[www.healthcare4kc.org](http://www.healthcare4kc.org)

The Healthcare Foundation of New Jersey  
[www.hfnj.org](http://www.hfnj.org)

Healthcare Georgia Foundation  
[www.healthcaregeorgia.org](http://www.healthcaregeorgia.org)

Health Foundation of South Florida  
[www.hfsf.org](http://www.hfsf.org)

Jewish Healthcare Foundation  
[www.jhf.org](http://www.jhf.org)

Robert Wood Johnson Foundation  
[www.rwjf.org](http://www.rwjf.org)

Kaiser Permanente  
[www.kp.org](http://www.kp.org)

Josiah Macy, Jr. Foundation  
[www.josiahmacyfoundation.org](http://www.josiahmacyfoundation.org)

Maine Health Access Foundation  
[www.mehaf.org](http://www.mehaf.org)

Missouri Foundation for Health  
[www.mffh.org](http://www.mffh.org)

Gordon and Betty Moore Foundation  
[www.moore.org](http://www.moore.org)

Nemours  
[www.nemours.org](http://www.nemours.org)

New York State Health Foundation  
[www.nyshealthfoundation.org](http://www.nyshealthfoundation.org)

Northern Virginia Health Foundation  
[www.novahealthfdn.org](http://www.novahealthfdn.org)

Northwest Health Foundation  
[www.nwhf.org](http://www.nwhf.org)

The Rapides Foundation  
[www.rapidesfoundation.org/site/](http://www.rapidesfoundation.org/site/)

Regence Foundation  
[www.regencefoundation.org](http://www.regencefoundation.org)

Richmond Memorial Health Foundation  
[www.rmhfoundation.org](http://www.rmhfoundation.org)

Fannie E. Rippel Foundation  
[www.rippelfoundation.org](http://www.rippelfoundation.org)

Sierra Health Foundation  
[www.sierrahealth.org](http://www.sierrahealth.org)

St. Joseph Community Health Foundation  
[www.sjchf.org](http://www.sjchf.org)

St. Luke's Health Initiatives  
[www.slhi.org](http://www.slhi.org)

The SCAN Foundation  
[www.thscanfoundation.org](http://www.thscanfoundation.org)

The Otho S.A. Sprague Memorial Institute  
[www.spragueinstitute.org](http://www.spragueinstitute.org)

Sunflower Foundation  
[www.sunflowerfoundation.org](http://www.sunflowerfoundation.org)

Tides Foundation  
[www.tidesfoundation.org](http://www.tidesfoundation.org)

UniHealth Foundation  
[www.unihealthfoundation.org](http://www.unihealthfoundation.org)

United Hospital Fund  
[www.uhfnyc.org](http://www.uhfnyc.org)

United Methodist Health Ministry Fund  
[www.healthfund.org](http://www.healthfund.org)

Universal Health Care Foundation of Connecticut, Inc. [www.universalhealthct.org](http://www.universalhealthct.org)

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