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Transforming Health Systems Through Leadership, Design and Incentives

Invitational Meeting Sponsored by:
Agency for Healthcare Research and Quality
Centers for Medicare and Medicaid Services
National Cancer Institute
Health Affairs

October 18-19, 2004
Rockville, MD

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Background

A growing body of research has documented sizeable problems in health care quality, safety, and efficiency. There is also considerable agreement that addressing these problems will require not only improved information technology, but also a broader transformation in the way we organize and pay for care.

On October 18-19, The Agency for Health Care Quality and Research (AHRQ), The Centers for Medicare and Medicaid Services (CMS), The National Cancer Institutes (NCI), and Health Affairs sponsored a meeting of experts (see attachment A for the list of participants) to explore ways to organize systems and incentives to foster quality, efficiency, appropriate clinical processes, culturally and ethnically sensitive care, and shared decision-making.

The charge to participants was to:

1. harvest promising system practices and prototypes for design change;
2. identify strategies for disseminating the best designs within the current regulatory and payment environment;
3. identify strategies for aligning financial and non-financial incentives to promote good design and promote the quality, safety, and efficiency of health care;
4. further partnerships within and beyond HHS that support the transformation of our nation's health care delivery systems.

Carolyn Clancy, MD, Director of AHRQ and Mark McClellan MD, Administrator of CMS, opened the meeting and reiterated their commitment to supporting and facilitating transformation of the health care system. They each briefly described efforts currently being undertaken by their agencies, and expressed hope that participants would help them identify and prioritize future efforts.

The meeting was structured to provide one day of presentations on current efforts to transform health care delivery systems. Researchers, administrators, and practitioners shared success stories and ideas on transformation. The second day, participants

focused on policy changes that were necessary to facilitate health system changes and ways to disseminate promising practices and support their implementation. (See attachment B for the agenda.)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[1] included a provision for a Health Care Quality Demonstration Program (Sec 646). This provision directs the Secretary to develop a five-year demonstration program to examine factors that encourage the delivery of improved patient care quality, including financial incentives, appropriate use of best practice guidelines, examination of service variation and outcomes measurement, shared decision-making between providers and patients, appropriate use of culturally and ethnically sensitive care, and related financial effects associated with these factors.

In carrying out this provision, CMS is directed to support linkages of relevant Medicare data to registry information from participating health care groups and for analysis supporting the purposes of the program. The provision also directs the NIH to expand its efforts to evaluate current medical technologies and improve the foundation for evidence-based practice, and AHRQ to use the demonstration as a laboratory for the study of quality improvement strategies and to evaluate, monitor and disseminate information relevant to such programs. One of the goals of this meeting was to inform the efforts of the agencies responsible for implementing the provision.

This meeting followed an earlier roundtable discussion on Health System Leadership and Design, which was held on July 1, 2004. Participants in that meeting, which included some of the participants in the current meeting, recommended that delivery systems and health care organizations be redesigned so that they can take advantage of new developments in information technology (IT), practices that promote safety and quality be implemented and sustained, more patient-centered care be provided, and preparedness for national emergencies be facilitated. Participants recommended that the next steps should include harvesting state-of-the-art design practices and identifying strategies to promote diffusion and adoption of these models and encourage further innovation.

Transformation Under the Current Policy and Financing Environment

The first day of the meeting focused on describing current initiatives to transform care under the current policy and financing environment. An initial panel discussed prototypes for redesigning health systems. Other panels discussed microsystem change within hospitals and health systems, the coordination of care in communities and between hospitals and community providers, and transforming community-based practices. There was considerable discussion among participants throughout the meeting. In addition, participants engaged in a written exercise where they identified the three most important things that key players could do to transform the quality and efficiency of the health care system under the current environment; the responses to this exercise are reflected in the discussion and key themes for each day.

[1] PL 108-173

Prototypes for Redesigning Health Systems

Steve Shortell, Ph.D. and Maggie Wang, Ph.D., described the results of their environmental scan to identify leading practices in systems redesign. An important theme of their environmental scan is the importance of multi-system change. They identified seven clusters of change mechanisms:

- redesigning care practices;
- using information technology for information, access and clinical support;
- managing clinical and organizational knowledge and skills;
- developing effective teams;
- coordinating care across conditions, care settings and time;
- incorporating outcome and performance measures for improvement and accountability;
- aligning incentives.

Major challenges to these change mechanisms include:

- managing physicians' resistance to change, due to concerns of reduced productivity and autonomy;
- incorporating redesign efforts into everyday operations;
- spreading successful redesign efforts within the organization and externally;
- accelerating the pace of IT adoption and implementation throughout the health care system.

Factors that predict the success of systems redesign include:

- authentic and credible leadership to communicate vision and share values;
- visible commitment of senior management to remove barriers and secure resources;
- quality-oriented culture and positive reward structure;
- strategic integration of system redesign into quality-oriented priorities;
- focus on change factors that are consistent with the organization's overall mission and strategy;
- deliberate incorporation of measurement and analysis into the redesign efforts to continuously monitor, benchmark, and facilitate knowledge sharing.

Jonathan Perlin, MD, Ph.D., provided some insight into the VA's remarkable transformation. The organizing strategy for change borrowed from the ideas delineated in the *Quality Chasm* report, and pointed them in direction of thinking of value as first maximizing quality per unit cost, and finally maximizing patient outcomes per unit cost. The VA looked for ways it could reduce variation by identifying instances where the knowledge base existed about optimal care, but care was not being provided. The VA identified measures to benchmark performance, identified supporting technologies including IT that could facilitate improvement, and established accountability for change. Dr. Perlin cited the VA's Electronic Health Record (EHR) as a major tool for facilitating change, and provided examples of where the EHR provides clinical reminders for decision support. Dr. Perlin noted that there is a performance contract that is formally

executed between the Under Secretary of Health and senior leadership at the VA; the contract is developed with the involvement of clinicians and managers and supports the strategic plan. This performance contract establishes accountability for change at the highest levels of leadership within the VA.

Microsystem Change within Hospitals and Health Systems

Eugene Nelson, Ph.D. opened the next panel by noting that the health system is actually a large system composed of smaller systems. These many levels link together and are interdependent in the health care system as a whole.

Patricia Gabow, MD, provided some insights learned from initiating change at Denver Health. They are using microsystem change to transform their organization, and balance broad system initiatives with many small, focused rapid-cycle initiatives. Dr. Gabow identified six perspectives that need to be considered for transformation:

- quality;
- efficiency;
- patient safety;
- customer service;
- architecture/environment; and
- workforce development.

Critical to the success of the initiatives at Denver Health is the development of a new organizational culture, new communication processes, broad employee engagement, the development of new tools and new skills, and identifying the right person for the job (not only in terms of technical skills but using personality as well). Their initiatives examine every activity, process and role. Nothing is spared!

Peter Pronovost, MD, Ph.D, then described his efforts at Johns Hopkins University Hospital to improve patient safety in the intensive care units, which he described as needing to be scientifically sound and feasible. He uses four questions to guide his efforts:

- How often do we do harm?
- How often do we do what we should?
- How often do we learn from defects?
- How much to we defer to wisdom of front line staff?

The responses to these questions allow him to develop structured initiatives that defer to clinical wisdom, and provide practical tools that are used in daily work. To select initiatives, they pick a population and outcome, identify what improves outcomes, measure to see if the appropriate steps are being taken, educate to maximize compliance, and measure again to evaluate if the intervention was successful. Executives adopt a unit within the hospital and are asked to learn from one defect per month (via presentations at board meetings). A positive outcome of their initiatives has been the empowerment of nurses at the front line, which has improved nurse retention.

Brent James, MD, provided details about their efforts at Intermountain Health Care. He described how training was needed to facilitate a clinical culture change. This enabled them to implement a strategic process analysis and identify areas for improvement. Key to this effort was an integrated management information system that monitors and reports a limited set of intermediate and final outcomes at regular intervals over time. This integrated management information system allows for benchmarking, monitors trends over time, and helps identify and track the success of improvement projects. Specific projects drill down and investigate an extended set of measures of process and outcomes data over a limited period of time. Outcomes can include medical, service, or cost outcomes. Dr. James found that it is helpful to develop a written model of processes, which can provide a foundation for professional consensus; this is key to effective measurement and leads to improvement in the model as well. Finally, he noted that integrated and aligned incentives are essential to achieving lasting change.

Coordination of Care in Communities and Between Hospitals and Community Providers – Toward Patient-Centered Care

Molla Sloane Donaldson, Dr.PH, moderated the next panel, opening with a discussion of coordination of care. She defined coordination of care as a process to reach the Institute of Medicine (IOM) aims by ensuring that accurate, timely information is available to patients and clinicians at the time of decision-making or patient care services. Coordination of care also helps in the transitions among settings. She noted that there are different types of mechanisms for care coordination, and suggested that leadership needs to reexamine their mental models. She also noted that it would be helpful to reduce variation by standardization of patient and information flow, reduce the need for case-by-case solutions, include patients and others as appropriate, and allow for evolution and emergent behavior.

Mark Clanton, MD, spoke about the need for quality, care design, and care reengineering from NCI's perspective. NCI has funded exploratory work for a number of years on nanotechnology, including a melding of nanotech and cancer research procedures he believes will have clinical applications in the near future. He described this new technology as a "disruptive technology" and indicated that quality standards, delivery methods, and payment models need to be developed. NCI is also working on "bioinformatics grids" that incorporate data from multiple clinical trials into one system, which will inform research and clinical care.

Lee Sacks, MD, talked about the value of organized medical groups and their unique capacity to integrate care. He also spoke about the additional infrastructure he believes needs to be added to create enhanced value. Some of the factors critical to the successes of Advocate Health Partners are their:

- contracting mechanism;
- high speed internet connection;
- data repository (CareNet);
- back office operations which support coordination;
- their intellectual and financial capital.

Dr. Sacks believes that alerts, rules and barriers are most effective in creating change, especially when automated; least effective is education and training.

Robert Nesse, MD, talked about the need for payment reform. Reimbursement rates should be based upon what it costs to provide care based on best practices for chronically ill patients. He believes the following critical factors need to be implemented for successful care coordination:

- minimal restrictions to competition and patient choice;
- accessible information and accountability;
- simplified regulations; and
- reimbursement that provides incentives for continuing care, coordination of services, and system savings.

Transforming Community-Based Practices

The next panel discussed the transformation of community-based practices. The first speaker was Ron Bangasser, MD. He described his practice's efforts to implement quality improvement, which started with improvements to their information technology. They provide 32 data measuring points for their physicians, which includes physician productivity and drug utilization. Data is used as an educational tool, and relative rankings are posted to encourage change. New physicians are assigned mentors. Additionally, they have in place a pay-for-performance program, and are currently experimenting with the use of pay-for-improvement in performance.

Anne Lewis described the transformation of clinical practice at CareSouth Carolina, which was based on the Wagner Chronic Care Model. Their model for improvement is a continuous loop of Plan-Do-Study-Act. Some of the barriers they found to improvement were:

- lack of IT infrastructure;
- working in isolation;
- the static system;
- leadership time spent putting out fires;
- no financing or financial motivation to do improvements.

Key to their ability to transform CareSouth Carolina was their investment in a data entry system and clinical registry with embedded evidence-based guidelines, which allows for population management, analysis and feedback. Other important factors were executive and clinical leadership aligned on the same goals, a focus on patient-centered care, engagement of the community, and the establishment of financial incentives that are not for providers alone.

Bertie Safford, MD, reported on Family Care Network's efforts to implement the Chronic Care Model and transform their organization. Currently, they have transformed their work flow and increased the role of clinical (non-physician) staff. They have also implemented group visits. Some of the key factors in their success were an existing community quality group and the precedent of cooperation around specific issues. Some of the barriers to continuing transformation include lack of funds, lack of community

infrastructure, and reimbursement tied to office visits, an arrangement which inhibits creative solutions to the efficient provision of effective care.

Discussion and Key Themes

The presentations outlined above provided fruitful material for discussion. Participants freely shared their perspectives, and a number of common themes emerged.

The most successful transformation focuses on the needs of the patient. Dr. Berwick noted the patient-centric focus of many of the presentations and summarized that transformation is not just about implementing one or two changes, but is really a concerted strategy to improve care from the patient's perspective.

The appropriate use of data is a key element in successful efforts to transform. One of the participants noted that in order for transformation to occur, we must "make data-driven decisions to set priorities, make changes and measure improvements, and ensure sustainability." In several examples discussed during the meeting, data was used to identify opportunities for change and measure improvements over time. A number of participants reported using recommended best practice standards as a benchmark against their own performance. Data were used to both compare aggregate performance against a gold standard, and to examine variation in practice within the system. Several participants felt that additional research to establish benchmarks in additional areas was necessary.

Information technology and Electronic Health Records (EHR) are important, because they make data available in a timely manner. While data tends to be more available in larger systems, even larger systems need to work to transform the data into useable measures to drive transformation. However, data are especially hard to obtain from physicians in small practices. There was hope that the availability of the VA's EHR will facilitate the implementation of IT for smaller practices.

One of the participants noted that data – when used to benchmark – provide motivation for change. A number of the speakers noted the use of interdisciplinary teams to look at data and set goals. Analytic support to analyze the data was cited as a key requirement. However, several participants noted that the analysis should not occur centrally within an organization; clinicians ultimately responsible for patient care need to be involved in analyzing the data in order to set priorities.

The data need to be current to be useful. Providers will have a harder time being motivated for change if the data are not timely.

Several participants pointed out that IT does not drive change, rather it plays a supportive role. The need for accurate and timely data to facilitate transformation will in turn drive toward IT solutions to make the data available. IT is used to support transformation by providing accurate and timely data.

IT can also facilitate change if used to develop alerts and reminders to make it easier for clinicians to practice according to recommended guidelines. One of the participants

noted that automated alerts, rules and barriers are most effective in changing behavior; education and training are not as effective.

Finally, participants noted that data generated through IT make population management easier. There was general consensus that one of the goals of transformation was to move to a population-based perspective.

Not all participants were sanguine about the use of data to drive transformation, however. One participant noted that "transformation is NOT practicing to the measures." In her organization, small, focused, rapid cycle initiatives that are driven by data are balanced by broad system initiatives. Throughout the meeting she cautioned that transformation needs to be broader than these data-driven exercises, that it involves a change in perspective and a change in management relationships.

Outcomes are the most important measures to create transformation. Outcome measures need to be defined around clear, concise, and measurable goals. It often requires the sharing of data across settings, since actions in one setting often affect outcomes in another. However, unless providers are part of a coordinated system they do not often see the ultimate outcome. Several participants pointed out the need to find ways to link particular actions to outcomes. The need to create a system where people can see interconnectedness was stressed. While there were few answers on how to do this for most of the care that is delivered outside of integrated systems, participants felt that this was an important area that needed further study.

Some participants suggested that reframing measures to reflect patient values may serve to broaden the perspective beyond specific clinical acts, and may be a good approximation of outcomes. However, there was little discussion of this point, and it needs to be further developed.

Most of the successful instances of transformation involved a local change champion. Much discussion involved how to create or foster local change champions. Some participants felt that collaboratives would help empower local leaders. One person noted that the use of collegial relationships to drive change is important because it empowers champions. Broad employee engagement – including not only physicians but also nurses and allied health professionals – is also important.

Several participants noted that the isolation of community providers, particularly rural providers, is critical to overcome. Finding ways to facilitate collaboration and interchange will be critical to driving change at the local communities.

Local input is important to customize approaches in order to obtain buy-in and create sustainable change. Several participants recommended that organizations set goals and provide flexibility to clinicians to establish local pathways to meet these goals. This involves setting targets and letting clinicians work out the path to achieve them. One participant described the optimal approach as "mass customization of ideas that work." This concept was reinforced in later discussions about the unique features of organizations at different levels. Successful practices are those that work best in context, but they may not be directly applicable in other contexts.

The discussion emphasized facilitating clinical responsibility at all levels, from physicians to nurses to allied health personnel, as appropriate. At several times discussants voiced their opinion that the current environment does not utilize all care providers to the best of their ability, and that this would be required to achieve transformation.

Organizational leadership – most often in the form of boards – can play a key role in facilitating transformation by holding participants accountable. Participants noted that boards can and often do prevent change from occurring through over-emphasis on short-term financial performance and risk aversion. However, many participants cited examples where board members overcame their initial reticence and played a strong role in transformation. Especially when boards hold the leadership of an organization accountable for change, they can be a powerful catalyst for change. The role of administration is to facilitate transformational change through the appropriate use of resources (for analytic support or IT infrastructure, for example) and not to dictate the pathway of change.

The use of incentives is a powerful tool to drive change. Participants agreed that incentives need to be:

- timely;
- transparent;
- accurate;
- consistent over time;
- focus on factors within providers' control;
- professionally legitimate; and
- clinically coherent

There was general agreement that quality is a "team sport" and incentives need to apply to a care team, not just an individual.

There was some discussion, but no agreement, on the appropriate aggregation of data to drive change. While some participants acknowledged that it is often easier to measure accurately specific clinical actions, these are not always indicative of broader system change. Consistent with earlier cautions about the goal not being practicing to the measures, participants questioned whether incentives should be used to drive specific aspects of clinical care or to drive the larger system.

Many participants noted that the current system does not provide good incentives for appropriate care management. Many instances were identified where organizations and individual providers saw payments decrease because they were providing better care. Dr. Iglehart questioned the extent to which third parties are currently taking steps to realign incentives to make it worthwhile to accelerate system improvement, and suggested that that would be a necessary step. Some participants acknowledged that, while payment is important, it cannot drive redesign. Others noted that payment incentives needed to change before transformation could be effective so that providers are not penalized for providing better care.

Payment incentives that allow flexibility to provide care outside the traditional office visit were identified as a key ingredient to facilitate change. A number of participants noted that capitated payment, partial capitation, or bundled payments would provide appropriate incentives. Others were skeptical, however, about the need for this to be a key ingredient, since the majority of care is delivered in settings where capitated payments are not common.

Several participants noted that incentives do not always have to be financial. Doctors and other clinicians have professional motivations that don't have to do with money, and incentives can utilize these professional motivations.

Potential Policy and Financing Changes that are Needed to Achieve Transformation

The second day of the meeting focused on identifying policies and financing changes that are needed to achieve transformation. Several private-sector initiatives were discussed as a model for more effective transformation throughout the system. In addition, key thought leaders provided insights into what would be required to achieve transformation. The majority of the day, however, was spent in discussion. Key points were reviewed, theories were raised, and many suggestions were made for action by a number of parties. In addition, participants engaged in a written exercise where they identified the three most important things that need to change so that key players could more effectively transform the quality and efficiency of the health care system; the responses to this exercise are reflected in the discussion.

Identifying Best Designs and Supporting Change

Colleen Conway-Welch, Ph.D., spoke about patient centered care and enabling health care providers to practice to the full scope of their licenses. She noted that there are currently strong barriers to using nurses, pharmacists, and psychologists to the full scope of their practices, and these barriers do not serve us well.

She noted the use of data and the need to identify best practices to benchmark existing practices as key to successful transformation that had been highlighted in several presentations, and suggested that it would be extremely helpful for AHRQ to develop a national evidence-based assessment center.

She ended her discussion with an admonition to not let the perfect be the enemy of the good. She suggested that we know enough to get started, and might identify "low hanging fruit" that we can focus on more immediately that can provide resources or motivation for future efforts.

Incentives for Health System Improvement: How do we get There from Here?

Doug Conrad, Ph.D., moderated the next panel and began by pointing out that a balanced scorecard is needed that includes both quality and efficiency. Incentives can be both financial and non-financial. The measures need to be transparent and timely and focus on what providers can control. They also need to be consistent over time. He

believes that currently incentives are based on percentiles of performance rather than attainment of absolute performance. He believes that the field should move to incorporate both incentives for performance as well as attainment.

The size of the incentive will be important, although it will probably be different for different sizes of providers. Small providers will be concerned with financing the infrastructure and administrative costs to change. Larger providers will have already incurred infrastructure costs.

While it is important to have some competition for quality, Dr. Conrad stressed we need to remember that quality is a team sport, and so the system must provide incentives for the team. Incentives should be perceived as clinically coherent, meaningful, and professional. Incentives should not crowd out the physician's own internal motivation to succeed.

Steve Shortell, Ph.D. presented insights obtained from research on transformation in northern California. He made a number of recommendations:

- foster close collaboration between payer and provider to manage a population of patients;
- facilitate and support the ability to provide better quality by smaller practices;
- configure an incentive system that supports redesign by subsidizing infrastructure building and also provides case management and IT services;
- design a payment system that encourages integration, such as bundling services;
- structure a payment model based on shared savings: consider savings shared between provider and patient as well as between payer and provider;
- move away from short term, visit-based reimbursement to quality and value-based reimbursement.

Dr. Shortell agreed that performance measures need to be adopted in an incremental manner, with as much consistency as possible over time. He suggested measures be appropriately categorized as: operational measures, measures undergoing testing, and measures under development.

Robert Galvin provided some background on General Electric's approach to purchasing health care, which focuses on both quality and efficiency, and which he believes is a win-win situation for all concerned. He noted that both quality and efficiency vary substantially within markets, and what General Electric has tried to do is provide information and incentives for patients to choose providers that are both high quality and efficient. He also voiced his opinion that the private sector can create ideas, but it takes CMS to really create change because of the large market share it controls.

Bruce Bradley discussed General Motor's experience. General Motor uses four tools available to them: benefit design, public policy, delivery systems, and member behavior and health. One of their efforts included bringing HMOs together to share best practices and improve care within the entire market, which they have found to be successful in driving prices down. General Motor also uses a value pricing strategy for health plan

choices, with data on quality and efficiency provided to employees, and financial incentives used to drive choice.

Promoting Good Practices and Designs

Stuart Guterman then opened the plenary on promoting good practices and design by stating that CMS' philosophy is to move to pay for care, not services, and pay based on value not cost. However, it is not always easy to consider how to operationalize the ideal payment philosophy. Fee for service payments are easy to operationalize because you know what you are getting. Capitation payments are another way to pay, but it is difficult to know how to allocate the payment among different providers; not many providers have been capable of or willing to accept the entire payment and be at risk for distributing it downstream.

CMS' approach to quality begins by defining quality measures and then collecting and disseminating information on quality. CMS is also experimenting with ways to better manage chronic care and is exploring how to encourage the development of improved office systems to better manage chronically ill patients.

Promoting Transparency: Reliable and User Friendly Information

The next session, on promoting transparency through reliable and user-friendly information, began with the moderator, Gary Young, J.D., Ph.D., raising two questions that he believes need to be addressed:

1. What information do consumers and providers need to select the most appropriate care, provider, and health plan?
2. How can public reporting be used to promote good system design?

He noted that, while the evidence is mixed but generally negative on the ability of quality reporting to change consumer behavior, there is some indication that it is successful at stimulating providers to change. However, providers generally do not like public reporting, perhaps because they feel that the measures are ambiguous or outside of their control.

Steve Wetzell emphasized the need for national standards to compare care across markets, increase credibility, ease the reporting burden, and create economies of scale and leverage. He endorsed the use of the National Quality Forum as an appropriate forum to create national standards for measures. He cited three sources of information available to create measures: administrative, patient experience, and clinical. The patient experience data may be easiest to use at this time. He emphasized the need to accelerate public reporting, using both regulatory and market levers.

David Wessner, of Park Nicollette, talked about the need to align costs and consumption to drive efficiencies. When people consume without consideration of costs, there is likely to be unnecessary spending. In addition, Mr. Wessner reported success in the use of management tools, such as Toyota Production Systems, to improve performance efficiency.

Discussion and Key Themes

Data to support transformation should come from clinical care and not be an add-on. A common theme heard throughout the discussion was the importance of relevant and timely data to assess performance. A number of participants acknowledged that, while an IT infrastructure was not a necessary precursor to using data to support transformation, it could facilitate the availability of timely data. At several points during the discussion participants noted that the use of data should not wait for the IT infrastructure, but that it should be an iterative process: identify and begin to use data and develop a clearer picture of how the IT infrastructure can support the effort.

Payers, including government payers, should facilitate the adoption of an IT infrastructure. There was widespread agreement that without a strong governmental role, isolated IT infrastructures would be developed that would not facilitate the sharing of data across settings or levels. In addition, participants recognized that a number of providers, especially small practices and those in rural areas or with disadvantaged populations, would not have the financial resources to develop IT infrastructure without considerable financial assistance. Participants were encouraged by the work done to date by HHS to develop standards and were especially heartened by the potential availability, free of charge, of the VA's EHR.

Common indicators should be developed and agreed upon across payers and across patient groups. Measures for reporting need to be relevant to both consumers and payers. Measures need to be accurate and consistent over time and across providers. They also need to discriminate and illuminate variation among providers; indicators are not useful if everyone scores the same. Indicators should include a mix of measures of absolute performance and relative improvement.

One participant noted that if we do not embrace national standards, we are going to have multiple report cards measuring multiple things, and this could create a "Tower of Babel" that will confuse all participants. In addition, the use of common measures and indicators will minimize the costs of reporting.

To create strong incentives to provide data and use indicators, some participants suggested that these quality measures and standards should be incorporated into the credentialing process.

The use of indicators in report cards and as the basis for incentives has a role. Public reporting has a role in benchmarking performance and creating impetus for change. Public reporting may also be an important building block for financial incentives. Financial incentives may be a quick way to infuse dollars to support change. However, several participants cautioned that financial incentives should not undermine the provider's professional values. Several participants felt that providers should not receive incentives for doing the right thing. Rather, incentives should drive change, such as technology acquisition. Finally, participants noted that indicators and incentives should cross settings, to facilitate better coordination of care.

The development and facilitation of leaders within organizations to become champions of change should be encouraged. Participants agreed that there was a critical need to encourage the development of leaders within organizations to become change champions and lead transformation. Leaders were defined as persons with vision regarding how to conceptualize and operationalize values and priorities. They tend to think differently – "outside the box" – about how to effect change. They also focus on the end point or vision. However, several participants noted that there is an incomplete understanding of what makes leadership and how to facilitate it. Further research may be needed regarding the elements of and success factors in leadership in different organizations and levels of care.

Management needs to move toward shared decision-making. There was widespread recognition that management needs to facilitate clinical care. Management can participate in goal settings but clinicians need to retain the responsibility and authority to develop specific models and pathways to achieve those goals. Several participants noted that there needs to be a better understanding and appreciation of the clinical process at the top leadership level in health care.

At several times during the day the discussion turned to the need to move to patient-centered care, rather than provider-centered care. Patient-centered care necessarily involves collaboration and information sharing among different providers and different levels of care. However, several participants noted problems with the current Stark regulations that prevent hospitals and medical staffs from collaborating. While some recognized the potential for abuse, many participants believed the benefits to collaboration far outweighed the potential harm and encouraged CMS to rethink the conceptual framework around the regulations.

Health care organizations and payers need to change their primary focus from financial productivity to quality and safety. Several participants noted that health care organizations are lagging behind other industries and need to focus on their core business in a different way. Some participants noted that Toyota Production Methods and other industrial engineering approaches can be useful. They enable institutions to focus on the primary goals of quality and safety and also reduce costs and increase efficiency. Health care needs to catch up with other industries and embrace the joint pursuit of quality and efficiency.

Payment methodologies need to be developed that pay for treated patients with good outcomes, rather than continue the fee-for-service bias to pay for work done. Participants embraced Mr. Guterman's characterization of CMS' goals to:

- pay for care not services
- pay for value not costs
- stop paying for what we don't want
- pay for what we want
- stop preventing others' efforts to do what we want.

They encouraged CMS to help facilitate transformation by anticipating the optimal delivery system and build payment systems to support and encourage it. There was

widespread recognition that the optimal delivery system would be patient-centered, not provider centered, and would provide incentives for providers to coordinate care across settings and over time. Several participants stated that the current fee-for-service payment system locks in the most expensive and least effective mode of providing patient care.

Dr. Wennberg noted that there were potentially more than one optimal delivery system, and that payment policy should include enough flexibility to allow for different care environments. His research has shown that the capacity of the local health care system may differ in different regions of the country, and this difference in capacity may account for a large portion of the cost differential among areas. However, different areas may choose to innovate in different ways.

While many participants agreed that capitated payments offered the best opportunity for aligning incentives, several other suggestions were made as well, including bundled payments, paying a case-management fee for the primary provider, or holding partial reimbursement in escrow to be paid out after a positive outcome is obtained.

The major benefit of capitation is that it allows one entity the flexibility to share information, coordinate, and arrange care among providers in an optimal fashion to produce the desired outcome. It also assigns accountability and responsibility for the outcome to the entity receiving the payment. However, there is some financial risk associated with capitation, which some organizations may not be able to bear. While capitation may be the best way to accomplish the goals identified, there may be other non-financial ways that do not require financial risk and that accommodate information sharing and professional accountability for achieving optimal outcomes. One participant suggested that technology that facilitated widespread access to the patient's record – even by providers that are not linked to a common organizational system – could create free market choice by patients of individual providers, and patients would not be limited to particular networks or systems of providers. Another participant noted that his organization is working on allowing physicians who are not part of their system to have access to patient records to facilitate quality of care.

Payment methods need to provide incentives for doing the right thing, and not penalize providers who provide good care. Payment methods need to find a way to enable facilities to retain some of the savings when they improve care. One participant cited the need make facilities "whole" when they improve care and lose revenues (e.g., under the current system a hospital is likely to lose revenue when it improves care and reduces admissions). Several participants encouraged CMS to relax regulations for providers with a demonstrated track record of good care and allow them the flexibility to continue to innovate.

Another suggestion was made to consider hospitalizations as a failure in the system. Organizations should be encouraged to focus on what went wrong in the continuum of care to cause the hospitalization and try to prevent it from happening again. A related suggestion with "more teeth" is to develop payment methodologies that penalize providers for poor outcomes or that fail to pay additional amounts for care for complications or adverse outcomes.

The concept of a medical home is key and the health care system needs to reorient to support that concept. Throughout the day participants flipped back and forth between focusing on how health care institutions can transform to better provide safe, high quality health care, and what the best attributes of the health system would look like from the patient's perspective. There was near unanimous agreement among participants that the current fragmented system does not serve patients well, and that efforts should facilitate the creation of a "medical home" that coordinates and rationalizes care for the patient, and provides continuity and choice. Participants agreed that the medical home did not have to be an individual provider, but that additional payment for that function was needed to cover the additional costs associated with this role.

Several participants noted the inequities in the current payment system for physician care where procedural disciplines are paid more than non-procedural disciplines. Given that providers who practice non-procedural medicine are more likely to play the role of the medical home, many felt that these payment inequities exacerbated the problems in the current system and contributed to fragmentation.

Payers should consider establishing incentives for patients to practice healthy behavior and choose health care providers wisely in accordance with data on quality outcomes. The Bridges to Excellence project has shown that there is much to be gained in alignment of incentives by all the parties involved. In addition, education needs to be developed to let consumers know that care has risks, and more is not always better.

Every system change will have unintended consequences. Participants recognized the need to build vigilance and follow-through into the systems, but were certain in their belief that continued experimentation was essential.

Disseminating Promising Practices and Supporting Their Implementation

Much of the discussion throughout the meeting focused on identifying the key attributes of successful transformation and exploring whether there were ways to disseminate these promising practices and support their implementation throughout the healthcare system. Common themes in the presentations led participants to conclude that the following components occur in successful transformation:

- commitment of senior management
- culture of excellence
- deliberate incorporation of measurement and analysis
- leadership vision.

The commitment of senior management was seen as key to securing the financial and organizational resources to effect change. Participants recognized that senior management needs a better understanding and appreciation of the clinical process of care.

Participants also discussed the role of boards in facilitating change. There was recognition that boards were often risk averse and focused primarily on the institution's financial health, and that this focus was not conducive to transformation. Suggestions were made to educate the board about the importance of safety and quality. Dr. Frasier noted that the NQF is currently pursuing an effort aimed at educating boards. Participants agreed that an effort to identify and publicize the expectations of governance – away from risk-averse behavior and more to leadership and facilitating transformation – was necessary.

A culture of excellence was another characteristic of successful organizations. This culture provides shared accountability and responsibility for clinical care at all levels of the organization. Participants agreed that organizations with a culture of excellence were those that facilitated clinical collaboratives, and where groups of clinicians at all levels met to identify goals and devise local solutions to achieve these goals. This flexibility allows the optimal solutions at each level of the organization and at each unit to prevail, rather than dictating a rigid structure for all components of the organization to follow.

The deliberate incorporation of measurement and analysis is another characteristic of successful organizations. Benchmarks are selected and performance is continually assessed in comparison to the benchmark. Intra-organizational variation is also analyzed and assessed; steps are taken to minimize intra-organizational variation.

Change agents, who exhibit leadership within the organization, are also essential to transformation. Participants recognized that the key attributes of leadership may be different at different levels within the organization. Participants spent a significant amount of time discussing ways to foster leadership and suggested various tools such as training, curriculum, and institutes. Mentoring and succession planning were also identified as critical to fostering leadership.

Some participants suggested that the motivations and incentives for leadership may be different for true innovators than for the next generation of leaders that must implement good ideas and processes that were developed elsewhere. This was identified as an area for further research.

Participants identified a number of activities that they felt deserved support. These included activities focused around dissemination, implementation, measurement, payment policy changes, and basic research.

Catalog best practices in an on-line journal, clearinghouse, or quarterly webcast.
Many participants indicated that good ideas do not make it into the published literature quickly enough, or with enough frequency, to help organizations struggling with transformation. A number of the leaders and change agents participating in transformation are not affiliated with academic institutions and thus do not have the incentives to publish in peer-reviewed journals. In addition, many individuals are busy with day-to-day activities and do not have the time or resources to pursue publication. Several of the participants suggested that web-based venues may an appropriate forum to disseminate good ideas and best practices. CMS has launched a website like this using their Quality Improvement Organizations (QIOs) and AHRQ is preparing one.

Collaboratives. Several participants felt that collaboratives were especially useful venues for creating ideas and fostering change agents. They felt that the exchange of ideas and values that takes place within collaboratives creates the needed energy to explore unique solutions to problems and provides a safe venue for participants to learn from both successes and mistakes.

Provide help with implementation. A number of participants emphasized that there is a difference between disseminating good ideas and instituting change. One participant indicated that 15% of the work is new ideas, and 85% is implementing them. Another participant stated "We know where to get the good ideas, but getting people to accept the ideas and helping them to implement them should be the next step." Participants cited maintenance of change – through staff changes and shifting priorities – as a particular challenge that organizations needed help with.

There was widespread agreement that assistance with implementation was necessary. While many participants recognized that collaboratives are a good mechanism, they are resource intensive and not everyone can participate. They stressed the need to identify other models for implementation assistance. One model that was suggested was the Regional Farm Board, which used local consultants to help implement change at family farms.

Measurement was another area where participants identified action priorities. Some participants felt that a national, evidence-based assessment center could provide reliable information on recommended practices that could be used to benchmark performance.

Participants also felt that collaboration between public and private payers was essential to identify standardized measures to use for reporting and incentives. The National Quality Forum was cited as an excellent model with a proven track record for initiating a consensus process to develop measures, but one participant noted that it has no sustainable financial model.

A number of payment policy changes were identified as necessary to facilitate transformation. Several participants suggested that financial and non-financial incentives be developed to strategically move behavior toward transformation. Participants agreed that both government and private payers need to coordinate to create incentives that work in the same directions to maximize impact. Incentives should be based on measures that are timely, transparent, accurate, consistent over time, and are professionally legitimate, clinically coherent, and respectful of clinical professional values. Incentives should capture both absolute performance and relative improvement. Along with the development of new incentives, many participants identified the elimination of existing disincentives as critical to foster transformation. The current system provides payment for things that can be easily measured; this may result in important care that is not easily measured and quantified not being provided sufficiently because the incentives do not exist to provide it; some examples identified include coordination of care, patient education, and consultation with peers (e.g., tumor boards).

Participants believed the system needs to include economic alignment, so that payment incentives for different parts of the system were similar; this would facilitate closer cooperation and collaboration on the patient's behalf. One participant suggested incentives for physicians to practice in higher quality hospitals. Other suggestions were made for incentives that crossed settings of care, such as incentives for appropriate transfer of information from hospital to step-down facility, and disincentives for overuse and poor quality care. Participants recognized that incentives may need to be different at different levels of organization: what works in one setting may not work and may even be counter-productive at another.

Payment methodologies that encouraged clinical coordination across settings were identified as a priority. While participants identified capitated methods as best able to promote coordination and patient-centeredness, they recognized that most providers do not practice in settings that can accommodate capitated payments.

The concept of a medical home was seen as essential to patient-centered care, and participants urged the development of payment methodologies that fostered this concept, including the use of care coordination payments. Several participants recognized the adverse incentives inherent in the current physician reimbursement system that provides higher reimbursement for procedural care and urged physician payment reform.

While there was no explicit goal to generate a research agenda, as often happens when thought leaders discuss the "state of the art" in a particular field, a number of topics that could benefit from additional research were identified. These include:

- Expansion of the number and types of guidelines or best practices that are developed around which benchmarking can occur.
- Development of payment policies to encourage coordination and information sharing across settings and over time, encourage a medical home, encourage cognitive services rather than procedural, prevent overuse, and allow for shared savings when system efficiencies are realized.
- Development of standardized measures for reporting and incentives, including appropriate levels of aggregation of data.
- Systematically identify relationships between specific provider actions and patient outcomes.
- Identify the elements of successful leadership at different levels of care and different settings. Identify whether these elements are the same or different for true innovators and the next generation of leaders who must implement new programs more broadly.

Conclusions and Next Steps

The meeting brought together experts to explore ways to organize systems and incentives to foster quality, efficiency, appropriate clinical processes, culturally and ethnically sensitive care, and shared decision-making. Participants presented examples of promising practices and prototypes, identified potential new strategies, and identified

future activities to achieve health care system transformation. A number of specific actions were identified for CMS and AHRQ to pursue, including ideas and suggestions that could be incorporated into the design of the Health Care Quality (Sec. 646) Demonstration. Some important themes from the meeting to consider in the design of this demonstration include:

- The demonstration should establish broad goals and promote benchmarking around a wide range of outcome measures, but should not prescribe a specific method for achieving them.
- The demonstration should be structured in a way that is patient centered by requiring participating institutions to create a medical home for patients.
- The demonstration should be structured to facilitate communication and information-sharing across settings and over time.
- Longitudinal outcomes should be established as benchmarks of success, and financial and non-financial incentives established for achievement of specific outcomes.
- The payment methodology should incorporate capitation or partial capitation so as to provide maximum flexibility for structuring patient care and provide incentives for efficient provision of care.
- Participants should be selected that can demonstrate sophisticated data and analysis capabilities. Continual benchmarking of performance to national standards or best practices should be an organizational priority.

The discussion also illuminated other, longer term considerations for CMS, primarily around payment policy changes that are needed to facilitate transformation:

- Payment policy reform is needed. Payment policy should facilitate patient-centered care and the existence of a medical home for chronically ill patients with payment of a care-management fee.
- Payment policy should include incentives for appropriate transfers across settings, or disincentives for transfers that occur inappropriately or with inadequate information or communication.
- Payments should include some disincentives for overuse.
- Physician payment policy should be reoriented to pay less for procedural care and more for cognitive services.
- Payments should include provisions for shared savings when care becomes more efficient.
- Consideration should be given to the development of incentives to patients for compliance and healthy behaviors to align incentives between patients and providers.
- Consider exploring specific “safe harbors” under the Stark regulations to allow hospitals and physicians to coordinate on efforts to increase quality and safety.
- Support the development of standardized measures for use in reporting and incentives. Consider the provision of data as part of the conditions of participation.

In addition, a number of potential roles for AHRQ, as funders of research and facilitators of knowledge transfer, were identified, including:

- Catalog and disseminate best practices. Potential vehicles include an on-line journal, clearinghouse or quarterly webcast.
- Foster and provide financial support for collaboratives.
- Develop innovative models for implementation assistance. Consider the Regional Farm Board as one potential model.
- Create a National Evidence-based Assessment Center to collect, develop and disseminate best practices.
- Support the development of standardized measures for use in reporting and incentives.

Attachment A

Participants List

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Agency for Healthcare Research and Quality
Centers for Medicare & Medicaid Services
National Cancer Institute
Health Affairs

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Transforming Health Systems Through Leadership, Design, and Incentives

AHRQ Conference Center
Rockville, MD
October 18–19, 2004

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as of October 13, 2004

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Attachment B

Agenda

Agency for Healthcare Research and Quality
Centers for Medicare & Medicaid Services
National Cancer Institute
Health Affairs

Transforming Health Systems Through Leadership, Design, and Incentives

AHRQ Conference Center
540 Gaither Road
Rockville, Maryland
October 18–19, 2004

Agenda
As of 10/18/04

Purpose

This meeting will explore ways to transform the quality and efficiency of American health care by changing the financing and organization of care. As reports by the Institute of Medicine and other expert groups make clear, many of the solutions to the problems of quality and efficiency lie in the twin areas of payment and organization. Changes in the way we organize and finance care can also help enhance our health providers' capacity to respond to terrorism and other emergencies and their willingness and capacity to implement new health information technologies.

The meeting will be jointly sponsored by the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the National Cancer Institute (NCI), and the journal Health Affairs. Together, we aim to identify the most promising strategies for redesigning clinical and nonclinical aspects of care and the best ways of providing incentives for care to attain the following outcomes:

- Improve health care safety, quality, and efficiency
- Assure appropriate use of best practice guidelines and reduced uncertainty and variation in care delivery
- Encourage shared decision making between patients and providers
- Deliver culturally and ethnically sensitive care

Meeting process

- Brief, springboard presentations showcasing leading innovations in health care delivery and finance

- Working sessions that examine prototypes (models), strategies, and priorities for transformational change. Participants will identify: (1) the most promising prototypes, (2) appropriate settings/populations to target, (3) ways to modify prototypes to fit other settings, and (4) success factors and facilitants.

Meeting outcomes

1. Identify prototypes for design change in clinical care in hospitals and in care that is coordinated between hospitals and communities. These design change prototypes hold promise for *improving quality (including safety), enhancing efficiency, fostering appropriate clinical practices, creating culturally and ethnically sensitive care, and supporting shared decision making*.

2. Identify strategies for disseminating and further improving the best design prototypes within the current regulatory and payment environment and for raising the bar for system improvement through continuous learning and improvement. Steps might include identifying best practices and the actions needed to apply them to a wide range of delivery settings; supporting dissemination through informational tools and technical assistance; and promoting technical innovations, such as health information technology, that can lead to clinical and system wide transformations.

3. Identify strategies for changing financial and nonfinancial incentives and reducing barriers to good design, create incentives for adopting and refining good design prototypes, and promote the quality, safety, and efficiency of health care.

MONDAY October 18

8:15 a.m.	**Continental Breakfast**
8:45- 9:00	**Promoting Quality and Efficiency in Delivery Systems** Carolyn M. Clancy, M.D., Director, AHRQ
9:00-10:00	**From Measurement to Action: Identifying and Implementing Quality Improvement Policies** Mark B. McClellan, M.D., Ph.D., CMS Administrator* Discussion • Given the now common understanding that large and inappropriate variations in clinical practices exist, how can payers act to promote appropriate care and reduce such variations? • How can we move beyond the measurement of problems and instead create and implement policies to solve them?
10:00 -10:15	**Break**
10:15-11:15	**Prototypes for Redesigning Health Systems** Presenters • Stephen M. Shortell, Ph.D., M.P.H., and Margaret Wang, Ph.D. • Jonathan Perlin, M.D., Ph.D. Discussion • What are the main design prototypes that show promise for transforming the delivery and organization of clinical care?
11:15-12:30 p.m.	**Microsystem Changes within Hospitals and Health Systems** Moderator: Eugene C. Nelson, D.Sc. Presenters • Patricia A. Gabow, M.D. • Peter John Pronovost, M.D., Ph.D. • Brent James, M.D., M.Stat. Discussion (see questions on handout)
12:30-1:30	**Lunch**

***Participating via Video Conference**

MONDAY October 18 (continued)

1:30-2:45	**Coordination of Care in Communities and Between Hospitals and Community Providers – Toward Patient-Centered Care** Moderator: Molla Sloane Donaldson, Ph.D. Presenters • Mark Clanton, M.D., M.P.H. • Lee B. Sacks, M.D. • Robert E. Nesse, M.D. Discussion (see handout)
2:45-3:00	**Break**
3:00-4:15	**Transforming Community-Based Practices** Moderator: John Iglehart Presenters: • Ann Lewis • Ron Bangasser, M.D. • Bertha H. Safford, M.D. Discussion (see handout)
4:15-5:00	**Taking Stock – Day One Wrap Up**

TUESDAY, OCTOBER 19

8:00 a.m.	**Continental Breakfast**
8:30-10:15	**Identifying Best Designs and Supporting Change**

Moderator: Donald Berwick, M.D., M.P.P.

Opening remarks

- Collen Conway-Welch, R.N., Ph.D.
- Donald Berwick, M.D.

Discussion

- In the current fiscal and regulatory context and in light of yesterday's discussions, which design prototypes seem most likely to promote the following outcomes:
  - Quality
  - Efficiency
  - Appropriate care
  - Shared decision making
  - Culturally sensitive care

- What strategies and tactics can best support dissemination and implementation of change?
  - Dissemination through agencies, networks, consortia, and Web sites
  - Skills and training – CEOs, mid-level management, professional staff
  - Peer-to-peer learning
  - Material and technical resources
  - Support for change process (e.g., TA)
  - Other

- How can steps toward change best be timed and coordinated?

10:15-10:30	**Break**
10:30-12:00 p.m.	**Incentives for Health System Improvement: How Do We Get There From Here?**

Moderator: Douglas A. Conrad, Ph.D., M.H.A., M.B.A.

Presentations:

- Stephen Shortell and Margaret C. Wang
- Robert Galvin, M.D., M.B.A.
- TBA

TUESDAY, OCTOBER 19 (continued)

Discussion

- What are the financial implications of design change for providers? How does the business case for redesign vary across settings (hospitals vs. community), types of delivery systems (integrated vs. nonintegrated) and populations?
- What changes in payment and regulation would remove barriers to change or create incentives for providers to enhance efficiency, shared decision making, culturally sensitive care, and coordination of care?
- Are the incentives for particular process improvements (e.g., rationalizing care to enhance efficiency) sufficient to produce broad clinical and organizational transformations? If not, what other incentives are needed?
- Should payers pay for outcomes (including user satisfaction), specific clinical practices (e.g., smoking reduction counseling) processes (e.g., formation of mental health teams), or tools (e.g., EMR)? If the incentives for promoting different objectives diverge, how can they be aligned?
- What are the financial implications of proposed design changes for patients?
- Which of the design prototypes discussed this morning should be given highest priority by payers?

12:00-1:00 **Lunch**

1:00-2:15 **Plenary on Promoting Good Practices and Designs**

Moderator: Stuart Guterman

- How can CMS use incentives in budget-neutral demonstrations to promote good practice and design and improve health care safety, quality, and efficiency?
- What metrics do payers need to assess attainment of the objectives for which payments provide incentives? Do payers have adequate metrics to assess these outcomes? If not how can they develop them?

2:15-3:30 **Plenary on Promoting Transparency: Reliable and User Friendly Information**

Moderator: Gary Jeffrey Young, Ph.D., J.D.
Presenter: Steve Wetzell

- What information do consumers and providers need to select the most appropriate care, provider, health plan?
- How can public reporting be used to promote good system design?

3:30-4:00 **Action Priorities – Conference Take Aways**

Moderator: Irene Fraser, Ph.D.

Discussion Questions -- for sessions on Microsystems, Care Coordination, and Transforming Community–Based Practices

1. Most promising prototypes -- In the current fiscal and regulatory context, which of the prototypes for this type of redesign can best promote the following outcomes:

- Quality
- Efficiency
- Appropriate care
- Shared decision making
- Culturally sensitive care

2. Target settings -- What settings, units (e.g., ICU, specialty clinics), and functions (e.g., nursing, phlebotomy, administrative services) should be given priority to enhance each of the above outcomes?

3. Modification -- What adjustments are needed to apply these prototypes to different types of settings than the ones in which they were developed (e.g., academic vs. community hospitals; clinics serving middle class vs. poor patients)?

4. Success factors and facilitation -- How did organizations that successfully implemented this type of change overcome existing barriers? Within the current fiscal environment, what types of drivers and facilitators are needed for other organizations and delivery systems to carry out this type of redesign?

Purpose

This meeting will explore ways to transform the quality and efficiency of American health care by changing the financing and organization of care. As reports by the Institute of Medicine and other expert groups make clear, many of the solutions to the problems of quality and efficiency lie in the twin areas of payment and organization. Changes in the way we organize and finance care can also help enhance our health providers' capacity to respond to terrorism and other emergencies and their willingness and capacity to implement new health information technologies.

The meeting will be jointly sponsored by the Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services (CMS), the National Cancer Institute (NCI), and the journal Health Affairs. Together, we aim to identify the most promising strategies for redesigning clinical and nonclinical aspects of care and the best ways of providing incentives for care to attain the following outcomes:

- Improve health care safety, quality, and efficiency
- Assure appropriate use of best practice guidelines and reduced uncertainty and variation in care delivery
- Encourage shared decision making between patients and providers
- Deliver culturally and ethnically sensitive care

Meeting process

- Brief, springboard presentations showcasing leading innovations in health care delivery and finance

- Working sessions that examine prototypes (models), strategies, and priorities for transformational change. Participants will identify: (1) the most promising prototypes, (2) appropriate settings/populations to target, (3) ways to modify prototypes to fit other settings, and (4) success factors and facilitants.

Meeting outcomes

1. Identify prototypes for design change in clinical care in hospitals and in care that is coordinated between hospitals and communities. These design change prototypes hold promise for *improving quality (including safety), enhancing efficiency, fostering appropriate clinical practices, creating culturally and ethnically sensitive care, and supporting shared decision making*.

2. Identify strategies for disseminating and further improving the best design prototypes within the current regulatory and payment environment and for raising the bar for system improvement through continuous learning and improvement. Steps might include identifying best practices and the actions needed to apply them to a wide range of delivery settings; supporting dissemination through informational tools and technical assistance; and promoting technical innovations, such as health information technology, that can lead to clinical and system wide transformations.

3. Identify strategies for changing financial and nonfinancial incentives and reducing barriers to good design, create incentives for adopting and refining good design prototypes, and promote the quality, safety, and efficiency of health care.