

New Models of Health Care Payment and Delivery

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Health care delivery in the United States will have to change substantially to avoid disrupting the overall economy and meet goals of providing optimal quality and safety for patients. While overall system reform has been called for and partially attempted, change is actually being accomplished through the development of a series of “new models” of health care. This article describes 6 types of new models: entrepreneur-driven activities, management innovations, applications of technology, changes in financing, market approaches, and structures that see changes in how health care professionals work. Because no single type of model will dominate, we will need to draw on all of these options for the health care system to move forward.

Today we see innovation and change as imperatives in how health care is delivered [1]. Costs are becoming burdensome in ways we could not anticipate a few years ago, and our expectations for quality are not being met by our health care “nonsystem” [2]. Since the 2008 election, health reform, including the adoption of new models of health care, has been either at or near the top of the political agenda. The agents of change are both conscious and circumstantial [3]. The conscious efforts to change the system often refer to some “model” to guide how we will restructure health care delivery. The circumstantial factors are the hard realities of the economy, politics, human behavior, and the environment. Any new models that we propose will have to fit into the circumstances if the models are to do what they promise.

Given the national scale of our health care delivery problems, we often look to other countries for guidance on how to change the system [4]. “Lessons” from these countries are often seen as not applicable to the United States because of our “exceptional” conditions and cultures—political, economic, and social. Still, it can be instructive to stand back and look at the possibilities that other nations offer and determine which can be adapted to the American context. In reviewing reforms across the globe, experts have found that there are specific templates for change that can be fitted into one of the following categories: financing, payment, organization, regulation, and behavior [5]. The models that are often suggested to improve health care use 1 or more of these “control knobs” to change the system. In 2011, we also see that to reform health care we must develop models that

make use of technology and data systems; these are additional control elements that are viewed as necessary parts of the tool kit for new models of care [6].

The policy forum of this issue of the NCMJ identifies a number of specific potential models, but it might be useful to look at them in a more general way to see how they might fit together with other approaches. These comparisons may help us understand how the models might work when they are deployed simultaneously. To that end, I have categorized the drivers of change and the creators of models into 6 groups: entrepreneurs, managers, technology, financing, markets, and professionals.

There are entrepreneurs who see a chance to add value to health care. These people are not always seeking profit; some are policy entrepreneurs looking to have their ideas adopted [7]. However, the more commonly encountered entrepreneur is seeking personal profit by creating a new and better product or process. The health care system hosts many entrepreneurial enterprises, but they are largely in commercial areas that focus on technology or specific products. Less often do we see individuals or companies selling new organizational forms, and we may not be allowing the power of entrepreneurship to drive change as much as we should [8]. All of the articles in the policy forum describe some degree of entrepreneurial effort to make changes to the system. This suggests that we ought to promote the kind of thinking behind entrepreneurial efforts and cultivate the development of individuals willing to push change. We need more people who are willing to take risks to promote new approaches, such as the authors in the policy forum.

In business and manufacturing sectors, we often see that improvements in productivity and quality are achieved by applying what might be called “engineering” solutions [2, 9]. These are innovations that focus on process and the application of ideas. Prominent examples include the Toyota “lean” production process [10], the use of checklists [11], and the carefully monitored integrated delivery sys-

Electronically published July 25, 2011.

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N C Med J. 2011;72(3):197-200. ©2011 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved.
0029-2559/2011/72305

tem [12]. These engineering solutions are diffusing through health care, but at an agonizingly slow pace. The struggle to reach “high-reliability” levels can be overcome through a combination of leadership, a culture of safety, and improvement in process, all of which are keys to well-engineered systems [13]. The articles in the policy forum do not specifically focus on any one of these process strategies, but they include elements.

For as long as management has existed, managers have been challenged to improve outcomes and make systems more efficient. The failures of the health care system are sometimes seen as the fault of failed management. Management fails when managers do not base their decisions on evidence [14], do not recognize the very interactive ecology of the organizations they manage, do not understand the values and goals of the professionals they work with, and fail to communicate the goals and objectives of the work they organize [15]. The role of management is often unstated when new models are promoted in health care; that is, we assume that the new ideas can be implemented rationally and effectively. In the policy forum, there are some very useful discussions of how management interacts with clinical care to improve quality, but these processes seem to be accepted as “natural” events rather than as difficult transformations of roles and structures in organizations. This suggests that management of new models is “organic” to their development and, perhaps, not replicable. We need to know much more about how, by working together, managers and clinicians have generated improvements, and the case studies included here are good guides. Three of the articles speak to how care can be better managed by using better coordination across disciplines and within practices: Wroth [16] writes about how adult care homes can benefit from a partnership between community health centers and the Community Care of North Carolina (CCNC) network, Crane [17] describes how the Flat Rock Advanced Primary Care practice model and the Bridges to Health pilot can serve as models to improve care structures, and Gray [18] outlines how a pregnancy “medical home” can work. The clinical lessons in these pieces are important, but the management lessons are equally salient to the problem of quality and efficiency gains.

Technology solutions for our health care costs, access, and quality problems are abundant and form a very active sector for innovation. The emphasis in health reform and new models for care has been on the application of information technology (IT), usually in the form of electronic medical records. However, these approaches have not lived up to their promises of quantum leaps in solving any of the major problems in these 3 areas, despite a steady flow of positive findings from case studies of discrete applications [19]. Still, the future systems of care will increasingly adopt IT. The question is whether we will bend the system to adapt to IT or whether we make IT work for us to solve our problems. The examples of IT applications in this issue of the NCMJ

offer descriptions of the latter: Schwartz and Britton [20] show how telehealth can fit the relatively low-tech needs of the Roanoke Chowan Community Health Center, whereas Pilkington [21] has made health IT work in the Southern Piedmont Beacon Community. Saeed and colleagues [22] show how telepsychiatry can provide very personalized and effective care. Technology must be applied by people functioning as managers and practitioners, and Cykert and Lefebvre [23] describe how regional extension coordinators promote the use of electronic medical records and support activities to enhance quality and efficiency in a North Carolina Area Health Education Center-based program.

We have depended for a long time on various financial incentives to promote change. Medicare and Medicaid waivers, case- and care-management incentives, and pay-for-performance schemes have and are being tried in North Carolina and across the nation, but their effect is relatively small compared to the size of the overall reimbursement structure used to pay for the bulk of health care services. The system is still primarily a fee-for-service structure, in which we pay for discrete clinical acts in an insurance context that includes a very strong cost-sharing element [3]. We have only glancingly thought about centralized, single-payer financing and, with one exception (in Vermont), have consistently rejected it. We experimented with “prepaid” practice and then attempted to find an intermediate solution in managed care, but we rejected both options. Now we are slowly seeing some benefit to managed incentives and are testing “bundling” as a way to produce, through models of integrated patient care, some sense of accountability for outcomes [24]. North Carolina has led the way with the use of some modified financial approaches that follow these trends to make care more efficient and effective; in their contribution to the policy forum, Wade and colleagues [25] describe how CCNC is combining Medicare and Medicaid populations, as well as the rules and payment systems distinctive of each program, into a coordinated system. Other articles describe programs that are embedded in or interact with CCNC.

Allowing markets and individual decisions to guide change has been a position of conservatives, libertarians, and their associated think tanks (eg, the National Center for Policy Analysis and the Cato Institute), but the role of markets in health care is also generally accepted by liberals as they design new models and strategies such as health insurance exchanges and value-based purchasing [26]. The benefits of the market are often promoted by individuals who press for “consumer-driven” health care [27]. But time and again, we find best intentions thwarted by the failure of patients (as consumers) to do what is best for themselves and the economy of health care [28, 29]. Market structures and systems will, however, have to be considered in any new models of care simply because we live in a market-driven environment and because people value choice independent of other things. Taylor’s [30] description of the Choosing Health Plans All Together program, which makes patients

better choosers, is an example of how choice can yield collective and individual benefits.

Professionals have an obligation to do what is best for their patients. This professional principle promotes a responsibility for the individual practitioner to change their practice if such change can benefit their patients. We see professional- and practitioner-driven changes all the time, and many are adopted as best or normal practice. Examples include the innovations led at the Geisinger system by a surgeon leader [31] and Don Berwick's (himself a pediatrician) emphasis on quality and innovations at the Institute for Healthcare Improvement and the Centers for Medicare and Medicaid Services. The challenge here comes with the fact that an action that, in the considered and evidence-based judgment of a practitioner, is deemed best for any single individual may, when done in aggregate, harm society. It is a common view that these practitioner-driven decisions are causing the system to become too costly [32-34], but it may be that we are actually ignoring the very practical and effective role that professionals can play in benefitting the system as a whole if they are given that general responsibility. Practitioner-driven improvement fits awkwardly in the context of markets, management, and even technology because it depends on subjective elements associated with decision making and the "art" of health care. Professionals are responding with a resurgence of the old idea of working in "teams" to help promote better clinical decision making that balances the benefits to patients with those to society and the economy. Levine and colleagues [35] describe a community-level, value-based care organization in Gastonia that uses team approaches and coordination, Lyn and Johnson [36] write about their experiences with community-based teams for the care of elderly individuals in Durham, and Fretwell and Old [37] explain how they use interdisciplinary teams in the PACE program for frail elderly people to make care more effective and efficient. These combinations of professionals organized into more-efficient and -effective structures will need to be a cornerstone of any new model that works.

The Idea of Making Innovation Normal

It may be that we need to avoid the idea that we are creating new things and instead change how we think about what is normal. After all, almost all of the innovations we describe in health care are essentially old ideas that have been given new names. Today, the phrase "the new normal" is used to describe the shifts in our behavior that come subtly but are later diffused throughout our lives. For example, squinting into the screens of smart telephones to see what we need to get at the store on the way home from work or snapping photographs on the same device and sending them to distant relatives are now common events that were unthinkable a few years ago. There is a name for this unconscious transformation of behaviors when it involves restructuring health care delivery: "normalization process theory" [38]. Normalization is not the same as adoption of innova-

tions, which is how many of us have thought about change. In normalization processes, changes are accepted and used because they are embedded in everyday activities from the very start. If changes do not quickly become part of routines, they are likely to fail; this is the unfortunate fate of many attempts to improve care or generate higher quality—they were simply too innovative. The innovation process is seen by those who must change as alien to the normal structures and processes, and, before long, the innovation is rejected or ignored. Making changes "normal" is a more lasting process and one that we understand less.

Occupational roles in health care are very important to successful outcomes, and we have begun to structure health care as a complex technical activity in which processes, often called protocols in this context, take precedence over individuals' discretionary choices. There is a sense that there should be more uniformity. The phenomenon of practice variation bumps up against this belief and generates questions over why the variation exists and prompts resolutions to eliminate or minimize this variation. Nevertheless, health care is a "high-touch" enterprise, and any new model will require combining the demands and structures of the occupational aspects with the care and precision of quality. The models described in this issue of the NCMJ depend on "new" occupational roles, which will create cultures of their own.

It would be remiss not to comment on the effects of macrorestructuring in the health care system that is happening at a level that defies being called a "model." This is the shift in the way physicians and other practitioners structure their practices [39]. Increasingly, these individuals are moving into employment arrangements, and their employers are more often hospitals that are part of integrated, regionalized systems of multiple institutions. Hospitals are, with greater frequency, becoming more integrated with the other levels of health care, and systems are now more common than independent institutions. These "clusters" of caregivers are also beginning to align themselves with nongovernmental insurers. An example of this form of alignment is provided by Bradley and Rubinow [40] and their experience in developing a medical center-insurer collaborative around the patient-centered medical home. These combinations, if they can stand the legal tests of our antitrust and competition laws, may overcome many of the barriers to the implementation of effective new models.

The Affordable Care Act created a new program that supports shared saving efforts in the form of accountable care organizations (ACOs) [41]. ACOs anticipate that we can identify structures that can be held accountable for improving quality, but such structures are the witches brew of management efficiency, professional obligations, occupational imperatives, and patient expectations—all buffered by a pervasive impulse to compete and to extract profit at all these levels. We can say that the process of change for improvement is dominated by circumstance, but there is evidence in the articles included here that conscious change

that builds on models of caregiving can work with the powerful external forces that have made improvement in health care hard to achieve. *NCMJ*

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Acknowledgment

Potential conflicts of interest. T.C.R. has no relevant conflicts of interest.

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