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# Organizing the US Health Care Delivery System for High Performance

A Report of the Commonwealth Fund

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**H**ealth care delivery in the United States has long been described as a "cottage industry," characterized by fragmentation at the national, state, community, and practice levels. There is no single national entity or set of policies guiding the health care system; states divide their responsibilities among multiple agencies, while providers practicing in the same community and caring for the same patients often work independently from one another. Furthermore, the fragile primary care system is on the verge of collapse. This report from The Commonwealth Fund Commission examines the problem of fragmentation in our health care delivery system, particularly at the community level, and offers policy recommendations to stimulate greater organization.

The fragmentation of our delivery system is a fundamental contributor to the poor overall performance of the US health care system. In our fragmented system, patients and families navigate unassisted across different providers and care settings, fostering frustrating and dangerous patient experiences. Poor communication and lack of clear accountability for a patient among multiple providers lead to medical errors, waste, and duplication. The absence of peer accountability, quality improvement infrastructure, and clinical information systems fosters poor overall quality of care. High-cost, intensive medical intervention is rewarded over higher-value primary care including preventive medicine and

the management of chronic illness.

## How Do We Want Health Care to Be Delivered?

If we do not want the status quo, how do we want health care to be delivered? The Commission has identified six attributes of an ideal health care delivery system, each of which has been demonstrated to be an important driver of high performance:

1. Patients' clinically relevant information is available to all providers at the point of care and to patients through electronic health record (EHR) systems.
2. Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.

3. Providers (including nurses and other members of care teams) both within and across settings have accountability to each other, review each other's work, and collaborate to reliably deliver high-quality, high-value care.
4. Patients have easy access to appropriate care and information, including after hours; there are multiple points of entry to the system; and providers are culturally competent and responsive to patients' needs.
5. There is clear accountability for the total care of patients.
6. The system is continuously innovating and learning to improve the quality, value, and patients' experiences of health care delivery.

## Is It Achievable?

After identifying these six attributes, we examined 15 diverse health care delivery systems. From the case analyses, four important lessons emerged:

1. Our ideal delivery system is achievable; existing delivery systems have many of the key attributes we have identified.
2. There is more than one way to organize providers to achieve those key attributes, ranging from fully integrated delivery systems and large, multispecial-

**Table 1. Policy Options to Facilitate Organization**

Policy Option	Why this would foster greater organization	Pros/Cons
Expansion of pay-for-performance programs	More organized delivery systems generally score higher on performance measures than less organized systems.	<i>Pro:</i> Focused on desired outcomes, as reflected in the measures on which incentives are based <i>Con:</i> Difficult to construct traditional pay-for-performance programs to encourage care coordination/greater efficiency
Global case payment	A single payment for an episode of care that may involve multiple providers and settings encourages care coordination, care transition support, and efficiency. Organized delivery systems are better equipped to succeed under such payments.	<i>Pro:</i> Strongly aligns payment with care coordination and efficiency; if quality incentives were in place, also aligned with high-quality care <i>Con:</i> Best suited for acute-care episodes; may be difficult to implement for ambulatory care; appropriate risk adjustment critical
Full population prepayment for organized delivery systems	Similar to episode-based payment, full prepayment for a population of patients encourages care coordination, care transition support, and efficiency.	<i>Pro:</i> Strongly aligns payment with efficiency; if quality incentives were in place, also aligned with high-quality care <i>Con:</i> Patients might be concerned that needed care would be denied to cut costs; appropriate risk adjustment critical
Enhanced fee-for-service payments for organized delivery systems	Paying providers in organized systems higher fee-for-service rates would create a direct financial incentive for providers to join such systems; short-term strategy to stimulate participation in organized delivery systems.	<i>Pro:</i> May be most effective in getting providers to participate in organized delivery systems; could be short-term strategy to stimulate participation <i>Con:</i> Not aligned directly with benefits of an organized delivery system; higher payments won't necessarily mean higher quality or efficiency
For primary care practices that provide comprehensive, coordinated, team-based care (ie, have the characteristics of a "medical home"), either supplemental payments (eg, per-patient fees in addition to fee-for-service) or comprehensive prepayment for primary care services	Alternate payment mechanisms would help primary care providers provide better care coordination, enhance access, and promote use of information technology.	<i>Pro:</i> Potential to increase quality and reduce overall health system costs <i>Con:</i> Practice-level payments don't directly address organization of larger delivery system; certification program would be required
Patient financial incentives (eg, reduced copayments or premiums) to register with an organized delivery system	Would increase providers' incentives to participate in such systems.	<i>Pro:</i> Likely effective in getting patients to register with organized delivery systems <i>Con:</i> Not directly aligned with increased quality/efficiency
Modifications and consistent interpretations of antitrust, Stark, anti-kickback, civil monetary penalties, and tax exemption laws to better facilitate clinical integration of providers	Current regulatory environment discourages certain types of clinical integration, especially between hospitals and physicians.	<i>Pro:</i> Likely provide a large stimulus to greater organization <i>Con:</i> May lead to abuses of system (organize to create monopoly)
Shift to enterprise liability for malpractice: physicians who are part of an organized delivery system would not need to carry separate liability insurance	Would provide a financial incentive for physicians to practice in organized delivery systems.	<i>Pro:</i> Greater incentives to ensure high-quality, safe care <i>Con:</i> Need to resolve enterprise liability with physician extenders

**Table 1. Policy Options to Facilitate Organization (continued)**

Policy Option	Why this would foster greater organization	Pros/Cons
Establish an accreditation program for organized delivery systems	Payers would be more likely to engage such systems in new payment arrangements, thereby stimulating growth.	<i>Pro:</i> Accreditation process could include not only structural and process requirements, but also performance standards <i>Con:</i> Would create an additional layer of administrative costs
Establish government-funded infrastructure for organized delivery systems in areas where such systems don't/can't naturally develop	Organized delivery system won't naturally occur in some areas because of economic, social, or cultural reasons.	<i>Pro:</i> Successful examples (eg, Community Care of North Carolina) <i>Con:</i> Difficult to determine when governmental intervention is needed
Require training programs to include competencies in practicing in organized delivery systems	Competent providers would be more likely to seek employment in such systems.	<i>Pro:</i> Might be most effective in modifying career behavior <i>Con:</i> Wouldn't reach providers who are out of training programs; no current capacity to provide training
As a condition of licensure, require competencies in practicing in organized delivery systems	Providers who are competent at practicing in more organized delivery systems might be more likely to seek employment in such systems.	<i>Pro:</i> Would cover all practicing providers <i>Con:</i> Difficult to implement outside residency
Require that providers adopt interoperable electronic health records (EHRs) within 5 years	Health information technology (HIT) infrastructure is necessary for organized delivery systems. Need to implement EHRs could provide an incentive for providers to join an organized delivery system.	<i>Pro:</i> Likely to be most effective strategy for accelerating HIT adoption <i>Con:</i> All providers may not be able to meet requirement
Payers should create a fund to help support provider adoption of interoperable EHRs and/or support the development of health information exchange networks	HIT adoption is a necessary infrastructure for organized delivery systems. Payer support could help facilitate formation/evolution of organized delivery systems.	<i>Pro:</i> Would address significant barrier to HIT adoption <i>Con:</i> Does not guarantee better clinical/financial outcomes

ty group practices to looser forms of organization such as private networks of independent providers (eg, independent practice associations) and government-facilitated networks of independent providers (see “Multiple Models of Organizing for High Performance” and “The Role of Retail Clinics”).

3. Although there are diverse approaches, some form of organization (ie, established mechanisms for working across providers and settings) is required to achieve these attributes (Table 1). This finding is

consistent with the literature, which suggests that greater organization is associated with better quality and, to some extent, greater efficiency.

4. Leadership is a critical factor in the success of delivery systems.

### Getting the Care We Want: Policy Recommendations

Despite the potential benefits, the financial, regulatory, professional, and cultural environments act as barriers to organizing health care delivery. Policy interventions are needed for this critical component of health system reform. The poli-

cy recommendations below would promote greater organization of the delivery system to achieve gains in the quality and value of care. In proposing these policies, we are guided by two principles:

1. The policies should move the system toward achievement of the attributes of the ideal delivery system we have identified (Tables 2 and 3).
2. The policies should allow for diverse models of organization to achieve these attributes, explicitly recognizing that different regions of the country may require different arrangements.

No single policy will fix the fragmentation of our health care system. Rather, a comprehensive approach is required—one that might lead progressively to greater organization and better performance. We recommend the following strategies:

**Payment reform.** Provider payment reform offers the opportunity to stimulate greater organization and higher performance. The predominant fee-for-service payment system fuels the fragmentation of our delivery system. We recommend that payers move away from fee-for-service toward bundled payment systems that reward coordinated, high-value care. In addition, we recommend expanding pay-for-performance programs to reward high-quality, patient-centered care. The more organization in delivery systems, the more feasible these payment reforms become (Figure 1). These payment reforms also could spur organization, since they reward optimal care over the continuum of services. Specifically, we believe that full population prepayment—a single payment for the full continuum of services for a given patient population and period of time—should be encouraged. Such payments should be adequately risk-adjusted to avoid adverse patient selection. If full population prepayment is not feasible, payers should encourage:

**Global case payments for acute hospitalizations.** Ideally, such payments should bundle all related medical services from the initial hospitalization to a defined period post-hospitalization (including preventable rehospitalizations). These payments also should be risk-adjusted to avoid adverse patient selection.

**Alternative payment structures for primary care.** Primary care prac-

## Multiple Models of Organizing for High Performance

There are several ways to organize providers to achieve high performance. Here are four models.

### **Model 1: Integrated delivery system or large multispecialty group practice, with a health plan.**

A single entity includes a delivery system (hospitals, physicians, and other providers) and a health plan. The insurance function gives it flexibility in organizing to deliver high-value care. Kaiser Permanente is a closed example of this model that exclusively serves patients who are members of Kaiser Health Plan. Others, such as Geisinger Health System, are open systems that serve patients both within and outside their health plans.

### **Model 2: Private networks of independent providers, such as an independent practice association (IPA) or virtual network**

In this model, a private association organizes multiple independent providers, or providers join together to share and coordinate services. An IPA usually contracts with insurance agencies to provide comprehensive health care services on a capitated basis, but makes fee-for-service payments to individual providers. The association or network may provide

infrastructure services (eg, performance improvement and care management). The Hill Physicians Medical Group and virtual networks in North Dakota are examples of this model.

### **Model 3: Integrated delivery system or large multispecialty group practice, without a health plan**

In this model, a single entity includes a delivery system but no health plan. Examples of this model include the Mayo Clinic and Partners Health-Care.

### **Model 4: Government-facilitated networks of independent providers.**

In this model, government takes an active role in organizing independent providers, usually to create a delivery system for Medicaid beneficiaries. Providers may develop care coordination networks, provide information technology infrastructure, perform care management, or deliver other services characteristic of an organized delivery system. Community Care of North Carolina is an example of this model from the case studies. The Danish health care system provides an international example.

## The Role of Retail Clinics

Retail clinics—clinics that offer a limited menu of medical services (such as the care of sore throats or routine immunizations) on a walk-in basis—deserve special mention because of their rapid proliferation in our health system. At first glance, it may appear that retail clinics further fragment our health care delivery system. Yet, that is not necessarily the case. Retail clinics, if part of an organized delivery system (eg, Geisinger), can promote easy access to care and greater efficiency. It is crucial to coordinate care provided by retail clinics with the care delivered by the patient's larger delivery system. This is most likely to be achieved with a shared electronic medical record system.

**Table 2. Policy Options and Potential Impact on Stimulating Six Attributes of Ideal Health Care Delivery System**

Policy Option The number (1 to 4) indicates the impact that each policy option could have.	Clinical information at point of care through EHR systems	Care coordination/ care transitions	Team/group accountability to delivery high-quality, high-value care	Enhanced access to care for patients	Accountability for total care of the patient	System innovation to continuously improve
Provider Payment Reform Expansion of pay-for-performance (P4P) programs	3	1	3	1	1	2
Global case payment	2	4	4	1	3	3
Full population prepayment for organized delivery systems	2	4	4	2	4	4
Enhanced fee-for-service payments for organized delivery systems	1	1	1	1	1	2
For primary care practices that provide comprehensive, coordinated, team-based care (ie, have the characteristics of a “medical home”), either supplemental payments (eg, per-patient fees in addition to fee-for-service) or comprehensive prepayment for primary care services	3	2	3	4	3	2
Patient Incentives Patient financial incentives (eg, reduced copayments or premiums) to register with an organized delivery system	1	1	1	1	3	1
Regulatory Changes Modifications and consistent interpretations of antitrust, Stark, anti-kickback, civil monetary penalties, and tax exemption laws to better facilitate clinical integration of providers	2	2	2	2	1	2
Shift to enterprise liability for malpractice: physicians who are part of an organized delivery system would not need to carry separate liability insurance	2	2	3	1	4	1
Accreditation Establish an accreditation program for organized delivery systems	3	2	3	3	2	2
Government Infrastructure Support Establish government-funded infrastructure for organized delivery systems in areas where such systems don't/can't naturally develop	4	4	3	3	2	2
Provider Training Require training programs to include competencies in practicing in organized delivery systems	2	3	3	1	2	2
As a condition of licensure, require competencies in practicing in organized delivery systems	2	3	3	1	2	2
Health Information Technology Require that providers adopt interoperable EHRs within 5 years	4	2	1	2	1	2
Payers should create a fund to help support provider adoption of interoperable EHRs and/or support the development of health information exchange networks	3	2	1	2	1	2

**Table 3. Models of Organization and Potential Policy Levers for Stimulating Models**

Models of Organization The number (1 to 4) indicates estimated importance of the levers; the text underneath refers to the relevant options for each lever	Payment reform	Patient incentives	Regulatory changes	Accreditation	Government infrastructure support	Provider training	Promoting health information technology (HIT)
Integrated delivery system or large multispecialty group practice, with health plan	4 • Expand pay-for-performance (P4P) • Population prepayment • Global case payment • Medical home payments	3 • Applied to delivery system	3	3	1	2	2 • Requiring HIT
Integrated delivery system or large multispecialty group practice, without a health plan	4 • Expand P4P • Population prepayment • Global case payment • Medical home payments	3 • Applied to delivery system	3	3	1	2	2 • Requiring HIT
Private networks of independent providers, such as independent practice associations	4 • Expand P4P • Population prepayment • Global case payment • Medical home payments	2 • Applied to network	4	2	2	1	2 • Requiring HIT • Providing HIT adoption support
Government-facilitated networks of independent providers	2 • Medical home payments	2 • Applied to primary care practice	1	1	4	2	4 • Requiring HIT • Providing HIT adoption support

tices that provide comprehensive, coordinated, patient-centered care (eg, certified medical homes) should be offered an alternative to fee-for-service payment. Promising alternatives include comprehensive prepayment for primary care services or fee-for-service payments plus a per-patient care management fee.

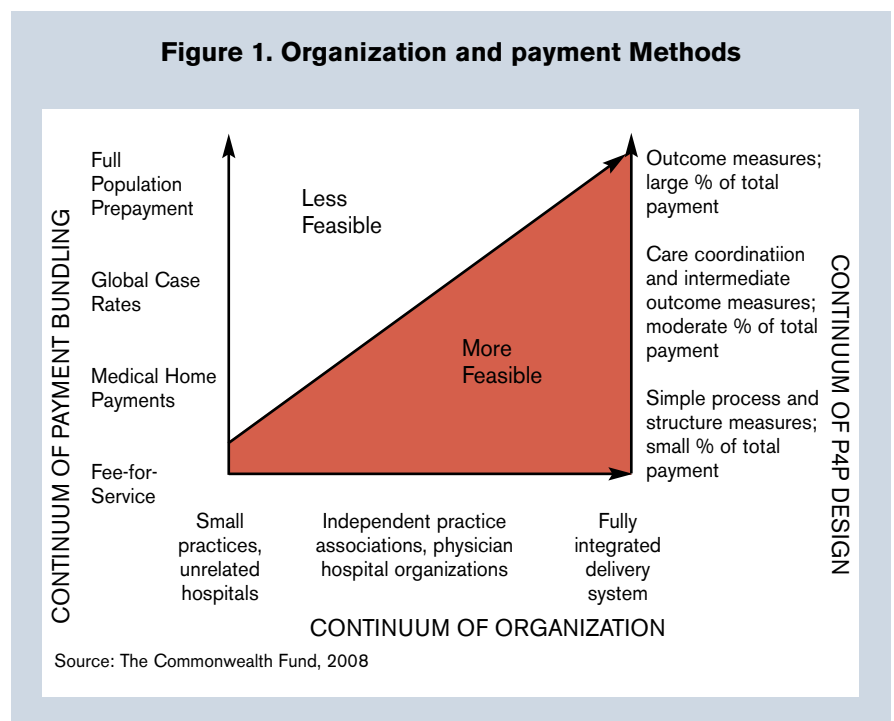
**Pay-for-performance should be expanded.** The more bundled the payment mechanism, the higher the proportion of payment that should be tied to performance. These programs should migrate away from measures that focus on individual processes in a single provider setting (eg, hemoglobin A1C testing rates for patients with diabetes) toward broader measures of quality, such as clinical outcomes (eg, blood pressure control or hospital readmission rates), care coordination, or patient experiences. Medicare should sup-

port further demonstration projects that test innovations in payment de-

sign and care delivery.

**Patient incentives.** Patients should

**Figure 1. Organization and payment Methods**



be given incentives to choose to receive care from high-quality, high-value delivery systems. This requires performance measurement systems that adequately distinguish among delivery systems.

**Regulatory changes.** The regulatory environment should be modified to facilitate clinical integration among providers.

**Accreditation.** There should be accreditation programs that focus on the six attributes of an ideal delivery system we have identified. Payers and consumers should be encouraged to base decisions about payment and provider networks on such information, in tandem with performance measurement data.

**Provider training.** Current training programs for physicians and other health professionals do not adequately prepare providers to practice in an organized delivery system or team-based environment. Provider training programs should be required to teach systems-based skills and competencies, including population health, and be encouraged to include clinical training in organized delivery systems.

**Government infrastructure support.** We recognize that in certain regions or for specific populations, formal organized delivery systems may not develop on their own. In such instances, we propose that the government should play a greater role in facilitating or establishing the infrastructure for an organized delivery system, for example through assistance in establishing care coordination networks, care management services, after-hours coverage, health information technology, and performance improvement activities.

**Health information technology.** Health information technology

## PROVIDER ACTION

### Impact to You

Our current health care delivery system is at the breaking point. The fragile primary care system is on the verge of collapse. The absence of peer accountability, quality improvement infrastructure, and clinical information systems fosters poor overall quality of care. These problems, combined with overall economic problems and a new administration, will certainly result in major changes.

### What You Need to Know

Physicians need to understand the coming changes in reimbursement models that will almost certainly include expansion of pay-for-performance, global case payments, and enhanced fee-for-service payments for organized delivery systems. These will lead to multiple models of organizing for high performance that will certainly include an expanded role for retail clinics.

### What You Need to Do

Practices should prepare for the coming changes by ensuring that information is available, care coordination occurs, accountability happens, and a high level of accessibility is the norm. Practices need to be prepared to evolve with the changes and demonstrate competency.

provides critical infrastructure for an organized delivery system. Providers should be required to implement and use certified EHRs that meet functionality, interoperability, and security standards, and to participate in health information exchange across providers and care settings within 5 years.

## Conclusion

Our fragmented health care delivery system delivers poor-quality, high-cost care. We cannot achieve a higher-performing health system without reorganization at the practice, community, state, and national levels. This report focuses on the community level, for which we have identified six attributes of an ideal delivery system. Our vision of health care delivery is not out of reach; some delivery systems have achieved these attributes, and they have done so in a variety of ways.

We can no longer afford, nor should we tolerate, the outcomes of our fragmented health care system. We need to move away from a cottage industry in which

providers have no relationship with, or accountability to, one another. Though we acknowledge that creating a more organized delivery system will be difficult, the recommendations put forth in this report offer a concrete approach to stimulate greater organization for higher performance. **MPM**

The full Commonwealth Report, notes, and references can be found at [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=698139](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=698139).

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