



trust for
healthcare
excellence

The Better Health Initiative:
Healthcare Professionals Driving
Delivery System Reform

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The Trust for Healthcare Excellence

The Trust for Healthcare Excellence (The Trust) is a Portland, Oregon-based 501 (c)(3) not-for-profit organization whose mission is to promote the collective efforts and conditions necessary for health and healthcare excellence. Through our programs and services, we are working with healthcare professionals and their organizations across the US to rebuild the foundations for healthcare excellence. While The Trust was started in 2007, its roots reach back to the early 1990's into the early days of healthcare improvement. The impetus to start The Trust was driven by the understanding that focusing on individual components of healthcare will not solve the challenges faced by the existing US healthcare system.

The Trust's work is focused on four highly related areas that collectively impact health and healthcare outcomes in the US: (1) the healthcare delivery system, (2) health professional education, (3) public health, and (4) healthcare in the media. Each of The Trust's initiatives encourage healthcare professionals to assume the leadership necessary to cultivate a more unified, cohesive plan for reform and to develop solutions to drive the systematic changes that our communities need.

This document will describe the Better Health Initiative, which The Trust launched in 2008, and provide a vision for national implementation . It will also explore the Better Health Initiative as the core component of The Trust's efforts to drive significant delivery system reform by engaging physicians and other healthcare professionals directly.

The Trust's work represents a call to action for healthcare professionals and their organizations across the country to drive toward excellence in health and healthcare. We have a professional imperative to respond directly and positively to the challenges posed by healthcare.

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The Better Health Initiative

Overview

The Better Health Initiative is a nationally-coordinated and locally-led effort whose goal is to engage physicians and other healthcare professionals directly in driving fundamental reform of the healthcare delivery system. Our aim is intentional and participatory action toward a coordinated, comprehensive, and effective delivery system. We seek a more evidence-based allocation of resources necessary to deliver improved health and healthcare outcomes at a lower cost to our society.

The Better Health Initiative (BHI) is “nationally-coordinated” by The Trust so that participating states and regions work from a similar platform, learn from each other, and collaborate on their work. The BHI is “locally-led” at the state or regional level because the hard work of deeply engaging healthcare professionals and driving real system change has to occur at the grass roots level.

Participating states drive real delivery system reform by directly engaging clinicians and other healthcare professionals in a process of direct dialog coupled with strategies for reform. They use and test innovative solutions for how we work and how we work together – the organized testing and spread of process changes within and between practices and among other healthcare organizations in our communities.

It works as follows: to provide the necessary convergence of efforts, the BHI consists of a Platform (described below) and national coordination provided by The Trust. Those states and regions who wish to participate review this document, discuss and agree with the BHI Platform, and develop the local leadership and funding necessary to guide this effort. The location and nature of the leadership differs by state depending on the nature of existing infrastructure. The Trust frequently assists in this preparatory process.

Potential states then make application to the BHI. Once accepted, state BHI leadership moves forward with the assistance of The Trust and other participating states to implement the necessary strategies. State leaders guide implementation and collaboration within the state. The Trust provides guidance and assistance in organizing the necessary efforts. Connectivity is provided via regular conference calls, email communication, site visits, state-wide meetings, and national meetings between participants.

The Better Health Initiative has been purposefully designed as a nationally-coordinated effort in order to cultivate common approaches to delivery system reform and to learn from our collective efforts. It is The Trust’s role to manage this process, provide connectivity, and disseminate information among participants.

By their nature, reform efforts are highly conceptual and iterative processes. There is no “shrink-wrapped” solution to address the complex systematic and emotional considerations facing US healthcare. However, we must start, and that means developing the tenacious local leadership necessary to drive real change.

Background

Despite intense reform activity focused on healthcare today, critical issues necessary to achieve real reform are not yet being adequately addressed – existing efforts are fragmented and not systematic. In addition, the direct involvement of healthcare professionals – physicians and others – in a collective, collaborative effort to transform healthcare has not yet occurred. The Better Health Initiative was developed to address these critical issues head-on.

The Better Health Initiative is a call for healthcare professionals to renew our collective stewardship for both health and healthcare in our communities. Clinicians in particular are uniquely empowered to exert an enormous positive influence on the system by taking leadership roles in the development, testing, and implementation of systematic changes in the delivery system – to date, we have not collectively made use of this opportunity in an organized way. We believe that the time has come. The imperative toward reform has never been greater, nor has the risk to our professionalism. The unwelcomed alternative is to have change mandated without our input and potentially at odds with what we know is best for our patients and the communities we serve.

Starting in March of 2007, a group of clinicians, healthcare leaders, insurance executives, public health officials, policy advisors, and others began formalizing a national approach to delivery system reform that directly engaged healthcare professionals in creating and leading the necessary changes. Their vision became known as the Better Health Initiative, and their early work resulted in the creation of the Better Health Initiative “Platform” consisting of a Statement of Purpose, Guiding Principles for Healthcare Reform, and an Evidence-Based Delivery System Design. This Platform serves as a common reference point and compass for those involved in the Better Health Initiative.

To achieve the delivery system reform that our communities need, The Trust began testing grass roots strategies intended to directly engage healthcare professionals in a more significant dialog about delivery system redesign. While we still have much more to learn, the result has been a set of processes and strategies that Better Health Initiative participants use to lead real delivery system reform.

The Better Health Initiative “Platform”

Participants of the Better Health Initiative agree to the following Statement of Purpose, Guiding Principles for Healthcare Reform, and Evidence-Based Delivery System Design.

Statement of Purpose

We are healthcare professionals building a coordinated, comprehensive, and effective health delivery system.

We are doing so by renewing our collective stewardship for health and healthcare in our communities through direct discussion among ourselves and others, and through action toward an improved health system. We will actively work for the wise allocation of resources and system design that delivers improved health and healthcare outcomes and lower costs across our society.

Guiding Principles for Healthcare Reform

For healthcare reform to succeed, there must be a clearly articulated and agreed upon set of shared principles that give guidance to reform efforts. These principles should provide a compass for healthcare decision-makers and practitioners alike in guiding both their overall planning and daily activities.

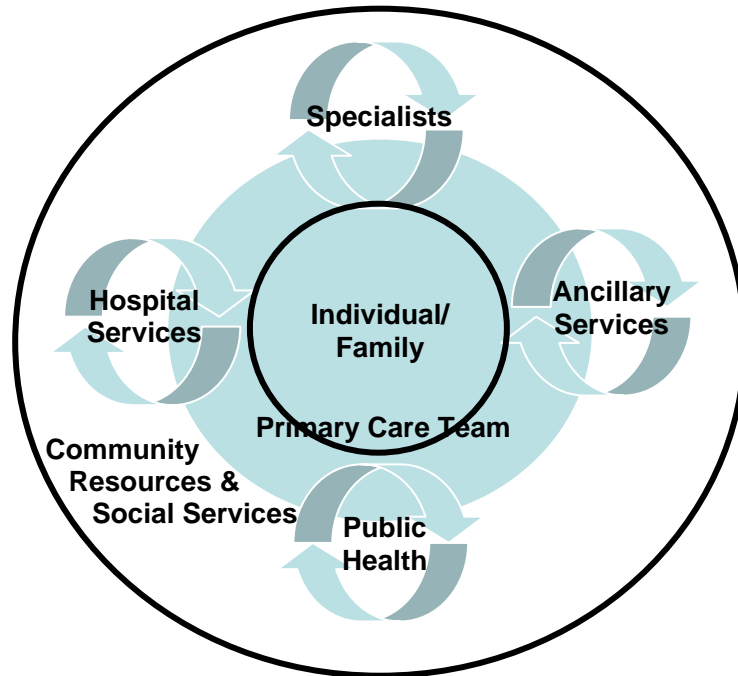
1. The objective of our health system is to deliver health as measured at the individual, family, and community levels.
2. Individual and community health are public assets. Universal access to basic health services is essential to the well-being of our workforce and our communities.
3. Public resources should be allocated in a way that maximizes health across the population.
4. Decision-making about the expenditure of public resources should be evidence-based and transparent.
5. Health services should be organized to provide comprehensive, coordinated, longitudinal mental and physical health care.

Evidence-Based Delivery System Design

For successful healthcare reform, there must be an agreed upon, evidence-based delivery system design toward which we all work. There is significant data to guide such a delivery system design at both the macro level and at very specific levels of detail. The following schematic provides such a high level evidence-based delivery system design. Based on data from both within and outside of the US, repeated studies show that the most cost-effective and clinically effective delivery systems are those that are the most primary care oriented. These systems are oriented around the individual and family and work toward the provision of comprehensive primary care services within a well designed and resourced primary care

system where other resources are organized to support the individual, family, and primary care team.

Optimal health and healthcare in a community is also dependent upon public health systems and the appropriate interaction between public health and healthcare. This model focuses on the delivery system and its interactions with the public health system. The design of optimal public health systems is not explicitly addressed here but will be addressed by The Trust through other efforts.



Financing and Delivery System Change

It is widely accepted that in order for any reform effort to be both substantive and lasting there must be significant change to the current financing system. The Trust readily acknowledges this and supports efforts aimed at financing reform. Within the context of the Better Health Initiative, we deemphasize the financing system as both the primary motivation for change and the primary barrier against change. While the financing system influences system design, our motivation toward delivery system reform is about providing better health and healthcare to the individuals and communities we serve.

History clearly illustrates that the current posturing that many clinicians take with respect to the delivery system, notably stating “I will change after you change first” doesn’t work. This approach has not served our profession, our patients, or our communities well. The continuing cycle of clinicians waiting for (and blaming) insurers, and insurers waiting for (and blaming) clinicians has proven, by any measure, unsuccessful.

The Better Health Initiative advocates for finance system change in parallel with delivery system reform – they must proceed together and iteratively in support of each other. We do believe that many of the necessary steps toward delivery system redesign will require clinicians to accept some risk – innovation and change always does. To support this, we are working with insurers on a number of short-term financing strategies to support this active and planned delivery system evolution – mechanisms to fund necessary transitional states and testing. We believe that clinicians are in a much stronger position when we exert collective leadership toward real system change while reaching out to develop productive partnerships with payers and others.

Discussions with insurance executives have resulted in several strategies to help to support testing and transitional states. They include:

- Creating ‘dummy’ CPT codes to support specific aspects of the work. For instance, some insurers did this as a way of funding e-visits before the AMA developed a specific e-visit CPT code.
- Creating a special statewide BHI “fund” to support testing of system changes. Various insurers would agree to contribute to the fund and provide oversight for the application of those resources. For example, a cardiologist or endocrinologist may wish to spend part of her week not in direct visit-based care within her office but rather out interacting directly with primary care practices and others in her community to improve the appropriate utilization of specialty services. Insurers might agree to support such activities in order to aggressively learn from them.
- Making transparent the process by which savings get back to employers and employees. Clinicians are frequently and rightly concerned that their hard work to save money benefits neither them nor their patients. To respond, insurers can create audit or money trails demonstrating how savings are applied directly back to employers and employees.

Frequently Asked Questions

1. Healthcare improvement and reform efforts are abundant. Why is this different and how would it fit into other work? Is this work competing with other efforts?

No effort to date has placed such central emphasis on the large scale direct engagement of healthcare professionals, in particular physicians, around stewardship. The Better Health Initiative represents a very critical social process among physicians and other healthcare providers. We believe that success in delivery system reform, the building of a genuinely integrated and coordinated care system, requires this social process at the outset to achieve the desired outcome: a coordinated, comprehensive, effective healthcare delivery system grounded in primary care that will improve health in our communities.

Our collective experience suggests that a carefully designed and managed social process that engages and safely challenges physicians and other healthcare professionals is critical at this time.

The Better Health Initiative is by design very synergistic with other local and national efforts, not competitive. Our intent is to inform and be informed by those efforts and, ultimately, to accelerate them.

2. Are you trying to control the reform process?

It would be more accurate to say we are trying to accelerate reform using values already shared by almost all healthcare professionals. We are not trying to control the process, but to accelerate it by creating an engaging, respectful, and organized approach.

3. While the Better Health Initiative is focused on healthcare professionals, it risks seeming overly physician-centric. At the same time, physicians must obviously be a critical part of the process. Please explain this balance.

While any reform effort must involve physicians, we are inclusive of all healthcare professionals and stakeholders. Out of necessity, we will work hard to engage physicians in particular because, in aggregate, physicians need to be better partners with others in our communities who seek similar aims for a reformed health system. Almost all non-physician healthcare professionals and stakeholders agree that it is necessary to get the physician community more deeply involved.

Progress in transforming US healthcare will require collaborative, cohesive, participatory, and convergent physician leadership and involvement - leadership that is strongly tied to a new level of stewardship for both health and healthcare. Everyone recognizes the powerful influence that physicians have and acknowledges their central role in delivering healthcare. Due to their unique role, physicians hold the primary

responsibility for applying healthcare resources and therefore should be key stewards of health and healthcare outcomes in partnership with others.

We realize that it will not be easy to move the physician community in a cohesive way, but we believe that it is necessary and possible. To do so, the physician community needs a safe place to address these issues directly with each other, to discuss substantive issues about the nature of our work, the way we organize our work, and the way we work together. Together, physicians must address very challenging issues such as our obligation to our community, our collective stewardship for healthcare resources, and more.

The discussions we need to have with each other are sensitive and more substantive progress can result from many direct “behind closed doors” discussions –physicians need a safe place and safe conditions in which to address these issues directly with each other. Direct physician-to-physician discussions present the best opportunity for physicians to develop the cohesiveness and trust necessary to fundamentally change their work, while being better partners with the wide array of non-physicians stakeholders.

4. Talk about reclaiming stewardship for health and healthcare sounds like an implication that physicians and other healthcare professionals are responsible for our healthcare problems. When did we abandon such "stewardship"? Most of us have been working hard to care for patients against enormous system pressures.

Physicians and other healthcare professionals have historically worked very hard to be advocates and stewards of healthcare for their patients. They fight hard to get people what they need. They have also worked hard to be stewards of their organization – their practice or hospital for example – in the service of patients.

However, the stewardship we are referring to is about overall accountability and safeguarding resources. Healthcare professionals, including physicians, have been quite disconnected from stewardship at the level of the healthcare system and of health in their community. We have failed to exert significant collective stewardship over total costs of care and the overall management of healthcare resources.

Healthcare is very fragmented by profession, by practice, by specialty, by geography, and more. Such fragmentation makes collective stewardship difficult, and we believe that it will only be through a new form of collective stewardship that we will truly be able to address the challenges that our national healthcare system faces.

Many physicians have viewed stewardship for the health of the broader community as beyond their capacity. Some have viewed population health as “in opposition” to meeting the needs of their individual patients, as in the case of costly care that provides some minimal benefit to an individual, while diverting resources from others. Our goal is to bring many more physicians to view stewardship of “the commons,” the resources that are public and shared by many, as a part of their critical role in society.

5. Healthcare professionals including physicians are very fragmented and your ability to reach them is limited. How do you propose to address that challenge?

We will bring healthcare professionals including physicians together through a thoughtful, stepwise building of relationships and consensus, driven by respected leaders within the various professions and specialties. Our early attempts at this tell us that such an approach is feasible and productive.

Bringing together healthcare professionals –within their own profession and with each other – requires a compelling imperative, a standard thoughtful platform for discussion, planning, and a safe environment for direct, honest discussion. We have been impressed with the positive response of physicians thus far and all indications are that other healthcare professionals will respond equally positively. Irrespective of profession, we believe that healthcare professionals, including physicians, know deep down that things are fundamentally wrong in US healthcare and given the right format and framework for discussion and action, they want to be a part of the solution.

6. I understand the need for discussion among physicians, but moving them from discussion to true action and system change is hard to imagine. What are your plans for that? What will that look like?

We believe physicians and other clinicians generally want what is best for both their patients and their community. Many of them now feel frustrated and powerless to influence the dysfunctional system in which they work. The Better Health Initiative provides a venue first for us to think differently together and then to design alternative ways of working with each other before we move to testing those methods.

Once we've built trust in local communities through discussion and relationships, we will move to an action phase of actively testing changes in how physicians and their medical groups work together. Starting small but being clear that our intent is to transform our collective work, we will visibly drive changes in the delivery system together.

We realize that this will be hard work - it will take persistence and it will likely be very uncomfortable for many. Given current levels of scrutiny, physicians and other clinicians are beginning to understand that they will be better off testing and making changes in their systems themselves before others force them to do so.

7. You talk about leadership, but obviously not all physicians, other clinicians or stakeholders can, will, or should be leaders. In particular with physicians, how should they respond to this need for leadership?

For healthcare to move forward, stewardship will require both leadership and active participation by clinicians in particular. The leadership we need is one that will help

guide the process without expecting to control it – the leaders will actively engage others to participate in the new system design. We’re not asking for blind participation, but rather active, positive participation through the lending of positive support, not opting out, demonstrating support for agreed upon issues, and supporting the testing of new methods of care. We will have to work together in new ways to participate and support our collective work, and to converge around a common platform of belief and action.

We do believe that broad based engagement and participation will be possible, but we’ll have to build toward it, starting off with a core group in various communities using local leaders to build involvement and participation.

8. When you say evidence-based system design, what do you mean? What evidence and how can a system design be evidence-based?

There is substantial peer-reviewed literature and shared experience on how optimal, cost effective healthcare can and should be delivered. There is evidence at both the system level (how to organize overall resources) and at the practice level (critical components of the medical practice and critical interactions between components of the system). Yes, more can certainly be learned about this, but there is substantive data from both within the US and internationally to give guidance on system design. Elements of effective care delivery systems are in multiple articles across a broad range of literature, and can be applied in an intelligent way to an integrated model by those with practical experience who can put the pieces together.

9. What are the implications of the evidence-based system design? I see the diagram, but what does it mean in practical terms?

To begin, let’s discuss the model overall. Notice that the model explicitly shows integration and communication among the people and entities caring for patients – there is no provision in the model for an isolated “silo” of services, because the available evidence shows the harm from silo care including medical errors, unaddressed needs, costly duplications, and diversion of resources from important health priorities.

Next, the model places the patient, family, and primary care team at the center. This is not merely symbolic, as it has been in many places for a long time. They are the drivers, coordinators, and the “bosses” of the delivery of care. The relationship between the primary care team and the individual and family is built on trust, access, and comprehensive care. The roles of all the elements around them (subspecialists, hospitals, ancillary care providers and suppliers of goods) are no less important—but they are explicitly no longer permitted to drive their corner of care autonomously. This too frequently results in the detriment of the patient and society. True collaborative, give-and-take collegiality is expected, not merely polite deferential collegiality as it has too long been defined.

10. Do you want to block access to specialty care?

No. We want to foster a system of care where patients are served by the healthcare professional best equipped to serve their need at the time – the right care at the right time delivered by the right individual. That means primary care providers working to their full capacity treating risk factors and chronic illnesses, like diabetes. It means specialty providers seeing only those patients or clients who need face-to-face contact with them for consultation or treatment, and referring people back to their primary care teams for other care. This is another area where, in the long run, payment reform will be necessary. A specialist cannot afford to provide unlimited, unpaid telephone advice to primary care providers, just as PCPs cannot afford to provide top-notch, guideline-based care for all chronic illnesses at current rates of payment for cognitive services.

11. Within the physician community, do you believe that it is necessary to pit primary care against specialists?

No, this is not our intent. We do not believe that it is either necessary or desirable to create adversity. We need all physicians and other healthcare professionals involved positively in the work. Our goal is to create a dynamic where physicians are advocating not for themselves but for each other and a better system in which to work. An increasing number of non-primary care professionals are speaking about the need to preserve and strengthen the primary care infrastructure. We will work to create a dynamic of mutual support – where physicians are supportive each other and other specialties, not just their own specialty.

12. If you aren't pitting primary care against specialists, then it is hard to imagine how you are going to make progress – at some point such a confrontation is going to have to occur?

We don't believe so, and our experience doesn't suggest so. The primary reason that many believe confrontation is necessary is because they have not leveraged the power of conversation and active engagement. Anger, misconceptions, and the lack of trust are always fostered when discussion is lacking. Dialog is the way to dissipate those negative influences.

We in the physician community are already colleagues, and we already work together daily. Dialog, in the right context and within the right framework, is always a more potent driver of change than confrontation. We believe that we can deal with very substantive issues in a positive way, including financial issues, if we do so via direct dialog around a shared imperative, shared values, and a shared vision for where the system needs to go.

13. Rational healthcare reform will require some physicians to make less money, and those groups will likely resist your efforts. How will you manage that?

This may or may not be true. We know that we need to leverage the expertise of individuals in very different ways. We know that many physicians and specialties are knowledge resources that are being underused – their current work doesn't maximize their knowledge or skills. We need to rethink how physicians work, and how specialty expertise is applied in the system.

Dialog will help us move toward new ways of thinking and working, while keeping the financing in mind. We expect that everyone will likely be uncomfortable as we move forward, and it is critically important to acknowledge this – but we believe that this dynamic can be managed positively.

14. Can you say more about how the Better Health Initiative feels about financing reform?

We know that widespread delivery system change cannot proceed without redirection of financing to support the necessary work by doctors and other health professionals. However, we want to avoid having the critical discussion of our stewardship and leadership strategies diverted by arguments over what the payment system should look like, for example single payer versus vouchers versus employer and individual mandates, or the specifics of how we better pay for the work of primary care teams. It is much too easy for money to become the focus, and thereby create the perception that this is just one more self-interested group of professionals.

We also believe that there is a tremendous amount of work that needs to be done within the delivery system before we can settle on more appropriate financing mechanism. Many say “pay us first and then we'll behave differently” but we believe that is a terribly poor expression of leadership. For us, leadership and stewardship will seek to define a new system first, in iterative steps, before or at least in concert with requests to be paid differently. Payment change before system change stands many risks and puts the cart before the horse.

15. How is the Better Health Initiative going to be financed? What resources are required and how are they supported financially?

States pay a yearly fee to participate and those fees will go to support the central effort. States will need internal resources to manage their statewide Better Health Initiative and the leadership of those statewide initiatives will need to identify that funding.

16. If this is successful, what concrete differences in the healthcare system will be evident and when will they be evident?

Primary care will be delivered and supported by local and regional care teams, some integrated within one organization, and some virtual organizations where physicians, midlevel practitioners, pharmacists, social workers, mental health professionals, nurses and others work together across boundaries, delivering team care to those who need it.

In the immediate future, this will consist of the rare existing models, with the addition of either funded or bootstrap “grassroots” pilots wherever fertile ground for development is found.

In the long term, we recognize that financing must support the adoption of the evidence-based delivery system across all communities large and small. Besides the development of funding mechanisms, there will be a lot of local development work to make practical the concepts of the primary care team in the unlimited variety of settings where those teams are needed. Such an evolutionary process is likely to take decades to reach its full fruition. We’ll never finish unless we get started.

17. What are you doing to educate Americans about what good healthcare really means?

This is one of the biggest challenges we face. Our current healthcare marketplace leads consumers to expect relatively unlimited, costly, silo-based specialty care as “the best care in the world.” Sophisticated consumers and some chronically ill individuals who have experienced the failures of that costly, fragmented system realize the need for a different delivery system.

One of our most crucial tasks is to bring physicians and other health professionals to a shared vision of a better delivery system, so that they will promote it not only to policymakers, but to millions of patients and clients. The Trust for Healthcare Excellence and state Better Health Initiative chapters cannot do this alone. Rather, we will do it through partnerships. We will be much more effective at this if we get our own house in order before we work on changing the way patients perceive, understand, and consume healthcare.

Becoming Involved

Involvement in the Better Health Initiative means developing the appropriate state leadership. The Oregon Better Health Initiative is one such example. Five organizations including the Oregon Academy of Family Physicians, Osteopathic Physicians and Surgeons of Oregon, Oregon Pediatric Society, and Oregon Chapter of the American College of Physicians have joined as signatories. Representatives from each have assumed leadership for the initiative and are driving implementation state-wide.

Perhaps the best way to get started is to simply call The Trust at 503-384-2040. As the national program coordinator, we will be happy to provide additional information and guidance.