Health Systems Transformation Resource List

Listed below are initial internet and journal publication resources for health systems transformation that may be used to develop educational materials. Please feel free to contact ACPM staff with additional resources that can be added to this list.

1) **Oregon Department of Health. Centers for Medicare/Medicaid Services (CMS)/Long-Term Care (LTC)/Coordinated Care Organizations (CCO) Study Group. Retrieved from** http://www.oregon.gov/DHS/cms/pages/index.aspx

   This study group is an exploratory stakeholder process that will result in a report to the Centers for Medicare/Medicaid Services (CMS) regarding the integration of DHS Medicaid-funded Long-Term Care (LTC) for the aged or people with disabilities into the Coordinated Care Organizations (CCO) global budgets.

2) **Valdovinos E, Srikantharajah J, Pañares R, Mikkelsen L, Cohen L, Cantor J. (2011). Community-Centered Health Homes: Bridging the gap between health services and community prevention. Retrieved from** http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html

   Details the "Clinical/Community Population Health Intervention Model"

3) **Ohio Prepares Leaders for Patient Centered Medical Homes in Patient Centered Medical Home & Workforce Development. 2014. Retrieved from** https://practicalplaybook.org/success-story/ohio-prepares-leaders-patient-centered-medical-homes

   Ohio's Patient Centered Medical Home Education Program works to incorporate the Patient Centered Medical Home (PCMH) model of care into medical and nursing curriculum. The Ohio Department of Health oversees implementation of the pilot program, which is supported by more than 47 primary care practices, four medical schools, and five nursing programs. The program has increased the number of primary care practices with PCMH recognition.

4) **Patient-Centered Medical Home in Action: Focus on Team-Based Care. Retrieved from** http://www.achi.net/Pages/SuccessStories/Story.aspx?ID=50

   Describes how Arkansas is working to transition to a PCMH model of care delivery.

5) **SAMHSA Enrollment Coalitions Initiative. 2014. Retrieved from** http://beta.samhsa.gov/health-reform/samhsa-health-reform-efforts/enrollment-coalitions-initiative

Each coalition works together to develop training and resources that will help community-based organizations and professionals explain the new health care law and encourage uninsured individuals to apply for coverage.

6) **The Office of the National Coordinator for Health Information Technology. Connecting Health and Care for the Nation: A 10-Year Vision to Achieve an Interoperable Health IT Infrastructure. Retrieved from** http://www.healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf

The U.S. Department of Health and Human Services (HHS) has a critical responsibility to advance the connectivity of electronic health information and interoperability of health information technology (health IT). This is consistent with its mission to protect the health of all Americans and provide essential human services, especially for those who are least able to help themselves. HHS plans to build upon the existing health IT infrastructure, empower individuals, baseline interoperability, leveraging the market, and protect privacy and security as they work towards a vision of the future interoperable health IT ecosystem.

7) **A Compendium of Proven Community-Based Prevention Programs. 2013. Retrieved from** http://healthyamericans.org/report/110/

The Trust for America's Health (TFAH) and New York Academy of Medicine (NYAM) released *A Compendium of Proven Community-Based Prevention Programs*, which highlights 79 evidence-based disease and injury prevention programs that have saved lives and improved health.

8) **Health Insurance Market Overview. State Public Health Leadership Webinar. 2013. Deloitte Consulting LLP. Retrieved from** http://www.cdc.gov/stltpublichealth/Program/transformation/docs/health-insurance-overview.pdf

The goal of the webinar is to create a foundation of understanding upon which to discuss the role of state health agencies in the health insurance market.

9) **Health Care Integration Initiatives. SAMSHA Health Care Integration. 2014. Retrieved from** http://beta.samhsa.gov/health-reform/health-care-integration

Primary and behavioral health care integration is an opportunity under the Affordable Care Act to improve health care quality through the systematic coordination of primary and behavioral healthcare. Provides information on improving healthcare quality through the systematic coordination of primary and behavioral healthcare.

10) **Nachuk, S. How to Better Share Knowledge Between Countries Moving Towards UHC. 2014. Retrieved from** http://www.rockefellerfoundation.org/blog/how-better-share-knowledge-between

Blog post featuring Joint Learning Network (JLN) partners using different approaches to build community, learn, and share practical knowledge between countries featuring the "knowledge co-production" approach—blending structured and unstructured approaches to building a learning community.

11) **Center for Medicare and Medicaid Services. Innovation Center. Retrieved from** http://innovation.cms.gov/

A program supporting the development and testing of innovative healthcare payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for individuals receiving Medicare, Medicaid, or Children's Health Insurance Program benefits. The CMS Innovation Center has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system.

12) **Report to Congress. National Strategy for Quality Improvement in Health Care. 2011. Retrieved from** http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.pdf

A strategy to optimize health outcomes by leading clinical quality improvement and health system transformation.

13) **Centers for Disease Control and Prevention. National Public Health Improvement Initiative. Retrieved from** http://www.cdc.gov/stltpublichealth/nphii/about.html

Through this program, CDC supports state, tribal, local, and territorial health departments to make fundamental changes and enhancements in their organizations and implement practices that improve the delivery and impact of public health services.

14) **Practical Playbook. Duke Department of Community and Family Medicine. 2014. A Practical Playbook: Public Health. Primary Care. Together. Retrieved from** http://www.cdc.gov/stltpublichealth/Program/resources/public.html

The Practical Playbook is a stepping stone in the next transformation of health, in which primary care and public health groups collaborate to achieve population health improvement and reduced health care costs. It supports increased collaborations between primary care and public health groups by guiding users through the stages of integrated population health improvement.

15) **Centers for Disease Control and Prevention. Primary Care and Public Health Initiative. 2014. Retrieved from** http://www.cdc.gov/primarycare/index.html

Fosters linkages between public health and primary care by integrating population health into medical residency program curricula and competencies; increasing clinician understanding of public health problems and national initiatives offering potential solutions; and increasing clinician awareness and use of CDC resources

16) **Cusack CM, Knudson AD, Kronstadt JL, Singer RF, Brown, AL. 2010. Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care. AHRQ Publication. Retrieved from** http://pcmh.ahrq.gov/sites/default/files/attachments/Information%20Technology%20to%20Support%20Transformation%20to%20Proactive%20Primary%20Care.pdf

Outlines the key IT functionalities for practice-based population health, developed from the perspective of providers.

17) **Primary Care and Public Health: Promoting Integration to Improve Population Health. 2012. National Academy of Sciences. Retrieved from** http://iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx

Recommends ways that CDC and HRSA can foster integration between primary care and public health through funding, policy levers, and other means.

18) **Building Blocks and tools: What will it take to transform health care? Transforming Health Care Delivery: Why It Matters and What It Will Take. 2012. Grantmakers In Health. Retrieved from** http://www.gih.org/files/FileDownloads/Transforming%20Health%20Care%20Delivery%20Primer%20March%202012.pdf

A March 2012 Grantmakers in Health issue brief on transforming health care delivery. Describes what constitutes an effective and efficient delivery system, including accountability, coordinated care, health care information available to providers when needed, and other topics. Also describes building blocks and tools that can be used to transform care including work force changes, quality improvement processes, and health information technology.

19) **MacDonald, I. 2014. 10 steps to change healthcare delivery and save money. Retrieved from** http://www.fiercehealthcare.com/story/10-steps-change-healthcare-delivery-and-save-money/2014-02-21

Guide offers roadmap for improving care without cutting provider fees.

20) **Rudisill PT, Callis C, Hardin SR, Dienemann J, Samuelson M. Care redesign: a higher-quality, lower-cost model for acute care. J Nurs Adm. 2014 Jul-Aug;44(7/8):388-94.**

The aims of this study were to design, pilot, and evaluate a care team model of shared accountability on medical-surgical units. American healthcare systems must optimize professional nursing services and support staff due to economic constraints, evolving Federal regulations and increased nurse capabilities. A redesigned model of RN-led teams with shared accountability was piloted on 3 medical/surgical units in sample hospitals for 6 months. Nursing staff were trained for all functions within their scope of practice and provided education and support for implementation.

Clinical outcomes and patient experience scores improved with the exception of falls. Nurse satisfaction demonstrated statistically significant improvement. Cost outcomes resulted in reduced total salary dollars per day, and case mix-adjusted length of stay decreased by 0.38. Innovative changes in nursing care delivery can maintain clinical quality and nurse and patient satisfaction while decreasing costs.

21) **Velianoff, GD. Advancing the Evolution of Healthcare: Information Technology in a Person-Focused Population Health Mode. The Journal of Nursing Administration. 2014 July-Aug.44(7/8): p 381–87.**

The current changes introduced into the healthcare delivery system through the Affordable Care Act require more than the isolated, quality/cost process solutions utilized to date. Robust information systems with capabilities to push information and provide valid analytics and decision support utilizing point-of-care data input are required to achieve a complex, person-centered, lifetime-focused model. This article presents a review of the current state of population health, a model identifying components within population health, and an example of information technology integration.

22) **Liang SF, Taweel A, Miles S, Kovalchuk Y, Spiridou A, Barratt B, Hoang U, Crichton S, Delaney BC, Wolfe C. Semi Automated Transformation to OWL Formatted Files as an Approach to Data Integration. A Feasibility Study Using Environmental, Disease Register and Primary Care Clinical Data. Methods Inf Med. 2014 Jun 6;53(4).**

This article is part of the Focus Theme of Methods of Information in Medicine on "Managing Interoperability and Complexity in Health Systems". Our results have shown that the proposed method provides a promising general approach to address data heterogeneity.

23) **Smith M, Saunders R, Stuckhardt L, McGinnis JM. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington (DC): National Academies Press (US); 2013 May.**

Best Care at Lower Cost emphasizes that a better use of data is a critical element of a continuously improving health system, such as mobile technologies and electronic health records that offer significant potential to capture and share health data better. In order for this to occur, the National Coordinator for Health Information Technology, IT developers, and standard-setting organizations should ensure that these systems are robust and interoperable. Clinicians and care organizations should fully adopt these technologies, and patients should be encouraged to use tools, such as personal health information portals, to actively engage in their care. This book is a call to action that will guide health care providers; administrators; caregivers; policy makers; health professionals; federal, state, and local government agencies; private and public health organizations; and educational institutions.

24) **Kaushal R, Hripcsak G, Ascheim DD, Bloom T, Campion TR Jr, Caplan AL, Currie BP, Check T, Deland EL, Gourevitch MN, Hart R, Horowitz CR, Kastenbaum I, Levin AA, Low AF, Meissner P, Mirhaji P, Pincus HA, Scaglione C, Shelley D, Tobin JN. Changing the research landscape: the New York City Clinical Data Research Network. J Am Med Inform Assoc. 2014 Jul-Aug;21(4):587-90. Epub 2014 May 12.**

The New York City Clinical Data Research Network (NYC-CDRN), funded by the Patient-Centered Outcomes Research Institute (PCORI), brings together 22 organizations including seven independent health systems to enable patient-centered clinical research, support a national network, and facilitate learning healthcare systems. The NYC-CDRN includes a robust, collaborative governance and organizational infrastructure, which takes advantage of its participants' experience, expertise, and history of collaboration. The technical design will employ an information model to document and manage the collection and transformation of clinical data, local institutional staging areas to transform and validate data, a centralized data processing facility to aggregate and share data, and use of common standards and tools. We strive to ensure that our project is patient-centered; nurtures collaboration among all stakeholders; develops scalable solutions facilitating growth and connections; chooses simple, elegant solutions wherever possible; and explores ways to streamline the administrative and regulatory approval process across sites.

25) **Kearney LK, Post EP, Pomerantz AS, Zeiss AM. Applying the interprofessional patient aligned care team in the Department of Veterans Affairs: Transforming primary care. Am Psychol. 2014 May-Jun;69(4):399-408.**

The Veterans Health Administration (VHA) is the largest integrated health care system in the United States, serving more than 8 million veterans. VHA is currently undergoing extensive changes to its health care delivery model, moving toward the full implementation of the patient-centered medical home. Mental health providers, including psychologists working in primary care, are playing key roles in this transformation to interprofessional teams and systems-as clinicians, researchers, program evaluators, and educators. Moreover, VHA mental health staff serves critical leadership functions supporting primary care in the broad transformation that is required to implement the medical home. In this article, we review the implementation of mental health integration into this new model of care.

26) **Boykin A, Lynn CE, Schoenhofer S, Valentine K. Health care system transformation for nursing and health care leaders: Implementing a culture of caring. New York, NY, US: Springer Publishing Co. 2014.**

Presents a theoretically grounded, proven caring-based model for healthcare system change for all stakeholders across the continuum of care and practical strategies for transformation in all aspects of a healthcare system applicable across the range of health

services. Describes how healthcare system change happens, who initiates it, and how to sustain it through caring science. Includes success stories from patients and their families, nurses, physicians, ancillary service providers, healthcare administrators, and others. Promotes inter- and intra-professional dialogue and collaboration

27) **Harburger DS, Stephan SH, Kaye SK. Children's behavioral health system transformation: One state's context and strategies for sustained change. The Journal of Behavioral Health Services & Research, Vol 40(4), Oct 2013. pp. 404-15.**

The purpose of this paper was to examine the State of Maryland as a case study of sustained change efforts in the service delivery system for children with significant behavioral health needs and their families. A punctuated equilibrium paradigm is introduced to describe Maryland's behavioral health system transformation over the course of three decades. The context and specific strategies that characterized Maryland's execution of its recent Mental Health Transformation State Incentive Grant are highlighted. There is a discussion of one of the pinnacle achievements of Maryland's transformation efforts, the recent statewide establishment of care management entities for children with behavioral health challenges, and its implications for behavioral health in the context of health care reform changes. This case study illustrates how a state can systematically and incrementally develop systems of care for children and families that are values-based, sustainable, and flexible.

28) **Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Bitz J. Large-system transformation in health care: A realist review. Milbank Quarterly, Vol 90(3), Sep 2012. pp. 421-56.**

An evidence base that addresses issues of complexity and context is urgently needed for large-system transformation (LST) and health care reform. Fundamental conceptual and methodological challenges also must be addressed. The Saskatchewan Ministry of Health in Canada requested a six-month synthesis project to guide four major policy development and strategy initiatives focused on patient- and family-centered care, primary health care renewal, quality improvement, and surgical wait lists. The aims of the review were to analyze examples of successful and less successful transformation initiatives, to synthesize knowledge of the underlying mechanisms, to clarify the role of government, and to outline options for evaluation.

Realist review methodology can be applied in combination with a complex system lens on published literature to produce a knowledge synthesis that informs a prospective change effort in large-system transformation. A collaborative process engaging both research producers and research users contributes to local applications of universal principles and mid-range theories, as well as to a more robust knowledge base for applied research. We conclude with suggestions for the future development of synthesis and evaluation methods.

29) **Achara-Abrahams I, Evans AC, King JK. Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. Addiction recovery management: Theory, research and practice. Totowa, NJ, US: Humana Press; 2011. pp. 187-208, 326, xi.**

The concept of recovery is fast becoming the prevailing paradigm in behavioral health policy arenas. Consequently, behavioral health care systems are trying to align their services with a recovery-oriented approach. To date, no blueprint exists to guide systems and communities through the complex process of transformational change. The vision of "what" a recovery-oriented system looks like is becoming increasingly clear, but the process for "how" systems transform and align themselves with this vision remains obscure. This chapter draws upon work in the City of Philadelphia to propose a framework for the recovery-focused transformation of behavioral health systems. Concrete examples of change strategies and lessons learned are discussed.

30) **Cashin C, Scheffler R, Felton M, Adams N, Miller L. Transformation of the California mental health system: Stakeholder-driven planning as a transformational activity. Psychiatric Services, Vol 59(10), Oct 2008. pp. 1107-14. US: American Psychiatric Assn.**

This study describes strategies developed by California counties to transform their mental health systems under the 2004 Mental Health Services Act (MHSA). This voter initiative places a 1% tax on annual incomes over $1 million; tax monies are earmarked to transform county-operated mental health services into systems that are oriented more toward recovery. MHSA implementation itself can be considered "transformational" by balancing greater standardization of mental health service delivery in the state with a locally driven planning process.

There are many obstacles to the successful implementation of these ambitious plans. However, the state-guided, but stakeholder-driven, transformation in California appears to generate innovative approaches to recovery-oriented services, involve consumers and family members in service planning and delivery, and build community partnerships that create new opportunities for consumers to meet their recovery goals.

31) **Martin CM. The social construction of chronicity – A key to understanding chronic care transformations. Journal of Evaluation in Clinical Practice, Vol 15(3), Jun 2009. pp. 578-85. United Kingdom: Wiley-Blackwell Publishing Ltd.**

The purpose of this paper is to argue the importance of contemporary analysis of the modern social construction of chronicity--encapsulating the world views of the chronically ill, and the medical and health system constructions of chronic disease, through the nature of care for chronic conditions. It is argued that chronic diseases are themselves, socially constructed, despite widely accepted disease classification systems.

Thus, there is a need to examine how different ideas have permeated our clinical and health system developments and their social context and vice versa.

Health care systems cannot afford to avoid, and should actively embrace the critiques of social theory and analyses in the transformations of health systems to improve chronic care. Creative tensions between empirical and intellectual critique, and a synthetic middle ground are likely to lead to more realistic and innovative approaches spanning the nature of chronicity and the transformation of Primary Care.

32) **Menser TL, Radcliff TA, Schuller KA. Implementing a medical screening and referral program for rural emergency departments. J Rural Health. 2014 Aug 13.**

Emergency Department (ED) overcrowding due to nonemergent use is an ongoing concern. In 2011, a regional health system that primarily serves rural communities in Texas instituted a new program to medically screen and refer nonemergent patients to nearby affiliated rural health clinics (RHCs). This formative evaluation describes the program goals, process, and early implementation experiences at 2 sites that adopted the program before wider implementation within the rural health system.

Primary data collection including document review, internal stakeholder interviews, and direct observation of program processes were used for this formative evaluation of program implementation in light of program goals and objectives. Fourteen key informants were asked questions related to the program concept, structure, and implementation.

The program, as implemented, aligned with initial program goals, but it was dependent on ED screening staff and RHC availability. Some adjustments to the program were needed, including RHC hours, consistency among staff in making referrals, patient education, and improving patient uptake on the referral. Stakeholders reported lessons learned related to training, staff buy-in, Emergency Medical Treatment and Labor Act (EMTALA), and intra-organizational cooperation. The system was able to leverage excess capacity of affiliated RHCs to accommodate low-acuity patients referred from the ED and may lead to improvements in Triple Aim goals of increased patient satisfaction, better population health and outcomes, and lower per capita costs. Lessons learned from this program may inform similar processes aimed to reduce nonemergency ED utilization by other rural health systems.

33) **Piper LE. The affordable care act: the ethical call to transform the organizational culture. Health Care Manag (Frederick). 2014 July-Aug;33(3):267-72.**

The Patient Protection and Affordable Care Act will require health care leaders and managers to develop strategies and implement organizational tactics for their organization to survive and thrive under the federal mandates of this new health care law.

Successful health care organizations and health care systems will be defined by their adaptability in the new value-based marketplace created by the Affordable Care Act. The most critical underlining challenge for this success will be the effective transformation of the organizational culture. Transformational value-based leadership is now needed to answer the ethical call for transforming the organizational culture. This article provides a model and recommendations to influence change in the most difficult leadership duty-transforming the organizational culture.

34) **Willging CE, Lamphere L, Rylko-Bauer B. The transformation of behavioral healthcare in New Mexico. Adm Policy Ment Health. 2014 Jul 1.**

Since 1997, public-sector behavioral healthcare in New Mexico has remained under continual transition. We have conducted qualitative research to examine recent efforts in NM to establish a recovery-oriented behavioral healthcare system, focusing on comprehensive community support services, clinical homes, and core service agencies. We examine how decisions made in the outer context (e.g., the system level) shaped the implementation of each initiative within the inner context of service provision (e.g., provider agencies). We also clarify how sociopolitical factors, as exemplified in changes instituted by one gubernatorial administration and undone by its successor, can undermine implementation efforts and create crises within fragile behavioral healthcare systems. Finally, we discuss findings in relation to efforts to promote wraparound service planning and to establish medical home models under national healthcare reform.

35) **Health System Measurements Project. Retrieved from** https://healthmeasures.aspe.hhs.gov/

The Health System Measurement Project tracks government data on critical U.S. health system indicators. The website presents national trend data as well as detailed views broken out by population characteristics such as age, sex, income level, and insurance coverage status.

36) **Clinical Trials.gov. PCI Informed Consent Into an Evidence-based Decision-making Tool (PRISM). 2012 Sept 7. Retrieved from** http://clinicaltrials.gov/ct2/show/NCT01383382?term=health+systems+transformation&rank=1

Using individualized patient estimates of procedural risks and benefits, this project will transform the process of informed consent for coronary angioplasty into a dynamic educational tool for patients and physicians and is a direct response to the Institute of Medicine's call for a more evidence-based, efficient, patient-centered healthcare system. It is hypothesized that patients will develop a greater understanding of their individual risks and benefits from PC, will be empowered to more actively engage in shared decision-making, as well as have improved awareness of their responsibility to adhere to

dual anti-platelet therapy if treated with a drug eluting stent. It is also anticipated that physicians, in turn, will use these individualized estimates to better discriminate between risks and benefits among different bleeding avoidance therapies so as to improve the safety and cost-effectiveness of PCI.

37) **Burke G. Trends and Changes in the New York State Health Care System: Implications for the Certificate of Need (CON) Process. United Hospital Fund. 2012 November. Retrieved from** https://www.health.ny.gov/facilities/public_health_and_health_planning_council/docs/con_redesign_report_appendix_e.pdf

This article discusses the benefits of moving healthcare towards a more patient-centered and holistic model, the factors that drive the change, two leading organizations that are driving the change, and changes that are happening in the physical environment of healthcare facilities.

38) **What is Happening in Healthcare Settings Today? Regents of the University of Minnesota and Charlson Meadows. 2012. Retrieved from** http://www.takingcharge.csh.umn.edu/explore-healing-practices/healing-environment/what-happening-healthcare-settings-today

This article discusses the benefits of moving healthcare towards a more patient-centered and holistic model, the factors that drive the change, two leading organizations that are driving the change, and changes that are happening in the physical environment of healthcare facilities.

39) **Miller, Harold D. Making the Business Case for Payment and Delivery Reform. Robert Wood Johnson Foundation. Center for Healthcare Quality and Payment Reform. Retrieved from** http://www.chqpr.org/downloads/BusinessCaseforPaymentReform.pdf?utm_source=Business+Case+for+Payment+Reform&utm_campaign=BusinessCase&utm_medium=email

In order to support improvements in both health care delivery and payment systems, individuals and organizations that purchase health care services need a clear *business case* showing that the proposed change in care will achieve sufficient benefits to justify whatever change in payment health care providers need to support the change in care. Health care providers also need a clear business case showing that they will be able to successfully deliver high-quality care in a financially sustainable way under the new payment system. This report describes a 10 step process to develop such a business case.

40) **Finger Lakes Health Systems Agency. Our Programs. Retrieved from** http://www.flhsa.org/our-programs

Finger Lakes Health Systems Agency is an independent health planning organization working collaboratively with multi-stakeholder groups to improve health quality and access and eliminate health care disparities. The first three programs, "CMMI Health Care Innovation Award," "Regional Commission on Community Health Improvement," and "Community Wide Care Transitions Intervention" may be of most interest to this initiative.

41) **Institute for Healthcare Improvement. Triple Aim for Populations. Retrieved from** http://www.ihi.org/Topics/TripleAim/Pages/default.aspx

The Institute for Healthcare Improvement has developed resources and spotlight articles emphasizing the triple aim framework: simultaneously improving the health of the population, enhancing the experience and outcome of the patient, and reducing per capita cost of care for the benefit of communities. This webpage includes links to video and online publication resources as well as a calendar of upcoming educational programs.