

Enhancing Performance Via Integrated Health Systems

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Integrated Health System

- Combines physician practices, health insurance plan, and hospitals
- Typically called an “integrated delivery system” in the U.S.

Today's Talk

- Is a fundamental change in health care needed?
- Organized processes to improve quality and control costs:
 - What processes?
 - Do they work?
 - What kinds of organizations can implement them?
 - How can organizations be encouraged to implement them?

- “We should recognize that the scientific side of medicine is up to date and in full synchronization with the peaks of human achievement, while . . . the social and the economic sides as developed are often archaic and ineffective in operation.”
- “The High Points in the Recommendations of the Committee on the Costs of Medical Care,” by Ray Lyman Wilbur, *Journal of the American Medical Association*, vol 207, #24, 1932.

“Between the health care we have and the care we could have lies not just a gap but a chasm.”

Institute of Medicine. “Crossing the Quality Chasm: A New Health Care System for the 21 Century” 2001.



"Doctor, you must stop addressing your Medicare patients as Comrade."

To Err is Human

- Preventable medical errors are a leading cause of death in the U.S.
- Cause more deaths than motor vehicle accidents, breast cancer, AIDS
 - Institute of Medicine. “To Err Is Human: Building a Safer Health Care System.” 2000.

To Err is Human

- 44,000-98,000 deaths per year in the U.S. from mistakes in care in the hospital
- this is the equivalent of two to four Airbus or Boeing Jumbo Jets crashing every week, with all on board dying

Quality of Outpatient Care Is Not What It Could Be

- 6,712 patients (national random sample)
- 439 quality indicators
- 30 acute and chronic conditions
- plus preventive care
- 99,000 individual “indicators” examined
- **Appropriate care given 55% of the time**

E.A. McGlynn, S.M. Asch, J. Adams, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348, no. 26 (2003):2635-2645.

Failures to Inform Patients of Clinically Significant Test Results

- 5000 patients in 23 medical groups;
- mean failure to inform rate = 9%
- range = 0-29%
- what failure to inform rate is acceptable?

– Casalino et. al., manuscript in preparation

The problem is bad systems, not
lazy or incompetent people.

Individual Physician View of Quality

- quality is what a physician does:
 - for whatever patients happen to show up
 - while the patient is in front of the physician
- this view is necessary, but not sufficient

Organized Process View of Quality

- quality is also what an organization (integrated health system, medical practice, sickness fund, disease management company . . .) does:
 - for the population of patients for which it is responsible
 - using organized care management processes
- should complement the individual physician view

Organized Processes

- During and between outpatient visits
- Hospitalized patients
- Transfers
 - outpatient \boxtimes hospital
 - physician \boxtimes physician

Population-Based Care

- Know who your patients are
 - for preventive care
 - by type of chronic illness
- Stratify the patients by risk
- Higher risk patients get more attention
- Care goes on **BETWEEN** visits, not just during visits
- Help patients learn to manage their own illness.

Know Who Your Patients Are

- Three possible ways:
 - patients assigned to the physician by the entity that pays for care (capitation, lists)
 - electronic registries
 - for diabetics, congestive heart failure, etc.
 - to track preventive care
 - card files for practices that lack IT

Stratify Patients by Risk/Need

- Sophisticated: use of predictive modeling software
- Unsophisticated: physicians and nurses refer patients for extra attention

Beyond the Traditional Office Visit

- How can a physician:
 - know that patients who should come in are coming in?
 - know that patients understand what they must do for their illness?
 - know when patients are deteriorating between visits?

Beyond the Traditional Office Visit

- How can a physician:
 - remember and find time to give all appropriate care:
 - acute
 - chronic
 - preventive
 - find time to coordinate a patient's care?

Care Between Visits

- Web-based information for patients
- periodic mailing of information \pm reminders
- patient education classes and/or group visits
- phone contact as needed: daily, weekly, monthly, quarterly . . .
- in-home biometric monitoring devices
- home visits by nurses
- nurse case management/coordination

Care During Visits

- for the physician:
 - reminders
 - electronic medication ordering and review
- for the patient:
 - education and preventive care (e.g. influenza immunization) from non-physician staff

Provide Easy Patient Access to the System

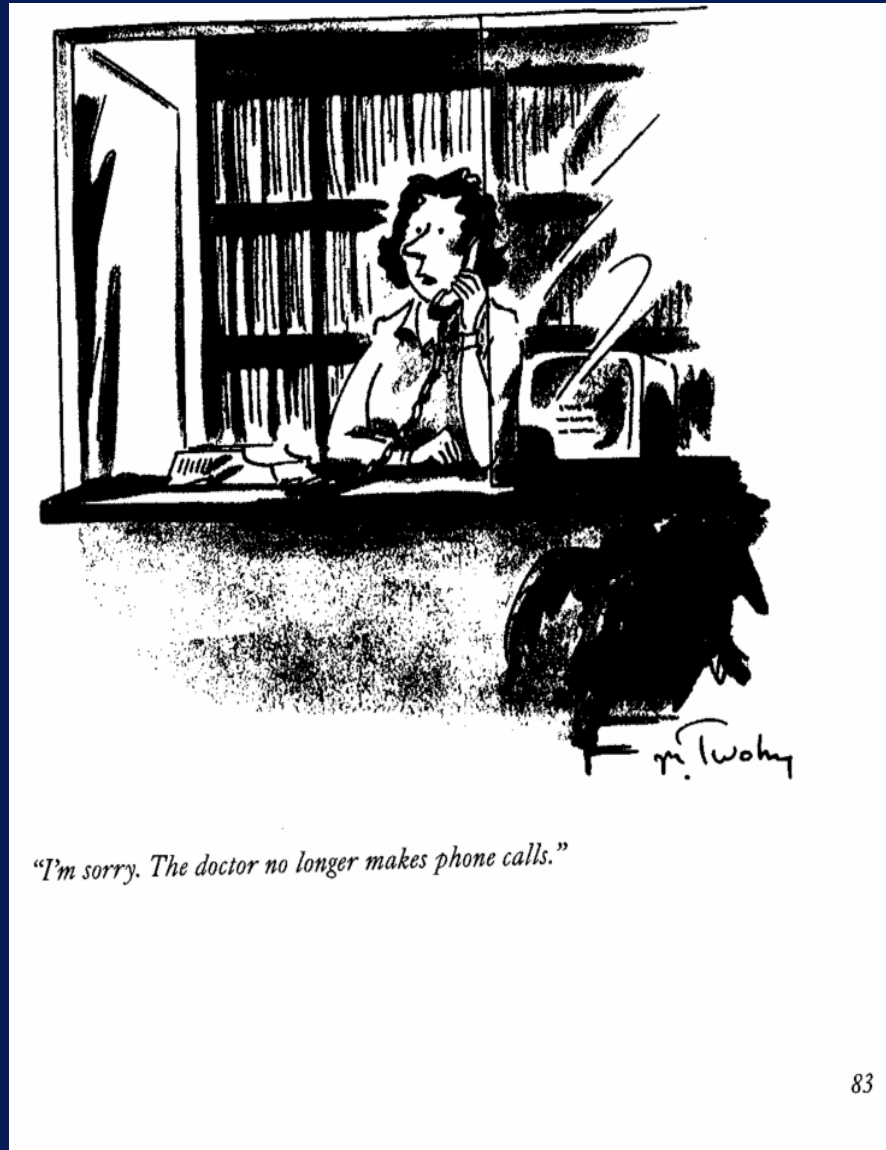
- phone calls and e-mail, with staff or physicians, can substitute for many face-to-face appointments
- same day access to face-to-face appointments as needed
 - the “Advanced Access” model

How should physicians spend
their time?



Hamster Care

- Like hamsters on a wheel
- physicians are running faster and faster
- but getting nowhere.



New Model of a Primary Care Physician's Day

	<u>Hours</u>
Face to Face Visits: (10, average 21 minutes each)	3.5
E-mail and Phone Contact with Patients: (30, average 5 minutes each)	2.5
Coordinate Care (contact with staff and physicians inside and outside the practice):	1.0
Review charts and staff reports re patients:	1.5
Patient contacts by MD:	40
Patient contacts by staff:	many

Advantages for Patients

- don't have to leave home or work
- don't have to find transportation
- don't have to bring the children or find someone to care for them
- don't have to wait in the doctor's office
- have adequate face-to-face time with unhurried physicians when time is needed
- easy phone and e-mail access

Advantages for Physicians

- adequate face time with patients who need it
- not necessary to run from patient to patient
- time to think
- time to coordinate with colleagues
- happier patients
- provide higher quality care

General Model:PDSA

- key principle: test quickly, on a small scale, modify as needed, then spread rapidly
- bring together a team
- identify a problem
- then iteratively plan, do, study, act

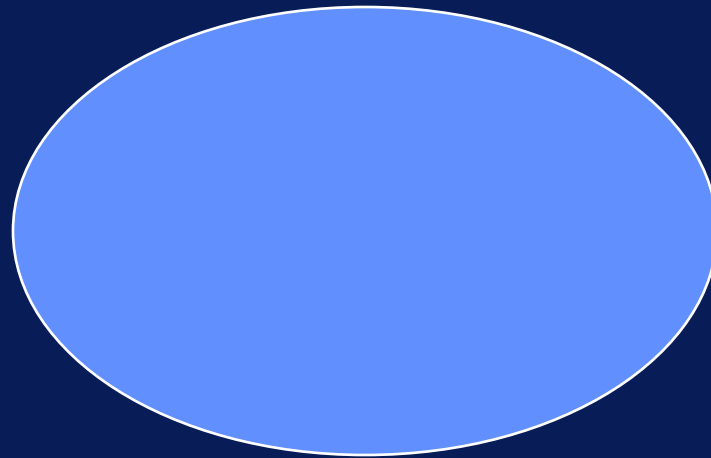
PDSA

Plan

Act

Do

Study



Plan

- team:
 - identifies goals
 - identifies what is to be measured
 - predicts what will happen and why
 - plans who, what, where, when, how

Do

- carry out the plan
- collect the data
- document experiences, problems, surprises

Study

- compare results with predictions
- analyze problems
- draw conclusions

Act

- modify strategy as indicated
- act to spread the strategy to a larger part of the organization and/or
- being a new PDSA cycle

How Prevalent Is the Use of Organized Processes to Improve Quality in the U.S.?

- physician groups: uncommon
- hospitals: more common, but still a long way to go
- health plans: more common, but not well-integrated with physicians
- integrated systems: much more common

Do Organized Processes to Improve Quality Work?

- many positive, unpublished examples in individual organizations
- literature to date suggests that they are useful, BUT
- very difficult to evaluate rigorously
- few truly rigorous studies exist

Success Factors for Effective Organized Processes to Improve Quality

- strong support from the organization's leadership and from physician "champions"
- trained staff are given time to devote to organized processes to improve quality
- the organizational culture supports quality
- improving quality is rewarded by payers

A Fundamental Problem:

Is there a mismatch between:

- THE TYPES OF ORGANIZATIONS WE HAVE

and

- THE TYPES OF ORGANIZATIONS WE NEED

to successfully use organized processes to improve quality?

Types of Organization We Have

- many very small physician practices
- very few large medical groups
- very few integrated systems
- similar in many European countries

U.S. Physicians

- 1/3 in solo practice
- 1/3 in practices of 2-4 physicians
- 90% in practices of ≤ 9 MDs

Advantages of Integrated Systems

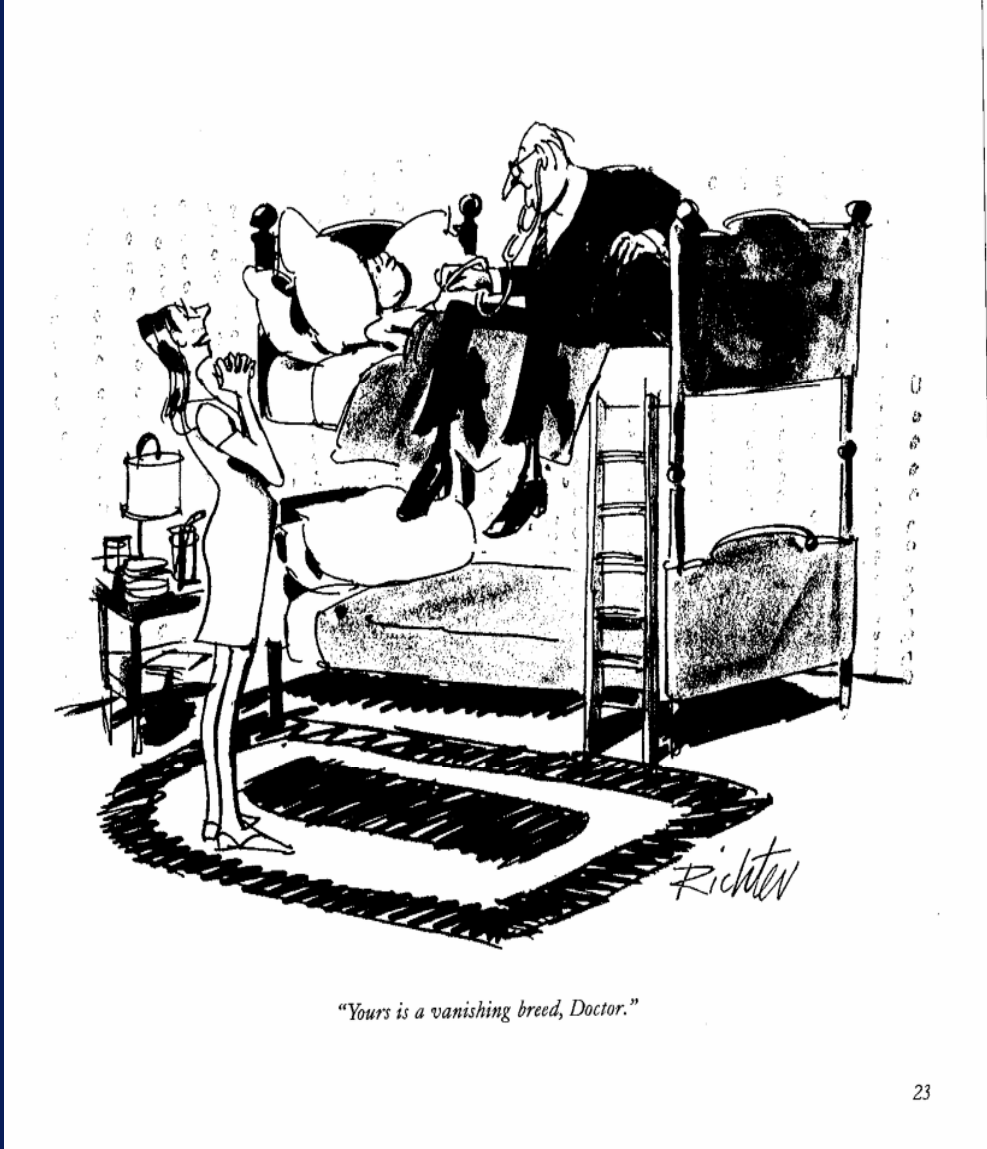
- economies of scale and scope
- sophisticated information technology
- access to data (patient visits, lab, etc.)
- sophisticated MD and non-MD staff with time to devote to organized processes
- aligned incentives (?) among health plan, hospitals, physicians
- multiple MD specialties working together, formally and informally

Disadvantages of Integrated Systems

- diseconomies of scale and scope
- relations among staff and between staff and patients may be less close than in small practices
- governance/internal political struggles/bureaucracy
- very difficult to create integrated systems

Advantages of Small Physician Practices

- close relations among staff and between staff and patients
- strong MD commitment to the practice
- in theory, can rapidly implement changes



"Yours is a vanishing breed, Doctor."

Small Practices Can Implement Some Organized Processes to Improve Quality

- simple registries
- simple reminders for physicians and patients
- chart review to measure quality
- group visits
- advanced access
- e-mail and phone access for patients
- the “Advanced Medical Home” (see American College of Physicians reference)

Disadvantages of Small Physician Practices

- lack of capital and of leadership time and expertise to create organized processes and to purchase and make good use of information technology
- lack of staff training and time to implement organized processes
- lack of strong governance \Rightarrow difficult decisions may never be made
- focus on the short term
- not a good locus for measuring quality or for taking financial risk for the costs of patient care

Do Integrated Systems Perform Better Than Small Physician Practices?

- many analysts believe that they do
- should be better able to implement organized processes
- Kaiser, VA, Mayo, Geisinger, and others are generally admired
- you will hear what Kaiser does
- data generally favors integrated systems
- but little data is available

Key Policy Decision

- Focus on creating integrated systems?

OR

- Focus on working with the small physician practices that exist?

Performance of an organization =
f(Capabilities + Incentives)

Two Approaches to Increasing Performance

- increase capabilities
- increase incentives

Capabilities

- leadership with time, skills, and support to implement organized processes
- clinical information technology
- organized processes incorporated as organizational routines
- physician and staff culture that understands and supports organized process view

Direct and Indirect Ways to Increase Capabilities

- Direct:
 - feedback/provision of data
 - technical assistance
 - infrastructure support (e.g. information technology)
 - “learning cooperatives” - e.g. the Institute for Healthcare Improvement (IHI)
- Indirect:
 - simply give incentives and let organizations increase capabilities as they think best

Possible External Incentives

- pay for performance
- public reporting of performance
- selective or tiered contracting
- regulation/mandates/licensing

Probably Need Some External Incentive:

- we are not just asking individual physicians to try harder
- we are asking physician groups and other organizations to make substantial investments in improving quality
- can't expect such investments without the ability to recover the investment

Incentives and Integrated Health Systems

- If incentives are strong enough
- and integrated systems are able to perform better
- then the number of integrated systems should increase.

Dealing with the Mismatch

- Integrated health systems and large medical groups have more capabilities
- “Outside” organizations might assist small physician practices
 - leading to the best of both worlds (gaining the advantages of the large and of the small)?
 - or to an inefficient mess?

Large Organizations Could Provide:

- registries and identification of high risk patients
- alerts for physicians when a patient is not doing well
- reminders for patients and physicians
- feedback to physicians on performance
- care for patients between visits
- nurse case managers

What Kinds of Organization Might Provide These Things?

- Payers: health plans/sickness funds/
government
- disease management companies
- hospitals
- “virtual” physician networks (e.g.
Independent Practice Associations)

Problems with “Outside” Organizations Providing Organized Processes

- Contact with patients comes from outside organization rather than from physician organization
- These organizations are distant from patients and physicians
 - patients may not cooperate
 - physicians may not cooperate
 - “one-size-fits all” processes
- Outside organization and physicians do not have shared IT/data systems
- **Integrated systems do not have these problems.**

Conclusions (I)

- The status quo is not acceptable.
- We need organized processes to improve quality
- Goal should be to increase the performance of organizations, not to exhort individual physicians to try harder.

Conclusions (2)

- Three important mismatches:
 - individual physician vs. organized process views of quality
 - fragmented delivery system with many small physician practices vs. need for organized processes to improve quality
 - current payment systems vs. need for practices/organizations to invest substantially in improving performance

Conclusions (3)

- integrated health systems have more capabilities than small physician practices.
- Compared to outside organizations like sickness funds or disease management companies, integrated systems should be better able to engage patients and physicians.
- But these systems have some disadvantages as well.
- And few exist; they are difficult to create.

Key Policy Decisions (1)

- Focus on creating integrated systems

AND/OR

- Focus on improving the performance of the smaller, non-integrated organizations that are far more common?

Key Policy Decisions (2)

- Focus on directly assisting organizations to increase their capabilities

AND/OR

- Provide performance incentives for organizations to increase their capabilities

“The mere operation of the machinery of modern medical practice requires great administrative skill and enormous expenditures. The physician can no longer be independent of these great agencies. He can, though, command them and see that they are used for their highest purposes, but in order to do so, he must take part in the business, social and economic reorganization that is required . . .”