

The Question of the Day

How do we get physicians to engage with each other in improving quality and value?”



History of Clinical Integration: *(The Dell Classics Version)*

- The oddballs and socialists: Mayo, Kaiser...
- The 1990s:
 - Primary care purchases
 - PHOs
 - Mergers and Systems
 - Much ado about lawyers, clout, and economies of scale
 - Much less about clinical care, improvement, and engagement
 - A lot of debris, a few survivors



And Then, Along Comes The Affordable Care Act

- This is a lot about ***insurance reform***.
- For doctors and hospitals, the clearest implication is ***more patients at reduced rates of payment***. (Docs, don't expect the hospital to be able to bail you out).
- Many experimental features of the ACA are aimed at driving the health delivery system to produce ***better value, not just higher volumes***. Some experiments might work. All of them benefit from some degree of clinical integration.
- Unintended consequences are likely
 - Market consolidation
 - 3 ways to get a better number: Improvement, suboptimization, and cheating



Reforms that Drive Value and Clinical Integration, Not Just Volume and Independence

- Simple Incentives:
 - Rewards for A's
 - Expanded public display of performance results for both doctors and hospitals
 - Value-based purchasing
 - Punishment for defects
 - Readmissions
 - Healthcare acquired conditions
- More Complicated New Models:
 - Episode-based budgets and bundled payments
 - ACOs, attributed costs, partial capitation, and OWAs



The Biggest Driver of Clinical Integration

“Even the insured can no longer afford our services.”

Jeff Goldsmith



Moving to a Value-Driven Business Model Will Require Real Clinical Integration

- The expanding “Risk Envelope” for hospitals and doctors
 - A la carte
 - Per RVU
 - Per admission
 - Per episode
 - Per enrolled life
 - Per whole community cost profile (ACO)

Volume



Where are you on this evolving spectrum?

Value





**Danger!
Cross
Quickly!**



**Per episode
Per enrolled life
Per community cost profile**

**A la carte
Per RVU
Per admission**



True Clinical Integration:

A Definition

“Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.”



True Clinical Integration: Four Examples

1. Institute for Clinical Systems Integration
2. GEMS
3. Consultants in Medical Oncology and Hematology
4. McLeod Regional Medical Center



ICSI

- Business driver: BHCAG's desire to purchase care from "the functional equivalent of an integrated delivery system"
- Professional driver: "To be part of what's right, rather than what's wrong, with American health care."
- Mayo, Park Nicollet, Health Partners, independent practices....eventually, 90% of care in Minnesota driven by common guidelines and quality improvement methods



GEMS Organizations

- Billings, Geisinger, Cleveland, Gundersen Lutheran, Guthrie, Henry Ford, Marshfield, Lahey, Mayo, Palo Alto, Scott and White...
- Better quality, lower cost (Weeks et al. *Health Affairs*, May 2010: 991-997)
- **Key Characteristics:**
 - **Physician leadership**
 - **Recruitment for values: teamwork, acceptance of “public practice,” responsibility for improvement and change**



CMOH

- 10-doctor oncology practice, first “Specialty Patient Centered Medical Home”
- Hallmarks
 - Intense collaboration with patients and staff
 - Standardization to evidence-based practices
 - Prevention of “Potentially Avoidable Complications”
 - Electronic measurement and performance monitoring built into routine documentation
- Results
 - Reduced emergency visits, readmissions, length of stay...
 - Higher patient satisfaction
 - Better outcomes



McLeod Regional

- Waiting list of doctors wanting to lead QI
- McKesson Award
- Hallmarks
 - Ask doctors to lead
 - Ask physicians what they want to work on
 - Make it easy for docs to lead and to participate
 - Recognize doctors when they lead
 - Back up physician leaders, with courage
 - Provide opportunities for doctors to learn and grow



The Four F's

Form

The doctors work
in our building



We employ/partner
with the doctors



Community
ownership

Finance

Individual
FFS



Evidence-based
case rates,
bundled
payments...



Population-based
budgets

Function

High quality care
for individual acute
and chronic
patients



High value care for
specific sets of
acute and chronic
disease patients



The Triple Aim:
High value care
for populations

Feeling

Individual
responsibility
and autonomy



Team accountability
Patient and family
empowerment



Care team, patient,
and community
responsibility
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Rushing to the ACO Operating Room: Have You Signed Your Informed Consent?

- Why are you doing this procedure?
 - Clout? Copycat? Community?
- What values will guide you?
 - Protection? Value? Patient-centeredness?
- Whom will you invite to join?
 - Everybody's welcome? A select few?
- Who will decide these things?
 - Those with the money? Those with the knowledge?
- ***What could possibly go wrong?***



Edgar Schein's view of what leaders can do to change and develop organizational culture

Primary Mechanisms

- What you pay attention to, measure, and control on a regular basis
- How you react to critical incidents and organizational crises
- Observed criteria by which you allocate scarce resources
- Deliberate role modeling, teaching, and coaching
- Observed criteria by which you allocate rewards and status
- Observed criteria by which you recruit, select, promote, retire, and excommunicate organizational members

Secondary Mechanisms

- Organization design and structure
- Organization systems and procedures
- Design of physical space, facades, and buildings
- Stories, legends, and myths about people and events
- Formal statements of organizational philosophy, values, and creed

Are ACOs the Answer to Care Coordination, Overuse, Safety...?

- If the Group Practice Demonstration Project is the model, perhaps not.
 - Hitting the “spending reduction targets” had more to do with coding than with actual cost reduction
 - Only half the groups got any extra payments
 - Groups who were already low in cost simply worked hard, made quality better, and got nothing.
 - Berenson, RA: Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere? Am. J. Mgd. Care Oct 2010 721-725



Achieving quality goals had nothing to do with getting shared savings payments

Summary Results of the Physician Group Practice Demonstration, Performance Years 1–4.*

Physician Group Practice	Percentage of Quality Goals Attained				Shared Savings Payments (\$)			
	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Billings Clinic, Billings, MT	90.91	97.78	98.11	92.45	0	0	0	0
Dartmouth–Hitchcock Clinic, Lebanon, NH	95.45	97.78	92.45	94.34	0	6,689,879	3,570,173	328,798
Everett Clinic, Everett, WA	86.36	95.56	94.34	94.34	0	129,268	0	0
Forsyth Medical Group, Winston-Salem, NC	100.00	100.00	96.23	96.23	0	0	0	0
Geisinger Clinic, Danville, PA	72.73	100.00	100.00	100.00	0	0	1,950,649	1,788,196
Marshfield Clinic, Marshfield, WI	81.82	100.00	98.11	100.00	4,565,327	5,781,573	13,816,922	16,154,242
Middlesex Health System, Middletown, CT	86.36	95.56	92.45	94.34	0	0	0	0
Park Nicollet Clinic, St. Louis Park, MN	95.45	97.78	100.00	100.00	0	0	0	0
St. John's Clinic, Springfield, MO	100.00	100.00	96.23	98.11	0	0	3,143,044	8,185,757
University of Michigan Faculty Group Practice, Ann Arbor	95.45	100.00	94.34	96.23	2,758,370	1,239,294	2,798,006	5,222,852

* Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

If you're really going to reduce costs for a population...

- You'll probably have to be driven by both upside and downside risks.
- You'll probably have to know who's in the population
- You'll have to find some way to align provider incentives with your business model
- You'll have to know how to reduce waste
- You'll have to control capacity, especially for overused services



Leadership, or Victimhood?

This is the true joy in life, to be used for a purpose you consider a mighty one, to be a force of nature, rather than a feverish, selfish clod of ailments and grievances, complaining that the world will not devote itself to making you happy.

GB Shaw