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Delivery System Reform: Moving From Fragmentation To High Performance

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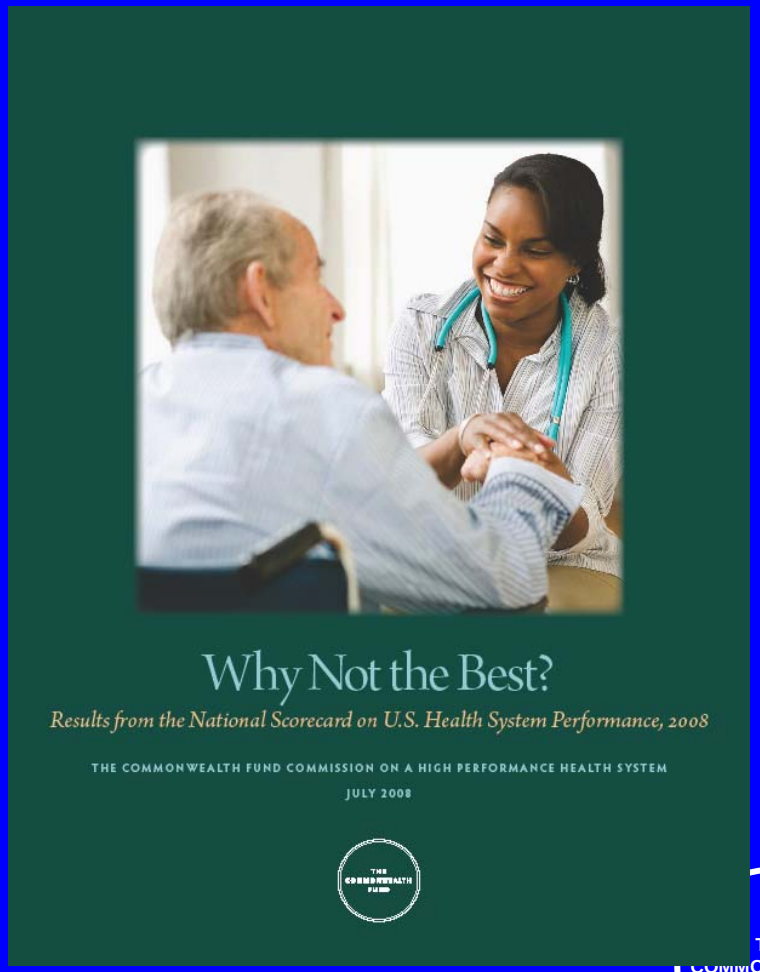
Commonwealth Fund Commission on a High Performance Health System: 2008 US Scorecard: Why Not the Best?

Chairman: James J. Mongan, M.D.
President and CEO Partners HealthCare System, Inc.



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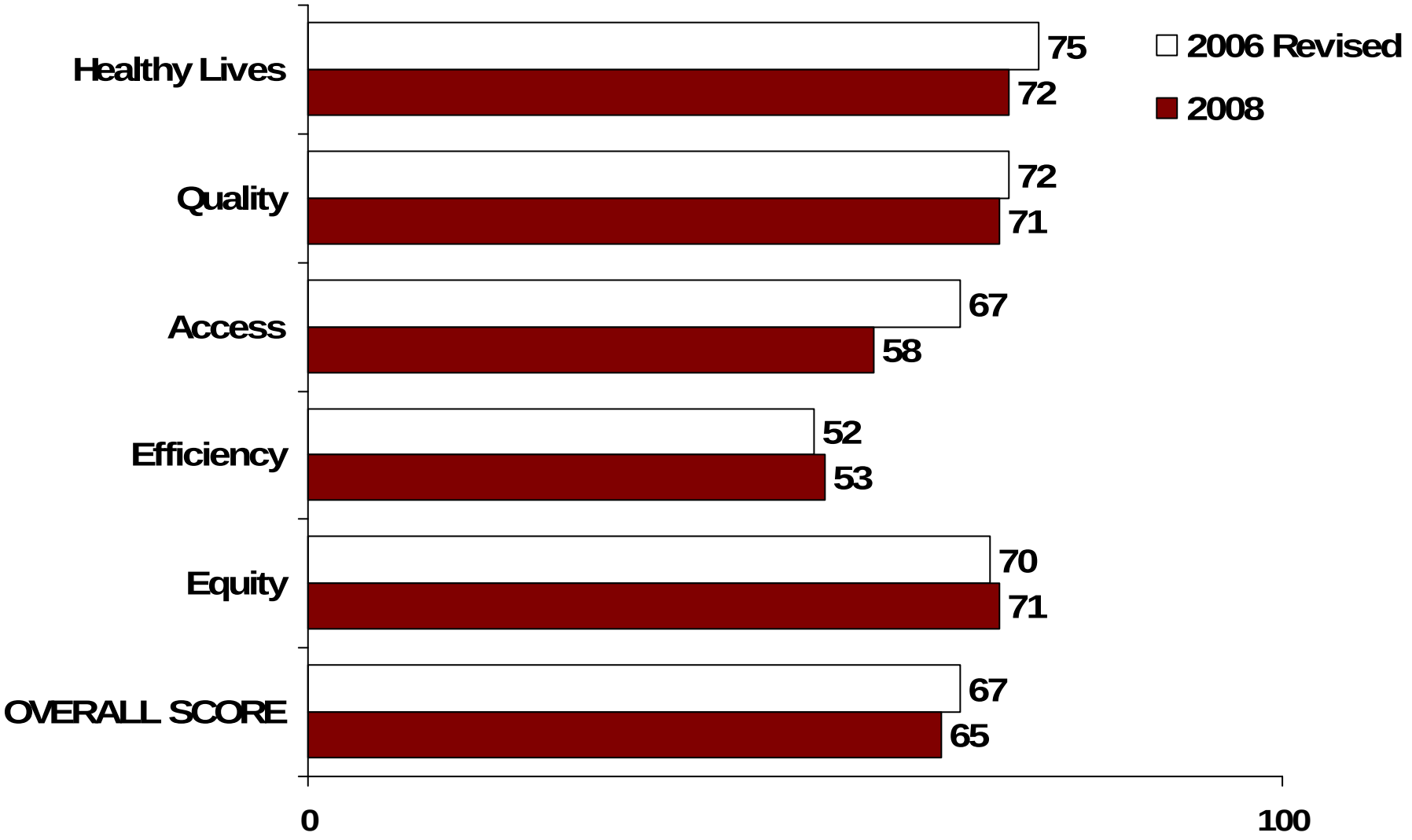
Scores: Dimensions of a High Performance Health System



Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

So, Why Do We Need Health Reform?

- Poor coverage, access
- Inefficient care
  - Unnecessary hospitalizations; high readmissions
  - Unnecessary duplication of tests
- Poor quality & safety
  - Poor application/execution of known effective practices
  - Frequent adverse events/error

Furthermore:

- Enormous variation in performance
- Overall high cost

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Five Key Strategies for High Performance/Health Care Reform

1. Extend affordable health insurance to all
2. Align financial incentives to enhance value and achieve savings
3. Organize the health care system around the patient to ensure that care is accessible and coordinated
4. Meet and raise benchmarks for high-quality, efficient care
5. Ensure accountable national leadership and public/private collaboration

Source: Commission on a High Performance Health System, A High Performance Health System for the United States: An Ambitious Agenda for the Next President, The Commonwealth Fund, November 2007

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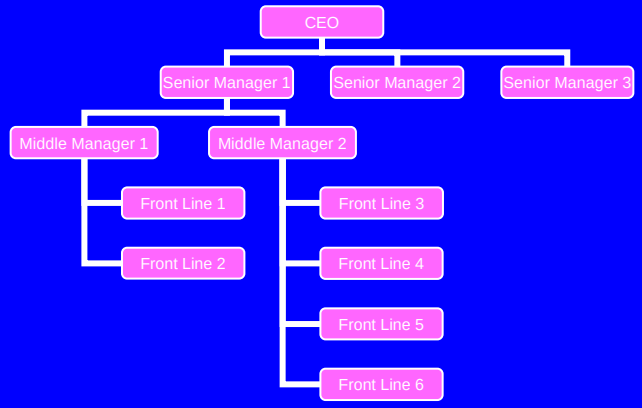
The Promised Land:

Higher Value Care: Higher Quality; Affordable Cost

Can We Reach It?

Organization and Payment

- **Organizations Matter**
  - Organizations are necessary but not sufficient for providing better, more coordinated care
  - Why?



- **Payment methods**
  - Incentives need to be aligned with performance (ultimately outcomes) not quantity of care

The Problem

"The American health care system is the poster child for underachievement… The largest limiting factor is not lack of money, technology, information, or even people but rather a lack of an *organizing principle* that can link money, people, technology, and ideas into a *system* that delivers more cost-effective care (in other words, more value) than current arrangements."

Source: Stephen M. Shortell and Julie Schmittdiel, in *Toward a 21st Century Health System*, edited by Alain C. Enthoven and Laura Tollen, 2004.

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Evidence on “Organization” - 1

- **Large practices perform better than solo/small practices**
  - **Large practices are twice as likely to engage in quality improvement and utilize EMRs (Audet et al, 2005)**
  - **Large practices have lower mortality in heart attack care than solo practices (Ketcham et al, 2007)**
- **Integrated Medical Groups perform better than IPAs (Independent Practice Associations)**
  - **Integrated medical groups have more IT, more QI (quality improvement) programs, and better clinical performance than IPAs (Mehrota et al, 2006)**
  - **HMOS that use more group or staff model physician networks have higher performance on composite clinical measures (Gillies et al, 2006)**

Evidence on Organization - 2

- **Any network affiliation is better than no affiliation**
  - Although integrated medical groups perform better than IPAs, IPAs are still twice as likely to use effective care management processes than small groups with no IPA affiliation (Rittenhouse et al, 2004)
  - Physician group affiliation with networks is associated with higher quality; impact is greatest among small physician groups (Friedberg et al 2007)

- **Medical groups may be more efficient**
  - Costs are about 25 percent lower in pre-paid group practices than in other types of health plans, but primary data are old (Chuang et al 2004)
  - Physician-to-population ratio is 22-37 percent below the national rate across 8 large pre-paid group practices (Weiner et al, 2004)

Organization as an Enabler of High Performance

Case studies of high-performing organizations clearly demonstrate that only organized systems can dramatically improve quality, efficiency, and patient experience.

Organizations can:

- **Ensure that relevant patient information is available to all providers who need it (information continuity)**
- **Coordinate patient care across providers and care settings**
- **Be accountable for care delivered**
- **Have providers work together to improve quality, efficiency, and patient experience (teamwork, peer review)**
- **Facilitate appropriate/easy 24/7 patient access to care**
- **Innovate and improve continuously**

Source: D. McCarthy et al. Case studies of high-performing organized delivery systems, summarized in: Shih et al. *"Organizing the U.S. Health Care Delivery System for High Performance",* The Commonwealth Fund 2008 (Pub.#1155)

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Performance Enablers in Organizations

- **Capital**
  - Infrastructure
- **Management**
  - Goals/targets
  - Day-to-day supervision
  - Targeted programs

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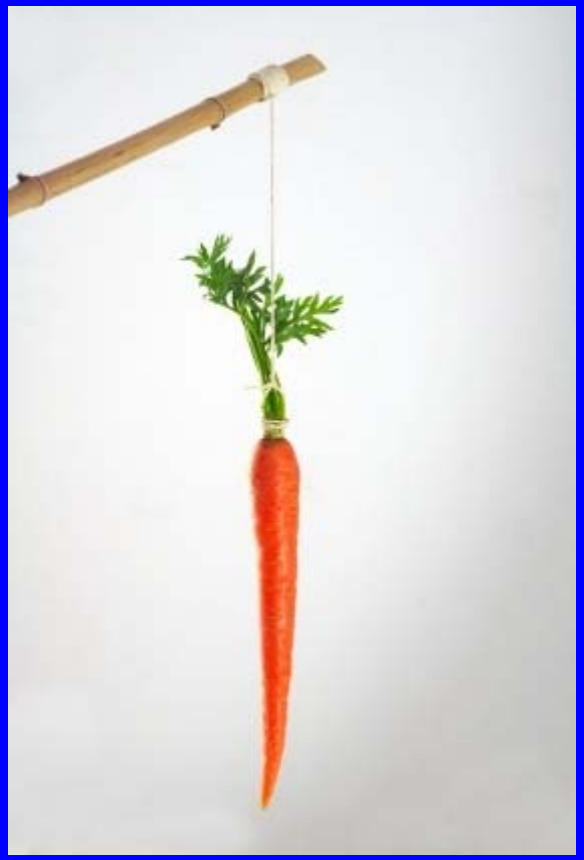
Physician Trends: Away from Small Practices but not Towards High Performing Organizations

- Proportion of physicians in solo and two physician practices dropping: 40.7% to 32.5% from 1996-7 to 2004-05 (Liebhaber and Grossman, 2007)
- But trend is towards mid-sized, single specialty groups of 6 to 50 physicians, not towards large, multispecialty group practices
- Trend is consistent with decline of risk-based capitation
  - in the current fee-for-service environment, mid-size single-specialty groups can negotiate higher payments, concentrate capital, and provide high-profit services (Pham and Ginsburg, 2007)

We Need to Change the Incentives!



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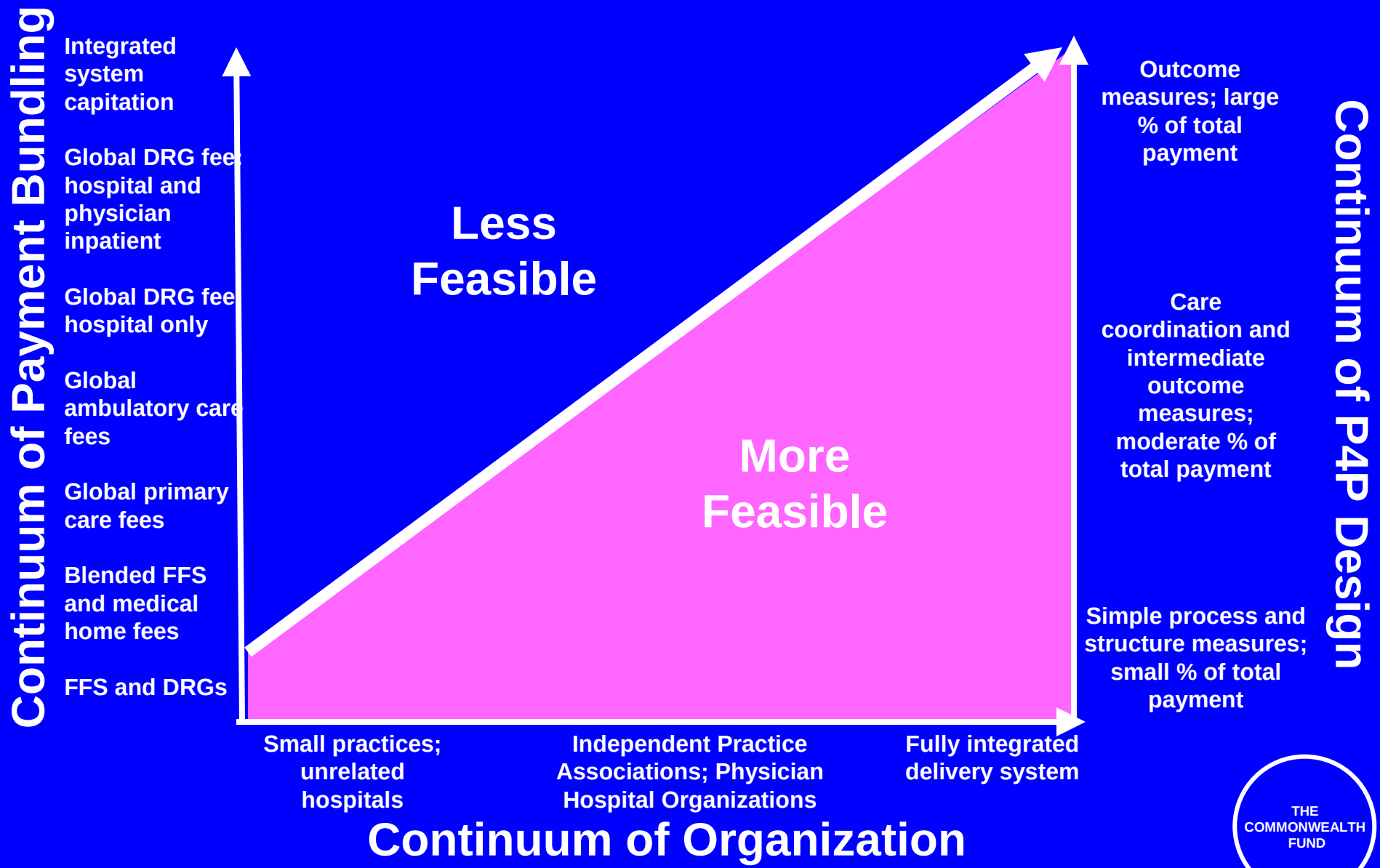
Organization and Payment Methods



Source: The Commonwealth Fund, 2008

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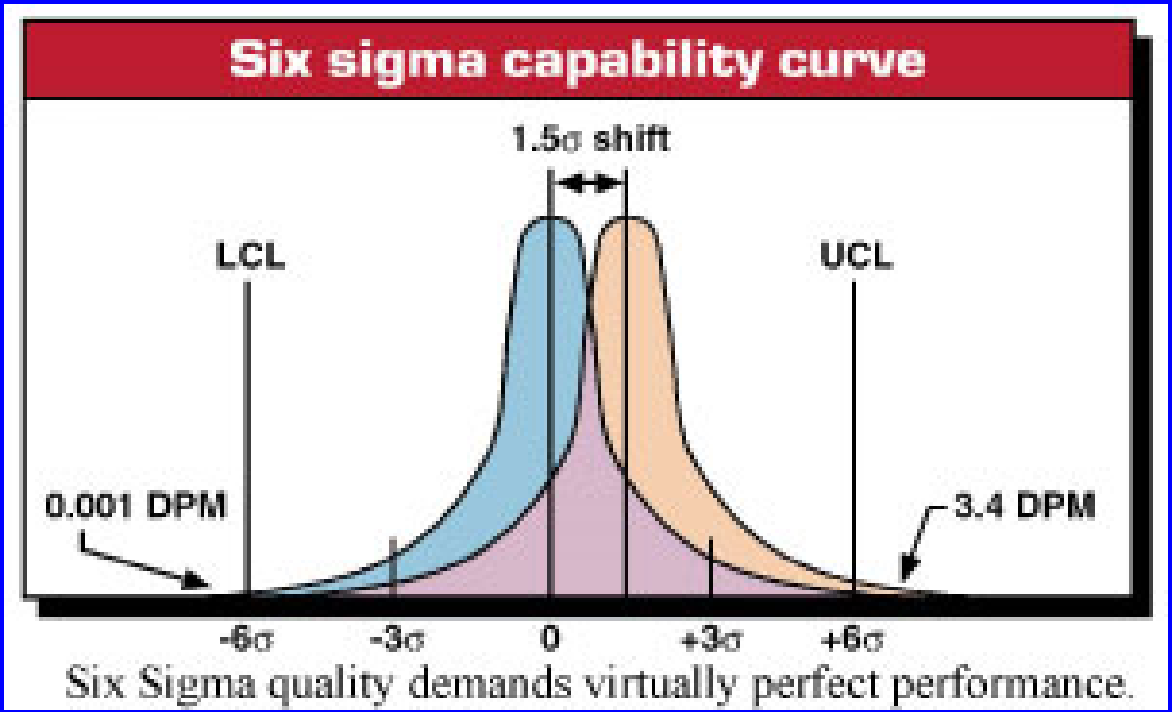
For You and Your Family: Perfection is the Expectation



Six Sigma quality demands virtually perfect performance.

Focus on Quality of Care Delivery

$$F = d/dt\ (mV)$$

Newton's Second Law

$$m_1V_1+m_2V_2+m_3V_3+m_4V_4+\ldots = 0$$

Momentum

$$F = m^*V_e + Ae\ (Pe - Pa)$$

Thrust

$$\Delta V = V_e\ \ln\ (m_0/m_f)$$

Change in Velocity

$$I_{sp} = F/m\ ^*\ g = V_e/g$$

Specific Impulse

YES, IT IS ROCKET SCIENCE!

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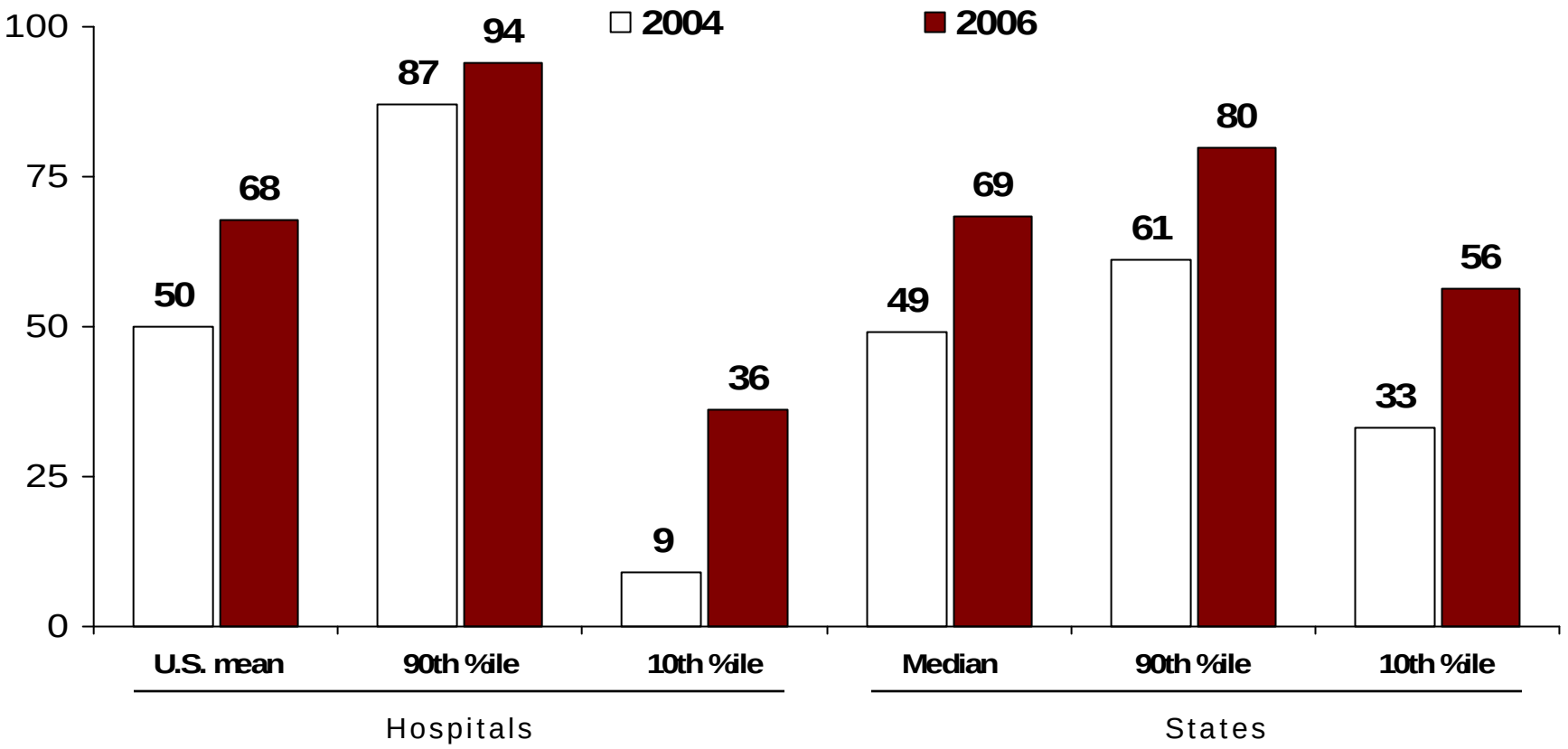
We’re Far From Perfection, But:

- **Improvement can occur and is occurring**

Heart Failure Patients Given Complete Written Instructions When Discharged, by Hospitals and States

Percent of heart failure patients discharged home with written instructions*



* Discharge instructions must address all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.
Data: A. Jha and A. Epstein, Harvard School of Public Health analysis of data from CMS Hospital Compare;
State 2004 distribution —Retrieved from CMS Hospital Compare database at http://www.hospitalcompare.hhs.gov.

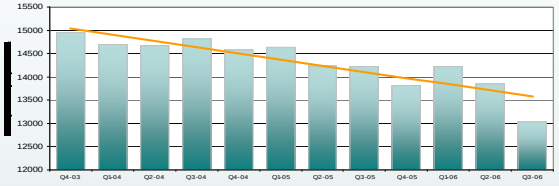
Association Between Quality and Cost:

Based on Premier analysis of 1.1 million patients

Hospital Level Cost Trend Emerges Over 3 Years

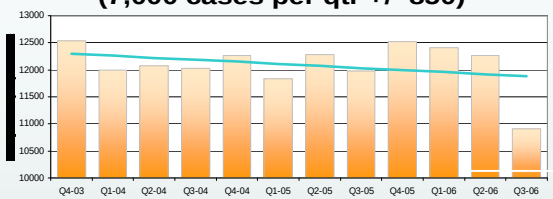
Median Severity Adjusted Cost per Case from October 2003 – September 2006

AMI Patients
(19,000 cases per qtr +/- 2,500)



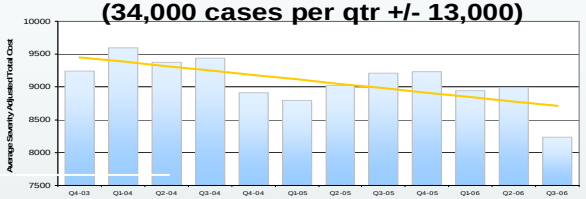
N of hospitals = 233 +/- 12

Knee Replacement Patients
(7,000 cases per qtr +/- 850)



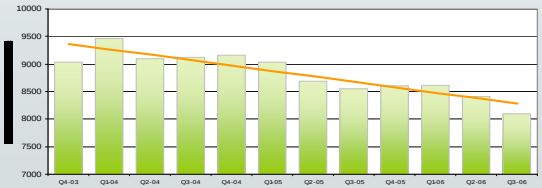
N of hospitals = 191 +/- 7

Pneumonia Patients
(34,000 cases per qtr +/- 13,000)



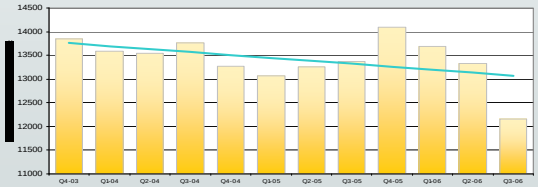
N of hospitals = 253 +/- 10

Heart Failure Patients
(27,500 cases per qtr +/- 5,000)



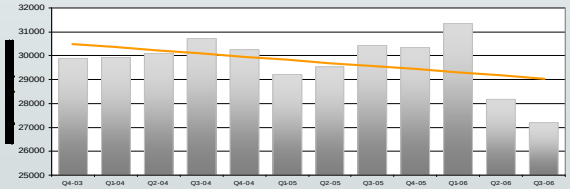
N of hospitals = 250 +/- 10

Hip Replacement Patients
(3,150 cases per qtr +/- 350)



N of hospitals = 145 +/- 8

CABG Patients
(8,300 cases per qtr +/- 1,750)



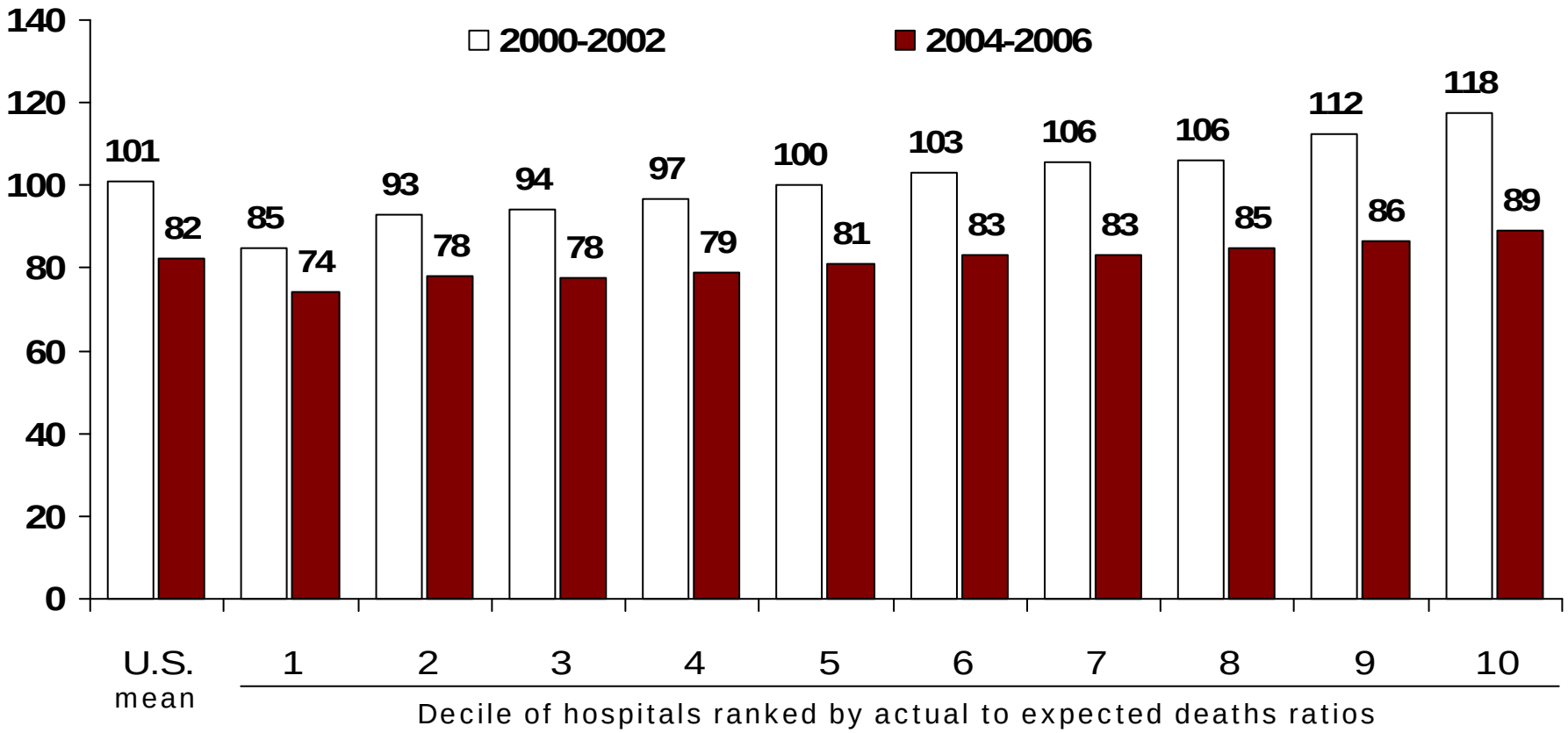
N of hospitals = 130 +/- 5

Statistical Significance: Cost -- AMI (p<0.01), HF (p<0.001), PN (p<0.05).

Hospital-Standardized Mortality Ratios

Standardized ratios compare actual to expected deaths, risk-adjusted for patient mix and community factors.* Medicare national average for 2000=100

Ratio of actual to expected deaths in each decile (x 100)



* See report Appendix B for methodology.

Data: B. Jarman analysis of Medicare discharges from 2000 to 2002 and from 2004 to 2006 for conditions leading to 80 percent of all hospital deaths.

We're Far From Perfection, and:

- Improvement can occur and is occurring in association with:
  - Public reporting, pay for reporting
  - Pay for performance
  - National "campaigns"

We Need to Change the Incentives!

Need A Vision?

- See a world in which health care is:
  - Always designed from the patient perspective
    - Simple, straightforward, culturally sensitive, patient/family involved
  - Efficient
    - No unnecessary steps
  - Safe and effective
    - Perfect = the right thing done the right way

Menu of Concrete Tasks for Health Care Leaders

- Improve coordination of care
  - Implement medical homes
  - Develop “episodes of care” as a product with competitive prices
- Reduce hospital readmissions
- Organize the health care system around the patient to ensure that care is accessible and coordinated
  - Follow patient journeys through your practices & hospitals and redesign/simplify care for the patient
  - Obtain regular patient experience information/feedback
- Put a robust infrastructure in place
  - Health Information Technology, decision-support systems
  - Shared decision-making
  - Seek/train the right workforce for effective, efficient care delivery
- Participate in collaborations & campaigns
- Make perfection your goal: settle for nothing less

Thank You!

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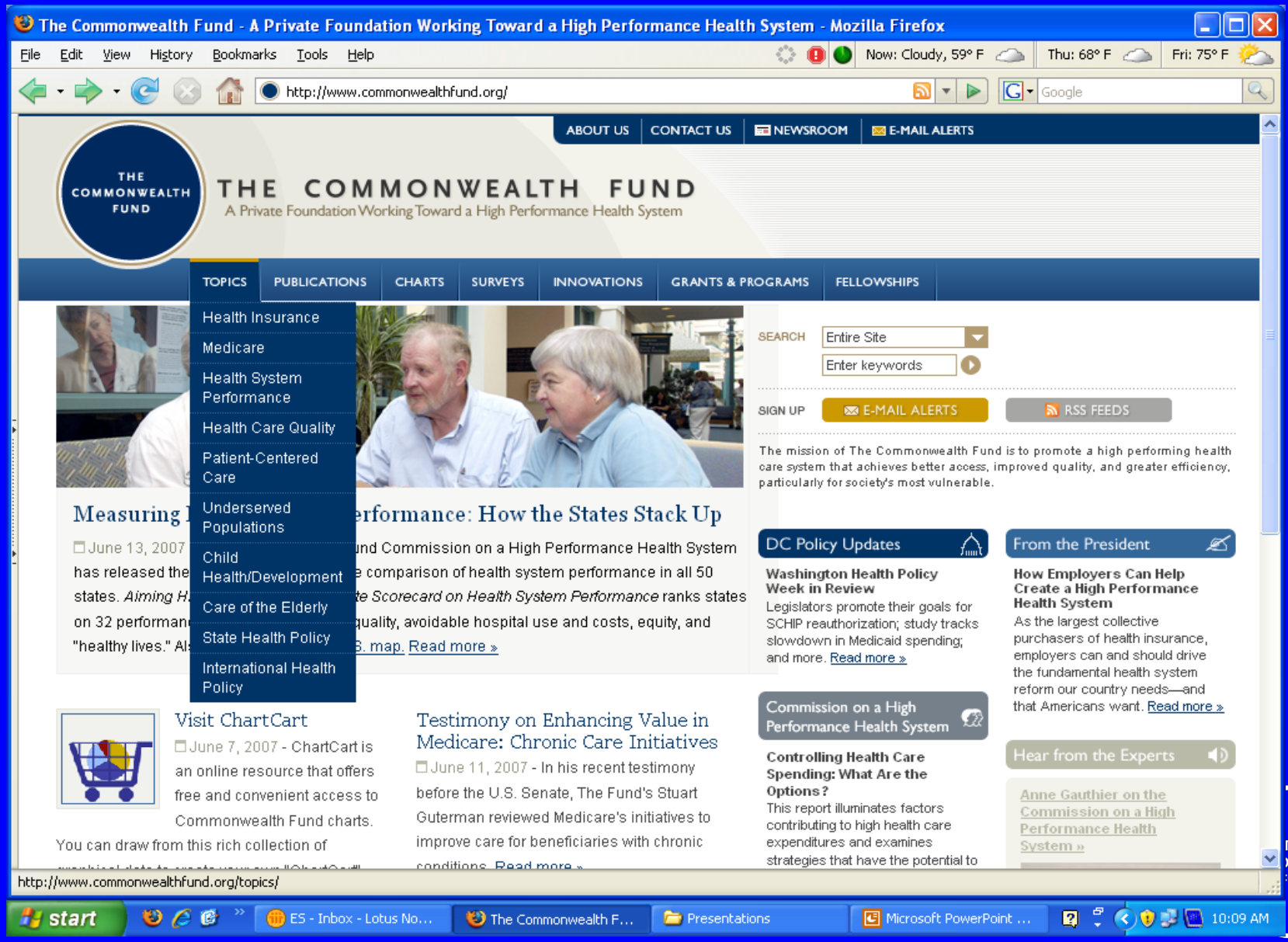

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