

Moving Toward Systemness: Creating Accountable Care Systems

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Can Payment and Other Innovations Improve the
Quality and Value of Health Care?
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The three legged stool is on the ground

- Access
- Cost
- Quality



We have a fragmented wasteful delivery system that is not nearly as good as it can and should be.

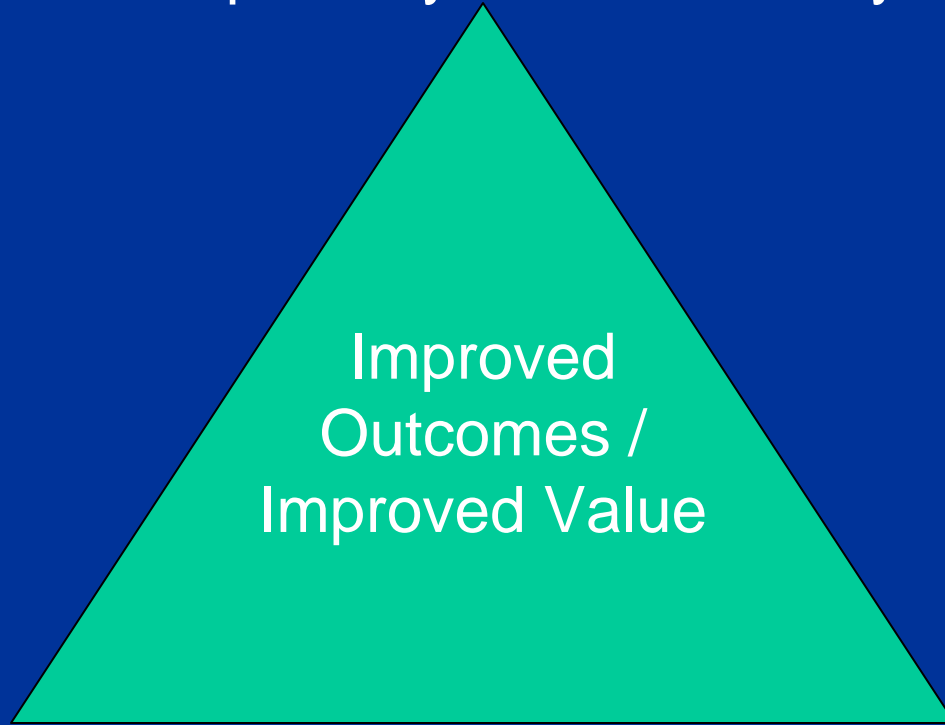
“Posterchild for Underachievement”

Performance Measurement /
Transparency / Accountability

Improved
Outcomes /
Improved Value

Incentives

Capabilities



Incentives

- Changes in Physician Payment - MEDPAC
- Paying for Results – Improved Quality and Cost Performance
- Public Reporting
- Recognition / Award Programs
- Intrinsic Professional Pride and Motivation

Desired Performance Capabilities¹

- Redesign Care Processes
- Effective Use of Electronic Information Technology
- Manage Clinical Knowledge and Skills
- Teamwork

¹ Adapted from Crossing The Quality Chasm, IOM, Washington, D.C., 2001

Performance Capabilities

- Care Coordination
- Performance and Outcome Measurement
- Adapt to Change

Hospitals and physicians need to form new relationships to enhance their capability to respond to the new incentives.

Accountable Care System Concept

An entity that can implement organized processes for improving the quality and controlling the costs of care and be held accountable for results.

Source: S.M. Shortell and L.P. Casalino, "Healthcare Reform Requires Accountable Care Systems", Fresh Thinking Workshop, Center for Advanced Study in the Behavioral Sciences, Stanford University, March, 2007

Six Models

- Multi-Specialty Group Practice (MSGP)
- Hospital Medical Staff Organization (HMSO)
- Physician-Hospital Organization (PHO)
- Interdependent Practice Organization (IPO)
- Health Plan-Provider Organization / Network (HPPO / HPPN)
- Independent Practice Unit (IPU)

Multi-Specialty Group Practice (MSGP)

- 17-26% of practicing physicians are associated with a MSGP of 100 physicians or more
- Increases to 35% if you include groups of 20 or more
- Many Advantages
 - Economies of scale
 - Greater use of IT
 - Teamwork
 - Shared learning
 - Prevention emphasis
- Disadvantages
 - Difficult to create – high capital needs
 - Diseconomies of large size
 - Potentially cumbersome governance and management

Hospital Medical Staff Organization (HMSO)

- Potentially Includes nearly all practicing physicians
- Most physicians have a primary relationship with a single hospital
- Advantages
 - Hospital Resources for IT adoption, quality improvement and performance measurement
- Disadvantages
 - Historically contentious relationship
 - Problematic leadership
 - Legal obstacles – gain-sharing and others

Physician-Hospital Organization (PHO)

- Involves a subset of all hospital medical staff physicians – based on quality and cost criteria
- About 1,000 PHO's currently exist
- Advantages
 - Can focus on higher-performing physicians – “internal tiering”
 - Hospital resources for IT, quality improvement and performance measurement
- Disadvantages
 - Potentially disruptive relationships between those physicians “in” and those “out”
 - Leadership challenges
 - Most existing PHOs not well managed or governed

Interdependent Practice Organization (IPO)

- Estimated 48% of all of office-based practicing physicians are in solo or two person partnerships
- Advantages
 - Dependent on strong leadership and governance structures
 - Ability to “pool” patients and practices to create virtual groups
 - Share IT, quality improvement, and performance measurement expertise and resources
 - Advantages for rural and small practices
- Disadvantages
 - Lack of needed leadership
 - Lack of start-up capital and resources
 - Physician resistance

Health Plan-Provider Organization / Network (HPPO / HPPN)

- Health plans develop exclusive relationship with a network of physicians
- Advantages
 - Availability of data, IT, resources for quality improvement (e.g. disease management programs) performance measurement and reporting
 - Lower transaction costs – physicians work with only one plan
- Disadvantages
 - One step removed from the actual delivery of care
 - Problematic leadership

Independent Practice Unit (IPU Porter and Teisberg)

- Specialized practices compete on cost / quality criteria
- Advantages
 - Potentially better outcomes at lower cost for targeted conditions and patients with single illness
- Disadvantages
 - Not well suited to patients with chronic illness – 75% of all expenditures
 - Barrier to coordination of care
 - Likely to promote greater fragmentation

There is increasing evidence that more organized forms of physician practice are associated with providing greater value (cost and quality performance) in the delivery of health care services.

Some Examples

Author / Date / Journal	Finding
Mehrotra, et al (2006, <i>Annals of Internal Medicine</i>)	<ul style="list-style-type: none">• Integrated medical groups (IMGs) more likely than IPAs or hybrids to have an electronic medical record and to use more quality improvement programs.• IMGs had higher HEDIS-like scores than IPAs on 4 preventive measures but not on 2 chronic disease measures.
Gillies, et al (2006, <i>Health Services Research</i>)	<ul style="list-style-type: none">• The greater the extent to which an HMO's physician network is characterized as either a group or staff model, the higher the plan's performance on four out of five composite quality measure.

Some Examples (cont'd)

Author / Date / Journal	Finding
McMenamin, et al (2004, <i>American Journal of Preventive Medicine</i>)	<ul style="list-style-type: none">• Medical groups four times more likely to offer any of 8 health promotion programs than IPAs; being a medical group rather than an IPA significantly and positively associated with increase in the number of programs offered.
Shortell and Schmittdiel (2004, <u>Towards a 21st Century Health System</u> , Enthoven and Tollen, eds.)	<ul style="list-style-type: none">• 12 large prepaid medical groups significantly more likely to use care management processes (CMPs) for patients with asthma, congestive heart failure, depression, and diabetes than other large but more loosely-organized groups.

Some Examples (cont'd)

Author / Date / Journal	Finding
MedPAC (2007, Congressional Report)	<ul style="list-style-type: none">• In 4 geographic regions studied, spending on the highest quintile of Medicare beneficiaries was lower for patients associated with multi-specialty or hospital-affiliated groups than for other patients.
Chuang, et al (2004, <u>Towards a 21st Century Health System</u> , Enthoven and Tollen, eds.)	<ul style="list-style-type: none">• Meta-analysis. Costs are about 25 percent lower in prepaid group practices than in health plans built around other types of provider groups; not possible to determine what aspect of the prepaid group practices drives down costs.

Some Examples (cont'd)

Author / Date / Journal	Finding
Asch, et al (2004, <i>Annals of Internal Medicine</i>)	<ul style="list-style-type: none">• VA patients scored significantly higher than other patients on RAND's Quality Assessment Tool Indicators for overall quality, chronic disease care and preventive care but not for acute care.

Current National Study of Physician Organizations II – Key Findings

- Patient-Centered Organizational Culture Strongly Associated with Greater Use of Recommended Care Management Processes
- Greater Participation in Quality Improvement Programs
- Being Externally Evaluated for Clinical Quality and Patient Satisfaction
- Very Large Size Medical Groups (400 physicians plus)

Source: Working Paper, National Study of Physician Organization and the Management of Chronic Illness 2, UC-Berkeley, University of Chicago, UCSF, 2008

Patient Centered Culture

- Assesses patient needs and expectations
- Promptly resolves patient complaints
- Complaints are studied to identify patterns
- Uses patient data to improve care
- Uses patient data when developing new services

Use of Care Management Processes (CMPs) by Physician Organizations, According to Type of Chronic Illness

Type of CMPs	Diabetes (n=523)† #(%)	Asthma (n=522) #(%)	CHF (n=526) #(%)	Depression (n=497) #(%)	% Using CMP for All Four Conditions
Patient list or registry	367 (70.2)	326 (62.4)	308 (58.5)	203 (40.8)	192 (39.1)
Provide patient educators	387 (73.9)	281 (53.8)	282 (53.6)	176 (35.4)	150 (30.5)
Physician feedback on quality	346 (66.1)	293 (56.1)	267 (50.8)	163 (32.8)	152 (30.9)
Nurse care managers	286 (54.7)	223 (42.7)	250 (47.5)	125 (25.1)	117 (23.8)
Patient reminders	269 (51.4)	184 (35.2)	184 (35.0)	98 (19.7)	94 (19.1)
Point-of-care reminders	268 (51.2)	190 (36.4)	174 (33.1)	114 (22.9)	96 (19.5)
No. (%) using all 6 CMPs	113 (21.6)	55 (10.5)	53 (10.1)	22 (4.4)	18 (3.7)
Mean CMP Use (out of 6)	3.7	2.9	2.8	1.8	11.1

Source: National Survey of Physician Organizations and the Management of Chronic Illness II (2007)

† The number of physician organizations treating each disease

What is needed to promote ACS development?

Focus on 3 I's¹:

- Information
- Infrastructure
- Incentives

¹ “VR Fuchs, “Health Care Expenditures Re-Examined,” Annals of Internal Medicine, 2005, 143(1):76-78.

Information

- Create a national performance measurement system (IOM recommendation)
- Create a national center for evidence-based medicine and management (Shortell, Rundall, and Hsu, JAMA, August 8, 2007:673-676)
- Create a national center for comparative effectiveness (IOM recommendation)

Infrastructure

- Create incentives for electronic information technology adoption
- Create incentives for medical schools and other health professional schools to teach content in process improvement, leadership development, change management skills and related skills

Incentives

- Recommend CMS reward physician differentially based on results
- Also build in incentives and rewards for improvement
- Create non-monetary recognition awards
- Experiment with bundled payments
- Create incentives for consumers to select the highest performing providers
- Expand public reporting of cost and quality data to include physician practices
- Reward or mitigate legal barriers to ACS information

In Conclusion

Is greater integration of the delivery system necessary to improve quality and efficiency?

YES

Can “systemness” be accomplished, even assuming it improves quality, when most of the care provided in this country is so diffuse?

YES, but with great difficulty. It is the fundamental challenge!

Selective Reference List

F.J. Crosson, "The Delivery System Matters," *Health Affairs*, V. 24, no. 6 (November/December 2005), pp. 1543-1548.

S. Shortell and L. Casalino, "Accountable Care Systems for Comprehensive Healthcare Reform," prepared for the workshop "Organization and Delivery of Care and Payment to Providers," Center for Advanced Study in the Behavioral Sciences, Stanford University, March, 2007.

D.R. Rittenhouse, K. Grumbach, E.H. O'Neil, C. Dower, and A. Bindman, "Physician organization and care management in California: from cottage to Kaiser," *Health Affairs*, V. 23, no. 6 (November/December 2004), pp. 51-62.

S.M. Asch, et al, "Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample," *Annals of Internal Medicine*, V. 141, no. 12 (2004), pp. 938-945.

A. Mehrotra, et al, "Do Integrated Medical Groups Provide Higher-Quality Medical Care than IPAs?" *Annals of Internal Medicine*, V. 145, no. 11 (December 5, 2006), pp. 826-833.

Selective Reference List (cont'd)

R. Gillies, et al, "The Impact of Health Plan Delivery System Organization on Clinical Quality and Patient Satisfaction," *Health Services Research*, V. 41 no. 4, part 1 (August 2006), pp. 1181-99.

S. McMenamin, et al, "Health Promotion in Physician Organizations: Results from a National Study," *American Journal of Preventive Medicine*, V. 26, no. 4(2004), pp. 259-264.

S. Shortell and J. Schmittdiel, "Prepaid Groups and Organized Delivery Systems: Promise, Performance, and Potential," in Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice. AC Enthoven and LA Tollen, Editors, San Francisco: Jossey-Bass, 2004.

L. Casalino, R. Gillies, et al, "External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients with Chronic Diseases," *JAMA*, V. 289, no. 4, (2003), pp.434-441.

L. Casalino, K.J. Devers, et al, "Benefits of and Barriers to Large Medical Group Practice in the United States," *Archives of Internal Medicine*, V. 163, no. 16 (2003), pp. 1958-1964.

Selective Reference List (cont'd)

A. Audet, M. Doty, J. Shasdin, and S. Schoenbaum, "Measure, Learn, and Improve: Physicians' Involvement in Quality Improvement," *Health Affairs*, V. 24 no. 3 (May/June 2005), pp. 843-853.

A.M. Audet, et al, "Information Technologies: When Will They Make It into Physicians' Black Bags?" *Medscape General Medicine*, Dec. 7, 2004.

D. Rittenhouse and J.C. Robinson, "Improving Quality in Medicaid: The Use of Care Management Processes for Chronic Illness and Preventive Care," *Medical Care*, V. 44, no. 1 (January 2006), pp. 47-54.

Shortell et al, "An Empirical Assessment of High-Performing Medical Groups: Results of a National Study," *Medical Care Research and Review*, V. 62, no. 4 (August 2005), pp. 407-434.

Medicare Payment Advisory Commission, *Assessing Alternatives to the Sustainable Growth Rate System*, March 2007, Washington, DC (p. 117), www.medpac.gov/publications/congressional_reports/Mar07_SGR_mandated_report.pdf

W. Manning, et al, "A Controlled Trial of the Effect of a Prepaid Group Practice on the Use of Services," *New England Journal of Medicine* 310, no. 23 (1984).

Selective Reference List (cont'd)

J. Kralewski, E.C. Rich, R. Feldman, et al, "The effects of medical group practice organizational factors on cost of care," *Health Services Research*, V. 35, no. 3, pp. 591-613.

K. H. Chuang, H.S. Luft, and R.A. Dudley, "The Clinical and Economic Performance of Prepaid Group Practice," in Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice, A.C. Enthoven and L.A. Tollen, editors, Jossey-Bass, 2004 (San Francisco, CA), pp. 45-60.

L. Tollen, "Organizing Medicine: Linking Physician Group Organizational Attributes to Quality and Efficiency of Care", Preliminary Draft, Kaiser-Permanente Institute for Health Policy, Oakland, California, August, 2007.