



Delivery Systems Matter!

Improving Quality and Efficiency in Health Care

National Conference Summary

The American health care delivery system is in need of fundamental change... The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.

– Institute of Medicine, 2001¹ –

With these words from its *Crossing the Quality Chasm* report, the Institute of Medicine (IOM) challenged Americans to rethink the way our health care delivery systems are organized. Despite universal acclaim for the IOM's prescription for change, this call to action is often lost in the debate about health care cost and quality. Instead, stakeholders have focused on more short-term fixes, such as innovations in benefit design and strategies to improve the purchasing power and acumen of individuals and small groups. However, these strategies will fail to deliver on their promise if they are built on the inadequate chassis of our current health care delivery system.

On March 17, 2004, a number of organizations convened a national policy conference to address these issues. The meeting, held in Washington DC, was entitled **“Delivery Systems Matter! Improving Quality and Efficiency in Health Care.”** The conference cosponsors were:

- Kaiser Permanente Institute for Health Policy
- American Medical Group Association

- Alliance of Community Health Plans
- Council of Accountable Physician Practices
- *Health Affairs*
- Institute for Healthcare Improvement
- The Robert Wood Johnson Foundation

The purpose of the meeting was to encourage discussion about the need and means to transform health care delivery systems, integrating and organizing them for improved quality and efficiency. Presenters addressed the following questions:

1. What evidence exists about the impact of delivery system structure on cost and quality?
2. What lessons from high-performing delivery systems apply to the health care marketplace as a whole?
3. What are some new models of delivery system integration?
4. What can policymakers and purchasers do to encourage greater delivery system integration?

The following is a summary of the conference.² The agenda, speaker materials, and biographies can be found at www.kpihp.org, along with a link to a webcast and transcripts from kaisernetwork.org.

THE IOM VISION AND WHY INTEGRATED DELIVERY SYSTEMS CAN GET US THERE

To frame the day's discussion, **George Isham**, MD, of HealthPartners moderated a panel that included **Harvey Fineberg**, MD, PhD, of the Institute of Medicine, **Francis J. Crosson**, MD, of The Permanente Federation and the Council of Accountable Physician Practices, and **Stephen Shortell**, PhD, of the University of California at Berkeley School of Public Health.

Dr. Fineberg outlined the IOM's challenge—and vision—for a 21st century health system, as presented in *To Err is Human*³ and *Crossing the Quality Chasm*.⁴ He noted that these

reports have helped transform the way we think about health care quality by asserting that quality is a systems issue, requiring a systems solution with action at multiple levels. In other words, poor quality is not simply about bad doctors. It is about the environment in which health care is delivered.

To transform that environment, Dr. Fineberg said, organizations must meet the following challenges:

- Redesign care processes based on best evidence;
- Make effective use of information technology;
- Manage clinical knowledge and skills;
- Develop effective teams;

- Coordinate care across conditions, services and settings; and
- Measure and improve performance and outcomes.

Are certain organizational forms better suited than others to meeting these challenges? Dr. Crosson focused on the organizational form of the multispecialty group practice (MSGP), a model with a 100-year history and a national presence. The MSGP model is compatible with both fee-for-service (FFS) and prepayment and could be available to a majority of Americans, 80 percent of whom live in populous metropolitan areas large enough to sustain a large, multispecialty group.

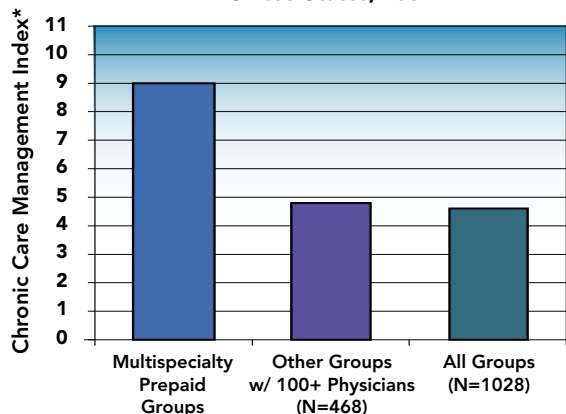
Some of the competencies of MSGPs—those which make them a uniquely stable platform from which to address the IOM's challenges—include: multispecialty coordination of care for complex and chronic conditions; an infrastructure to use evidence-based and systematic care processes to improve quality and efficiency; and the resources and organizational capability to deploy state-of-the-art clinical information technology (IT).

Crosson concluded that for MSGPs to make the most of these competencies, they need three things from purchasers and policymakers:

- Better quality and performance measures;
- Linkages between those measures and the flow of dollars; and
- Incentives for investment in clinical IT.

Professor Shortell reviewed current evidence about the impact of delivery system structure on the six quality criteria identified by the IOM's *Chasm*

Figure 1: Chronic Care Management in Multispecialty Prepaid Groups Versus Other Physician Groups, United States, 2002



*Chronic Care Management Index is on a scale from 0 to 11. Measures include patient self-management, linkages to community resources, delivery system re-design, decision support tools, etc.

Source: National Study of Physician Organizations and the Management of Chronic Illness, School of Public Health, University of California, Berkeley, November, 2002.

report: safety, effectiveness, efficiency, patient-centeredness, timeliness, and equity. Little existing research separates health maintenance organizations (HMOs) by type, for example, “delivery system HMOs” based on multispecialty prepaid group practices versus “carrier HMOs” based on insurance products. The general HMO/FFS literature is mixed; in some areas HMOs perform better, while in others, FFS is superior.⁵

However, new research on organized groups and health plans affiliated with them demonstrates that they achieve better clinical effectiveness and

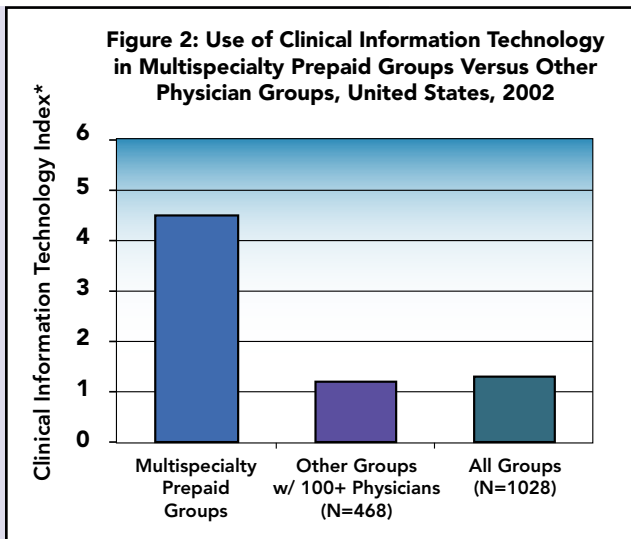
more use of evidence-based care management.⁶ In a national survey of physician organizations, multispecialty, prepaid group practices consistently outperformed other large groups in measures of chronic care management and use of information technology (see Figures 1 and 2). They were also more likely to operate in a purchaser environment that rewards quality (e.g., through bonuses) and to report a positive financial impact from investments in chronic disease management.

Shortell concluded that there is mounting evidence of the superior quality

provided in the prepaid, multispecialty group setting but that further research is needed. In addition, there will always be some consumers who simply prefer—and can afford—care delivered in the traditional, solo- or small-group, FFS setting.

Professor Enthoven stated that purchasers must accept some responsibility for the limited presence of integrated delivery systems, asserting that “purchaser policies choose the delivery system.” Few employers provide incentives that would lead employees to choose integrated systems. One such incentive is the offering of multiple delivery systems, not simply multiple carriers with the same all-inclusive network, nor multiple products from a single carrier. Also important is a contribution policy that allows employees to keep any savings resulting from choosing a more efficient plan.

Enthoven also suggested the use of two-carrier “exchanges” to allow separate delivery system-based health plans to go to market as a “single solution” for an employer wanting to offer choice. In this type of arrangement, the employer may pay premiums to a single entity (the exchange), which then remits risk-adjusted payments to the health plans. Such exchanges and similar arrangements—variants of the health insurance purchasing cooperative—already exist. In California, Kaiser Permanente and HealthNet have joined forces to provide a “paired offering” to employers, with risk adjustment performed at the back end by an independent third-party actuary. In the Northwest, Group Health Cooperative and Kaiser



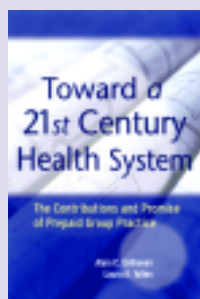
* Clinical Information Technology Index is on a scale from 0 to 6. Measures include standardized problem list, laboratory findings, medications prescribed, radiology findings, progress notes, medication ordering reminders and/or drug interaction information.

Source: National Study of Physician Organizations and the Management of Chronic Illness, School of Public Health, University of California, Berkeley, November, 2002.

WHY HASN'T THE INTEGRATED DELIVERY SYSTEM MODEL BECOME DOMINANT?

The next panel, led by **James Robinson**, PhD, of the University of California at Berkeley, included **Alain Enthoven**, PhD, of Stanford University and **Robert Margolis**, MD, of Healthcare Partners medical group in Southern California.

Many of the Delivery Systems Matter! speakers also contributed to a newly-published book, **Toward a 21st Century Health System: The Contributions and Promise of Prepaid Group Practice**, edited by Alain Enthoven of Stanford University and Laura Tollen of Kaiser Permanente. Published by Jossey-Bass, the book is a collection of research and essays regarding the contributions and future potential of prepaid and multispecialty group practice. Covered topics include: clinical and health services research, chronic disease management, national health policy, innovations in pharmacy benefit management, physician staffing patterns, quality improvement, and more. For more information, please visit www.kpihp.org or e-mail laura.a.tollen@kp.org.



Permanente have both partnered with Cigna in exchanges administered by BENU.

Dr. Margolis offered further insights into why integrated systems have been more successful in California than elsewhere. In California, capitation is strong; health care premiums are among the lowest in the nation; and benchmarking and “pay for performance” initiatives have created pressure to improve quality. In much of the country, however, where these factors have not been present, a number of challenges face integrated care systems, including:

- Difficulty creating group culture among physicians, who, by training, tend to be highly individualistic and self-reliant;
- A need for strong physician leadership;
- Lack of capital necessary to start and maintain a large group;
- Uneven regulatory environments that place greater burdens on HMOs than on PPOs; and
- Lack of risk adjustment, making it a liability for a group to excel at caring for sick people.

Perhaps most importantly, Margolis said, health plans built around integrated care systems have held *themselves* back due to a reluctance to develop the higher cost-sharing insurance products the market currently demands.

WHAT ARE THE NEW MODELS OF INTEGRATION?


The next panel, moderated by **Christine Cassel**, MD, of the American Board of Internal Medicine, assumed that while

organizationally integrated delivery systems can be a platform for the future and an incubator of new approaches, they are not feasible everywhere. Therefore, stakeholders must envision new models that can increase integration among looser networks of physicians and across communities.

Ed Wagner, MD, of Group Health Cooperative discussed coordination of chronic illness care across settings and organizational lines, focusing on the Improving Chronic Illness Care (ICIC) initiative (www.improvingchroniccare.org). Among other activities, ICIC seeks to develop the technical and cultural supports for “systemness” among smaller, independent practices. The initiative uses the chronic care model developed by Wagner and his colleagues as a basis for regional and local-level collaboratives designed to improve clinical performance. Wagner stated that we should view systemness as a “community property,” not solely an organizational one. As an example, he discussed a breakthrough collaborative in Indiana, in which the state Health Department and Medicaid are providing web-based chronic disease registries to all Medicaid providers in the state.

Researchers at RAND Health will present results of an evaluation of the ICIC initiative in June at the Annual Research Meeting of AcademyHealth.⁷ Previewing those results, Wagner said that about 70 percent of teams in the series have achieved improvements in patient care.

Paul Tang, MD, of the Palo Alto Medical Foundation (PAMF), a large multispecialty group in California, spoke about the importance of clinical information technology in coordinating



care. He focused on the role of patient connectivity in creating “continuous healing relationships” by giving patients access to their providers when and where they need it, not solely during scheduled visits.

Dr. Tang demonstrated “PAMFOnline,” a web portal that gives patients secure access to their personal health information. Through the system, patients can book appointments, renew prescriptions, check lab results, review instructions from previous appointments, and communicate with their physicians. About 20,000 patients, reflecting the age profile of the PAMF patient population as a whole, use the online system.

Far from being the “worried well” whom some hypothesized would be the most likely to use such systems, PAMFOnline users have more chronic diseases and take more medications than non-users. Patients especially like the online access to lab test results and their medical records, and the ability to communicate with their physicians. Ninety-three percent of patients and 90 percent of physician users report being satisfied with PAMFOnline (www.pamf.org/PAMFOnline/Demo/home.asp).

David Brailer, MD, PhD, of the Health Technology Center, discussed the concept of the

community-wide health data exchange. He focused on the Santa Barbara Project, a community data exchange funded by the California HealthCare Foundation. The Santa Barbara project is an effort by local health plans and providers to create a full-scale health information utility available to patients and physicians in the community. While Santa Barbara and a few other sites, including Indianapolis, are leaders in this type of activity, Brailer estimated that there are currently 100 to 150 similar projects being formed or under active consideration around the country.

These projects have experienced some challenges, but none has proven insurmountable. Governance is an issue, as it is important to balance proprietary concerns with the need for common data standards and rules. There have also been legal concerns around anti-kickback and antitrust laws, although these fears tend to far exceed true legal barriers. Another challenge has been the development of the technical infrastructure to support security and identity management.

Perhaps the major challenge is that there can be financial winners and losers when the data exchange does what it is intended to do. When communities improve clinical efficiency, entities that rely on high-volume, incidental care (e.g., hospitals) may be harmed.

Benefits of the community-wide data exchange include:

- Longitudinal patient-specific data, reducing fragmentation of the health record. A shared longitudinal health record is commonplace within organized delivery systems but has been difficult to develop in communities dominated by solo and small-group practice.
- Patient control of their own records, reducing patient reluctance to switch providers for fear that their records would not follow them.
- Enhanced disease management capabilities through use of information technology.
- Shared infrastructure, allowing each organization to access a broad network of data and computing power at low fixed costs.

John Cochran, MD, of the Colorado Permanente Medical Group (CPMG) discussed the importance of physician leadership. He noted that information technology and chronic care models are *tools* for improving care delivery, but they will not be successfully adopted without strong physician leadership. “All great ideas still need to be executed well in order to be successful,” he added.

CPMG contracts with a network of non-Permanente physicians for care delivery in Colorado Springs, and it has a partnership with a non-Kaiser hospital in Denver. In this environment, Dr. Cochran said, it is especially important to foster physician leaders who can influence the delivery system



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– John Cochran, MD –

The Kaiser Permanente Institute for Health Policy

exists to provide a focus and resources for Kaiser Permanente to better participate in shaping the nation's health policy agenda. Working in collaboration with foundations, policy institutes, research programs, policymakers, and others, the Institute seeks to develop unbiased information about health policy issues and alternatives with the goal of improving health and the manner in which health care and financing systems serve Americans. For more information, please visit www.kpihp.org, or call (510) 271-6399.

beyond the organization's walls. Examples of how this is accomplished include the following:

- In Colorado Springs, the network of non-Permanente, community physicians is linked to CPMG in various ways. Their department chiefs attend CPMG meetings, and CPMG leadership visits the community hospitals regularly.
- Kaiser Permanente's primary hospital in the Denver area is Exempla/St. Joseph's. CPMG plays a strong role in the leadership of the hospital and maintains hospitalists there.
- In the area of community leadership, CPMG is helping to address the nursing shortage in Colorado. Through its Preferred Clinical Partners program, the group has started three new nursing programs in Denver, in which CPMG physicians serve as mentors and faculty.

Dr. Cochran concluded by saying that for physicians to be true health system leaders and advocates for patients, rigorous performance management is key. "Physician leaders, by definition, must only protect [the] patients," he stated. "We don't protect the physicians.... Our doctors are not...all above average. We have to deal with physician performance issues if we're really going to be the ultimate fiduciaries for patients."

Carolyn Clancy, MD, of the Agency for Healthcare Research and Quality (AHRQ) outlined several exciting opportunities for improving chronic care management in the recently-passed Medicare bill.⁸ The bill directs AHRQ and

the Centers for Medicare and Medicaid Services to work together on disease management in fee-for-service Medicare. Clancy noted that 60 percent of doctors in the United States practice in groups of six or fewer, caring for the majority of the population. As a result, we need to focus on coordinating and improving care outside of integrated delivery systems, as well as within them.

Clancy also spoke about upcoming research and demonstration projects designed to support implementation of IT and chronic care management. AHRQ is investing \$50 million in IT research in several areas:

- Planning grants for rural and under-served communities to conduct needs assessments for investments in health information technology;
- Research on the business case for health information technology (e.g., What are the up-front and transition costs? Is there a case for public investment? What are the gains and losses in revenue and efficiency attributable to implementation of the technology?);
- Research that demonstrates and evaluates the impact on quality, safety, and efficiency of specific applications of health information technology, such as computerized order entry, electronic prescribing, and full electronic medical records; and
- Demonstrations at a state or regional level that build upon the experience of the Santa Barbara data exchange project by supporting exchange of health care information across multiple providers in a community.



WHAT CAN AND SHOULD PURCHASERS AND POLICYMAKERS DO?

The final panel discussed the roles of purchasers and policymakers in promoting greater delivery system integration and organization. **Robert Berenson**, MD, of The Urban Institute, provided the public policy perspective, and **Patricia Nazemetz** of Xerox Corporation provided the purchaser perspective. The panel was moderated by **John Iglehart**, Founding Editor of *Health Affairs*.

Dr. Berenson began with an overview of several recent articles based on site visits in 12 communities under the Community Tracking Study.⁹ The researchers reported a growing feeling among health care stakeholders that government intervention is necessary to fix the health care system. This is a marked shift in attitude since the failure of the Clinton health reform efforts.

Berenson agreed that there is an important role for public policy in fixing health care markets and improving coordination of care. In particular, he asserted that the traditional Medicare program—not solely Medicare managed care—could promote group practice and should be a strategic partner in these activities. Although traditional Medicare is an any-willing-provider system, it could nevertheless drive improvements in the delivery system through

payment differentials, pay-for-performance, and beneficiary incentives to choose efficient providers.

Medicare is also ideally suited to address chronic illness care. Under both the new Medicare bill and the Benefits Improvement and Protection Act (BIPA) of 2000, there are a number of demonstrations in this area. Berenson proposed a three-tier approach to using Medicare payment policy to improve care coordination for beneficiaries with complex chronic conditions. This would be accomplished through the use of care management fees as follows:

- A small per-member per-month care management fee for physicians meeting basic standards;
- A larger fee for physician groups meeting standards of integration (for example, as measured by Shortell and colleagues using the National Survey of Physician Organizations¹⁰); and
- Full payment for Part B (and possibly Part A) services, in addition to a care management fee, for integrated care systems able to accept capitation.

Ms. Nazemetz began by saying that in the employer community there is a sense that the health care system has taken a few steps backward since the late 1980s and early 90s, when the nation's large employers started talking about and promoting organized systems of care. Employers are disillusioned

and tired of fighting to change the system; they want to concentrate on their core business. As a result, a number of changes are necessary to move markets toward integration and encourage employers to be more responsible purchasers.

1. Change the tax code to allow employees to save tax-deferred money to spend on health care – eliminating the “use it or lose it” rule of flexible spending accounts.
2. Make premiums for *qualifying* health plans tax favored, regardless of the source (employer, employee, individual, etc.).
3. Create community-responsive underwriting rules and payment schedules for services to ensure that risk is spread evenly and care is accessible.
4. Implement standards for collection and dissemination of health care quality data so consumers are better informed.

Nazemetz also prescribed specific changes for both health plans and purchasers. Health plans should be more creative in product design. Integrated care systems must develop single replacement products, find ways to provide services to self-insured groups, and offer products at the lower price points demanded by purchasers. Purchasers should “pay for technology,” rewarding providers and plans for investing in IT. And, as Enthoven noted, they need to think about the incentives created by their premium contribution policies and the type and range of choices they provide.

Sponsors

This conference was co-sponsored by the Alliance of Community Health Plans, the American Medical Group Association, the Council of Accountable Physician Practices, *Health Affairs*, the Institute for Healthcare Improvement, The Robert Wood Johnson Foundation and the Kaiser Permanente Institute for Health Policy.



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SUMMARY AND CONCLUSIONS

Jack Ebeler, President of the Alliance of Community Health Plans, summarized major themes from the conference. To adapt the platform of the large multispecialty group so that it is relevant for independent physicians and communities, he said, there is a clear need for the following:

- A better understanding of the factors leading to successful group performance;
- Rigorous, transparent quality measurement;
- Incentives/payment for performance;
- Risk adjustment; and
- National operating standards for information technology and incentives for its use.

Ebeler added that to make significant improvement in the delivery system, we also need leadership and a sense of urgency. In addition, while group-level capitation may be helpful in creating performance incentives, the structure of payments to physicians within groups is also important.

Finally, he said, the policy agenda is critical. Medicare is a likely leader in standards, payment for performance, and chronic care management in both organized groups and the traditional fee-for-service program. Private payers are more likely to put their hope and efforts into consumer incentives and tax changes. Critically, both the public and private sectors must focus on incentives for technology.

Endnotes

¹ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, DC: National Academy Press, 2001), pages 1 and 4.

² This summary is based, in part, on the remarks of the day's final speaker, Jack Ebeler, President of the Alliance of Community Health Plans.

³ Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000).

⁴ Institute of Medicine, 2001.

⁵ K. Chuang, H. 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. Enthoven and L. Tollen, Editors, (San Francisco: Jossey-Bass, 2004).

⁶ S. Shortell and J. Schmittiel, "Prepaid Groups and Organized Delivery Systems: Promise, Performance, and Potential," in *Toward A 21st Century Health System: The Contributions and Promise of Pre-paid Group Practice*, A. Enthoven and L. Tollen, Editors, (San Francisco: Jossey-Bass, 2004); L. Casalino et al, "External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients with Chronic Diseases." *JAMA* 289(4): 434-441; D. Styf, K. Chenok, and G. Pawlson et al, "A Comparison of Health Plans and Their Delivery System Relationships on HEDIS Performance Indicators." Council of Accountable Physician Practices, February 2004, working paper; E. Levin, et al, "Innovative Approach to Guidelines Implementation is Associated with Declining Cardiovascular Mortality in a Population of Three Million" (abstract) Presented at the American Heart Association's Scientific Sessions 2001, Anaheim, CA, November 12, 2001.

⁷ See www.academyhealth.org for more information.

⁸ See the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

⁹ See *Health Affairs*, Volume 23, Number 2, March/April 2004; in particular: L. Nichols, et al, "Are Market Forces Strong Enough to Deliver Efficient Health Systems? Confidence is Waning," pp. 8-21.

¹⁰ National Study of Physician Organizations and the Management of Chronic Illness, School of Public Health, University of California, Berkeley, November, 2002.