Kaiser Permanente Institute for Health Policy

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Improving Health Care Quality Through "Systemness"

KEY POINTS:

- The American health care delivery system is not well organized to achieve optimum quality.
- While health care overall is poorly organized, pockets of improved "systemness" do exist. From them, we can learn about the organizational attributes that are associated with improved quality.
- In purposefully organized systems of care, health care providers collaborate across disciplines and settings — and over time — to coordinate a patient's total care.
- Key organizational attributes explored in this paper include cohesion of physician practice, scale, and affiliation with a larger system.

What policymakers need to know about "systemness" in health care:

- The American health care delivery "system" remains largely rooted in the cottage industry model of solo or small-group practice medicine (almost 50% of practices have 1-2 physicians, while only 11% have 11 or more). Key elements of the health care delivery enterprise — physicians, hospitals, pharmacies, laboratories, and so on — are neither purposefully organized to act collaboratively across disciplines and settings nor signaled to do so by market forces. A growing body of evidence suggests that this lack of systemness contributes to documented shortfalls in quality and efficiency.
- Fundamental redesign of the overall enterprise, not tinkering around the edges, is needed to improve U.S. health care. As noted by the Institute of Medicine in its groundbreaking report *Crossing the Quality Chasm*, "The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."
- Despite the disorganized nature of health care delivery, pockets of systemness do exist. From these exceptions – which include large, multispecialty medical groups and vertically integrated delivery systems — we can learn how "systemness" impacts quality of care.
- Public policy can foster or hinder systemness, especially in the areas of standard-setting for quality measures and health information technology. Another important focus for public policy is reform of the payment environment, which can make systemness more attractive to health care providers. Value-based purchasing initiatives have the potential to encourage systemness by paying for quality and efficiency outcomes that may be easier to achieve in systems than in the fragmented, cottage industry.

What Can We Achieve Through Systemness?

Several recent studies offer compelling evidence that American health care is not nearly as efficient nor as evidence-based as it needs to be, and that we suffer from the triple quality shortfalls of underuse, overuse, and misuse of care. Although there are no silver bullets for improving health care, we know that the delivery system must be organized to take advantage of the many drivers of quality. Specifically, the Institute of Medicine's 2001 report *Crossing the Quality Chasm* proposed that a 21st century delivery system must meet six challenges:

Further Reading and Resources

L. Casalino, R. Gillies, et al, "External Incentives, Information Technology, and Organized Processes to Improve Health Care Quality for Patients with Chronic Diseases," *JAMA*, V289, no.4, (2003), pp. 434-441.

D. Cortese and R. Smoldt, "Taking Steps Toward Integration," *Health Affairs*, Web Exclusive, December 5, 2006, pp. w68-w71.

F. J. Crosson, "The Delivery System Matters," *Health Affairs*, V24, no.6 (November/December 2005), pp. 1543-1548.

A. Mehrotra et al, "Do Integrated Medical Groups Provide Higher-Quality Medical Care than IPAs?" *Annals of Internal Medicine*, V145, no.11 (December 5, 2006), pp. 826-833.

Council of Accountable Physician Practices: *www.amga-capp.org*

Commonwealth Fund Commission on a High-Performance Health System: *www.commonwealthfund.org/programs/*

- Redesign care processes;
- Make effective use of information technologies (IT);
- Manage clinical knowledge and skills;
- Develop effective teams;
- Coordinate care across patient conditions, services, and settings over time; and,
- Incorporate performance and outcomes measurement for improvement and accountability.

These challenges can be more easily met with the resources and capabilities of an organized system of care.

What Does Systemness Look Like? The Broad Outlines

Delivery systems organized to meet the IOM's challenges come in a variety of shapes and sizes, ranging from relatively decentralized, virtual (IT-enabled) systems, to highly organized, "shoulder-to-shoulder"-type integrated delivery and insurance systems, such as Kaiser Permanente, Geisinger, or Health Partners. Most of these models have, as a foundation, a multispecialty physician group practice. There are about 175 such practices in the United States, each with 100 or more physicians, according to the Council of Accoutable Physician Practices.

A growing body of research links organized physician groups to higher quality. This literature indicates that more highly organized physician groups exhibit the following characteristics, which are necessary but not sufficient for achieving improved systemness in health care:

- ***Cohesion.*** This term describes the degree to which physicians practice collaboratively in a group — not necessarily in the same building, but with a shared purpose and a collective ability to carry out shared intentions. Group practice members share experiences and learnings, an approach to practice, and measures of performance. They may also share finances and common, comprehensive patient records.
- ***Scale.*** Most physicians in the United States are in solo or small-group practices that lack the volume of patients needed to support quality improvement infrastructure, such as disease management teams, electronic records, peer review systems, and systems for developing and sharing best practices. Experts disagree on the group size necessary to ensure quality, but the need to provide a range of specialties and subspecialties dictates relatively large numbers of practitioners.
- ***Affiliation.*** This characteristic situates the practice in a larger context. Is the practice part of a larger system that can provide infrastructure support? Can care be coordinated and/or integrated across all elements of the care system (for example, physicians' offices, hospitals, patients' homes) and over time? Such a system might be created, owned, or supported by a health plan, a hospital, a physician group, or an independent entity.

Research shows that these physician group attributes — cohesion, scale, and affiliation — are associated with enhanced quality, as measured by various indicators, such as: HEDIS scores; use of specific evidence-based practices; presence of care management guidelines; use of health information technology; and presence of other quality improvement activities. (This paper does not explore the links between these quality measures and outcomes, but literature on each is available.)

The View from Inside High-Performing Systems

Although research suggests a link between group practice organizational attributes and quality, we don't know exactly why these links exist. Most likely, the attributes of cohesion, scale, and affiliation are proxies for other, harder-to-study characteristics. Leaders of high-performing integrated delivery systems suggest several characteristics are key to their performance:

- *Governance.* As used here, governance refers to an organization's ability to set goals purposefully and implement a plan to achieve them. Someone or something (for example, a board of directors) can cause the organization to act both collectively and intentionally to improve quality or efficiency.
- *Strong Physician Leadership.* Many of the best-known integrated delivery systems and large multispecialty medical groups were founded by charismatic physician leaders who had a vision of a more organized system of care.
- *Organizational Culture.* Shared vision, values and sense of mission around stewardship for both individual patients and populations is critical to performance.
- *Clear, Shared Aims.* Clarity of aims and objectives allows for meaningful measurement of performance and encourages internal, transparent sharing of performance data. Shared aims also ensure that different parts of the organization are not working at cross purposes or hampering one another's attempts at achieving improved quality and efficiency.
- *Accountability and Transparency.* Improved accountability to employers and patients, coupled with transparency of information, can help improve quality. Research shows that groups with external incentives — financial or otherwise — for improving quality tend to score better on quality indices.
- *Patient-Centeredness.* Historically, a key role played by individual physicians has been developing and maintaining the connection to the patient. As physicians organize and affiliate with other parts of the delivery system, that one-on-one relationship must be leveraged to connect the patient to the delivery system as a whole.
- *Teams.* A number of experts have suggested that multidisciplinary teams of providers (such as physicians, nurses, care managers, nutritionists, and psychologists) can provide higher quality care than individual providers because they collectively have a better understanding of patients' needs.

Figure 1 links these more nuanced organizational attributes — the true descriptors of systemness — to quality of care. The attributes listed in the center of the left-hand triangle can be thought of as underlying the original three elements proposed in the research literature (cohesion, scale, and affiliation). These three attributes, in turn, are associated in the literature with various quality measures, which are, in turn, linked to actual quality of care.

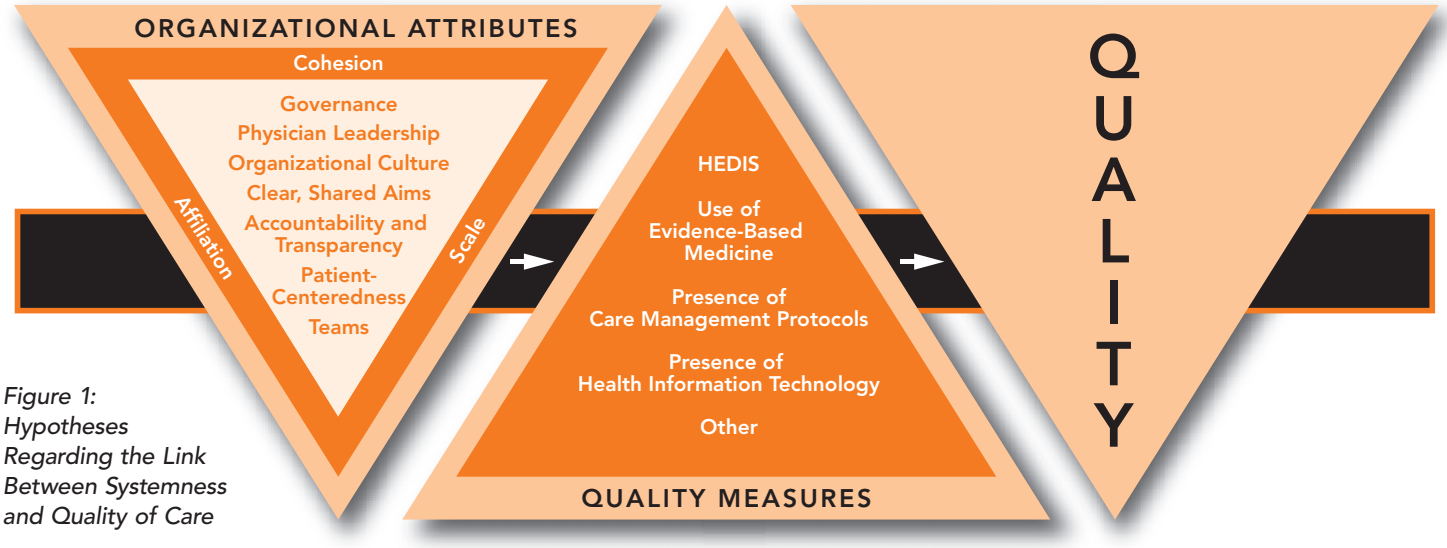

Figure 1: Hypotheses Regarding the Link Between Systemness and Quality of Care

Policy Implications: Standard Setting and Payment Reform

Evidence is growing that improved systemness drives quality improvement. However, until we better understand how specific organizational attributes contribute to systemness, policymakers should strive to create an environment that rewards quality itself (rather than tying incentives to organizational attributes.) Important areas of focus include development and widespread adoption of common quality performance measures, as well as implementation of electronic medical records, which enable the collection and analysis of quality data. Both these objectives could benefit from federal support to achieve common, industry-wide standards.

Another important area of focus is the payment system. No amount of evidence of the superiority of systems will encourage providers to join group practices if payment incentives work in the opposite direction, as some do today.

The pure fee-for-service (FFS) payment model can discourage the organized, integrated care that is the hallmark of systems. Under FFS, physicians and hospitals are rewarded for taking actions — doing procedures, prescribing drugs, performing tests, and so on — whether or not the best evidence calls for such action. In addition, FFS payment causes us to ask the wrong questions in evaluating quality — "Did the patient survive the bypass surgery?" instead of, "Could the bypass surgery have been avoided?" Fee-for-service may also stand in the way of cooperation and collaboration across the delivery system, as each provider has an economic interest in providing more services for the patient, rather than in collectively determining how much and what mix of care is ideal.

Changing payment systems to reward quality and efficiency requires action on two fronts, both of which are examples of "value-based purchasing." First, payments need to reward better care. Payment schemes designed to do this include prepayment (coupled with quality measurement and reporting) and pay-for-performance, which builds on FFS. Second, the unit of payment needs to be large enough to encourage providers to seek efficient combinations of care resources. For example, a bundled payment for a complete episode of care or a specific condition might encourage coordination of inpatient and post-acute care and better prevention. For more examples of value-based purchasing initiatives, see sidebar (right).

As policymakers and purchasers focus on outcomes, researchers should continue studying high performing health systems to understand the connection with quality and value. This work will provide a foundation for understanding how the best attributes of organized physician groups can be adapted for use in the broader, less systematized health care mainstream.

Value-Based Purchasing Initiatives/Proposals

- **Prometheus Payment Model,** *www.prometheuspayment.org.* Risk-adjusted global payments to physicians and hospitals for treating specific conditions; "evidence-informed" case rates.
- **Integrated Healthcare Association Pay-for-Performance Initiative,** *www.iha.org.* Seven major health plans in California using common performance measures to reward physician groups for performance in clinical care and patient experience.
- **Medicare Group Practice Demonstration,** *www.cms.hhs.gov/DemoProjectsEvalRpts/MD/.* Under the Medicare FFS program, medical group practices can receive bonuses for overall savings and quality improvement related to patients with chronic, high-cost conditions.
- **Patient-Centered Medical Home,** *www.acponline.org/hpp/adv_med.pdf.* Care management fee paid to physicians who use information technology and other practice innovations to improve the management and coordination of care; promoted by American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association.
- **Bridges to Excellence,** *www.bridgestoexcellence.org.* A variety of programs that reward physicians and practices for adopting systems of care that result in practice reengineering, adoption of health information technology, and improved patient outcomes; a collaborative effort of health plans, large employers, and providers.

In Focus is a series of briefs designed to bring key research findings on important health policy issues to the attention of health policymakers. This issue of *In Focus* is by Laura Tollen, MPH, of Kaiser Permanente's Institute for Health Policy.

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