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”
Incentives

Performance Measurement / Transparency / Accountability

Improved Outcomes / Improved Value

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 Capabilities

- 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.

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

<table>
<thead>
<tr>
<th>Author / Date / Journal</th>
<th>Finding</th>
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</table>
| Mehrotra, et al (2006, *Annals of Internal Medicine*) | • 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, *Health Services Research*) | • 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)

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<td>McMenamin, et al (2004, <em>American Journal of Preventive Medicine</em>)</td>
<td>• 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.</td>
</tr>
<tr>
<td>Shortell and Schmittdiehl (2004, <em>Towards a 21st Century Health System</em>, Enthoven and Tollen, eds.)</td>
<td>• 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.</td>
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<td>MedPAC (2007, Congressional Report)</td>
<td>• 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.</td>
</tr>
<tr>
<td>Chuang, et al (2004, Towards a 21st Century Health System, Enthoven and Tollen, eds.)</td>
<td>• 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.</td>
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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)

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

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


† The number of physician organizations treating each disease
What is needed to promote ACS development?

Focus on 3 I’s¹:

• Information

• Infrastructure

• Incentives

• 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


