ACHIEVING CLINICAL INTEGRATION:
Observations From the VISNs and Beyond

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March 26, 2013
Health care financing will increasingly move from volume-based to value-based payment.

Multiple ‘value-based payment’ strategies are now being tried; more to come.

Essential to the success of value-based payment strategies - and to improving health care generally - is achieving greater integration of clinical services (‘clinical integration’).

This presentation will highlight selected experiential observations about achieving clinical integration based on the >15 year history of the Veterans Integrated Service Networks (VISNs) in the VA Health Care System and other sources.
WHAT IS “CLINICAL INTEGRATION”?
Clinical Integration Defined

“. . .an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”*

Clinical Integration Defined

“...comprehensive, coordinated programs of care management designed to improve quality and cost-effective care through use of IT systems, practice guidelines, care protocols, referral policies, quality benchmarks and performance assessment.”*

*Statement by a senior FTC official, 2009
SOME OBSERVATIONS ABOUT ACHIEVING CLINICAL INTEGRATION
The VISNs changed the basic operating unit of the VA Health care System from individual hospitals to networks of facilities that integrated their services to serve a defined population in a specified geographic area.

In the VISNs, the hospital was envisioned to be an important but less central component of “larger, more coordinated community-based networks of care” in which emphasis is placed “on the integration of ambulatory care and acute and extended inpatient services so as to provide a coordinated continuum of care.”

*Vision for Change, 1995
Observation #1.

Achieving clinical integration is fundamentally about changing the culture of health care; it’s more sociological than technological.
Health Care Culture is the Biggest Barrier to Clinical Integration

- Health care evolved as a ‘cottage industry’ of competing independent practitioners taking care of acute illness and injury
- Advances in biomedical sciences leading to progressively greater specialization and narrowing of focus
- Physician training has preferentially selected individualists and ‘independent thinkers’
- Increased separation of clinical and administrative activities; disdain for rules and procedures
- Separation of clinical medicine and public health; separation of management and clinical medicine
- Focus only on individual patients
- Practitioners idolized and rewarded for ‘rescue care’; insulated from and unaware of costs
- Infatuation with technology
Changing Health Care Culture Requires New Ways of Thinking and New Competencies

- Systems thinking
- Collaboration and teamwork concepts
- Quality management and process improvement science
- Information management
  - Incident and anomaly analysis
  - Social network analysis
- Complexity (chaos) theory
- Population health management
- Conceptualizing hospitals as cost centers instead of revenue centers
- Viewing admissions as largely predictable and preventable (in chronic condition) and readmissions as system failures
To stay fiscally healthy, state's hospitals want fewer patients

By Anna Gorman
March 4, 2012, 5:15 p.m.

To survive the unprecedented challenges coming with federal healthcare reform, California hospitals are upending their bedrock financial model: They are trying to keep some patients out of their beds.

Hospital executives must adapt rapidly to a new way of doing business that will link finances to maintaining patients' health and impose penalties for less efficient and lower-quality care.
Observation #2

Strong and respected clinical leadership is essential.
Leadership is Needed for Specific Purposes

1. Understand and define reality
2. Be a creator - articulate a values-based and actionable vision; engineer the change strategy and plan
3. Take risks
4. Find needed resources
5. Prioritize goals and objectives; harmonize and align competing agendas
6. Forge partnerships and collaborations
7. Communicate – spread the vision, tell ‘the story’; be a bridge between the boardroom and the bedside; ensure values are incorporated into operational policies and practices
8. Build and sustain trust; foster transparency
9. Shape the culture; nurture collaboration and teamwork; promote a culture of ownership and empowerment that supports innovation and learning
10. Ensure appropriate recognitions and rewards are made to reinforce desired behaviors and outcomes; identify what is valued
11. Maintain focus on the vision; take the long-term view
12. Be accountable
Observation #3.

Finances must be aligned with desired outcomes and may be achieved by multiple means.

Removing the financial disincentives for integrating care may be more important than providing monetary incentives for new behaviors.
The Long-Term Effect of Premier Pay for Performance on Patient Outcomes

Ashish K. Jha, M.D., M.P.H., Karen E. Joynt, M.D., M.P.H., E. John Orav, Ph.D., and Arnold M. Epstein, M.D.

Conclusions

We found no evidence that the largest hospital-based pay-for-performance program led to a decrease in 30-day mortality. Expectations of improved outcomes for programs modeled after Premier HQID should therefore remain modest.

By Andrew M. Ryan, Jan Blustein, and Lawrence P. Casalino

Medicare’s Flagship Test Of Pay-For-Performance Did Not Spur More Rapid Quality Improvement Among Low-Performing Hospitals

ABSTRACT Medicare’s flagship hospital pay-for-performance program, the Premier Hospital Quality Incentive Demonstration, began in 2003 but changed its incentive design in late 2006. The goals were to encourage greater quality improvement, particularly among lower-performing hospitals. However, we found no evidence that the change achieved these goals. Although the program changes were intended to provide strong incentives for improvement to the lowest performing hospitals, we found that in practice the new incentive design resulted in the strongest incentives for hospitals that had already achieved quality performance ratings just above the median for the entire group of participating hospitals. Yet during the course of the program, these hospitals improved no more than others. Our findings raise questions about whether pay-for-performance strategies that reward improvement can generate greater improvement among lower performing providers. They also cast some doubt on the extent to which hospitals respond to the specific structure of economic incentives in pay-for-performance programs.

Bonuses for docs do little to improve diabetes care

By Kerry Grens NEW YORK | Thu Apr 26, 2012 5:23pm EDT

NEW YORK (Reuters Health) - Small financial incentives aimed at getting physicians to make sure their diabetic patients receive recommended routine exams may not lead to changes in doctors' behavior, according to a new study from Canada.
Are salaried physicians the key to health reform?
By anne
Created Jul 28 2009 - 10:06pm

Increased doc employment at hospitals a 'building block' for coordinated care
By acaramenico
Created Nov 29 2011 - 10:45am
Three major Memphis, Tenn.-based hospital systems have more than tripled the number of physicians employed in the past year, reports the Commercial Appeal.

Hospitals invest in employing MDs, but stakeholders question value
By sjackson
Created Mar 2 2011 - 9:55am
Staffing your health system with fully employed physicians should ultimately improve coordination of care, and perhaps boost overall quality...right? Not so fast, according to survey results from the Center for Studying Health System Change, based in Washington, D.C.

Physicians leaving practices for health system employment
By khoung
 Created Jun 13 2011 - 1:03pm
By 2013, less than a third of physicians will be in private practice, electing instead for employment with larger health systems, according to a new report released today by management consulting company Accenture Health. The rate of independent physicians employed by health systems will grow by an annual rate of 5 percent over three years, according to the report.

Physician Alignment: The Collaborative Care Disconnect
By Philip Betteze

Physician/hospital alignment Employment agreements in the reform era
Finances must be aligned with desired outcomes and may be achieved by multiple means. Removing the financial disincentives for integrating care may be more important than financial incentives for motivating new behaviors… Employing physicians is a weak strategy for creating financial alignment.
Observation #4.
Clinical integration requires new tools and an enabling infrastructure.
Clinical Integration Infrastructure

- Knowledge transfer and communication tools (EHR, decision support, registries, HIE, scheduling, telehealth, social media, etc.)
- Performance management system – performance measurement, standardized and consistent metrics, reporting and analysis mechanisms, feedback, accountability and rewards
- Care/disease management tools and competencies
- Teamwork skills and processes
- Clinical guidelines and care protocols, care review and adherence mechanisms
- Education and training to develop new competencies
- Human capital management
- A broadly participatory and structured method to balance patient and provider freedom of choice with efforts to coordinate care and control costs
- Patient/family involvement mechanisms, shared decision making
Electronic records no panacea for health care industry

Studies show errors, inefficiencies still occur in medical services

By Bill Toland, Pittsburgh Post-Gazette

It has become health care industry dogma that electronic records can help improve efficiency. Reduce errors. Save lives. And -- just maybe -- put the brakes on runaway health costs, by allowing better sharing of patient information and eliminating duplicative services.

The Impact of eHealth on the Quality and Safety of Health Care: A Systematic Overview

Ashly D. Black¹, Josip Car¹, Claudia Pagliari², Chantelle Anandan², Kathrin Cresswell², Tomislav Bokun¹, Brian McKinstry², Rob Procter³, Azeem Majeed¹, Aziz Sheikh²

¹eHealth Unit, Department of Primary Care and Public Health, Imperial College London, London, United Kingdom. ²eHealth Research Group, Centre for Population Health Sciences, The University of Edinburgh, Edinburgh, United Kingdom. ³National Centre for e-Social Science, University of Manchester, Manchester, United Kingdom.

There is a large gap between the postulated and empirically demonstrated benefits of eHealth technologies. In addition, there is a lack of robust research on the risks of implementing these technologies and their cost-effectiveness has yet to be demonstrated, despite being frequently promoted by policymakers and “techno-enthusiasts” as if this was a given. In the light of the paucity of evidence in relation to improvements in patient outcomes, as well as the lack of evidence on their cost-effectiveness, it is vital that future eHealth technologies are evaluated against a comprehensive set of measures, ideally throughout all stages of the technology’s life cycle. Such evaluation should be characterised by careful attention to socio-technical factors to maximise the likelihood of successful implementation and adoption.

The Double Edged Sword of Performance Measurement

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J Gen Intern Med
DOI: 10.1007/s11606-011-1981-5
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Clinical integration requires new tools and an enabling infrastructure, but effective use of these tools requires a culture of collaboration and continuous improvement.

Technology is not transformative; the relationships that it supports are.
Observation #5.

A strategic communications plan is an essential and integral component of the clinical integration strategy.
Strategic Communications Plan

- Has a defined message
- Utilizes physicians and nurses as the messengers as much as possible
- Is health literate and culturally appropriate
- Recognizes the special needs of the health care workforce (e.g., night workers) and generational issues
- Uses both conventional and unconventional methods
- Utilizes internet and social media
Observation #6.

Care delivery assets will need to be restructured (e.g., less hospital and greater ambulatory and virtual care capacity).
VA Care Delivery Asset Changes 1995-1999

- Closed 55% (28,986) of acute care hospital beds
- Reduced staffing by 12% (25,867 FTEs) but increased the number of caregivers
- Merged 52 medical centers into 25 multi-campus facilities
- Opened 302 new community-based clinics
- Reduced admissions by 350,000 per year
- Reduced bed days of care per 1000 patients by 68%
- Increased ambulatory care visits from 24M to 37M per year
- Implemented virtual health/tele-health strategies
Health care mass layoffs escalate
Aug. 6, 2012

The number of people losing their jobs in a mass layoff from a hospital or an ambulatory care center spiked of Labor Statistics. A mass layoff is defined as at least 50 people losing their jobs from a single entity in one day. in June, according to a monthly report issued July 20 by the U.S. Bureau

Northwestern hospital confirms 230 layoffs

By Peter Frost Tribune reporter 6:26 p.m. CDT, August 22, 2012

Northwestern Memorial Hospital confirmed Wednesday that it has laid off 230 employees over the last month as part of an effort to reduce its cost structure by a quarter by 2017.

Health system cost-cutting changes will include staff reductions


CUMBERLAND — Changes are coming for the Western Maryland Health System and its employees. The changes will include staffing reductions through attrition and some “involuntary separations.”
Observation #6'.

Care delivery assets will need to be restructured (e.g., less hospital and greater ambulatory and virtual care capacity), but the broader social impact of these changes must be recognized.
Observation #7.

Health care operates as a complex adaptive system, so change cannot be specified and controlled to the same degree as in more linear processes (e.g., manufacturing)
Characteristics of Complex Adaptive Systems

- Nonlinear and dynamic; do not inherently reach fixed equilibrium points, so behavior appears chaotic
- Composed of independent agents
- Agent’s needs and desires are not homogeneous, so their goals and behaviors are likely to conflict
- Agents are intelligent and learn. System behavior changes over time
- Adaptation and learning result in self-organization; behavior patterns emerge
- No single point of control; no one is “in charge”
Observation #7'.

Health care operates as a complex adaptive system, so change cannot be specified and controlled to the same degree as in more linear processes; small changes in critical elements of the system need to be leveraged to produce large change.
What are the Critical Change Levers for Health Care Today?

1. Payment/payment reform
2. Performance measurement (and public reporting)
3. Health information technology
4. Patient engagement, consumer activism
5. Regulation/regulatory relief
Observation #8.

There always will be unintended consequences.
Observation #9.

Achieving clinical integration is hard work and the effort required for even the seemingly simplest or least controversial changes should never be underestimated…and it always takes longer than you think it should.
Observation #10.

The future is not what it used to be....
QUESTIONS