

One-day Conference: Delivery Systems Matter! Improving Quality and Efficiency in Health Care March 17, 2004

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MALE VOICE: ...for health policy. And it's a real delight to welcome you here for this program on the delivery system matters. Back in mid-2001, Alain Enthoven and I were reminiscing about the current state of affairs of health policy was a time when managed care bashing was at its height. And one of the conclusions from our discussion was that the country as it debated these issues was potentially throwing the baby out with the bathwater and that there were many elements that occurred in development in the 70s, 80s and 90s around the more effective organization and financing of care that were important to remind the country had take place, had contributed value and would continue to do so.

That discussion led to the publication last week of a book, which is in your bag, entitled "Toward a 21st Century Health System - The Contribution and Promise of Prepaid Group Practice." One of its conclusions is that prepaid group practice is particularly well-suited and in fact in the forefront of pursuing the agenda laid out by the Institute of Medicine in the Quality CASM Report, both pursuing efficiency, quality and the other aims set forth in that report.

And I want to start our meeting with particular thanks to Alain and the authors, who contributed to this book, for the work that they've done - kind of a compass which they've given us. And I'd like both Alain and Laura Tollen, his co-editor,

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who is also with the Kaiser Permanente of the Institute for Health Policy, to stand and receive our appreciation.

[Applause]

Now in the interim, since that initial discussion, cost-sharing HSAs, MSAs and a variety of other things have really been in the forefront of our healthcare policy agenda. And the purpose of this meeting really is to consider the question, those things may in fact be necessary to manage our ever-increasing healthcare costs. But at least from some of our points of view, they are far from sufficient. And in fact, the delivery system does matter. The way in which care is organized in finance is an important issue and along with the IOM and a number of others, we are seeking to have a more robust discussion of that issue.

Our meeting today is co-sponsored by a number of organizations - The Alliance for Community Health Plans, The American Medical Group Association, The Council of Accountable Physician Practices, Health Affairs, Robert Wood Johnson Foundation, and the Institute for Healthcare Improvement.

I'd like to introduce Marie Schall, who is the Director of the Office of Practice and Outpatient Settings at IHI, to say a few words on behalf of our sponsors.

MARIE SCHALL: Thanks Bob. On behalf of Don Berwick and the Institute for Healthcare Improvement, I also would like to welcome you - all of you here today. Those of you that know

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Don know that he would, you know that he would be here with you if he could. Unfortunately, he's not able to be here today. But he very much wanted to be because he cares so passionately about delivery system change. And we applaud Kaiser and the work that they've done to put together this conference, and the other sponsors for their work in bringing all of us here together.

The passion that Don has for delivery system change is reflected in the mission of our organization, which is to enhance quality in the healthcare system. We measure our progress on how well healthcare is delivered to patients in a safe, effective, patient-centered, timely, efficient and equitable way. We're currently measuring our progress by using the dimensions of the IOM with organizations that are working with S&R Impact Network by developing a global set of measures that reflect these dimensions of the IOM.

But as we all know that measurement is not enough. It gives us a place to start. It helps us to focus our attention on what needs fixing. Ultimately what really matters is that we can all say to the patients that we serve, that we can deliver care to them that has no needless steps, no needless pain and suffering, no needless waiting, no needless helplessness and no waste. That's the bottom line. It's what our patients experience with us in our healthcare systems.

We have a slogan at IHI that we borrowed from Drethis

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[ph], which is that knowing is not enough, we must apply. And willing is not enough, we must do. We think that this conference has a tremendous potential for enhancing what we know about delivery systems and what we can learn about how to change them.

We urge everyone here to apply the ideas and the insights and the knowledge that we all gain here today to work to make the delivery systems that we all are associated with better so that our patients can receive the best medical care every time for every patient.

We're pleased to be here with you and we join with you in this important work. So, welcome. Thanks.

MALE VOICE: You'll note in the bag which you've been given, in addition to the book, is an issue of Health Affairs, a program for the day. And in the program are bios of all our speakers. So we will be parsimonious on that front and allow you to read them. You'll also note that there are copies of most of the slides that you'll see so that you can follow along if you'd like to do so.

And without further ado, I'd like to introduce the first panel on the IOM vision in why integrated delivery systems can get us toward it. I'm pleased to introduce to you George Isham, who will be the Chair of this session.

George is the Medical Director and Chief Health Officer for HealthPartners in Minnesota. He's a leader in the field.

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He chaired IOM committee which led to the report on priority areas for national action, transforming healthcare quality. He's an author and active on a variety of fronts in healthcare. So George, we're delighted to have you in this session.

GEORGE ISHAM: Thank you very much and good morning. Delivery systems do indeed matter in my opinion. And I think we'll begin to discover that with this panel. We'll exam the IOM vision and why integrated delivery systems can get us there.

In Minnesota, if you ask Minnesotans, one in eight of our patients will reply that they have been harmed by healthcare. And that's the - those are the things that they know, not all the things that we know as professionals that happen behind the scenes that they don't know about. And I was thinking about that after the fact that if you disappoint just even one person in the service kind of related industry, they'll tell I think ten or twenty of their friends how much - how badly they were treated. So if one in eight of our patients reply that they have been harmed if you ask, imagine what they're telling their friends and neighbors about healthcare. And are we really surprised that we've got such a crisis or confidence in healthcare?

I think that we will start the discussion in terms of need for change by looking at the IOM vision and I can imagine no one more qualified to do that than Dr. Harvey Fineberg,

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President of the Institute of Medicine. He has served as provost of the Harvard University for a number of years, then Dean of the Harvard School of Public Health. He spent most of his active career in fields of health policy and medical decision-making, and he's been a leader in a number of very important ways. His full bio is in your material.

And I think it's important for us to understand that vision and the direction it's going and I look forward very much to hearing Dr. Fineberg's comments.

Following Dr. Fineberg will be Jay Crosson, who will discuss the characteristics of integrated delivery systems that are aligned with the IOM's vision. And I'm particularly grateful for Jay's leadership on this issue. He's been particularly energetic in putting together a number of projects and discussions in bringing focus and attention to this issue.

And I'm grateful because in Minnesota, being from Minnesota, we have a number of efforts that take advantage of the characteristics of group practice, which we have to take a good deal of effort to explain when we come to places like Washington and other places where group practice isn't as nearly as prevalent.

So a couple of the things we're doing in terms of taking advantage of the characteristics of group practice is using the Institute for Clinical Systems Improvement, a collaboration of group practices, to implement evidence based

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clinical practice guidelines. And then through another collaboration, the community measurement project, using a collaboration of medical groups, health plans and MCQA to provide clinical performance information to improve care and to inform the public.

So I'm grateful to Jay for drawing attention to this issues because I think that we need to pay much more attention to the structure of group practice and how it can contribute to improving healthcare.

Jay is Executive Director of the Permanente Federation, the National Organization of Permanente Medical Groups, and the Physician Component of Kaiser Permanente. He's also co-chair of the Kaiser Permanente Partnership Group, which is the Kaiser Permanente Joint Management body and serves as CEO and President of the Permanente Company. He's a member of the California Medical Association Board of Trustees, Secretary of its Governing Board and as has already been mentioned, a leader and Chair of the Council of Accountable Physician Practices and an AMGA affiliate, which is a health policy alliance among the nation's largest medical groups. And he has a number of other very substantial achievements in his career.

The third member of our panel is Dr. Stephen Shortell. And I'm looking forward in particular to his discussion of the evidence of the impact of delivery systems' structure and organization on efficiency, safety and quality. And as he and

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I were talking, who also teaches, and I was very much delighted to learn recently that in Minnesota, an inter-disciplinary group of health professional students are advised by a forward-thinking University of Minnesota faculty members, working in teams, inter-disciplinary teams of a medical student, nursing student, public health student and business school students to work on projects to improve quality of safety in healthcare delivery. And they're a little ahead of the structure of the rest of the academic environment.

And I think it's particularly exciting that they're working on how to work together as teams of cross professions and discovering many of the cultural barriers that prevent effective collaboration across those boundaries today.

And I think that we must listen very, very carefully therefore to Dr. Shortell's presentation so we can learn the lessons and so that we can create the organizations and the environments to allow these inter-disciplinary teams to reach their full potential in really addressing patient safety and improved care.

Dr. Shortell is Blue Cross of California Distinguished Professor of Health Policy and Management, and Professor of Organizational Behavior at the School of Public Health in the Haas School of Business at the University of California Berkley. He's also Dean of the School of Public Health at Berkley and holds appointments to the Department of Sociology

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at UC Berkley and at the Institute for Health Policy Studies at the University of California San Francisco.

He's a leading healthcare scholar, a recipient of many awards and is an elected member of the Institute of Medicine, The National Academy of Science and he's currently conducting research on quality improvement initiatives and the implementation of evidence-based medical practices in physician organizations. And very much looking forward to that discussion.

So I hope you will find the discussions panel very informative and thought-provoking and compelling. Yogi Berra might have said, "We need to get to the future faster." I believe our patients deserve it and our hearts, souls and minds must demand it. The future is something we need to create and I look forward to this discussion creating the environment for a productive discussion over the course of the day around how we all might participate in doing that. So first up, Dr. Fineberg.

HARVEY FINEBERG: Good morning everyone. It's a great pleasure for me to welcome you, particularly in this place at the National Academies. It's a treat to be on a panel with my very distinguished colleagues and look forward very much to hearing the remarks that Jay and Steve will offer a little bit later. I want to thank you, George, for your kind remarks, but even more for your leadership and assistance in guiding the

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work in quality for the nation and also for the Institute of Medicine.

And it's especially a treat for me to be in the presence of so many people whose work and leadership directly contributed to the development of the themes, the ideas, the principals, the basic blueprints that make up the Institute of Medicine approach to quality.

In the course of the deliberations of this day, a lot of attention I believe will be devoted to the ways in which organized group practice of various forms can affect improvements in quality. Much of that in effect is looking downward, looking at the performance of the organized groups for their own panels and pools of patients.

I think it's also important for us in the course of this day to look upward and outward in thinking about organized group practice and its features as models, as potential exemplars of approaches that can be more widely applicable than to the practices themselves. And to set the stage for that, I just want to take a moment to put on the table six attributes of a more idealized health system that we might aspire to achieve in the course of this century.

It would be a health system that would begin from a population and ecological perspective. It would inform and identify health as a property of communities as well as a property of individuals. It would put much more stress than we

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do currently on the prevention of disease, from the utilization of basic biologic science toward that end to the introduction of individual behavioral change to the resources that communities and states can bring to bear to set up the circumstances in which people can live healthier and more fulfilling lives. It would in other words embrace public health as well as medicine.

In medical care, it would provide a system that was available to everyone, accessible, and to the individual, affordable. It would move beyond the piecemeal coverage and unequal treatment, the disparities, that we experience today. It would be a system that was centered on the needs of individual patients. It would not be driven by the interest and needs of providers. It would be a system that was based on evidence, not a system that operated according to the latest anecdote.

And most fundamentally for our discussion in the course of today, it would be a system that was driven by quality concerns and value - in that sense value, I mean quality achievable for a given cost, not simply driven according to prices.

Now I want, in outlining briefly what the Institute of Medicine has done in approaching this subject, to say a word about a predecessor study to the Quality CASM Study, which you're all I'm sure also familiar with, which was in effect the

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study that highlighted the problems of errors that George has alluded to that brought to public attention in a more powerful way than previous work that had been established in the academy about errors ever had accomplished.

In fact, after this study appeared, released in late 1999, published in 2000, a survey of the Kaiser Family Foundation said that more than half of the American public had followed media coverage reporting and discussing medical errors. There was an appropriation to the Agency for Healthcare Research and Quality of an additional fifty million dollars to cope with the safety problem. The President brought together leadership from the Cabinet, and particularly asked the Department of Health and Human Services to spearhead an Interagency Coordinating Committee that continues the leapfrog group, sponsored by the Business Roundtable, which had been in place was energized and newly activated and focused on the problems of quality and safety.

There was a group called the National Academy for State Health Policies sponsored by The Robert Wood Johnson Foundation that brought together leadership at the state level working on the problem and many, many organizations - professional and otherwise - rallied suddenly to the cause.

The landmark study that really set the blueprint for the premise of the IOMs work in quality was the report that appeared the following year, 2001, Crossing the Quality Chasm.

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If the errors report made a lot of noise, the CASM Report shed a lot of light. In thinking about the impact of the Quality CASM Report, I would highlight three key attributes that I think were really fundamental to what it has accomplished in outlining a blueprint for change.

The first is that it did establish a common set of attributes, dimensions of quality, definitions of quality that everyone would adopt. Secondly, it stressed the fundamental point that quality was an expression of system performance that problems of quality were system problems and that the solution to those problems rest in improvements in the systems of care and nothing else.

And finally, the report in outlining a blueprint said we need to act at many levels. We need to act at individual and community level. We need to act at the level of the interaction of the physician and the patient, the micro system as Steve Shortell and others have called it. We need to act at the organizational level and we need to act in the environment of care.

And it's particularly around the organizational level that we're going to be, I think, focusing most of our attention because after all, the question before us during the course of the day is, what impact can the special organizational forms that we are discussing have on quality?

Just to review very briefly the various definitions and

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elements that I know we'll be seeing in a recurring form - the basic six dimensions, already mentioned - healthcare should be safe. It should be effective. It should be patient-centered. It should be timely. It should be efficient. It should be equitable.

The first four of these really relate to individual patients almost exclusively. The latter two, to individuals to a degree, but also to aspects of group performance, or collective performance and allocation of resources and fairness across patients.

In focusing on the activity and responsibilities of organizations, the CASM Report stressed six elements that it said were necessary organizational supports for change to reach quality. And these are also very basic elements that I think we're going to be seeing in a recurring form today that we had to look as organizations at the processes of care, utilize information technology, manage, knowledge and skills in clinical settings, develop teams, coordinate care across conditions, measure and improve performance. Those basic six elements.

What I wanted to do for a few minutes is to describe for you some of the work that the IOM has pursued through its Board on Healthcare Services, led by Janet Corrigan, and our Board on Services and various committees that have been established in looking into work that derives from the original

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blueprint in a sense, but builds from it into important new areas of endeavor, all in the pursuit of improved quality of care. We refer to these studies in fact as the Quality CASM Series. And I just want to highlight a few of them, some of which I know are also available outside.

The first has already been mentioned - leadership by example was a report that focused specifically on the ways that the federal government can utilize its key programs to set quality standards for healthcare delivery. It turns out that about one-third of all Americans are beneficiaries of, and the majority of health providers are participants in, one or more of these programs - Medicare, Medicaid, the SCHIP program, the Department of Defense Tricare program, the Veterans Administration and the Indian Health Service. One of the key ideas from this report had to do with opportunities to pay for performance - to look at models and experiments of introducing new payment systems.

The second report was done explicitly at the request of Secretary Thompson for a rapid report on models and experiments that could be done at state levels to accomplish demonstrations of improvement in healthcare. And that report appeared in the middle of the year 2002.

The priorities report, also briefly mentioned, was a critical response to a request from the Agency for Healthcare Research and Quality to identify areas of need where there was

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enormous potential to make a difference for patients and where there was a gap between what was known in the evidence base and what was actually done in practice. And the group assembled worked very hard to identify the criteria that they would employ for the individual and collective priority areas and presented a report that has served to be, I think, an important foundation for other work forthcoming, one of which I will allude to in another minute.

On health profession education, a group like this was brought together assembled in a summit on professional education. The key attribute there was bringing together people from different ones of the health professions to think together about ways that joint education would contribute to the kind of teamwork that is required in the coordination of care and demonstration of care optimal for today's patients with chronic diseases.

The study on nursing was especially important because of the role and critical nature of nursing care in prevention of many errors, as well as in the care of patients in many settings. And this report has similarly had significant effect in thinking about the conditions of nursing care in our meeting healthcare institutions.

The most recent of the series just appeared very late last year, it emphasized the role of information technology in improving our performance on quality. It built on an earlier

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letter report that talked about eight elements necessary for the electronic health record. But in this report, the main emphasis was on the importance of government action to promote data standards, standards that would relate to the interchange of information to terminal logic use of clinical information and to the representation of knowledge in electronic form so that organizations that are contemplating investment in information technology could proceed with a much higher order of confidence that that investment will not be out of date in a very short time.

The report also called upon the Congress to enact enabling authorities and to provide financial support for such an endeavor. Personally, though this was not explicitly in the report, I think we do need a kind of Hill Burton for the 21st Century that would enable the necessary infrastructure investment to be made across the country so that we could provide the database that is essential to all efforts at improving quality and indeed providing the necessary care to patients.

Now, one of the most interesting follow-ups to the Quality CASM series was a group gathered here just a couple of months ago, who were brought together from fifteen different communities, representing leadership in the health areas there, to speak together and work together about how they could jointly make measurable progress through specific strategies,

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improving the quality of care in five of the twenty priority areas that had been identified in the earlier committee's work. And they were focused specifically on asthma, chronic heart failure, depression, diabetes, pain control and cancer.

The meeting had a little bit of the character one felt of a revival session in which the spirit moved and people got very energized about what they could accomplish. One of the hopes is that through local action in this way coordinated across the various sectors, there will be additional demonstration of success.

Now I want, in just a few minutes, to reflect with you if these are the organizational challenges and if this is the direction that one wants to go through any form of care, what are some of the facilitators or barriers to change to improve quality? And how does organized group practice stack up compared to other options in looking at those barriers?

One facilitator and barrier that I would like to highlight that is implicit in so much of what we talk about, is the culture of healthcare, the culture of medicine, the values that we bring. Culture in this sense, I am talking about the shared belief systems. The things that everyone knows because it's just there. What makes something thinkable is culture. What makes it unthinkable?

And here as an illustration, if you agree that mindless variation is the enemy of quality, then I think a corollary of

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that is that an emphasis on autonomy is also an enemy of quality. And I believe that the balance of independence with informed action based on evidence is a critical challenge but flies in the face of certain cultural values.

The second is basically motivation. What are the incentives and the disincentives to act to improve quality? What is the degree of the alignment of the incentives built into a system - financial and otherwise - with the desired actions toward quality? And I know we're going to be hearing more about that later this morning.

Third is leadership. Are there the individuals who can articulate for their organizations the direction, the emphasis, the determination and the persistence that are necessary to effect lasting change toward improved quality?

Fourth, where will the financial resources be mobilized? Who has access to what levels of capital? What scale of operation is required to make investment worthwhile?

Fifth, where are the managerial skills? Not just the clinical skills, but the managerial skills necessary within any organization to change, to improve, to emphasize quality? How are those manifest?

And finally, is there a capacity within the organization to effect the kinds of change and to make them stick within the organization's priorities; within the organization's objectives; within the organization's reward

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systems; within the organization's internal information and managerial systems?

I would like to suggest that at least a couple of these, I believe, have a special value and meaning for organized group practice. And specifically, I think the alignment of incentives and the capacity that organizations with defined responsibility for populations of patients naturally have over time, represent significant and distinctive advantages from the point of view of what it takes to effect change, to improve the quality of care.

But I would like to conclude by suggesting that we would benefit from reflecting on at least two kinds of questions in the course of the day. The first is, what are the particular attributes of the delivery system that we are talking about that we believe influence quality and efficiency? This question is prompted in part by a recognition that the closer one approaches what might be called group practice, organized group practice and other variants, the more variation one sees within.

The more difference in terms of the levels of organization, the size, the geographic reach, the range of services that are incorporated and provided, the function and relationship to the patient population as well as the form of organization and variety of relationship to the provider population. The managerial systems that are in place, the

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nature of information technology deployed, etcetera.

The second basic question is, what are the lessons from prepaid group practice and from integrated systems that are pertinent, not only for similar systems, but also that may be more widely applicable in healthcare? So I circle back to where we began.

What can we learn within to benefit the performance of organized systems and what can organized systems teach to improve healthcare throughout our country? Thank you very much. [Applause]

JAY CROSSON: Good morning and thank you so much for coming here to share in this, what I hope is going to be a very important discussion. My path this morning is to talk to you about something I believe very strongly in. And that is that multi-specialty group practice, as it exists in the United States, is a model or a platform to build the kind of delivery system, the kind of 21st Century delivery system that Harvey was describing. I'd like to talk to you about what those specific characteristics are and how I think that might - that change, that development - might begin.

I'd like to start with this quotation, which is in fact from Crossing the Quality Chasm. It says, "The Committee is confident that Americans can have a healthcare system for the quality they want, need and deserve. But we're also confident that this higher level of quality cannot be achieved by further

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stressing current systems of care. Current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

When I read that, I thought two things. Number one, this is an optimistic statement. I don't know about the rest of you, but for the last few years, every meeting I've gone to on health system change has been either frankly pessimistic or in fact one that further delineates in great detail the nature of the problems without necessarily posing solutions. And I think this meeting this morning, if we're successful this morning and this afternoon - if we're successful - is really about beginning the process of answering the question about what the solution ought to be and what direction we may need to go in.

The statement also is challenging. It lays out a challenge for the country. It essentially says it's not going to be easy to get there. It's not merely a question of how to tinker with healthcare financing, but something more significant and more fundamental is needed.

Just to show you that we have consistency here, I'm going to use the same slide that Harvey did, which really lays out the, as he said, the organizational support issues, or in many ways, the challenges for the country in terms of what kind of characteristics are we going to need in this 21st Century delivery system?

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Well we need a system that bases care on evidence - evidence-based medicine at the core of physician decision making. We need to use effectively the kind of information technology that is finally, after twenty years of anticipation or more, finally available, finally affordable, and in fact in the process of being implemented in many parts of the country.

We need to take the cottage industry if you will, of medicine and transform it into a election of learning organizations using knowledge and skills management. We need to get individuals who, by their nature, are independent-minded. And I speak about my physicians colleagues particularly, but not only. Get them focused on working as members of teams.

We need to be able to effectively coordinate care across multiple conditions because as the population ages, more and more Americans have in fact multiple medical conditions and we need to be able to coordinate the care across settings - medical office, hospital. Most importantly, I think for the future, the home, where in the end, much of care is going to be delivered. And we need to use performance measurement and outcomes report to create a system of accountability.

So how do we get there and what's the first step? The thesis I have, and I'd like to work with you on, is that I believe American multi-specialty group practices, if properly supported with incentives, perhaps with assistance from

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government, can in fact be the model or the platform, if you will, to begin to build that 21st Century delivery system.

In fact, group practice in the United States has been around for a long time. It started in Minnesota with the Mao Brothers, who learned that if they were going to be able to have folks at that time drive from all over the Midwest and receive care and then be able to go home, they had to have all the physicians in the same place. And that was the first of multi-specialty group practices.

Subsequently, other groups, Kaiser Permanente most notable among them, grafted onto the group practice model the idea of population management prepayment. The fact is group practice is a proven model. Not all are the same but there's a substantial commonality of purpose and commonality of structural elements across the major group practices in the United States. And many of those are fifty years old or older.

Sometimes when I talk about group practice, particularly in parts of the country that don't feature group practice prominently, people say, "Well that's interesting. It's a California phenomenon or it's something that is not generally available to Americans." And while that's true, you might be surprised to look at that map, which shows the United States and the places - more or less because the person who put the dots on there was a little geographically challenged.

[Laughter] But more or less, these are the places in the

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United States where there is a multi-specialty group practice in place with over a hundred physicians practicing together. And it's about three hundred or three hundred and twenty. If you actually use fifty as the cutoff point, then that number is about six hundred and fifty. So we have somewhere between three hundred and six hundred functioning multi-specialty group practices across the Country.

Now there are plenty of places, you can see from the map, where there aren't any. It certainly is not prominent in many rural areas in the United States. And there are some built up areas, for example metropolitan New York City is a good example of where group practice is not prominent. But particularly in the West, particularly in the upper Midwest and many other parts of the country, we actually have many group practices. In fact could begin to be the native for developing something new.

If you crosswalk that, and you can remember the last map, and you crosswalk that to this map, it suggests to me actually - again projecting forward - that we could anticipate if group practice became a model to build on - somewhere around eighty percent of Americans live in communities that are large enough to be able to support a multi-specialty group practice. It still doesn't solve the problem of rural healthcare delivery and that would have to be addressed in some ancillary way.

I'd like to spend a minute or two on the question of

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payment methodology. You probably notice in the discussions today, that there will be an active dialogue. And sort of - Alain Enthoven and I were talking earlier this morning - it's almost like a chicken and the egg phenomenon. Is it the delivery system model that matters and then can - and pull or influence the financing mechanism because of the rationality of paying a large multi-specialty group on a population basis, or is it the financing mechanism that needs to change that will then bring about consolidation of practices? And I think you can get arguments on both sides.

Mostly what I want to talk to you about though is not the financing mechanisms and its connection to the delivery system, but the nature of the delivery system itself. Now, I have spent twenty-seven years at Kaiser Permanente and there's no question in my mind that in fact the fundamental innovation, or the pair of innovation that's created Kaiser Permanente sixty years ago, was the annealing together of multi-specialty group practice and prepayment. And that in our hands and in the hands of others has created something that really produces the greatest healthcare delivery I've ever seen in my experience.

And I'll read from my good friend, Jamie Robinson, here. I looked through your chapter for the right quote, Jim. "In principal, capitation..." and this means group capitation "...spurs physician organizations to adopt the most efficient

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scale and scope for their enterprise. The appropriate mix of primary care physicians, specialists and non-physician caregivers, and most importantly, the clinical processes that minimize long-term costs, including appropriate technology, evidence-based guidelines and disease prevention."

The case I want to bring today - and it's one that I believe strongly also - is that many of the characteristics that we need for the 21st Century healthcare systems that Harvey defined and that were present in the Quality CASM, are actually characteristics of multi-specialty group practice. And it's my belief that by fostering those and supporting the development of more group practices, eventually we will see a rationalization of financing. That's a good topic for conversation.

What are some of the characteristics of those group practices, which we can use to build on? Well there are three principal ones and I think they deserve some focus. First of all, multi-specialty coordination of care for complex and chronic conditions - diabetes, coronary artery disease, cancer and the management of the frail elderly among others. These are in fact the healthcare conditions, as many of you know, that account for about two-thirds of the cost. And unless we're lucky, all of us in this room, at some point in our life, we will be faced with one or more of these conditions.

In fact, group practices do this better than anyone

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else. I think all of us who are in group practice recognize that. I'm thinking of an example and I think the best one that comes to mind is the award that AMGA gave last year to the Henry Ford Medical Group for its management of prostate cancer. It's probably a model for the nation, but one which brings together in a very focused way, all the various specialties to focus on this particular disease process.

The second characteristic is - and I think Harvey mentioned this in his talk - it's really the infrastructure to be able to use evidence and systematic care processes to improve quality and efficiency. So that in group practices, what we used to call guidelines are actually not books that sit moldering on a shelf somewhere. They are in fact very real devices that are used and flow through the management structure of the medical group to produce better results.

I can't think of a better example than one from my own organization and that is the impact that we have had in Permanente Medical Group in Northern California on the prevention and management of coronary artery disease. Because ten years ago, we set out to reduce the mortality rate from coronary artery disease in our 3.3 million members in Northern California through cholesterol management, proper management of hypertension, management of diabetes and particular attention to the management of acute myocardial infarctions in our hospitals.

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As many of you may have seen in press coverage in the last few months, we are now in Northern California, Kaiser Permanente, one of the few places in the United States where heart disease is no longer the leading cause of death among our members. Although it still is in non-Kaiser Permanente members in Northern California, as well as the rest of the country. And I can tell you that that change is directly related to the activities I described.

And finally, as Harvey also mentioned, it's the special capability that exists right now in multi-specialty group practice to actually afford, invest in, and most importantly effectively deploy the kind of clinical information technology that's now available. This is where that investment is being made. And it is where the benefits are first going to be realized.

Kaiser Permanente is spending about two million dollars... Two billion dollars, excuse me, just a rounding error. [Laughter] Two billion dollars over the next few years to put clinical systems both in our hospitals and in our offices. But many others are doing it, and you're going to hear later from Dr. Paul Tang from the Palo Alto Medical Group in California, who is probably one of the leading groups producing this kind of investment and change.

They're not alone. They have created in the medical group community, under the auspices of AMGA, a new project

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called the Council of Accountable Physician Practices, which now includes these groups and as of last week, the Mayo Clinic. Twenty-three groups in all to focus on using our assets together to promote accountability in medicine including measurement and common work on outcomes.

What's most significant here I think is the fact that of these twenty-three groups, only nineteen either have, or are in the process of putting in, a complete automated medical records, with access to information across the complete continuum of patient care. And the ones you see up there with the E, actually are ones who have invested in one particular commercial vendor. I think you can imagine that before very long, there will be created here a pretty formidable asset, both for investigation and for quality improvement.

What are some of the barriers to multi-specialty group practice becoming the model that we can build on? Well there's several. And again, I think Harvey touched on a couple of those. It is not easy to build a group. Group culture is something special and it takes time. Its contrary traditional physician culture - physicians by their nature don't like to work together and it takes some work to do that. There are a number of failed models from the 1990s. Bicorn [ph], Med Partners, the whole integrated delivery system issue that created some sense of failure on the part of physician groups and among how policy people needs to be reckoned with.

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Most importantly, I think there is a lack of consistent public and private market incentives to produce the kind of investment in consolidation and to improve the kind of quality and efficiency that group practices can produce to reward that in an effective way. And again, as Harvey pointed out, a new kind of physician leadership is needed and that in fact was the reason that we created the CAP project.

So finally, I'd like to propose this following paradigm. I believe these barriers can be overcome, but help is needed to make integrated health systems more advantageous, more obvious and more compelling to patients, providers and others, we need some help. And I would specifically propose three things.

We need better, more specific performance measurements. I was here in Washington three weeks ago or so for the ACOVE presentation, actually was part of that, I see Bob Brook in the back. That's the kind of work we need. Very specific, usable, actionable performance measures. We need those performance measurements more effectively linked to the flow of dollars, both from public and private payers. Early efforts that pay for performance are a beginning of that process, but we need something a good deal more specific and more generalizable [ph].

Finally, we need public and private incentives for clinical information systems to foster improvement in

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performance and accountability, but most importantly, we need those incentives to drive the appropriate use of clinical information technology, not just to taste people to make investments that may make anyway, but to drive the kind of investments and more importantly, to drive the kind of use of the system.

The hypothesis then is that since we're in a market-think mode in the country right now, that such a value driven market should generate sustainable consolidation in delivery system rationalization. In other words, if we create the environment that fosters physicians coming together and working cooperatively, we provide some economic drive for that. And I think we will see physicians being rational as they are, that that kind of consolidation will develop. It can be fostered. It can be speeded up. But of course, that's going to require a substantial change in thinking and the kind of general support that we don't see right now.

And I would believe, in answer to Alain that if we do that, we may very well see then a resurgence of the prepayment model. Because I think once you have these systems in place, once payers recognize the value of it, then the rationality of prepayment, prospective payment for care, comes back. What seems to be on the decline right now may very well return in forth. Thanks very much. [Applause]

STEPHEN SHORTELL: We're keying up here. Let me begin

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by trying to underscore a sense of urgency for what we're about here today, this morning and this afternoon.

And I want to suggest that in tell perhaps the last five or six years, most of the healthcare problems we've had in America have been of an acute episodic sort emergency care, acute illness and so on. That as we now know, is no longer the case. Over a hundred million Americans - a hundred and twenty-five million Americans with chronic illness - half of those have two or more chronic illnesses. And so we've had a delivery system built to the code, if you will, of the 1900s, deal with acute and episodic illness that is now facing a much different reality for all of us. And that reality calls for a very different kind of delivery system, and that's what we're about today.

And it seems to me the inherent advantage of what Jay has suggested and Harvey's alluded to and George and the rest of us are going to wrestle with throughout the rest of the day, is the fact that prepaid group practices, what differentiates them is that they represent a care system. And chronic illness requires a care system. Not individual acute episodic care, which our healthcare system currently is largely designed for. So part of the question is, what is the evidence that these kinds of care systems actually deliver better care and might garner the kind of support and incentive for change that we'd been talking about.

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And that's what I want to present today. Some of what I'm going to talk about isn't in your handout. It's because these are new and emerging data. They are fresh data, so much so that they are in working papers that are currently under review, or will be under review, with various journals. And we do not want to risk prior publication. But nonetheless, I am going to talk about them here.

If we tee this up, this comes from some interview that we did and just to frame this a little bit, direct quote from one of the directors of a medical group, "I tell our Trustees when you walk into our group, you're walking into the arms of an organized group practice. You walk into our competitor, you're walking into the equivalent of a farmer's market where there are a bunch of people sitting there in stalls, selling their wares and leaving at the end of the day when they are done. They don't particularly care what the farmer's market is like, as long as the bathrooms are clean and the lights are on. They don't particularly care who is selling stuff next to them because they are not integrated."

Now, just to frame this a little bit in context, I think we should acknowledge that some progress is being made on some of the problems we face. For example, death rates due to stroke have come down. They've fallen by more than one-third in the past two decades. Death rates from heart attacks have also been cut in half. Millions of women enjoy longer lives,

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quality of life due to advances in breast cancer treatment. But the point is that only about half of Americans receive recommended treatment for their condition - this is Duran [ph] work last summer. And we might add that you can understand that when you look at the provider side, some work we've done - our team at Berkley about position organizations in this country used less than half of the recommended care management processes for patients with this chronic illness. That's the other side of the story.

And my point is simply this - the American healthcare system is the poster child for underachievement. That's the point. We can talk all we want about how wonderful we are and we do some things well. We're nowhere near our potential. To err is human pointed that out, crossing the Quality CASM pointed that out, etcetera. There is huge, what I will call, value leakage. Value leakage. We are not taking advantage of how good care in this country could be that directly would impact the quality of our lives. These are just a few examples from the National Committee for Quality Assurance controlling high blood pressure, we do a lousy job, results in twenty-eight thousand deaths - 1.2 billion dollars. Diabetes control, thirteen thousand seven hundred deaths are in seventy-eight million. Smoking cessation, that's direct, the overall is probably four hundred fifty thousand deaths. This is two thousand seven hundred if you want to look at it that way,

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ninety-seven million cholesterol management and so on. So we have a huge problem of value leakage.

This slide's been alluded to. This is what I want to take as true in terms of the evidence as we know it about prepaid groups on the right hand side. Those are the outcomes we want to produce. And as Jay has said, it's the care system that's really going to be important here and these redesign imperatives, and yes, it is within the context of payment alignment and financing as well. But all the attention we've been giving to the financing element, that's like trying to clap with one hand. Unless you marriage that with the delivery system reform, we're not going to get any noise out of this and this is what this meeting is about.

I'm going to skip these definitions in the interest of time. I think we know what they are. But I do want to underscore again the components that Jay has alluded to. Multi-specialty groups - this is kind of the DNA, ok, of the reform delivery system. It may take different forms. It could be mixed together in different ways. Multi-specialty groups, healthcare teams, practicing healthcare team support - it's not an individual support - define populations, aligning finance and payment, effective medicine and management partnerships - absolutely key. Evidence-based management, as well as evidence-based medicine and putting those together, enhanced information capability and accountability. These are the key

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components that we're working with.

There's a lot in the literature, existing evidence, how often others and colleagues - this is summarized here for you. I would just point out that one of the problems with that literature we have today is a lot of it has been done on HMOs overall and doesn't separate out, if you will, carrier HMOs that are based most on insurance products versus delivery system HMOs in making some of those comparisons.

So, let me go through the six aims and a little bit of the evidence. On safety, is there any evidence that prepaid groups do a better job on the safety issue, on keeping patients safer if you get your care from a prepaid group than a non-prepaid group? And this is an area that really begs for a lot more work. There is a safety agenda. To my knowledge at least, there's nothing in the literature yet that directly looks at safety issues that compares prepaid groups with other forms of care. We can hypothesize that prepaid groups indeed will do a better job because their information capability or accountability, teams that can catch each other and learn from each other, etcetera, but there's nothing in the literature yet that I'm aware of.

But there is some new and emerging evidence around effectiveness in terms of quality and outcomes of care. Let me summarize a little bit briefly and then go through a few numbers. Multi-specialty groups are more likely to use

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recommended evidence-based care for patients with chronic illness. They are more likely to report a positive financial outcome from that investment. Those who are aligned - any group that's more aligned with an HMO or a hospital or a health system that has that kind of integration resources and backup use more recommended care processes than freestanding physician groups.

Health plans that are more closely affiliated with tightly managed physician groups or that employ their own physicians, perform significantly better on clinical performance measures with no difference on patient satisfaction in comparison with other types of provider delivery systems.

Jay has alluded to Kaiser Permanente's experience to some extent in Northern California in providing breast and cervical cancer screening, diabetes care, cholesterol management and follow-up care after hospitalization for mental illness. They are consistently rated the best. The death rate that Jay has cited cut from fifteen percent decline in an eight-year period, largely due to the fact they have a care system for these people. It's a coordinated strategy of implementing guidelines.

These are the citations and evidence to kind of a visual here in the work that we did with over a thousand medical groups, the ones that Jay showed across the country, plus four hundred others. You can see that we broke out the

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multi-specialty prepaid groups in our database. We had twelve of those and these are the recommended care management practices, disease registries, guidelines, automated reminders, patient self-management programs and so forth. Significantly, these are done much more by these multi-specialty groups. And what's interesting here, if you look at that slide, even compared to other large groups of one hundred or more doctors, which is the middle bar shown here and the overall is on the right. Chronic care management index, this is based directly on Ed Wagner's work, the chronic care management model. We also broke out the data that way. Same story. These prepaid groups, the twelve multi-specialty prepaid groups, significantly twice as much as other groups.

Clinical information technology - we developed a clinical IT index based on the electronic record, the electronic use of information for lab and pharmacy data and so on. Again you can see that these large multi-specialty prepaid groups significantly more use of clinical information technology than other forms of care delivery.

They also happen to be located in markets. Perhaps they push the market. Perhaps the market pushes them, we don't know. We can't talk about causality. These are cross-sectional data. But there's more external incentives. They're getting rewarded for doing this work and this is what we need to create across the country. And it's beginning to happen

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with some demonstrations, but perhaps these need to be accelerated. We need to accelerate the learning.

Here's the question on pursued financial impact of investment. We were not able to measure the actual dollars, a few individual delivery systems have, but if you ask them - as you can see here - asthma, forty-one percent say that they believe it's been financially viable the impact of the investment in IT; congestive heart failure, less so in depression - that's across the board as many of you know - diabetes and smoking cessation as well.

Ok. I want to move now to some data that you don't have and I'll highlight it here quickly. This is the Council of Accountable Physician Practices that Jay has alluded to. And here we're up to about eighteen members. So we were able to take our data and break them out and compare them to all the others in our sample that are not members of CAP that are medical groups. You see here it's a very consistent story of statistical significance in which these eighteen accountable physician practices that were listed there by Jay, on the care management index, twice the rest of the sample. Diabetes - the POCMI simply stands for Physician Organization Care Management Index - twice as congestive heart failure, even depression - although it's lower - registry index, case management index. Do they use case managers for severe diabetics, severe asthmatics to coordinate the more complex care of the handoffs

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and the communications you can see there? All the way down the line and the clinical IT is also significant. We just missed the stars on that. So that's the... These are the members again. Jay has mentioned those as well.

This is a different cut at the data. This is data that comes from the Alliance of Community Health Plans - ACHP - and in the first column, we're comparing their scores on NCQA, non-group managed care organizations. If you look down just those first two columns and look at the asterisks, these are difference here at the 05 level. You can see in almost every case, except the blood sugars - but in almost every other case, the organized groups outperform the non-group managed care organizations.

Then the two columns on the right look at inter-study organized groups, so we get the end up a bit to thirty-one there and compare them with the non-group managed care organizations. And again, in every single case - although the magnitude here - almost every case - some cases it's not large - but consistently favors the organized groups.

This continues on - appropriate medications for people with asthma. No difference there. On the others, hospitalization follow-up, thirty days for mental illness, you can see there. And down the line, patient satisfaction, customer service - not as many differences around some of the patient satisfaction items.

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So if we were to summarize just the results of this work which again is still under review and emerging, effectiveness of care there are no difference on ten of the measures. But the organized groups were better by up to five percentage points on twelve measures and by more than five percentage points on twenty measures. We move to patient satisfaction - no differences on fourteen. The organized groups were worse on four measures by up to five percentage points and actually better on two measures.

If you were to translate that, NCQA has their quality dividend calculator, which I won't go into here in the interest of time, but basically if you just look at the differences between non-organized groups and organized groups, you get the difference column and this can translate into how many lives would be saved annually if the non-organized groups were to do the things, the care management processes, that the organized groups do? And you can see the number of MI's averted, strokes averted, sick days annually averted - over a million in terms of cholesterol management, diabetes is there as well, breast cancers more in terms of lives saved. And these are conservative estimates. There are some other estimates that would place these numbers even higher.

Ok. All of that's in terms of effectiveness. I'm going to hurry up now in the interest of time in terms of efficiency generally lower cost due to less hospital use, more

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coordinated care and possibly closer management of patients with high-cost chronic illness. It's not due so much to economies of scale or scope, it's actually due perhaps to better utilization of resources, better management of people with chronic illness, aside from issues of size or scope of products delivered.

Personalized care, generally lower for all HMOs, but recent data suggests no difference for tightly organized prepaid groups. The earlier evidence is based on all HMOs, which include the carrier HMOs, as well as those that are more delivery system HMOs. But again, more research is needed here.

Timeliness, generally lower, again based on the HMO literature, but it may be changing and it should be subjected to more research. Equitable - we really know very little about this. Is care more equitable if it's delivered in prepaid multi-specialty groups than other forms of care? Are there no differences in what patients get and their outcomes of care by their race or ethnicity or where they live or their gender? Major research areas. As far as I know, we don't know very much about that. We can hypothesize, it might be more equitable.

I want to conclude a few quotes again from some of the interviews we did in addition to the quantitative data, multi-specialty prepaid groups can promote the principal of patient centeredness. Because teamwork provides a framework for that

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and it's a system of care. It can provide greater efficiency through the aligned financial incentives in which the organization you see encapsulates. It's the benefits of that alignment captures the rewards of that efficiency.

It can enhance effectiveness. We've got data to show that now as well. It's the most advanced approach, said one person, for dealing with chronic illness management and disease prevention. It can promote the use of information technology because the integrated structure allows them to maximize the return on the IT investment. It's more difficult to do in more fragmented delivery models through online access to physicians, prescriptions, lab tests, etcetera. It's not impossible to do in other models, and we'll be hearing more about that today.

It makes care more transparent to the common record changes or practice style automatically because we are more prudent about what we do. But a lot of people still like farmer's markets. Thank you very much. [Applause]

GEORGE ISHAM: Thank you for that terrific set of presentations. There are two microphones. One in each aisle. And we have time for questions and comments. And I'd like you to begin to approach the microphones and formulate your questions. And I was thinking, you know, the delivery system does matter. That's the title of this conference. And the question sort of posed by these three presentations.

I mean we've got Harvey Fineberg today. You know, boy,

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a system is required. We've got Jay Crosson who is pointing out that there are attributes to existing systems that provide an it is for us to build on. And then we have Steve Shortell, really talking about there is some evidence that there is a relationship to organization structure. So it poses some very, very compelling questions for us and I guess we're ready for some questions right there. Go ahead.

MARSHA GOLD: Hi. Marsha Gold, Mathematica [ph]. I have to ask you the question that probably is in the back of a lot of people's minds. You said, Steve, a lot of people still like the farmer's market and I'd probably say too that a lot of physicians like the farmer's market because the patients might not like the farmer's market if there wasn't much farm goods there. So the question I have is how much... I mean how do we deal with that issue of is this at all real? I mean how do you get from a whole bunch of little boxes with doctors all over the place?

Is it at all realistic to think that you could move them into groups? Because even in the data that you put up there, I don't know what share of the population is in that hundred and plus group, but then even if you look at Steve's data, even the large groups, they're not all the same. And it's a very small number that do the better things to look at. So let's say we're true believers and this makes sense and there's a lot there. Why is this different than many years ago

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when people said, "Well you're never going to change the system if you just look at prepaid practice or multi-specialty groups because it's never going to go there?" I mean, make this tangible in terms of it being really policy salient and how do you get from here to there? Can you get from here to there?

STEPHEN SHORTELL: Let me start off on that. Probably all of us would want to comment. I don't think you're going to get there in big leaps, although that would be great. I think you're going to get there in steps and I'm certainly not suggesting that the prepaid - strict peer prepaid group practice model is the only way to achieve some of these possible advantages.

So as an example, I think that physicians slowly are continuing to see the advantages of practicing in larger forms of some sort. There may not be a hundred doctors and there may not be, you know, prepaid. But they're seeing the advantages as the population they are treating changes in some of the younger physicians and nurses and other health professionals come out of their schooling.

I think that what really is going to matter is the following: We need to create a better financial environment with the incentives, through programs like rewarding results, pay for performance, bridges to excellence, national investment in IT, that will enable more loosely organized physicians to see the benefits of coming together in somewhat larger

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collectivities and at least begin to get the advantages for their patients through relationships with health plans, for example, where you can create almost virtual group practices in many sense, to get some of these advantages that perhaps is much easier for the prepaid groups to get. So I am very encouraged actually by some of the demonstrations that are currently going on that I think we'll push in that direction.

The second point I will make is the notion of the tipping point. Many of us I'm sure read Malcolm Gladwell's little book a couple years ago on the tipping point. I think what Jay and others in this conference is about - and you look at that map, that the prepaid group practice model for decades was an aberration. You know, there's Kaiser Permanente and you know all the problems they had and malt top [ph] cocktails being thrown through the windows in Los Angeles and so forth and so on. [Laughter]

You know, it's taken decades, you know to get past that. This is now, if you will, the new poster child for achievement. And my point is, it's going to have a diffusion effect. And let me just give a brief example. I don't think in California, which I now know best, we would be doing some of the things we are doing in California, our medical groups and health plans, if there weren't a Kaiser Permanente in the state. So as such groups anchor themselves in other states, they are going to have a diffusion effect on other practice

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models.

JAY CROSSON: I mean I would second that. And I think we do see it in California right now. In Northern California, where I live, you know we are almost - you can almost see that in five years, there will just be a two, or perhaps three group practice-based delivery system provision for the majority of the population. It's already sixty percent. Sixty percent of the people who live in Northern California are either cared for by Permanente Medical Groups or our Sutter [ph] Medical Groups.

And my guess is in five years it will be eighty percent. Perhaps some of the other groups will consolidate. Southern California is a little behind that curve. But I think we see the dynamic when you get a kind of delivery system constructed that is so obviously compelling to people and to physicians. In our situation, physicians line up at the door to get a job in our medical group because it's the best place to practice medicine.

When you layer onto that the kind of obvious improvements in care that clinical information technology is going to make manifest to people, not just the fact that the doctor has your records no matter where you happen to show up for care, but then in fact, you can communicate with your record and with your physician over the Internet and you can only do that for these kind of organized systems.

It's not going to take very long before doctors get the

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idea - this is where you need to go and three or four patients get the idea that there's something different going on in these settings. And if we can get the kind of incentives that I talked about earlier, we can get the kinds of measurements that can really only be successfully delivered on in this setting. We can get the flow of dollars to follow those measurement - those performance on those measurements and we can get these systems in place and get the investments made more quickly, than my belief is we will see the market begin to shape itself around what is obviously, after a while, the way to deliver healthcare.

But that is not a quick process. It's going to take some time. It's going to take investment. It's going to take focus and a level of understanding about the fact that the delivery system is important that we frankly don't have right now.

GEORGE ISHAM: Ok. We have a few minutes left. So I'm hoping to briefly formulate a question than answers to allow us to get two more... [Laughter] So Greg and then I'm going to go here...

GREG FOX: You know me better than that George. [Laughter] Greg Fox [ph] from [unintelligible]. I have been a longtime great fan of prepaid group practice in my early days at Group Health [unintelligible]. But I think there's an extremely important and extremely urgent thing that we need to

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do. And that is to follow-up on some of the research that Steve and Ed Wagner and others are doing, and that is to really look at what the real critical elements that link this to quality. Because after all, our focus has to first be on quality and efficiency - that part of quality some don't - quality and efficiency, not necessarily on the size of the organizations in the practice. If that turns out to be absolutely essential, great. But if not - and I think there's some interesting evidence that maybe it's not.

Ann Wilson and I are doing a project, the ABIM Foundation - through the ABIM Foundation - that is looking at small practices of less than fifteen that seem to be achieving - there are not many of them - but seem to be achieving really outstanding qualities themselves. So I think it's really urgent for us to find out very quickly what the real critical elements of this, how do they link together, and how do they really form a package.

JAY CROSSON: I think that's a fair enough comment. It sort of reminds me of the old joke of the drunk looking for the quarter. Now you want to make sure you're not just looking under the lamppost because that's where the light is. In fact, I think the best information that we have is on the places that have the scale and size and information technology to deliver the evidence and we shouldn't be blinded by that, despite our prejudices.

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GEORGE ISHAM: Ok. Let's have this question right over here.

BURT SIDEMAN: I'm Burt Sideman [ph] and I'm with the Kaiser Middle Atlantic Board, but I speak only for myself. [Laughter] I think we have to go back and look at where prepaid group practice was in the 70s, the 80s and so on. And what went wrong in terms of public understanding and acceptance of prepaid group practice. It's a shame to say so, but in the very groups that supported prepaid group practice, promoted prepaid group practice - and I'm talking about the labor movement with which I was associated for a long time.

The word HMO has become anathema and we have to recognize that. We can't just act as if it isn't a fact. It is a fact. Whereas, in those days, it was considered an ideal and I think that I'd like to ask the members of the panel, maybe we can go back to some of the crossroads that we took and determine whether taking those crossroads rather than the alternatives, which was following out the principals of prepaid group practice at that time, have had some influence on the fact that there is so little public acceptance now of HMOs that people use. People need liberals. Use HMOs as being something that's wrong and that we shouldn't be doing or that we shouldn't ask people to move into and so on.

JAY CROSSON: We've asked some of the same questions. I thin I asked Alain a few weeks ago what was the day when

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Kaiser Permanente stopped being accused of being a socialist conspiracy and became part of the overbearing capitalist system of the United States. [Laughter] I'm not exactly sure when that happened.

I think... I don't know. And I think... First of all, I think you can't go backwards. I think the financing of healthcare in this country seems to be, at the moment anyway, moving in a different direction. I think we've all been tarred by the anti-managed care, anti-HMO brush. I don't know where financing is going anymore than anybody else does, but it seems to be changing. I think the money is going to flow differently. I think - my own sense here is, for example, that the difference between prepaid group practice and non-prepaid group practice is going to become a lot smaller.

First of all, the prepayment, or not prepayment, at the group level, as opposed to the individual physician level, is not as significant as you might think because groups that get fee for service all or in part, but still pay the physicians on a salary plus a small performance basis, have many of the same dynamics that we associate with prepaid group practice. I think Jamie has that in his chapter, and it's true. But we see in the CAP groups, for example, the most important thing is how the physicians are paid and what they're incented on as opposed to where the dollars flow into the group.

Secondly I believe that as we get into the world of

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consumer products - consumer directed products - we're going to find even in our organization, I would say in five years probably twenty-five percent of our revenue, again at the group level - or at the plan level - actually is going to be fee for service payment. And we in fact are going to find ourselves in a mixed model in the future, whether we like it or not because of the direction of financing.

But my own belief is that it's fundamentally the nature of the delivery system structure and then how the incentives are organized within the group that creates the kinds of dynamics we've talked about. And I believe that that is more generalizable if we want to go in that direction than many might believe.

GEORGE ISHAM: I'm afraid we're going to have to move on. I apologize to the questioners, but we're going to have to move on. I want to thank this panel, for one raising the issues... [Interposing] [Laughter] But we need to keep to our schedule and this does get the questions on the table. I think this panel has done a really good job of pointing out, one that systematic change is required; and two, there are some ideas out there and that some of the issues had begun to be raised about which we'll need to create the conversation and have conversation over the rest of the day. So I want to thank very much the panel. Please join me in thanking them.

[Applause]

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