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SCALE
Versus
QUALITY:

SYSTEMS
And the

Physician Leadership Challenge

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Four Key Interrelated Themes

• Total Cost of Care - Affordability
• Consumer Engagement
• Quality and Safety
• Governance and Leadership
All I know is just what I read in the papers, and that's an alibi for my ignorance.

Will Rogers
“The U.S federal government is on an unsustainable fiscal path, the debt as a percentage of GDP is growing, and now growing sharply…. The single biggest thing that drives the unsustainability is health care.

We spend 17% of GDP, everyone else spends 10%...It’s not that benefits are too generous. We delivery them in inefficient ways.”

Jerome Powell
Chair, Federal Reserve Board.
February 26, 2019
Testimony to Senate Banking Committee

February 26, 2019
In 2017, U.S. life expectancy dropped for the third year in a row.

The last time there was a two year drop was 1962-1963.
The last time there was a three year drop was 1916, 1917, and 1918, a period which included the worst flu pandemic in modern history, and World War I.

Washington Post Wonkblog “Americans are dying younger than people in other rich nations” December 27, 2017;
“Johns Hopkins wrote the rules on patient safety. But its hospitals don’t always follow them.”

By NEIL BEDI and KATHLEEN McGRORY

Tampa Bay Times   Dec. 29, 2018

A woman went to a hospital for back surgery — and left without one of her kidneys

By Lindsey Bever
November 2, 2018 at 3:37 PM   The Washington Post
Charlie Munger, a vice chairman at Berkshire Hathaway, claims the "rampant waste" of the healthcare industry will lead Democrats to implement a single-payer healthcare system the next time they control all three branches of government, according to CNBC.

"A lot of the medical care we do deliver is wrong — so expensive and wrong. It's ridiculous," Mr. Munger told CNBC.

Mr. Munger has served as chairman of the board of trustees at Los Angeles-based Good Samaritan Hospital for 31 years.
The Risks of Hospital Mergers

In retrospect, it looks as if Massachusetts made a serious mistake in 1994 when it let its two most prestigious (and costly) hospitals — Massachusetts General Hospital and Brigham and Women's Hospital, both affiliated with Harvard Medical School and known as Partners HealthCare. The merger, driven by an urgent need to consolidate services and raise funds to meet the region's growing demand for care, was intended to create a superregional system capable of competing with national hospital systems. However, the consolidation of systems has many unforeseen consequences, and the outcomes are now being questioned.

For one, the integration of the two hospitals has created a complex system that is difficult to manage. The consolidation has also led to increased costs and inefficiencies, as well as a decline in patient satisfaction. The merger has also been criticized for its impact on the local community, as it has led to a concentration of resources in a few large hospitals, leaving smaller facilities struggling to compete.

Moreover, the merger has raised questions about the role of academic medical centers in the region. Partners HealthCare, the result of the merger, is one of the largest hospital systems in the United States, with a significant influence on medical research and education. However, some have argued that the consolidation of resources in a few hospitals could stifle innovation and limit the availability of specialized care.

Despite the challenges, Partners HealthCare remains one of the most powerful forces in the region, and its success or failure will have a profound impact on the future of healthcare in Massachusetts and beyond.
A Merger Creates, Expands, or Transforms a System
Pick on Someone Your Own Size!

INSURERS

SYSTEMS
In the 1990s and beyond, provider mergers were fundamentally aimed at increasing Hospital System MARKET POWER and then translating this into increased PRICING POWER against the Insures/Payors.
THE CORE EXISTENTIAL QUESTION:

“WHERE DO SYSTEMS COME FROM MOMMY?”
WHAT IS A “SYSTEM”?  

MOST SYSTEMS BEGAN WITH THE “HOLDING COMPANY” MODEL: ATTEMPTING TO CAPTURE EFFICIENCIES WHERE POSSIBLE BUT RESPECTING AND PRESERVING THE INDIVIDUALITY AND INTEGRITY OF SUBSIDIARY ORGANIZATIONS AT ALL TIMES.
WHAT IS A “SYSTEM”?  

1. AN INTERDEPENDENT COLLECTION OF COMPLIMENTARY PARTS THAT FORMS A COHESIVE WHOLE.

2. SAMENESS: THE SAME THING IS DONE THE SAME WAY THROUGHOUT THE SYSTEM

3. SYSTEM: WHERE THE WHOLE IS MORE IMPORTANT THAN ANY OF ITS PARTS; i.e. THE PARTS SERVE THE WHOLE, NOT THE OTHER WAY AROUND.

4. “THE EXTENT TO WHICH FUNCTIONS AND ACTIVITIES ARE APPROPRIATELY COORDINATED ACROSS OPERATING UNITS…SO AS TO MAXIMIZE THE VALUE OF THE SERVICES DELIVERED.” (Gillies, Shortell, Anderson, and Mitchell,

5. STANDARDIZING AND CENTRALIZING KEY MANAGEMENT, GOVERNANCE, AND CLINICAL SYSTEMS.

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WHAT IS A “SYSTEM”?

6. FUNCTIONING LIKE A SINGLE INTEGRATED ORGANIZATION RATHER THAN A COLLECTION OF INDEPENDENTLY FUNCTIONING PIECES.

7. A TIGHTLY-KNIT ORGANIZATION THAT SHIFTS DECISION-MAKING RESPONSIBILITY AND AUTHORITY AWAY FROM SUBSIDIARY OPERATING UNITS TO THE CORPORATE LEVEL.

8. SYSTEMNESS EQUALS CORPORATE CONTROL, COORDINATION AND CENTRALIZATION

9. STANDARDIZING AND CENTRALIZING KEY MANAGEMENT, GOVERNANCE, AND CLINICAL SYSTEMS.
WHAT IS A "SYSTEM"?

A BALANCING ACT OR AN ABSOLUTE CHOICE?
• “evidence from three decades of hospital mergers does not support the claim that consolidation improves quality.”
• “greater market concentration led to higher spending.”

DO MERGERS REDUCE COSTS?

Hospital consolidation generally results in higher prices. This is true across geographic markets and different data sources. When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.

Physician-hospital consolidation has not led to either improved quality or reduced costs. Studies find that consolidation was primarily for the purpose of enhanced bargaining power with payers, and hence did not lead to true integration. *Consolidation without integration does not lead to enhanced performance.*

The Impact of Hospital Consolidation. Update. June 2012. Publisher: Robert Wood Johnson Foundation

Publication: The Synthesis Project

Author(s): Gaynor M, and Town R
# Mergers Don’t Measurably Increase Quality

Source: Vogt and Town, 2006

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<tr>
<th>Author</th>
<th>Geographic scope</th>
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<td>38 HCUP QI measures</td>
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Size, Scale, and Reputation Do NOT Protect You!!

- Providence Health- $511 million decline (-$250 million net ops loss)
- Dignity Health- $487 million decline (-$63 million net ops loss)
- Catholic Health Initiatives - $525 million decline (-$460 million net ops loss)
- Trinity Health- $411 million decline ($46 million net)
- SSM (St. Louis)- $220 million decline ($10 million net)
- MD Anderson Cancer Center ($266 million loss in FY16; $23 Million in FY17)
- Partners (Boston)- $214 million decline (-$108 million loss)
- Cleveland Clinic- $341 million decline ($139 million net)

Courtesy Jeff Goldsmith
Laws of Systems
(From Deming, Batalden, Reinertsen, Others)

1. Every System is Perfectly Designed to Produce the Results it Gets.

2. In Order to Optimize the System, One or More Parts Must Be Sub-Optimized.

3. If Each Part is Optimized, the SYSTEM Will Be Sub-Optimized.

4. Complex Adaptive Systems are Not Like Complicated Machines, They are More Like a Flock of Birds.
Laws of Systems

There are Three Ways to Achieve a Better System Number:

1. Improve The System
2. Sub-optimize the System
3. Cheat

As Leaders Put More Incentives on “Achieving the Number”, The Likelihood Increases of More of 2 and 3.
KEY LEADERSHIP PRINCIPLES for SYSTEMS and PHYSICIAN GROUPS:

1. Authority. System leadership operates on the principle of *centralize authority and decentralize decision-making*. This is clarified and operationalized through the development and use of an authority matrix.

2. Leadership. The purpose of leadership is to lead the system, not to represent the interests of constituencies, stakeholders, regions, or pieces of the system. Therefore, governance composition models are competency-based, and not representationally based.
THE FALLACY OF COMPOSITION

- WHAT IS GOOD FOR THE INDIVIDUAL IS NOT GOOD FOR THE GROUP

- WHAT IS GOOD FOR THE GROUP IS NOT GOOD FOR THE INDIVIDUAL
Driving Effective Physician Leadership Oversight of SYSTEM Safety and Quality
Moody’s Investors Service Special Comment
May 9, 2012

“The most meaningful cost reduction strategies will involve standardization of clinical care and elimination of variation in patient procedures. This will be a multi-year, ambitious journey requiring strong physician, management and board leadership"
Physician Leaders/Boards play a key role in quality and safety. To be effective, they must...

- *See the problem*: What?
- *Own the problem*: Who?
- *Solve the problem*: How?
“The great obstacle to progress is not ignorance but the illusion of knowledge.”

Daniel Boorstin
As a general rule, trustees think that their hospital’s quality is much better than the doctors, nurses, and executives do.

See The Problem?

- A study in the April, 2011 journal of *Health Affairs* found that on average, 1 in 3 patients admitted into a hospital suffer a medical error or adverse event – nearly 10 times greater than previously believed.

- On any given day, about 1 in every 20 patients is affected by an infection related to hospital care.

- On average, 1 in 7 Medicare beneficiaries is harmed in the course of care, costing the government an estimated $4.4 Billion every year.

- Medicare Readmission rates within 30 days – cost of $26 Billion every year.

- Hospitals Kill between 180,000 and 400,000 people every year!
Stages of Facing Reality

• Stage 1 “The data are wrong”.
• Stage 2 “The data are right but, it is not a problem”.
• Stage 3 “The data are right; it is a problem but, not my (our) problem”.
• Stage 4 “We accept the burden of improvement”.
Patterns of Behavior That Must Change if Healthcare is to become Safer

- “Normalized deviance” from safety rules
- “Willful flaunting” of safety rules
- “Check the boxes” approach to safety rules
- “I must show that I’m strong and don’t need to ask for help” approach to teamwork
- “I don’t dare to speak against the authority gradient” even if something is obviously wrong
Three Big Questions for the Leaders/Board and Members to Understand:

1. Why does Your Physician Group/System do Safety/quality improvement?

2. Do You have a shared, system-wide definition of quality? Of Safety?

3. What can Physician Leaders/Board do to improve quality and patient safety?
A Brief History of Quality/Safety

The Code of Hammurabi (CIRCA 2,000 B.C.)

“If the surgeon has made a deep incision in the body of a free man and has caused the man’s death or has opened the carbuncle in the eye and so destroys the man’s eye, they shall cut off his forehand.”
What Is Quality?

- “Quality...You know what it is, yet you don’t know what it is. But that’s contradictory...But when you try to say what quality is, apart from the things that have it, it all goes poof!...If no one knows what it is, then for all practical purposes it doesn’t exist at all. But for all practical purposes it really does exist. What else are grades based on? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously some things are better than others...But what’s the ‘betterness’?

- What the hell is quality?

- What is it?”

Robert M. Pirsig
Zen and the Art of Motorcycle Maintenance
Pursuing Perfection in Quality and Safety

Quality: Deliver all and only the care that we know will help

Safety: Do not harm
Pursuing Perfection in Quality and Safety

Quality: Deliver all and only the care that we know will help.

Safety: Do not harm.

Despite all the advances we have major defects in both of these curves.
The Virginia Mason Quality Equation

\[ Q = A \times (O + S) \div W \]

Q: QUALITY
A: APPROPRIATENESS
O: OUTCOMES
S: SERVICE
W: WASTE
The Best Boards

1. Adopt bold, specific, system-level strategic aims
2. Oversee system-level measures of progress toward those aims, using a “strategic dashboard”
3. Develop a strong Quality Committee
4. Build Will
   • Eliminate the denominator
   • Put a face on the data
     • Start every meeting with a story
     • Convert data to names, dates, and events
   • Harness the power of transparency
   • Face up to the difficult conversations
     • Change the culture
Edgar Schein’s view of what leaders do to change patterns of behavior

**Primary Mechanisms**
- What you pay attention to, measure, and control on a regular basis
- How you react to critical incidents and organizational crises
- Observed criteria by which you allocate scarce resources
- Deliberate role modeling, teaching, and coaching
- Observed criteria by which you allocate rewards and status
- Observed criteria by which you recruit, select, promote, retire, and excommunicate organizational members

**Secondary Mechanisms**
- Organization design and structure
- Organization systems and procedures
- Design of physical space, facades, and buildings
- Stories, legends, and mythos about people and events
- Formal statements of organizational philosophy, values, and creed
Physicians today must absorb three messages:

1. Quality is measured not by volume, diligence, or even skill. Quality is measured by **Results**.

2. Cost does matter. “**Value**” in health care means achieving good outcomes as efficiently as possible.

3. **Teamwork** is required (coordination, information sharing, goal setting, accountability).
Clinical Integration (CI)

Clinical integration is

Integration of Physicians with each other (and often with a hospital or hospital system) on a Clinical basis to

- Determine the right and best ways to practice medicine
- Commit to practice that way
- Commit to mutual accountability
- Develop active performance improvement programs to enhance healthcare quality and efficiency

Aligned Incentives
CI Practical Requirements

- Leadership group of physicians is key
  - Willing to be measured and improve (a direct appeal to the ethos of physicians)
  - Able to communicate
  - Respected
  - Collaborative

- Clinical Performance Improvement Projects
  - PQRS, attestation for meaningful use, Medicare levy, performance measures
  - Ambulatory pathways and protocols
  - Hospital quality, safety and cost efficiency projects
    - Choose wisely—doable projects with clear benefits
    - Patient centered
MHMD agrees to:

- Maintain primary *loyalty* to physicians
- Negotiate well to *align incentives*
- Include physicians in work and decision making
- Provide *clear and timely information*
  - Membership Criteria, Quality Measure Scoring
  - Accountability / Improvement Process
  - Contract, Financial Performance
- Provide physicians with information, services, and education to ensure high quality and ease practice burdens
- Seek feedback from its physicians
- Maintain confidentiality
- Communicate, communicate, communicate
- Make meetings worthwhile and engaging
- Create leadership training programs
Physicians agree to:

- Practice evidence-based medicine
- Uphold regulatory, quality, and safety goals
- Report quality data
- Meet CI criteria
- Come to meetings and performance feedback sessions
- Pay attention to information from MHMD
- Accept decisions by physicians in MHMD committee settings
- Be flexible, share ideas
- Collaborate with colleagues and hospitals
- Behave as professionals
Clinical Integration takes effort!

- Participating physicians must **participate**
  - Participate in selecting quality measures
  - Participate in reporting performance (e.g., PQRS measures)
  - Participate in determining what level of performance is the goal (setting **realistic** goals)
  - Participate in committee work, performance feedback, and quality improvement activities
- **Time, effort and IT infrastructure all required**
- **Those who do not participate even after remediation, must be removed!**
Mandatory OB 22 hour CME training for both physicians (to maintain credentials) and nursing (to maintain job) with incentive for early completion

Maternal Deaths

2009 – 5 deaths (18.5/100,000)
2010 – 4 deaths (16.4/100,000)
2011 – 1 deaths (4.3/100,000)
2012 – 3 deaths (12.8/100,000)
2013 – 0 deaths (0.0/100,000)
2014 – 0 deaths (0.0/100,000 plus the brain dead MVA patient)
To get a more complete answer to the question “How safe are we?,” leaders must also ask:

- How well are we performing our key safety processes? (Reliability)
- How safe are we today? (Operational Awareness)
- How safe are we going to be tomorrow? (Anticipation and Preparedness)
- How well are we responding to past events? (Integration and Learning)

Disruptive Leadership Questions:

How Can You Save Money for Your Clients/Patients? Provide VALUE?
Give them Better Experience?
Give them safer care?
And,
Still Stay in Business???
“And How Can Man Die Better Than Facing Fearful Odds
For the Ashes of his Fathers
And the Temples of His Gods”

- Lord Thomas Babington Macaulay