Re-Engineering of Care: Surgical Leadership

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It is a great honor to be the invited speaker for the 2013 American College of Surgeons' Commission on Cancer Lecture. As most of you know, I have been associated with the Commission on Cancer for over three decades. The executive and voluntary leadership of the College and the Commission have to a large extent been responsible for the major clinical improvements in hospital-based care for cancer patients over many years. Today's lecture represents a continued commitment to that important process.

I have spent the last 13 years at a remarkable organization with unusual capabilities to scale one possible care optimization model that looks to the future of healthcare reform (Figure 1).

Geisinger Health System is a truly integrated health services organization encompassing every component of healthcare delivery, an unusual fiduciary structure that includes both insurance payer and clinical care enterprise, a stable patient demography that consists of large rural and post-industrial urban populations, the ability to assess new care delivery results not just over days or months but over generations, and finally, a remarkable electronic infrastructure that has been functionally refined now for almost 20 years.

Geisinger services three unique market demographies. In northeast Pennsylvania there is population growth from significant migration out of the greater New York metropolitan area and a consolidation of provider entities into two major systems, Community Health System out of Brentwood, Tennessee and Geisinger Health System. These two systems have markedly different business models, the former being hospital-centric and Geisinger focusing more on population based care. The Central Susquehanna market is a static demography with older, poorer and sicker patients compared to just about any part of the United States outside of the deep South. And our western demographic (focused in Centre and Juniata counties) is a mix of the other two.

On the payer side of Geisinger, there is a complete overlap in all three of the above provider markets and in addition there is significant market extension by the insurance companies into areas southeast and south central in Pennsylvania where there is no Geisinger-employed provider coverage. Most recently, the insurance company has ventured into Maine, New Jersey, Delaware and West Virginia in a variety of relationships with preferred non-Geisinger providers – attempting to recreate the Geisinger insurance - Geisinger provider "sweet spot" with select non-Geisinger delivery systems.

The major Geisinger value advantage and its innovation engine is in fact the overlap between the patients that Geisinger cares for and the members that Geisinger insures. We call this our Geisinger innovation "sweet spot." If one or another new care technique developed in the "sweet spot" creates better outcome over time for an individual or a cohort of patients, total cost of care most often goes down. This quality improvement is a direct benefit to our patients. The cost reduction represents a direct financial benefit to our insurance company's business model. That value can then be redistributed within our single fiduciary back to the particular component that deserves the credit regardless of whether it is the insurance company, the doctor group, or the hospital platform. Some of the value must of course be given back to the buyer of our medical services as either premium or co-pay decreases. Although Geisinger is often referred to as the Kaiser Permanente (KP) of Pennsylvania, Geisinger and KP are quite different. Almost 50% of the care given to Geisinger's insurance members is provided by the non-Geisinger physician panel in non-Geisinger owned hospitals. And all of the Geisinger owned hospitals are open to non-employed physician staff with a number of Geisinger owned hospitals including those in northeast Pennsylvania having the majority of patient care provided by non-Geisinger physicians. Therefore, when there is a significant hospital-based care redesign or population-based ambulatory care redesign that seems beneficial, the initial results most often obtained within the Geisinger sweet spot, can be tested by scaling into the more heterogeneous independent physician market. And finally, if the "sweet spot" innovation is sustained, it is scaled to all patients including those cared for by Geisinger providers but insured by non-Geisinger payers (still over 50% of our system's payer mix). The innovative non fee-for-service reimbursement packages, for example our so-called single price "warranty," have remained thus far restricted to our Geisinger payer-provider interaction.[1,2]

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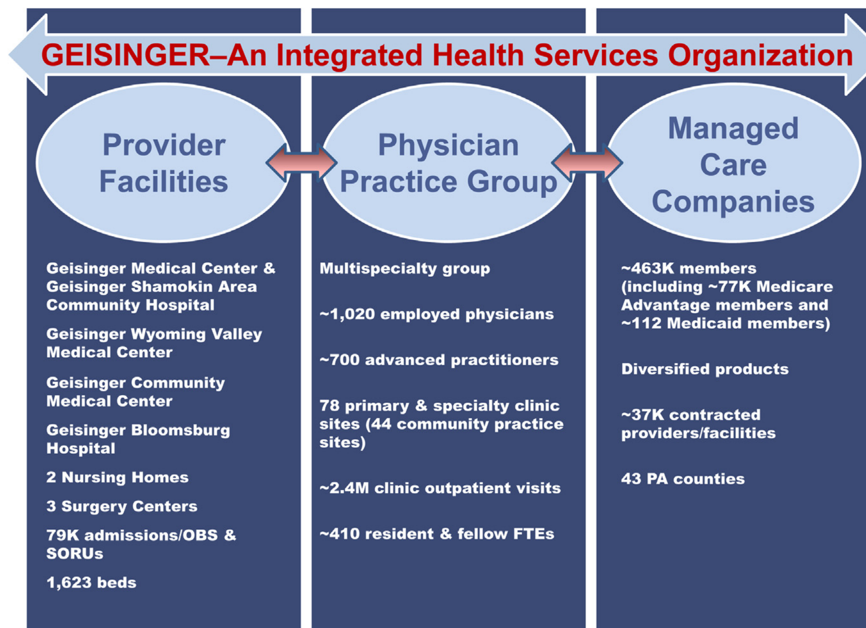

Figure 1. Geisinger, an integrated health services organization.

A formal set of strategic priorities drive the Geisinger operations:

Quality and Innovation
- Patient Center Focus
  - Patient activation (empowerment)
  - Culture of quality, safety and health
- Value Re-engineering

Market Leadership
- Extending the GHS Brand
- Scaling and Generalizing Innovation

The Geisinger Family
- Personal and Professional Well Being

Up to 20% of total cash compensation for providers and up to 40% of total cash compensation for clinical and administrative leaders are based upon achieving the goals encompassed in our strategic priorities set.[3] Geisinger's top goal focuses on quality and fundamental innovation in caregiving. This discussion highlights the value re-engineering aspect of our innovation commitment and whether or not re-engineered care can be generalized beyond the unique Geisinger fiduciary structure, culture, and market.

Geisinger care re-engineering is based upon two touchstones. One emanates from the 2003 McGlynn, et al., Rand study that postulated almost 45% of routine care provided in a variety of markets for a variety of prevalent medical problems was either too much, too little, or wrong.[4,5] This initial study has been substantiated numerous times and is now widely accepted. And even if one discounts the result because of a variety of methodological issues, the fact that a significant amount of cost in caregiving does not bring value to the people who get the care or may in fact hurt them is, in my view, a remarkable opportunity. Geisinger's care re-engineering attempts to remove as much of this unnecessary or hurtful cost as possible while maintaining or improving near-term as well as long-term patient outcome.

Our second lynchpin for re-engineering care is an extension of the knowledge that cost and quality do not correlate.[6,7] This has been known for several decades and in fact our more recent care redesign road tests at Geisinger convince us that, more often than not, high cost patient populations are those that have worse healthcare quality outcomes. Thus high cost is usually a surrogate marker for bad outcome. Value re-engineering should therefore accomplish two goals simultaneously: better outcome and lower cost. Patients and professionals are no longer faced with choosing between cost reduction and quality!

The Geisinger care transformation initiatives are:

- ProvenCare® for Acute Episodic Care (the "Warranty")
- ProvenCare® Chronic Disease
- ProvenHealth Navigator® (Advanced Medical Home)
- Transitions of Care
- PRIDE (Proven Innovation Drive for Excellence)

Here, we will discuss several examples of what we call ProvenCare® Acute, our version of hospital based or

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