Keynote panel “Is the Kaiser model of fully integrated systems outdated in a wired world?”

By Katharina Janus

Katharina Janus moderated the panel discussion and initiated the conversation. Frank Maddux started by putting forward some statements. In his opinion the wired world is just beginning. Steve Cases’ book “The Third Wave” indicates that the connected health world will change fundamentally how we view work. In a connected health environment there will be a greater opportunity to extract the essence of what Kaiser does well. Moreover, the wired world will expand beyond geographic areas. Components will include data access to encourage patient empowerment and improving engagement, creating team pathways and algorithms in a cross organizational fashion, as well as building on examples of Kaiser in a more distributed type session to improve outcomes. He pointed out that the healthcare delivery system falls into three categories, first, a delivery system for healthy people which supports behaviors for good health. Second, a responsive system that reacts to acute healthcare events with strong diagnostic and therapeutic tools, and third, a chronic disease system, which identifies problems and the expected crises. This differs from the responsive system since you want to keep people healthy and avoid crises.

Sherry Glied provided another perspective to the discussion by pointing out that the most striking part of the Kaiser model is how unsuccessful it really is as efforts to expand the model failed. In other words, in 30 years, the Kaiser model in her opinion is still the same. Even though it is a lodestar of what we want to be, it only worked in one setting in a magical place but magic is not a way to build a healthcare system. One question is if IT can help reproduce the parts we like about Kaiser without needing to re-build Kaiser? Moreover, can we think outside healthcare? What are the boundaries of the organization? Technology really drives these boundaries as we can see in different sectors. IT also allows us to move things internally and it makes it easier to contract out. IT allows you to make more AND buy more and ways to monitor within the firm that you couldn’t before.

From Arthur Klein’s point of view, Kaiser is a very attractive model. But there aren’t enough resources to horizontally and vertically integrate care without partnerships. However, the approach is interesting, given that it is one of partnership and incrementalism. Partnership relies on looking at best in class and to provide care that Mt. Sinai cannot provide. For incrementalism, it’s focusing on a few diseases that can be managed well and looked at if there are resources internally or if not. Each of these require different decisions about partnership or building capabilities in-house. Further, Arthur emphasized that we’ve learned from disease management and case management, that success in population health requires skills outside a physician’s traditional training, e.g. dealing with the social determinants of health. Achieving these skills won’t be possible without partnership with other academic centers such as schools of social work. In addition, it is also relevant to look into cultural transformations which only happen through blood, sweat, and tears. In his opinion, we need two forms of management as we embark on a new age of healthcare; leaders that set directions and managers under them that can execute these directions. These skill sets are very distinct and separate.

Physicians can find IT to be a barrier to patient interaction. Talking about IT, we can’t forget all the other aspects that are necessary and the invaluable position that partnerships make. CityMD is a wonderful example of partnership. The phenomenon of urgent care surprised all of the academic medical centers in the Northeast. However, to replicate this would be financially impossible. It took 2 years for Mt. Sinai to open 3 urgent care centers. The best decision was to partner with a company with philosophical alignment and IT.

Federico Lega engaged in the discussion from a different angle by providing insights on the Italian system. In Italy there is a bureaucratic management structure. In the 90s there was an introduction of market-based systems for doctors. Then came along chronic care and the study of market based systems and contract based systems. Kaiser and the NHS were both references. However, it was discovered that a contract based system was the wrong thing. There were issues in aligning incentives and interests that cost a lot. These systems gained efficiency but lost on quality of care. The transition of the patients amongst the various silo-ed levels was difficult due to unaligned incentives of providers at each level. If you want to move into population health management, you need to manage and share data. In his opinion, a contract based system will make this difficult. New technology would have been a great resource to do this in the past. In the future, services to the patients will be delivered by different professionals. But how do you do this in a contract based system? It becomes difficult because each actor will not be happy to give up turf and scopes of practice. When moving to a market based system, costs went up dramatically. He concluded that the Kaiser model is still something we should consider for the future but even the smartest contract based system will not gain the results of an integrated system.

Michael Sparer's first thought on the topic was that we are still a long way from a wired world. In reality, there are still hospitals where one department can't talk to another department due to incompatible systems. If you look at systems that are touted as models, none of them seem to replicate particularly well. Micro and macro politics matter in these things. If you are contracting, it's not so easy to develop contracts that align all partners' interests. Different organizations have different missions with different goals and pressures. Thus, contracting requires each organization to change how they work. If it would be easy to pick up the Kaiser model, it would have been done already.

Arthur pointed out that we can also learn a lot from these new innovative systems. Mt. Sinai, for example, has learned that owning different institutions doesn't bridge the cultural gaps and differences. In a difficult regulatory environment, some partnerships and shared governance can be very cumbersome to develop. NYC is uniquely competitive and there are so many providers that there is an opportunity if you do your due diligence (politically, social, culturally), there are more opportunities to create the right partnerships than if you were in a more isolated area. The answer for NYC would be different than for any other setting. However, there is a worry of losing the collegiately that made Mt Sinai academically pre-eminent and turning the hospital more competitive.

Katharina Janus, the moderator of the panel, broadened the discussion of the panelists by bringing in the European perspective. From a US perspective it is not surprising that contracting is okay. However, this is not the case in Europe where there is a more regulatory environment. She raised the question whether there can be a Kaiser prototype in the European context?

In Frank's opinion, the wired world allows for the chance to look closely at contracting-based systems. Fresenius' urgent care business, for example, is very interested in taking data and developing it into a usable form. Across cultural boundaries there is a way to make partnerships work. Systems won't get there until there's an opportunity to do this.

Sherry emphasized that one reason why this question is so hard to answer is that there is nothing that defines the boundaries of the health system. How many countries, for example, include dental care or mental care? All of the health systems don't "own" their physician staffs. The cultural differences are bigger and smaller than we know. However,

although some people argue that it is difficult to replicate, Sherry bets that a lot has been replicated already. Contracting may exist but just not on healthcare professional services.

What is important to keep in mind according to Frank is, that we don't want to replicate Kaiser entirely, but just the things that they do very well and recognizing the balance between broad and local. What functions should be centralized and locally administered.

Federico agreed that subcontracting is possible and that public-private partnerships are the future. But we should not forget that there needs to be one overarching actor that aligns strategy and forces certain behaviors.

Katharina Janus highlighted that Germany is a good example for what Federico said. In Germany, many initiatives are borrowed from the US such as incentive payments. It was something to "play" with but was never serious. It is kind of creating a system of half-way competition and that is a challenge. If you want to work in a system with this halfway approach its more difficult to establish an organization that is more or less wired.

Arthur raised the question on how much will you integrate and how much will you partner in your system. Organizations start to think that their success is proprietary and not public knowledge. Anything that improves quality is a public good. But several national partners view it now as intellectual property. It raises a whole other issue (in his opinion a crazy one) as success stories shouldn't be a proprietary system.

Frank expressed that one driver of this is that the shift from volume to value is the high risk of being killed during this switch. The intellectual capital developed to make this change becomes a moat protecting them during this transition.

Due diligence is required in partnership by determining who is best in class. There also needs to be a cultural meeting of the minds that requires a unique skill set for management and leaders. This, according to Arthur, requires trust in relationships, which is not necessarily a skill that is teachable or even a good that organizations are willing to work for. There is no contract that can solve the issue of "where we will be in 6 months, 1 year, 2 years" The most finely tuned contracts require trust.

Frank added that the wired world will challenge the understanding of what trust means and encourage higher transparency of information and exchange. The challenge is to recognize that information that is needed to promote an efficient system is not information that needs to be kept so close that no one can use it.

Moreover, Frank emphasized that certain things like data can be submitted very easily. However, other things look very different in a verbal discourse then in an email. In his opinion, no degree of electronics will replace maintaining a direct communication. Trust is the key. For both partners it must be a win-win situation including trust and fairness. Thus, fairness must be embedded in the contract and discourse that follows. We are at a tipping point from moving to a collegial environment to a more competitive environment and that can threaten this trust and fairness.

Some of the evidence we have says that any partnership built on contracts and not values or ideologies, will only last until there is a more convenient option. Organizations are also subject to the management influences which means that things will change if management changes. If contracts fail, colonization may be the only option.

During the discussion with the audience, a question was raised regarding the role of health outcome benchmarks in order to answer the question which is the best structure of

delivery care instead of focusing on the regulatory differences between sectors and countries.

Sherry points out that one important aspect is how you measure things. If you can't measure things well, you are not able to monitor them. In her opinion, IT or benchmarking doesn't tell you how to go about changes but it can provide another perspective on how you think about different elements of it. Other panelists added that when talking about benchmarking it is vital to look in detail and think very carefully what you are benchmarking. Specifically, when looking into outcomes, it is necessary to keep in mind the tremendous influence of socioeconomic factors, such as insurance status, education and health literacy on outcomes of care. The science of benchmarking is a very difficult science and there are huge external factors that you have to look at when exploring why something is the way it is.

A statement was made from the audience that the Kaiser model does mean different things to different people and that Kaiser is at the cutting edge of using wireless technologies in order to augment what we see as the traditional Kaiser model. In his opinion, the wired world is not a threat to Kaiser currently. The question should rather be if small practices are at risk in our wired world and what does that mean for our health system? It was emphasized by the panelists that the technological advances are moving much faster in healthcare than in other sectors and that small practices or solo providers have to be consolidated in this process and be somehow integrated into cooperations to build capacities that they would not have on their own. A survey on medical students showed that graduates prefer to have group practice experiences rather than pursuing the pathway of individual practices.

In a final round of conclusions, the panelists gave a final statement on what they think the future will look like. Michael mentioned that the technological advances will continue and that the challenge will be to find out what to do with these advances. In his opinion, there won't be one single model of any sort. Federico concluded that he can't predict what the future will look like but that he would like to see systems that work much more with patients as co-producers. New technologies are already enabling this and he hopes that this will advance even further in the future. In addition, he agreed that there will be a wired system but that there is a strong need to have an umbrella strategy to deal with these systems. Last but not least he emphasized the need for more transparency to enable us to look into outcomes. However, looking into outcomes does not only include measuring outcomes but also managing outcomes. Federico told the story of Naples where they measured the mortality rate of patients. The results showed that no one died in Naples' hospitals. The reason was that due to cultural reasons, people preferred to have their loved ones at home, so they reached an agreement with the hospital that they send the people back home without registering their death to provide the families and friends with the opportunity to grieve at home for a week. Arthur expressed that it will be a pleasure of having disruptive technologies that change trajectories. But it is important to adapt to the real world as there will always be unexpected things happening, e.g. Zika virus, that will disrupt societies that we will have to deal with. Sherry added that we have to recognize that dealing with new technologies will include a huge amount of failure and that we have to accept that failure is part of our economy and life. Last but not least Frank emphasized that health care will always be first and foremost human interaction. Systems will be driven to be more organized and technology will provide the ability to make them more transparent and precise. However, we need to be aware that we will spend a lot of money on healthcare systems and much of it will be wasted.