

## **Chapter Two**

The Optimal Care System Should Be the  
Goal of the Business Model We use to buy  
Care

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## **The Optimal Care System Should Be the Goal of the Business Model We use to buy Care**

The most effective way of changing care delivery is to change the business model we use to buy care. We get what we pay for -- so if we want better, safer, more effective and more affordable care, we need to put in a place a business model that pays for better, safer, more effective and more affordable care.

Before we put in place any new business models to actually buy health care in this country, it's a good idea to think about what care we want to buy. We need to be very clear about what we want to achieve through the care delivery process before we change the way we buy care.

Clarity is a good thing for any buyer in any industry. Health care is a complex topic, so it is a particularly good idea to achieve some clarity about the overall care we want to buy before we start making either incremental or massive changes in the way we buy care.

Several macro purchasing goals are actually relatively easy to identify. Those purchasing goals can create a context that can help us think about all of the various elements and tools and products we can put in place to achieve those goals.

## **We Need Patient Focus and Continuous Improvement as Care Goals**

For starters, we clearly need our care delivery to be more patient-focused. We also need care delivery to be safer, better coordinated, data supported, and continuously improving. As the first chapter of this book pointed out, we should insist on continuous improvement as a foundational philosophy, skill set, and business model for American health care. We will only continuously improve care delivery if we consciously make continuous improvement a foundational goal of the business model we use to buy care and if we actually pay caregivers to continuously improve.

We also need to make affordability a major goal. The current market models obviously do not support or create affordability. We need affordability to be a key part of the thought process and the financial

reality for caregivers. We need to very consciously make affordability a key component of the way we buy care in the future and we need to reward caregivers who provide affordable care.

The first chapter of this book outlined how dysfunctional, unsafe and inefficient that current care delivery reality often is. If we want better, superior, and more affordable results for the money we spend, then we need to be much more skillful in using the cash flow of care financing to make those better results happen.

Understanding, articulating and then clarifying the overall goals before building the basic set of tools to achieve those goals is a philosophy that has been learned, developed and field tested over three decades of direct experience being the CEO of one care system or another. The experience of the author in managing complex organizations for quite a few years has led to the deeply held belief that random change is rarely a good thing to do in any organizational setting. Piecework and incidental solutions can far too easily end up with unintended and dysfunctional consequences. Even the best intentioned piecework perspectives and unlinked and isolated solutions to subsets of complex situations can easily end up being unintentionally counterproductive and even equally unintentionally perverse relative to the processes we need to improve and the problems we need to solve.

### [First, We Need To Define the Goals](#)

We need to look at the goals before we look at tools. It is amazingly easy to focus initially on tools instead of focusing on goals. Tools are fun. Tools seem to be easy to understand. Some of the most intriguing tools have their own seductive pull. There are some lovely and handy tools -- but if we focus just on tools instead of goals, we are likely to find ourselves with less than a complete solution set, and we can have a tool create its own momentum that may achieve some marginal benefit but not help us address in a systematic way the issues we need to resolve.

Far too many health care reform strategies today start purely with pieces of the solution set in mind and with specific tools instead of beginning the planning process by setting overall goals for optional care

delivery and then figuring out what tools are needed to achieve these goals. People far too often focus on just one favorite tool and then believe that tool will be a magical solution for major portions of the health care problems we face.

Some people believe that the real problems of care delivery would be solved, for example, if we just had more primary care doctors. That point of view has a lot of supporters.

Other people believe with great passion that the problems of care in this country would be solved if we just had better electronic medical records in all of our care sites. Some very well intended people very strongly see having electronic data about care to be an end in itself. A few people believe that some of the new care monitoring portable tools and computer apps can fix care by improving specific pieces of care delivery.

The truth is, we could add quite a few primary care doctors to our total infrastructure of care and creating that additional primary care medical resource might solve absolutely nothing of any significance if we did not also change any of the key processes of care delivery and if we did not use that new resource well. Likewise, we clearly could computerize all care-related data, and we could then just as easily have that new computerized electronic care data functionality be useless -- either because that newly electronic data literally isn't used or because that new electronic data is not used well.

The new computer applications could give us a nice set of targeted data then -- but if it isn't linked to a care plan and care team of some kind, it can be just another interesting data silo.

Primary care doctors, electronic medical records and new care apps are each just care improvement tools. They are not end points or solutions in their own right. We need to understand our real end points in order to solve the issues we need to solve in health care. We need to understand and clearly define our actual fundamental care delivery goals and then we can figure out how both electronic medical records and primary physicians and a broad array of other highly useful tools can all combine in some important, strategic and functional ways to help us to achieve that clearly defined set of care improvement goals.

## The Patient Needs To Be the Center of the Care System

So what should we want to achieve with the care system in this country and what tools do we need to put in place to make that improved care system a reality?

Let's start with the patient.

As our very first priority, the patient should be at the core and the center of our care delivery system. The patient needs to be at the center of the reform thought process and at the center of basic care delivery functionality. Being patient centered should be a key first priority of our planning process and our business model for care.

When you look at the good things we want to accomplish, with the care delivery in this country, we obviously need patient centered care to anchor that agenda. We don't have patient-centered care today. Care today is focused far too often on the business needs of caregivers. Care delivery is centered on the infrastructure functionalities and the operational realities of the caregiver business units. That is the wrong focus. That focus gives us far too many of the dysfunctional processes that are embedded in the current delivery mechanisms for care.

The basic premise of this chapter and this book is that we need to start with the patient as both the center of our planning process and as the strategic focus for functional care delivery. We need to design the sites of care and the tools we use to support care very clearly around the patients who will be receiving care.

That seems obvious -- but it isn't the way we usually set up processes and care sites and data flow today.

It would be a mistake to simply perpetuate a care infrastructure that is built primarily around provider cash flow. We also don't want to continue to support a care infrastructure that is structured most heavily around the convenience or the functionality of caregiver business entities.

Patient-centered care should center our thought processes.

Being patient centered is not an idealistic, theoretical, ideological, rhetorical, or even a politically correct top priority goal for health care

delivery planning. It is common sense. Patient centering is actually a highly practical and extremely functional operational anchor for care design. Speaking from decades of experience in designing and implementing care delivery processes, the author knows that building on that patient-centered focus is extremely useful in very productive terms in putting together the tool kits and the data flows that are needed to support care. Centering the care we create on the patient is actually a highly functional and practical way to think about the processes of care. That focus and priority creates and sets up a very practical operational context for figuring out what to do and how to do it in the functional delivery of care. With that patient focused goal in mind, we can design both the processes and the key tools that are needed for patient-focused care delivery. It is very much the right focus and the right first priority to center our planning on the patients.

That should be an easily understood goal and it can be very useful as we figure out the rest of the key elements we need to enhance in care delivery.

### **Care Should Be About Patients**

Care is, of course, inherently about patients. To improve care delivery, we need to understand and focus on the needs of the patient as the rightful center of the care processes we build and use. Care happens to patients and care is done to patients. Care meets the needs of patients. The tools that are made available to caregivers should improve the ability of the caregivers to meet patient needs.

Our data collection should follow that exact same top priority -- with a clear focus for our data on the patient.

### **Data Should Be Patient-Focused**

We need the data base planning and the operational reality for care delivery to be focused on the absolutely clear goal of having all of the data about each patient available to the patient's caregivers in convenient

and usable ways at the point of care when it is needed for the patients care. Care is much better when caregivers have all of the information about their patients at the time of care. Mortality rates improve when caregivers have a high level of patient centered data. We need to design our care support tools with that goal in mind. Our data flow between all of the electronic storage sites for care data should be set up and designed to achieve that goal of patient centered care -- with the data flow set up to optimize the care delivered to individual patients.

### **Patient Centered Care Isn't Our Usual Organizations Model**

The key operational unit in any combination of care delivery processes and care delivery data flows should be the patient who is receiving the care. That guideline seems obvious and even simplistic -- but it actually is not how we usually organize care data or care in this country today. The bad, dysfunctional, wasteful, disrespectful, ineffective, inefficient and sometimes counterproductive care delivery processes we see far too often in far too many places in health care delivery are usually the processes that have been built around the care delivery business units and not around the patient. Patients are often badly served, inconvenienced, and even sometimes insulted and demeaned at a basic, human level by some of the existing procedures and by a number of the care related processes that are functionally focused on caregiver business units instead of on patients. Good processes should be centered on patients and good processes should have the care delivery infrastructure able to support the needs of each patient. To make that focus successful, the flow of data should be set up so that the data follows the patient and is available to the caregivers at the point of care.

Today, most of the time -- when patients get care, their caregivers have incomplete data about the patient's full set of medical information. That problem of incomplete data exists because health care data today is not patient-centered. Health care data is care-site centered. That data availability model is not the best way to use data to improve care.

The business model we use to buy care should help make both that patient focus by the care teams and that patient-centered data flow happen.

So being patient centered should be a key first priority for our planning processes and for the new business model we use to buy care. When anyone purposes any changes in the way we deliver care, ask the simple question -- will the data that results from this piece of care flow in practical and usable way to a data tool that will allow that data to be accessed the next time this patient receives care? If the answer to that question is no, then the process should be improved until the answer is yes.

### **Care Delivery Should Benefit Financially By Meeting Patients Needs**

The second priority of the new business model we use to buy care should be to enable caregivers to benefit financially by meeting the needs of their patients for continuously improving and hugely affordable care. That goal of having care providers benefit financially from the new approaches is an absolute necessity if we want any significant new approach to succeed. We need to incorporate the explicit goal of having caregivers benefit from both continuous improvement and affordability into our business model redesign or the redesign will fail. That approach can be done. If we set the new business model up correctly, the caregivers will profit from doing intelligent care redesign. If we set the model up well, our caregivers will also benefit financially from skillfully using and optimizing the amazing new tool kit of care support tools that are coming into existence to support the delivery of care. We have wonderful opportunities in front of us to improve access to care and to improve care delivery functionality in patient friendly ways. New tools are being developed every day. We will have wonderful opportunities to use those new care support tools to make care more affordable. As you will read later in this chapter, there are some very impressive and existing new care support tools coming into existence. Unfortunately, because of the piecework approach we use to buy care today, the current business



model of care delivery actually tends to resist those tools. The current caregivers far too often create both significant barriers and sometimes crippling impediments to the use of those new care support tools.

In-home monitoring tools, electronic medical visits with physicians and nurses, remote diagnosis support tools and electronically connected care follow up processes all can make huge sense for patients. A whole generation of those tools is emerging daily. That's the good news. The bad news is that the effective use of far too many of those new care support tools and approaches can be crippled, detoured, and even stifled by the way we buy care. We need to set up a financial model that encourages and rewards our care providers for using those tools and using them well -- instead of using a financial model to buy care that penalizes our caregivers when those tools are used.

### **The Patient Focus Should Drive Decision Making**

With that patient focus as our goal for both care and caregivers, we need a cash flow for care and a model of care that has the patient as the focus of a fully functioning and continuously improving care system.

As part of that strategy, we need to free the key care sites from their current financial addiction to piecework fees. Multiple studies have shown that current care delivery is motivated and activated far too often more by the existence of a billable technology than by the actual patient need for that technology. There was an all too familiar scandal last year when Medicare discovered it had a lot of hospitals doing double CT scans for all of their Medicare patients.<sup>89</sup> Those double scans were clearly incited by revenue stream goals for the care sites rather than the care needs of the patients. Horror stories about unneeded and even dangerous care approaches exist and abound. Horror stories about unnecessary surgery, useless and expensive procedures, and care delivery activity volumes that create no improvement in patient care can be found in multiple books and reports. We don't need to repeat those horror stories about unnecessary and sometimes dangerous care in this book. Other books have written clearly about those problems. The

Institute of Medicine has published a couple of very powerful books that clearly address those issues.

As we build a new business model that we can use to buy care, we need to embed in that model the fact that patients need data supported care. We also need to embed in that model very direct support for team care. Most care costs in this country come from patients who have chronic conditions and multiple care needs. We know very clearly that the patients who have both chronic conditions and co-morbidities very much need data supported team care. We clearly do not want a business model for care that continues to create real barriers to team care, coordinated care, and to care that is well supported by the next generation of innovative and flexible care support tools. Instead, we need a business model for care that reaches out and effectively uses the various technological improvements in the way we distribute care that are becoming available to us. We want optimal, patient-focused, continuously improving processes for care...with patient needs trumping care business unit billing priorities.

### **We Need Patient Centered Data**

Data will be a key tool to achieve those goals. Having the right levels of data about care delivery also needs to be a top priority for the way we buy care. We need to be very clear and very insistent that the right flow of data happens and that the data that is collected is used to improve care.

The last chapter outlined a number of process engineered care improvements that have saved many lives and kept people from a lifetime of damage and harm. Those systematic care improvement programs succeeded because those care sites had key pieces of data. Those successes could not have happened without that data. We need both outcomes based care data and we need patient centered data so we can create and enhance patient centered care.

Those two data collection goals should clearly dictate our design of both data gathering approaches and data flow to a very large degree. We

need to start the care improvement process with patient data. We need all of the information about each patient flowing from site to site with full care-related information about each patient available in real time when that information about each patient is needed by the care team that is delivering care to each patient.

Caregivers can do a much better job in taking care of patients when all of the care information about a given patients is available to the caregiver at the point of care. Having that kind of shared information created a tool kit that has dropped the HIV death rates for one huge care team to half the national average.<sup>90</sup> That level of shared information has simultaneously cut the number of broken bones in seniors treated by that care team by over a third.<sup>91</sup> Those care improvements happened in a large integrated care setting and they were possible because those caregivers have a fully functioning electronic medical record in place. The medical record for that care team has all of that data for each patient and their systems make that data about each patient available in real time to support their caregivers. The approach works. Lives are saved. Care is better because the caregivers have better information and have it in real time.

We need to be very clear about the need to achieve that same data availability goal and tool kit for each patient in all of our care settings in this country. That level of data supported care should not be limited to a small number of virtually limited care settings. We need to set a national goal to make that level of care support possible for all of our caregivers and all of our patients.

That need for an available care database and the value that tool kit creates when it is ready for use for each patient by caregivers at the point of care seems painfully obvious when you understand functionally and operationally how to deliver the best care and how to use those tools to actually improve care. But that organizational approach to data flow is currently not how either databases or data flows exist in most care sites in this country today. We still accept data isolation as a reality in too many settings. That is clearly an area where we need to make some significant improvements.

## Paper Medical Records Are Dangerous and Dysfunctional

We also, as a key priority for the future functionality of care delivery, need to be very clear about the need to move way from having major portions of the health care data base stored on paper. In this day and age, it seems almost a little odd to have to make that point in a book chapter about the future delivery model for health care functionality. The need to move away from the paper storage of data to electronic data storage seems to be almost too obvious to need to be mentioned in this chapter. But the sad truth is that most medical information in this country is still stored on paper rather than being stored in computers.

We need to change that data storage reality.

The care delivery system of the future needs interactive data about patients to deliver best care. Paper -- for obvious reasons -- has a very hard time being interactive.

When medical records are all on pieces of paper, then each of those pieces of paper and each data piece are inherently inert. The logistics of data isolation in a paper based non-system are clear. Pieces of paper can't link with each other, and pieces of paper can't exchange data with each other. Paper medical records create a huge barrier to data sharing between caregivers. Paper records also make basic tracking of care quality and care outcomes extremely difficult.

At this point in our history, as the first chapter of this book pointed out, there is no excuse for that kind of data isolation and for that level of information segregation. Medical records can easily be electronic. Those are some great electronic medical records systems in use today in many sites and those tools are continuously improving. The data for each patient and each piece of care can easily be connected electronically when connectivity is part of the basic agenda -- when systems are put in place in the right ways, basic patient information should be able to flow to each and every other relevant care site for any given patient in real time. The technology exists to do that work today. The next generation of patient data files should be designed to be very much patient-centric and those data designs should be focused on creating care support tools that are built around the care needs of each patient.

### Data Should Be Continuously Available

The new business model we use to buy care should demand -- as a basic condition of paying providers for the delivery of care -- that shared data be both available and actually shared. Any data isolation that exists for any reasons other than protecting patient confidentiality should be penalized -- not rewarded -- by the business model we use to buy care.

### Data Should Be Built Around the Patient

As noted above, the patient needs to be the focus of our overall data strategy.

Data for the next generation of care obviously should be built around each patient -- so that we can meet the care needs of each patient in the most fully informed way.

Caregiver teams for each patient who needs caregiver teams should have easy, fully confidential and fully protected access to complete medical data about each patient that can be used to support their care.

That goal should be embedded in the business model we use to buy care. It is the right thing to buy. As noted earlier, some of the best computer supported care sites in this country that already have that kind of patient-centered complete access to data have cut stroke deaths by nearly half.<sup>92</sup> Those care sites that have that level of available data and computerized care support tools sites have literally cut HIV deaths to half of the national average.<sup>93</sup> They also have fewer heart attacks, and lower rates of diabetic complications. Some of the best equipped and most patient focused care teams have even reduced broken bones in seniors by over a third<sup>94</sup> by having and using patient-centered databases that anchor and support patient focused team care in those settings. That work can be done. It isn't a theoretical or hypothetical set of objectives. The goal of having patient-centered data for all patients in this country is an important functional goal that we know is entirely realistic and achievable because it is being done well in some settings now. The value

of being able to provide full data about their patient to caregivers at the point of care is being proven every day. Lives are saved. Damage is being averted. Care can be both safer and more affordable when the outcomes of care are improved by access to care data about each patient in real time at the point of care.

### **We Need Computerized and Accessible Medical Libraries**

Doctors need more than just complete patient-centered care data. Doctors also need complete data about medical science. That issue was discussed in Chapter One. We very much need our caregivers to deliver the best care to our patients. To deliver best care consistently and well, caregivers need complete data about the most current medical science for the patients' conditions. To deliver best care, our caregivers also need easy access to data about the current set of medical best practices for multiple health conditions.

Knowledge is a wonderful thing. Knowledge about current medical science should be a standard care expectation, not a rare exception.

We very much need easy and convenient access for our caregivers to the medical knowledge and to the medical science that is directly needed by each caregiver for each patient's care. The unfortunate problem we have in this country of too many caregivers not being able to consistently keep up with current medical science was mentioned in some detail in chapter one. That "inability to keep up" with current science and with current best practices by our caregivers should not be acceptable to us as a nation. We will soon spend nearly three trillion dollars for care.<sup>95</sup> We should expect that we are getting the best care for that money. Easy access by each caregiver to the best levels of current medical science should clearly be both a basic requirement and an explicit goal of the business model we use to buy care.

This is, unfortunately another area where we fail to deliver a very basic care supporting tool to our caregivers for far too many patients. The truth is -- as chapter one described in some detail -- most caregivers in this country do not have access to a good tool that can be

used to do that work. As a result, of that tool deficit we fail to meet that basic goal of full access to current science in far too many care settings in this country, today.

One important IOM Taskforce recently filed a well written report that concluded clearly that far too often American caregivers today do not have current knowledge about many relevant developments in the science of care.<sup>96</sup>

### **The Logistical Barriers to Medical Science Data Distribution Are Clear**

Again -- as we look at how we should be delivering optimal levels of care, we need to recognize that the logistical issues and the functional challenges and barriers that exist today to easy access by caregivers to current medical knowledge are obvious and clear. There is no shortage of new science. There is a lot of new research being done for multiple medical issues. Absolutely wonderful learning about the science of care is happening in multiple settings. That is the good news. That is also the bad news. Multiple settings are involved. Tens of thousands of medical journals are published every year.<sup>97</sup> The ability of any solo caregiver or of any solo care site to keep up with all of those current scientific developments is clearly frequently inadequate. The keeping up processes are often extremely difficult, and the data flow about new science is often dysfunctional to the point of creating what are sometimes dangerous levels of knowledge impairment relative to particular points of care delivery and current medical science by individual caregivers.

### **Knowledge Deficiency Is Not a Good Foundation for Care**

We should not accept that too frequent knowledge deficiency -- even partial knowledge impairment -- as the foundational status for medical knowledge for our country's caregivers.

So how can we achieve a much better level of consistent and accessible information sharing about best care for all caregivers?

The answer is amazingly simple. The last chapter also made this point. We need a very basic information access tool made available to all caregivers.

### **Doctors Need Electronic Medical Libraries**

Electronic medical libraries are a key part of that information availability answer.

Our caregivers all should be able to use robust and current electronic medical libraries that are consistently available and very easy to both access and use. As part of the business model we use for buying care, we simply need to insist that -- in order to be paid fully for delivering care -- each care site should certify that it has access to real-time electronic care library information. As a practical issue, we don't need to have any caregivers certify that the information that is in whatever library is available to them will be used for each patient and for each piece of care. We don't want to monitor the library's level of use or do patient-specific oversight of any kind. The doctors should know and will know based on their own judgment when they each need to reach into the library for pieces of information. We don't need to mandate consistent use of that library. We definitely should, however, mandate absolutely consistent access to that level of information by every key caregiver. We should simply have all licensed caregivers certify that a full scope information access tool exists in their practice and that current medical science is actually available to that caregiver in their care site at the point of care.

### **Urgent Information Should Be Distributed Quickly**

If we really want the best care outcomes for a wide range of patients, we need to be able to communicate important new information to the infrastructure of caregivers quickly and well.

We actually need new medical science made available to caregivers at a couple of levels. We need a passive sort of information sharing



system -- a library that simply allows all caregivers to scroll through new and old medical science easily by topic. We also need a more proactive communications tool set. We need a process that identifies urgent new care science and care delivery information and then makes that urgent information available very quickly to care settings where that piece of information can change care and save lives.

An example of a need for very rapid information distribution to caregivers might happen when a prescription drug is found to be dangerous and is recalled. Likewise, there are times when pieces of medical technology are found to be dangerous and also need to be recalled.

Both hip implants and heart implants have had recent situations where new science has shown that some types of existing implant technology have been discovered to be harmful and even dangerous.<sup>98</sup> That new set of information about the danger levels should result in those implants or those devices to be either recalled or closely monitored. In each of the instances that have occurred to date, we have seen that those care sites that now have electronic care data about each and every patient and each and every implant have been able to learn about the alert and then sort through their full array of relevant data in hours or -- at worst -- days to figure out which of their patients might be affected. The best EMR supported care sites can usually do that work overnight or even faster.

By contrast, the care sites that still use paper records for all of their patient data can take months to figure those issues out. It can take months or even years in a paper based system to simply get a sense of which patients might be affected by the bad technology. In some cases, and in some settings, literally no one is accountable to conduct that search process through those paper record files to find any patients who might be affected by that information.

In the current non-system, there have some situations where recalls or major product warnings have happened and many of the patients who should have been contacted or supported by their care team fall between the data flow cracks and never learn of their risk -- until the device actually fails and they are damaged. That level of inadequate

information availability about the key patient care issues should be unacceptable. We clearly need the kind of patient-centered dataset that can add huge positive ability for caregivers to do that work on behalf of patients.

### **It Can Take Months or Years to Share New Learning Without Electronic Support**

When medical research or various safety learnings identify better ways of delivering care, it can be a very hard – even impossible -- thing to make all relevant caregivers aware of that care improvement opportunity. Systematic notifications about those new learnings usually do not happen today. Several studies have shown that an important new medical learning can take years to have an impact on care for most care settings. There are no mechanisms in most care sites to even disperse and distribute key new pieces of information to relevant caregivers and there are almost no systems anywhere to track to see if important new information was ever used by the caregivers.

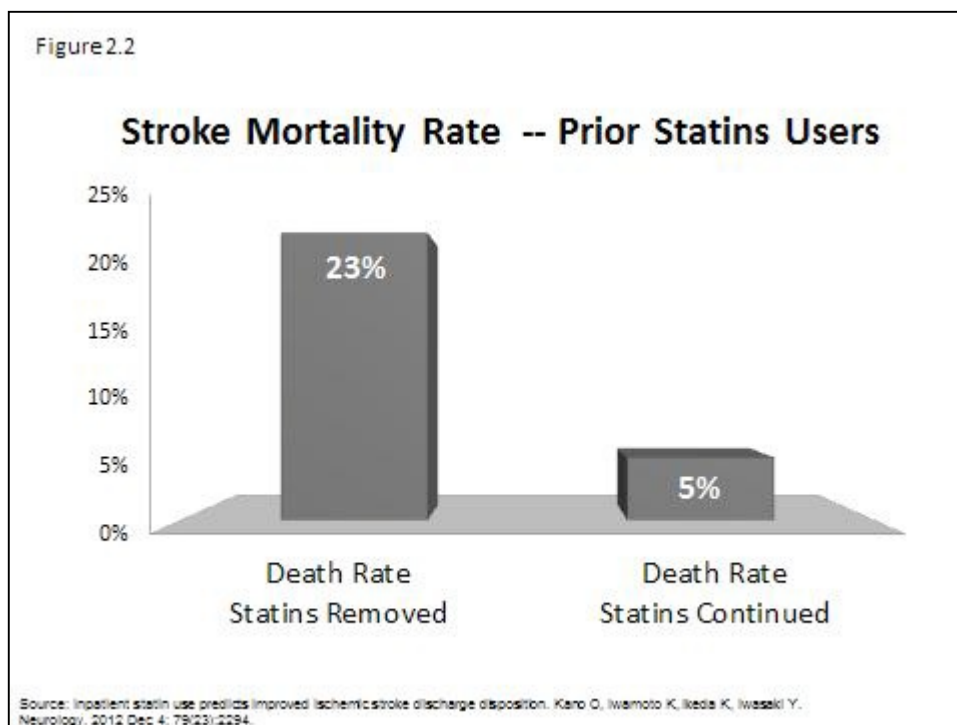
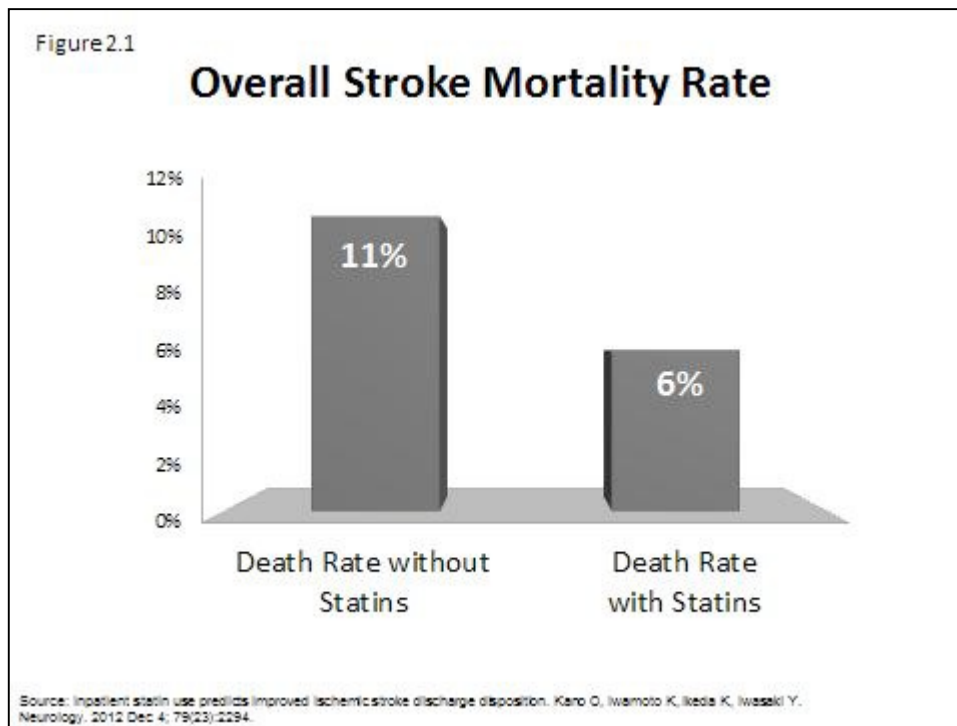
There is a better way. If we design the information and care support systems well, we can use support processes embedded in our care sites to do that work and to do it well.

### **The Death Rate For Stroke Doubled Without The Drug – And No One Knew**

As one real-world example of how computer support tools can improve care, we should look at some recent work that was done to figure out the impact of statins on the death rate for stroke patients. That piece of research was done by Kaiser Permanente researchers using the new Kaiser Permanente expanded electronic medical record database. The researchers looked at stroke patient hospital care and they focused on stroke patient survival rates. The study actually looked at a computerized database for millions of patients for three full years. They drifted down to look specifically at patients who had been hospitalized

for stroke. The data search in the electronic medical records for those patients was a gold mine. The EMR-based study learned that stroke patients who received statins while they are hospitalized for stroke had an average 6 percent mortality rate. That same research showed that the stroke patients who did not receive those same statins while they were in the hospital being treated for their stroke had an average 11 percent mortality rate.<sup>99</sup> That is a much higher death rate. Eleven is nearly double six. That is a huge difference in the rate of stroke patients dying. The data showed that the major difference in the death rate for those stroke patients was based on the differential use or non-use of just one medication -- a medication that is easily available to all hospitals.

That difference in overall death rates wasn't even the most dramatic finding that resulted from that particular research, however. The same study also learned that if the hospital stroke patients had been taking statins prior to admission and if their statin medication was continued for the patient in the hospital -- the death rate actually dropped to five percent. That's a great outcome. But the researchers also learned that if that same medication was being used by the patient before the stroke and the use was discontinued while the patients were in the hospital, the death rate for those discontinued patients who didn't get the statins jumped to 23 percent.<sup>100</sup>



So the death rate for stroke patients who went down one treatment path is one in four patients and the death rate for stroke patients who went down the other treatment path is only one in twenty patients.

That is obviously extremely important information. A lot of people have strokes. Likewise, a lot of people are taking statins. The researchers learned that the death rate for stroke patients literally doubled or quadrupled based on the care choices made by their care team about the use of statins.

So why is that example of important medical research included in this book chapter about optimal care delivery approaches?

It's important to understand what was done with that care-changing new information. In an optimal medical science information distribution situation, patients would hope that all hospitals and all physicians in the world who treat stroke patients would actually know about those important care results relative to statins and stroke patients.

That universal learning did not happen in the real world. Learning did happen. That information was shared through "normal" channels with the rest of the health care world. And the sharing process largely failed.

The point about how difficult it is for caregivers across the country to "keep up" is very relevant to this story. Unfortunately, there is literally no systematic approach that can be used for knowledge sharing about important new scientific discoveries for care sites across the planet today.

That particular set of information about stroke death was shared through the normal channels that exist. That new science about stroke deaths went into the usual distribution process that we use for new medical science. That particular piece of research was published in a highly respected medical journal. Anyone who read that particular journal that month might have learned about those results. That journal and that piece and research are on file.

So that very important piece of information about major differences in the death rates for stroke patients was shared with the health care world in the usual way that medical information is functionally shared with the health care world. It went to a "refereed journal". Publishing new science in a refereed medical journal is a very good thing to do. The steps that are involved in a refereed journal screening process include having objective experts on any given topic read the information that is proposed for inclusion in a research paper and those experts gave as

judges and evaluators before the information is actually accepted and then published.

These steps can add real value. It creates a lovely intellectual rigor for the information. It improves the science and gives readers and the journal the comfort of knowing that objective experts have looked at the materials and the data in the paper. It is a good process.

On its own, it is also a functionally inadequate process. Unfortunately, the facts are that the pure publication of that kind of information in a refereed journal isn't enough to get that important new information to all relevant caregivers. In this case, that journal publication obviously did not and could not get that information to all doctors and all hospitals that are treating stroke patients.

The journal that actually published that research had important and relevant readers -- but that article also was one of tens of thousands of refereed journal research articles that were published that same year.<sup>101</sup>

The truth is, for any given article on any given care topic, most caregivers who treat patients in America will never read any particular single study or any single report. Publishing new medical science in refereed medical journals is clearly a good thing to do. A very good thing. But it isn't enough. Publishing something really important about patient care in a journal that 90 percent to 95 percent of our relevant caregivers will never see and will not read is not an optimal or even a functionally adequate way of sharing really important new key information about improving care with all of the people who should learn that information.

### **We Need A Mechanism To Trigger Alerts About Important Learning**

What would a more optimal approach to sharing that kind of information look like?

Because every individual caregiver can't possibly read tens of thousands of medical journals every year, there needs to be a resource put in place that has appropriate, well-qualified care experts very intentionally and consistently scanning through all of that medical research information. That expert-reader scanning process needs to look

for breakthrough ideas as well as looking for key pieces of research that can either point care in a new direction or reaffirm the validity of old and in-place care approaches and directions. Patients deserve to have that scanning resource in place and functioning for the use of their caregivers.

Caregivers who want to keep up with current medical science also need to have a resource of that nature up and functioning to do that work for them. That resource should scan the new learning in health care and should make key pieces of information available in a systematic and convenient way to caregivers. Ideally, there should be both a prioritization process and a functioning mechanism that can be used to get that key information in front of the front line care practitioners.

If that kind of resource had existed and if it had been in place last year when the stroke death rate research was done and published, the set of objective medical experts who did the screening of all research studies could have read the article, appreciated the huge importance of that particular discovery, and they could have both flagged that piece of research and given it a high priority for distribution and teaching for all relevant care teams and caregivers.

That is not an unreasonable expectation for either patients or caregivers. The right information distribution model for new medical science could have highlighted that piece of critical research and then the distribution model could have ensured that all caregivers who treat those patients would have easy access to that piece of information.

### **Only The Internet Can Easily Distribute That Information**

This is another key area where the internet can be a lovely resource to enhance the provision of care. Ideally, that kind of lifesaving information should flow electronically to all relevant caregivers. It is clear at a very basic logistical level that only the electronic distribution of that kind of information can achieve the very best results. Mailing a hard copy of a printed journal to thousands or even tens of thousands of people is obviously not going to reach all the people who need to be reached with that information.

Electronic versions of the journal could reach more people—but electronic versions of those Journals only reach the caregivers who pay to subscribe to the Journal. Simply adding that information—and other information like it—to an electronic medical library would be a very good thing to do. That would be a far superior mechanism for sharing that information with all caregivers. But even inserting the information entirely into an electronic medical library would probably not have been adequate to create targeted sharing of important new information of that magnitude.

For the most important pieces of new medical information, we need to go a couple of steps further on down the distribution road to create prioritized information sharing. In an optimal care delivery information support world, there should also be reminders and prompts available for the relevant caregivers and those reminders should be embedded in the actual computer systems that are used by each of the caregivers at the point of care.

Real time reminders about that particular piece of stroke treatment information could be extremely useful to the caregivers. When the death rate quadruples if the doctors choose the wrong treatment path, than information about the right treatment path should be prompted and available for the caregiver at the point of care.

We need actual electronic reminders given to caregivers about that new science and those reminders should happen at the actual point and time of care could remind each relevant caregiver to do the right things for their stroke patients. The findings from that particular study literally create an issue of life and death for patients. A lot of people die from strokes. A lot of people have prescriptions for statins.

We also know from other data that the stroke mortality rates actually vary significantly now from hospital to hospital. Death rates for strokes vary from care setting to care setting. Some of that unnecessary variation in the percentage of people dying from stroke could be ended or reduced if there were consistent reminder mechanisms in place to remind the relevant caregivers at the point of care in each hospital what the very best current medical practices are for their stroke patients.



### **Electronic Reminders Only Exist in Some Settings Today**

That work can be done. That is not a hypothetical or theoretical suggestion. Those processes exist in some care sites now. It is entirely possible to insert electronic prompts and automated reminders about key points into care processes -- but that particular tool can only be done at the point of care if the care site treating the patient actually has an electronic care support tool kit and electronic medical record support system in place that can do that work at the point of care.

### **It Is Entirely Possible To Give Caregivers That Tool Now**

That piece of information is relevant to a Chapter that is describing what the providers of healthcare should build into their purchasing specifications for care delivery. These tools should be included those specifications. That ability to do electronic information sharing with care team members about important medical science and about best practices for medical conditions actually exists today in most of the large multispecialty group practices.

The ability to do that level of care support can also be found in a number of hospitals who have implemented well designed electronic medical records. Those reminders can be in place when those particular hospitals use their computerized record systems well. Those electronic reminder systems can and should remind caregivers very consistently at the point of care when the right thing should be done for a given patient.

At Kaiser Permanente -- the care site where that actual original piece of stroke mortality research was done -- the research, document itself, was included in the comprehensive Kaiser Permanente Electronic Clinical Library. That Kaiser Permanente electronic medical library is available to all KP physicians and caregivers in real time...wherever they may be. That library contains all basic medical text books and journals.

So that piece of refereed journal-published research actually was included in the KP electronic library. In addition to sharing the actual research paper electronically, the care support team at Kaiser Permanente also built that important piece of science into the set of recommended

care protocols that are developed and undated regularly for Kaiser Permanente caregivers.

There are currently 2,500 care protocols in the Kaiser Permanente electronic medical library.<sup>102</sup> Those protocols are developed by medical experts using current medical science. That recommendation to add that particular medication to the treatment plans of every relevant stroke patient was very quickly added to the recommended Kaiser Permanente care protocol in place for stroke patients.

### **Make the Right Thing Easy to Do**

That was not the end of the information distribution process at Kaiser Permanente for that stroke research.

Most importantly -- and most effectively -- that life-saving piece of information about stroke patients was also very carefully and systematically made available in all Kaiser Permanente owned hospitals to doctors at the point of care.

The basic mantra of the Kaiser Permanente care team is to make the right thing easy to do. That guideline of "Making the Right Thing Easy to Do," is used at Kaiser Permanente for both caregivers and patients. In this instance, the right thing to do is to provide statins to the stroke patients. To make that piece of advice easy to do, the care support team at Kaiser Permanente also embedded that information into the computerized recommended order set for stroke patients that pop up on the computer at the point of care for stroke a patient. The order sets are not mandatory -- but they are very convenient and they have great utility as a care support tool.

So that recommendation to the physician to use that medication was simply added to the set of real-time electronic care "prompts" and it was added to the onscreen suggested "order set" for the computer support systems that the doctors in Kaiser Permanente hospitals use at the point of care for their stroke patients.

The point-of-care real time order set is an extremely important care improvement tool. Adding that particular drug suggestion to the

suggested “order set” that appears on the screen for the doctor at the point of care in the hospital ensures that those key information elements will be available in a very convenient way for the relevant doctor at the most useful, convenient and relevant time for that information to appear. Making the right thing easy to do is a very good thing to do. The death rate from stroke for Kaiser Permanente patients has dropped by over 40 percent over the past few years.<sup>103</sup> The full set of care support tools -- combined with Kaiser Permanente’s extremely successful and also computer supported highly patient focused hypertension reduction agendas -- have combined to achieve those results.

### **Most Hospital Do Not Offer Reminders Of Best Practices At The Point Of Care**

Sadly, most hospital care sites do not have that tool kit. Most hospitals and physicians do not have an electronic medical library. Very few caregivers or care systems have care reminder prompts or even recommended treatment order sets in place. Some patients die and many are damaged for life because that tool kit doesn’t exist in their hospitals. Being damaged for life is a very sad care outcome.

The full set of problems that too often results from suboptimal care is bigger than just the difference between hospitals in their stroke patient death rate. Strokes kill people and strokes also create damage in many of the people who survive them. For stroke patients, the likelihood of the patient going home and achieving high levels of recovery after their stay in the hospital instead of having to go to a nursing home from the hospital with permanent damage after their inpatient stroke care is over is significantly better in Kaiser Permanente hospitals as a result of those interventions. The likelihood of going home without damage is higher because that set of automated care reminders exists in those hospitals and because the patients in those hospitals who receive that treatment approach are not -- on average -- damaged as badly by their strokes.

### All Hospitals Need Better Care Support Tools

These care reminders are a lovely care support tool. That kind of support system for physicians should not just be a feature and function of care in Kaiser Permanente hospitals or other major care systems. All hospitals should use those tools. It is important to recognize that the employers and the government agencies who buy care can help make that tool kit happen. Chapter five explains how using better care-related purchasing specifications can help improve care in those directions in many settings. The organizations that pay for care -- the employers who buy insurance coverage for their workers, the government agencies that pay for care for their beneficiaries and the private health plans that serve as our primary care purchasing mechanism for care in this country -- should all insist that the hospitals they pay for care for stroke patients should have those kinds of basic functional electronic care support tools in place for their physicians at the point of care in order to be paid in full for hospital care. If the care sites do not have these care support tools in place, they should give payers a time frame for when the tools will be installed and used.

Care can get a lot better -- and care will be cheaper -- when patients get best care and when caregivers have all of the information they need to provide each patients care.

The chapter of this book that deals with the changes we should make in the business model we use to buy care deals with those issues. For the purpose of this chapter, it's good just to point out that we need our care delivery infrastructure to have both easy access to best medical science and easy access to useful care support tools. That is particularly true in the hospitals for patients who need best care because those patients are clearly in need of care or they wouldn't be in a hospital.

### We Do Not Want Computers to Dictate Care

That recommendation to have computer triggered care prompts and care reminders does not mean that we want computers to practice medicine. That would be both incorrect and wrong.

We absolutely do not want the computers or the people who run computers to dictate care. Computers should never dictate care. We do, however, want the computers that are used in each care setting to offer easily accessible data and easily accessible medical science. We also want computers to offer easily accessible information about best care to the appropriate caregivers in real time. We very much want the computers to sometimes trigger or flag key pieces of information and we even want our computers to sometimes ask questions to the relevant caregiver about some aspects of care when that questioning and that reminder process could improve care and possibly help save lives.

The good news is, we do not need to invent that whole array of next generation care support tools.

Those tool kits exist. Prompts and reminders happen in some care sites today. As noted above, they are used now in some systems supported care settings. Those tools actually work. We need to use them when appropriate for all patients and we need all caregivers to have easy access to the right information about best care. We pay \$2.8 trillion for care in this country today.<sup>104</sup> We should be buying the right care and we should be buying the right processes of care when we are spending that much money on care.

### **We Very Much Do Not Want Anyone Dictating Care Approaches**

This is very much not, however, a suggestion that we should have someone or anyone dictating care protocols to our caregivers. We absolutely do not want computers practicing medicine and we also do not want mandatory care protocols imposed by outside agencies or outside parties dictating care. Having the government impose specific and detailed delivery care mandates should not be a function of either our business model for care or a function of our regulatory model for care. This is not a suggestion that specific care protocols or specific approaches should somehow be determined, defined, and then dictated by outside parties. That level of care-related dictation by outside parties would be a mistake.

Why would that be a mistake?  
Care would suffer if that happened.  
Why would care suffer?

### **Continuous Improvement Needs to Be Our Goal**

Continuous improvement is our goal. Continuous improvement should be our mantra. We need continuous improvement. Continuous improvement should be a core philosophy in our infrastructure for care. We will only optimize the delivery of care in this country if we are committed to a process of continuously improving care and then actually continuously improve.

We want and need care to be continuously improving. We need to nurture and support and encourage and protect continuous improvement as a philosophy, a commitment, a strategy, and a skill set. Continuous improvement done in a systematic and consistent way is needed for care to get continuously better. That is why we should not mandate specific protocols. Continuous improvement requires continuous flexibility. Mandates can create rigidity. Mandated specific protocols have an inherent rigidity that is created by their mandate. Rigidity is bad. Rigidity and continuous improvement are a bad and non-functional combination. One kills, impedes, or impairs the other. We obviously very much do want care protocols for care delivery and we very much want medical best practices but -- with very rare exceptions -- we do not want anyone external to the care process dictating the specific care protocols we all use. Rigid, mandatory, regulation based very specific and detailed care delivery rule sets and process mandates can and will stifle continuous improvement processes in operational care sites.

Continuous improvement should be our goal -- almost our obsession -- so we should not allow the use of rigid rules about processes that lock specific care delivery processes into place.

### **Continuous Improvement Should Anchor Our Thinking**

Continuous improvement is a good thing.

We need patient centered care that continuously improves.

We definitely do want continuous improvement to become a core mantra and a basic priority for the entire infrastructure of American health care. We need an industrial revolution for care delivery that is firmly anchored in continuous improvement. Continuous improvement needs to be a major part of our tool kit. Our business model and our regulatory model should both reflect the fact that we need continuous improvement for our care infrastructure. We clearly have huge opportunities to make care better. Care today tends to be badly organized, unconnected and many aspects of the care information are entirely unintentional -- driven by revenue streams rather than by patient needs. Care does not get better in that dysfunctional context. We want care to continuously improve. We can make care safer, more efficient, and more affordable when we look in a systematic way at entire processes of care delivery and then repeatedly engineer and reengineer care around the patient in a continuous improvement context and approach.

### **Care Can Be Best Engineered in Packages -- Not Pieces**

Most health care in America is sold by the piece. This book discussed that issue in several places. We currently have a piecework cash flow that funds care. That piecework approach and cash flow makes reengineering care very difficult.

When care is sold entirely by the piece, then the cash flow for the caregivers is obviously dependent on not losing any of the billable pieces of care from the overall process of care. Asthma care that is sold by the piece generates a flood of cash that is triggered when patients have an asthma crisis. Asthma care that is sold by the piece also experiences a direct, immediate, and major dearth of cash flow when those asthma crises do not occur. Dearth can discourage care improvement.

A cash flow dearth is -- for obvious reasons -- not good for the financial health of caregiver business units. Anyone with enough

intelligence to get through medical school or through health care administrator training knows that dearths of cash are hard to use to keep a business intact and alive. Dearths don't bank well. So when asthma care is purchased entirely by the piece, we generally don't see caregivers spending time and energy putting in place various care approaches that will keep asthma attacks from happening and that will cause asthma billable events to shrink.

This chapter isn't intended to explain the specifics of how the business model we use to buy care needs to change in order to allow caregivers to sell asthma care as a package and not just sell asthma care by the piece. Chapters four and five both deal with those issues. But this chapter does have the task of pointing out how the different the consequences of the two approaches are.

### **Patient-Focused Asthma Care Creates Fewer Crises**

When asthma care in any care setting is sold as a package and not just by the piece, asthma care becomes much more patient focused. when caregivers have a direct cash flow that can support prevention and when caregivers are not dependent on each asthma crisis to make money, the care delivery perspective changes. The total care approach for the asthma patients generally gets much better when that cash flow change happens. Patient focused asthma care involves and includes proactive interventions, quick response times and effective and timely patient education. In the right business model for asthma care, the thought process about that care for those patients is focused with real energy on reducing both the number and the severity of asthma attacks... not just responding after-the-fact on a piecework basis to each incidental but revenue rich asthma crisis. Those are two very different approaches to care. It is a very different business model for care.

The normal functionally and the standard care patterns for each asthma patient today in our piecework care model generally involves the business sites of care waiting for an asthma crisis and then doing expensive (and profitable) and usually entirely reactive things to and for



each patient in each situational setting to help resolve each situational care crisis.

### The Care Sites With A Different Business Model Build Patient-Centered Care

Some care sites today already do have a different business model where they currently do sell care by the package and not by the piece. Those sites who sell an entire package of care today can and do look at asthma care at the patient level rather than just reacting at the incident level to each asthma crisis triggered “moment of care.” When the payment model works well, the sites that sell care by the package can actually benefit financially by averting asthma crises rather than literally losing money when an asthma attack is prevented. In the package care model, the caregivers also benefit financially when the asthma care needs of patients are handled so well that the care team response to an asthma issue doesn’t always become a full medical crisis. That is much better care for asthma patients. The thought processes for each of the two approaches are fundamentally different.

The care sites and care teams that have a total package of care focus for asthma care tend to develop an early intervention plan for each asthma patient. Prevention becomes a top priority when the cash flow model changes. That is a good thing. Prevention works. The number of asthma crises for those patients are reduced. The truth is, nearly 70 percent of today’s hospital-admission triggering asthma care crisis -- in many care settings -- are preventable.<sup>105</sup> Care is better and life is better for the patients who are not going through those crises. Patient-focused, proactive asthma care is far superior to crisis focused, fee-fed asthma care. The caregivers can afford to reengineer the procedures of care when the caregivers are prepaid and when the caregivers can benefit from the reengineering. Without that very basic change in the cash flow, for caregivers, reengineering simply changes provider revenue in an adverse way. As this book says several time -- no industry ever reengineers against its own self-interest. That is true of any other industry and it is

very true of health care. So we need to make care reengineering in the best interest of the care industry and reengineering will quickly happen.

Asthma obviously, isn't alone in offering us a universe of opportunity for better care that is anchored on a better business model and reengineered processes of care.

### **Congestive Heart Failure Care Is Also Better As A Package**

For patients with chronic conditions -- and particularly for patients with multiple conditions -- we really need proactive and intervention-focused, process-based thinking to make care better and more affordable.

Congestive heart failure (CHF) is another good example of an area of care delivery where looking at the total care needs of each patient in a proactive way creates far better -- and less expensive -- care than a care delivery approach that is focused entirely on responding on a piecework basis to CHF crises after they occur.

Multiple settings have shown that care is much better for those patients when their personal CHF crisis are reduced or prevented. A congestive heart failure crisis can be pretty grim for patients. Those crises are really not pleasant experiences for patients. When patients have a congestive heart failure crisis, they are often drowning in their own fluids. Those CHF crises can be horrible, terrifying, painful, frightening, demoralizing and deeply unpleasant experiences for the patient.

They are actually very much like a typical asthma crisis. And -- like the asthma crisis -- most of those terrible and painful CHF crises do not need to happen for most of those patients. Hugely competent, proactive patient-focused, well organized care approaches for each congestive heart failure patient can use systematic intervention processes to cut those horrible crises by half or more.<sup>106</sup>

Patients' lives are obviously significantly better when that happens. Cutting the number of CHF crises in half also reduces the cost of care for those very expensive patients by almost half. So care is better and care

also costs less when it is delivered in a proactive patient-focused package rather than simply being sold to the patient after the fact entirely by the piece. Continuous improvement can also happen once the care is set up as care processes instead of being triggered as purely reactionary incidents of care.

Once caregivers begin looking at these issues through the lens of continuous improvement and not through the lens of piecework-billing volume, creativity can flourish and care finally can get continuously better.

### **Proactive Care Needs to Be Incented By the Business Model for Care**

The sheer value of patient-focused care and of proactive care and interventional care strategies as the basis for our new continuously improving business model for care is obvious. This isn't a theoretical or ideological or philosophical insight or aspiration. It is an entirely practical and highly functional aspiration. The functional ability of care teams to actually do proactive patient focused care clearly exists. We know that is true because in some care settings whose business model already incents and rewards those approaches, care teams are doing that level of proactive intervention care now and they are doing it well. People have significantly fewer asthma and significantly fewer CHF crises in those care settings. So we clearly would be well served to put the tools and the financial models in place to make that kind of purchasing and care process improvement happen in more places for more medical conditions.

### **Most Care Costs Come From Patients With Co-Morbidities**

Another major focus of the new business model we should be using to buy care should be to put programs and tools in place to help achieve team care. We need care to be data based and we need care to continuously improve. We need process reengineering to maximize the

effectiveness of our ability proactively to reduce care crises. We also need a care delivery business model that incentivizes team care.

Why do we need team care?

We want health care costs in this country to go down and team care is a great tool for achieving that goal.

We need to recognize the very powerful reality that most health care costs today come from patients with chronic conditions and co-morbidities -- multiple health conditions. We know from multiple studies and we each tend to know as patients from our own care experiences that most of the patients in this country who have co-morbidities have badly coordinated care today. Their care is badly coordinated because we haven't built any care coordination processes and we have not implemented any care coordination tools in most care settings. We don't support team care financially and we don't support it functionally with team care tools. We very much need to improve the processes of team care for those patients who have multiple health conditions if we are going to reduce costs for those patients. We need to do that work as a conscious strategy rather than hoping that somehow the infrastructure of care will spontaneously and magically improve in a number of key areas. The opportunities for better care based on care teamwork are huge and they are very real. We actually can cut the needed hospital days by half or more for many of those patients with multiple health conditions if those patients get great care and if they -- as a result of better care -- have both fewer direct crises and fewer complications. To do that care coordination job for those patients well, we need the caregivers who share that patient to be able to function as a team.

### **We Need Care Coordination Tools**

For our caregivers to function as a team, there are a few very basic sets of logistical issues and operational realities that need to be addressed. Tools are the first issue. We need tools. Chapter one talked about our tool deficits and our tool gaps. They are very real. Tools are essential. Most caregivers do not have the right set of care coordination

and care support tools today. We need to build the right tool kit to support team care and coordinated care and then we need to put that tool kit in place and use it.

What will those particular tools do? Information sharing is a key functional need. Minimally, we need all of the caregivers who collectively treat patients who have co-morbidities to be able to share current information about each patient they share. That data sharing need is particularly important for all of the patients who have co-morbidities. That tool to share knowledge is actually equally useful in many respects for many other patients who have serious single illnesses. That tool is needed for the patients because many of the patients who have very serious single primary illnesses often have multiple doctors as well who can't easily share information. We clearly need a care delivery infrastructure and care delivery tool kits that allow our caregivers to share information as needed for each shared patient -- with a focus on information sharing for the patients who have co-morbidities and complex medical conditions.

### **Team Care is Wonderful**

We clearly need to build business models for care that will both create care teams and make it possible for patients to have easy access to those teams.

We clearly need to support and facilitate team care if we want to achieve the goal of improving care and reducing the costs of care. We need doctors, nurses, pharmacists, lab techs and various categories of therapists working together for each patient in ways that their collective and joint care is focused on their patients and not just on the cash flow and the operational convenience needs of various provider business units.

### **Patients and Caregivers Need Data about Care Consequences**

Chapter one talked about the extreme variation in care outcomes and even mortality rates that can happen between care sites and care approaches today. Far too often, those significant performance differences exist and they are invisible both to the caregivers and to the people receiving care. We also should do much better in regard to sharing data about care performance levels with both patients and caregivers.

Both patients and caregivers will benefit.

Patients should be able to know what the likely outcomes are for various medical procedures and patients should be able to compare performance for various care sites and care teams.

Care sites very much need comparative data about their own performance in key areas. The chart below was referenced in chapter one. It shows the sepsis death rate in a number of individual hospitals as it occurred over several years at a major American hospital system. That comparative data helped those care sites improve care. That death rate chart shows why data is so important to caregivers. Having the data very clearly and directly helped bring the death rate down for those care sites. A decade ago, no one even measured outcomes like sepsis death rates at the caregiver level. For the hospitals on this chart, data on that topic was not gathered, collected, received, or even considered ten years ago. As noted earlier, sepsis is actually the number one cause of death in American hospitals -- killing more patients than stroke, heart disease or even cancer.<sup>107</sup> Sepsis is the single biggest cause of death in hospitals and most hospitals do not even collect the level of data that is shown on those charts.

### **Hospitals Didn't Believe that Data Was Needed**

People who run hospitals very much want to do the right thing. Until fairly recently, however, the people who run hospitals believed that doing the right thing actually did not require using a lot of data.

For the hospitals on this chart -- before the initial data set was collected -- everyone in each care site believed that their own hospital was doing a great job on sepsis care. People at those same data-free care

sites also believed they were doing a great job on all of the other care-related infections for their patients. All of the care sites shown on this chart believed they were using best practices and all of the care sites believed that their outcomes for patients were as good as or better than the outcomes at other care sites. Then the first actual measurements were done at the hospitals. The hospitals that did that initial measuring of their own performance and then built their first level of data comparison capabilities actually learned very quickly there actually were major differences in death rates between hospitals. Sepsis turned out to be an area of significant performance variation. The hospitals learned in a very powerful way that everyone in the hospital world was not delivering great sepsis care. Results were inconsistent. Some very good people who had believed very sincerely and honestly that their own hospital care was the best available hospital care on the planet learned after looking at real data about sepsis outcomes that their results for that condition were actually worse than the results in other hospitals in the comparison group.

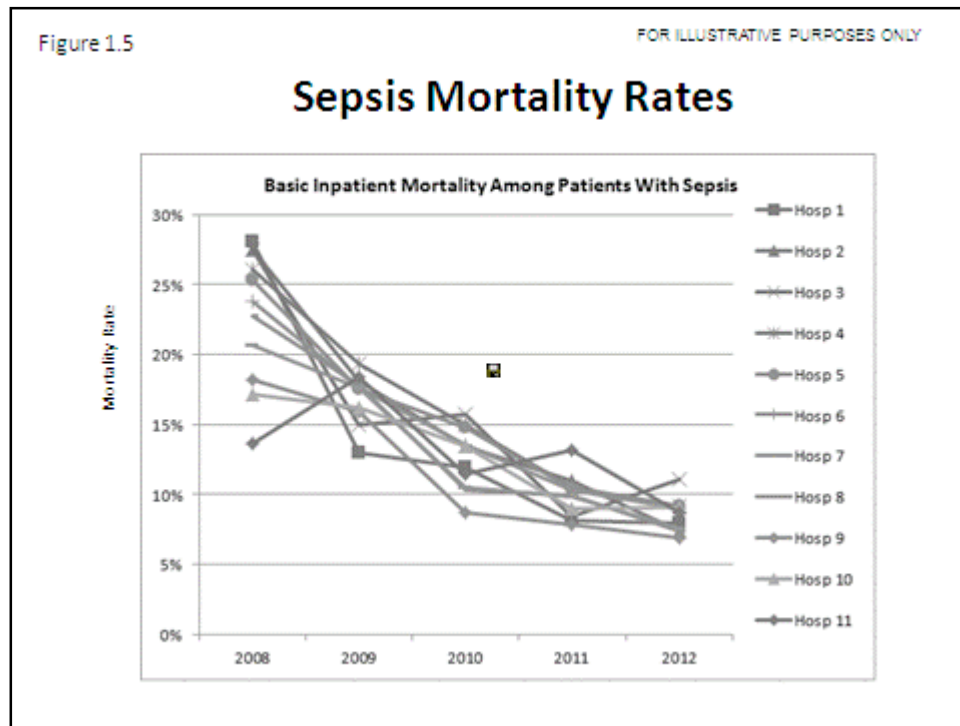
That was unexpected. And it was shocking to many people.

That data was golden. It was honest. Some of that data was painful.

Overall -- having that data was, in total, wonderful.

That data has saved a lot of lives.

Because that comparative data finally existed and also because the data was made available, accessible, and transparent to the care teams at each hospital, all of the care sites in that hospital system began the process improvement work that was needed to bring down the death rate from sepsis at their hospital. The next chart shows very clearly the reduction in overall death rate for all of those hospitals as a group over a couple of years of continuously improving care.



The mortality rate in those hospitals is now far below the national average death rate in American hospitals for sepsis. Lives are being saved every day in those hospitals that would be dead in most other care settings. There is no possible way that those absolutely impressive levels of performance improvement in all of those hospitals could have happened without that data.

### Other Hospitals Need To Collect That Data

What does that example have to do with the data elements that we want to build into the future business model of care? We should want all other hospitals in this country to do down similar paths of data-based continuous process improvement for multiple important areas of care. It is possible to do. Buyers can help make that happen, as chapter five explains. We need to buy care in a way that will incent and reward a continuous improvement process approach that will make the outcomes in all American hospitals in key areas get better every year.



So why did these hospitals manage to achieve those reductions in the sepsis death rate while other hospitals here made a lot less progress? The business model used to buy care was relevant. Those hospitals on this chart actually benefited financially by improving sepsis care because these hospitals are already selling care by the package and not selling care by the piece. Those hospitals do not lose revenue when sepsis patients are quickly cured. For other hospitals that sell care entirely by the piece, an equivalent improvement in sepsis care results could have reduced revenue by many millions of dollars per hospital. The business model of selling hospital care as a full package instead of selling that care purely by the piece enabled that stunning level of care improvement to happen. And allowed all of those lives to be saved.

### **Hospitals Need A Business Model That Rewards Better Care**

Those sepsis results show why we need to change the business model for other hospitals in a couple of key ways -- to stop paying more money when care is bad and paying even more money when care is worse.

We need that same commitment to continuous improvement to be true in other hospitals as a core financial and operational reality that allows those hospitals to benefit when sepsis response minimize damage to sepsis patients.

In a nutshell, we need to put American hospitals into a financial reality where better care creates financial rewards rather than creating financial penalties. This book addresses some new ways of compensating hospitals that can work toward these goals -- including having hospitals functioning as part of the new Accountable Care Organizations approaches to care delivery that are described in chapter four and five. Quite a few care organizations are trying to set up Accountable Care Organizations as a way of creating team care and changing the business model to reward proactive care instead of penalizing it.

The new ACO models for care delivery and care financing that are being built have the potential to create a new financial reality and a new

cash flow model for hospitals and care teams that will incent and deliver better sepsis care rather than penalize it. The ACO's that sell care by the package will also have the potential to incent better asthma care and better congestive heart failure care. That ACO strategy is discussed in both chapters four and five. For this chapter, the point to be made is that care can get a lot better when the business model we use to buy care rewards better care. We need business models that allow and incent better and safer care to be the norm rather than the exception.

Consumers deserve safe care. The business model we use to buy care and the care support tools we use to deliver care need to support safety, and patients need to know which care sites create the most risk for them as patients.

### **Patients Should Know Which Care Sites Are Safe**

In the new health care world we are building, patients should have much better data about care delivery performance and care outcomes. Having access to key pieces of needed data about care outcomes and care safety is an area where one very effective tool we might want to use to improve the business model of care might be the law, itself. Laws create their own business reality. Business models can be created by the market place -- and business realities can also can be created by regulatory edict. In some cases, laws clearly have a role to play in making care better. Laws about care delivery very much create their own business reality about care delivery for care sites. When something specific is required by the law, care sites tend to invest the resources needed to do whatever is required by the law in order to stay in business or avoid regulatory penalties.

### **We May Need Regulations About Care Outcome Reporting**

Laws are a clumsy and potentially damaging tool to use to structure specific aspects and care delivery, but laws can create a context for data availability that can be extremely useful for caregivers, patients, and

buyers. We may actually want to set up a few additional regulations about care data reporting that will require care sites to gather and report a whole array of outcomes related data about specific aspects of care.

In the best of all worlds, that data about care quality could be voluntarily reported. That voluntary reporting approach for care outcomes has not happened in most care settings, however. Some care sites already do that data gathering work and they do it well -- but the sad truth is that too many sites will not gather or report significant levels of outcome data voluntarily. That lack of outcomes data for care delivery isn't good, if our primary goal is to improve the quality of care and also -- in the process -- allow patients to make informed choices about care sites based on comparative performance and safety data. We need to use a combination of market forces and regulatory oversight to make appropriate levels of safety data available to consumers and caregivers.

### **Safety Is A Key Issue**

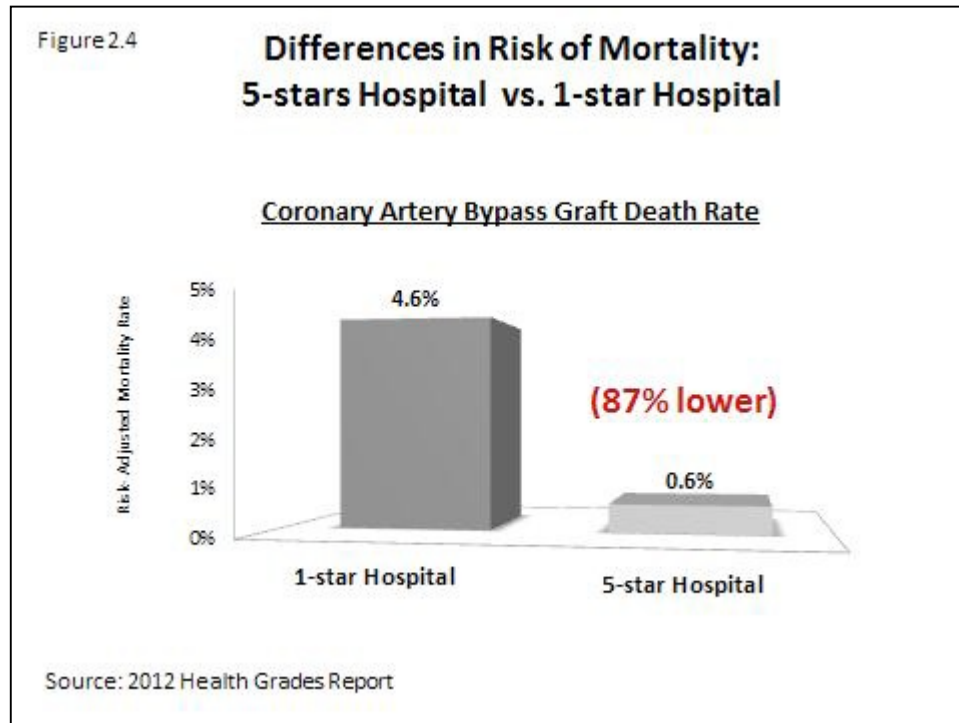
Safety is a good place to start when we are looking at areas where data transparency can be useful and meaningful.

Patients should know which care sites are safe. The business model we use to buy care should make safety a priority and the specifications used by key buyers should make public data about safety levels a mandate. As the last chapter of this book pointed out, the death rate triples and quadruples for several categories of care if you go to the wrong hospital or to the wrong care team.

The next four charts show some graphic and powerful differences in care outcomes by hospitals. The National Health Grades Report rated an array of hospitals in this country.<sup>108</sup> The Health Grades teams looked at available performance and operational data and then they assigned from one-star to five-stars to each hospital based on the quality improvement and the continuous improvement programs that are in place at each hospital.

What did they learn?

They learned that the existence or the lack of existence of very basic data based quality programs in each measured hospital had a huge impact on saving people's lives in each hospital setting.



The hospitals that were given five stars were hospitals that had extensive quality improvement programs in place. Those hospitals clearly used their data to improve the quality of care. One-star hospitals had less data, fewer reporting processes and when you look at the results, it's clear that the one-star hospitals clearly did not improve some key areas of care.

Heart surgery was a good example of differences in care outcomes between the five star hospitals that have formal data based quality assurance programs in place and the one-star hospitals that rely primarily on good will and good intentions to make better care happen.

The hospitals that only had one-star ratings had one out of every 20 coronary artery bypass surgery patients die.

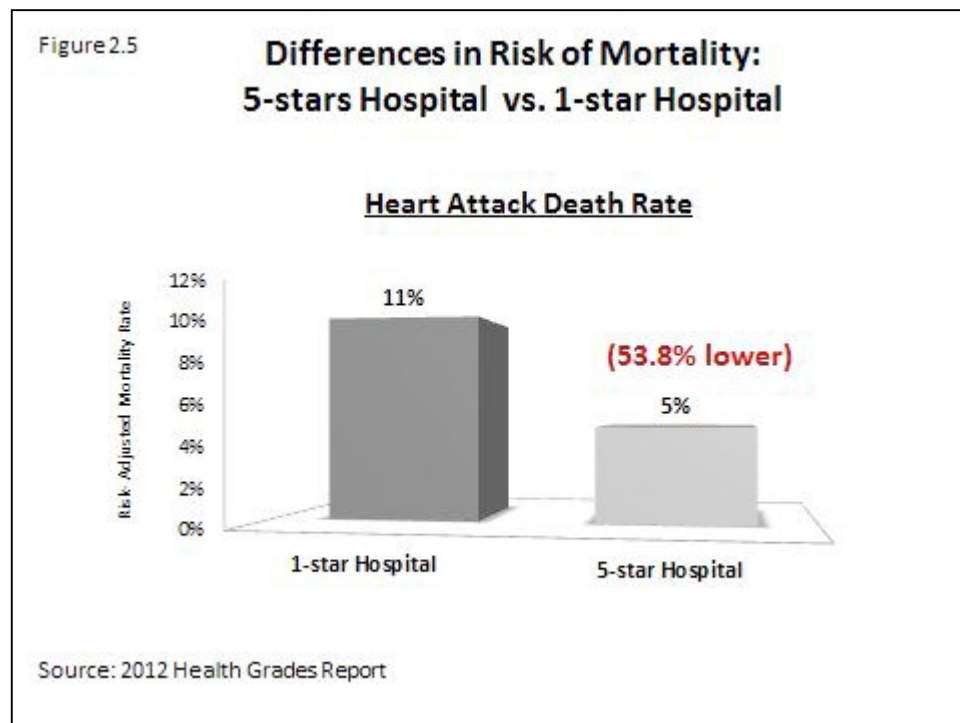
By contrast, the five-star hospitals in the Health Grades report has less than one out of 100 of their patients with that exact same surgery dying.

Earlier studies of mortality levels for that heart bypass surgery have shown that the death rate for the worst hospitals in America who do that particular heart procedure has actually ranged closer to one in ten of their surgery patients dying from that surgery.<sup>109</sup>

So if you need that particular heart surgery and if you go to a high quality, data supported five-star hospital, and have the surgery, your likelihood of death is only one in a hundred. If you go to a one-star hospital, your chance of dying jumps to one in twenty. And if you go to an even lower performing hospital -- if you go to a worst care performers for that particular surgery -- your chance of dying from the same exact surgery jumps to roughly one in ten. One in ten is a very different risk level for a patient than one in a hundred.

Heart attacks also result in very different outcomes when you compare one and five-star hospitals.

The difference in death rates between the one-star hospitals and the five-star hospitals for basic heart attacks is also worth knowing. Look at the chart below. Over ten percent of the heart attack patients die in the one-star hospitals. Less than five percent of those some patients die in the five-star hospitals.



Our current business model for care makes no differences in the way we buy care for any of those fairly dramatic differences in care outcomes. We don't change the cash flow for care in any way based on these very difference care outcomes. That is obviously a flaw in the way we buy care today.

As we build our business model for care, we definitely should -- at a bare minimum -- insist that any of the patients who will be undergoing those surgeries should know clearly what those relative mortality risk levels are for each site before having the surgery. Likewise, we need a business model for care that creates an information flow so that patients who have heart attacks can easily know that their personal death risk doubles if they go to a hospital that only gets one star for its safety programs and its care processes instead of earning five stars.

Ideally, we should pay hospitals less for a bad mortality rate and more for a good mortality rate. The chapter of this book on how employers should establish performance specifications addresses those issues in more detail. At this point, we just need to keep in mind that the business model we use to buy care should probably be set up to encourage data supported care because the hospitals included in the star rating system who had the best results were the hospitals with the most intense care data.

### [Sepsis Death Rates Vary As Well](#)

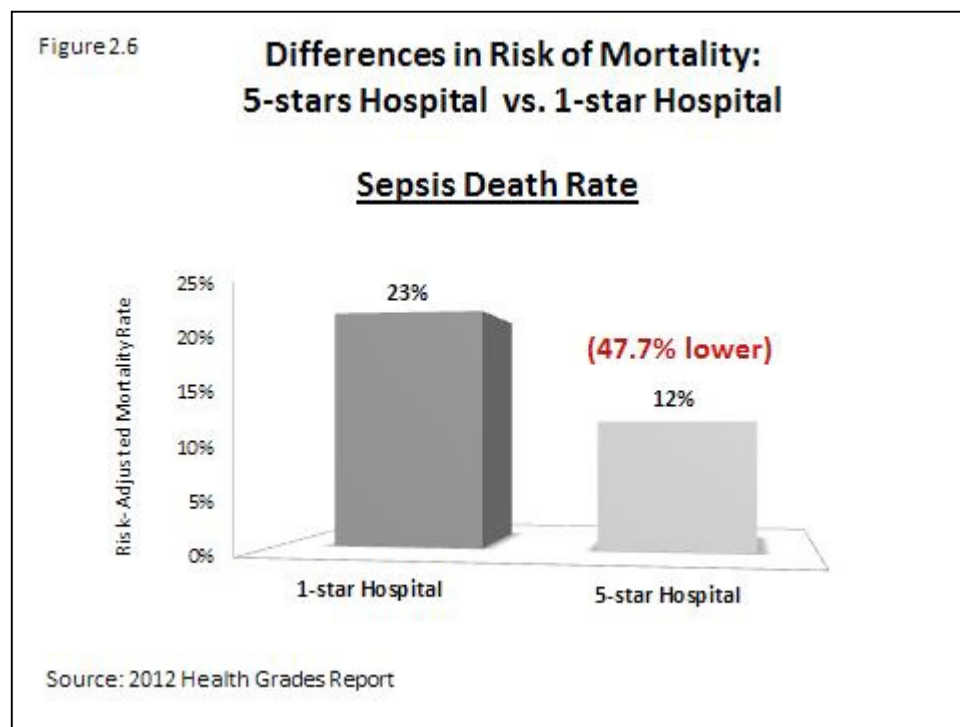
The patterns of sepsis care -- not surprisingly -- look very familiar for the hospitals included in the star rating system.

The wide variation in performance that exists now relative to mortality levels for patients with sepsis in American hospitals and the many opportunities we have for care improvement for sepsis patients have both already been discussed in this book. The National Health Grades report looked at sepsis care, as well and their data confirms the points made by this book. Their outcomes numbers directly reinforced

the point that was made earlier about the benefits of systematic care improvement for sepsis care patients.

The next chart shows the impact of systematic care improvement in hospital settings for sepsis patients. The 12 percent mortality rate for sepsis they report for the top performing five-star hospitals that were included in their study is clearly a great success story. That 12 percent number is a bit higher than the best hospital performance results in the other care system that was mentioned earlier in this chapter -- but their five-star hospitals mortality level for sepsis is clearly a lot better than the 23 percent mortality number that is the average death rate the National Health Grades Organization uncovered in their one-star hospitals. In some hospital settings, the death rate reaches 30 percent of sepsis patients.

The chart below shows the sepsis mortality rates for the one and five-star hospitals rated by Health Grades.

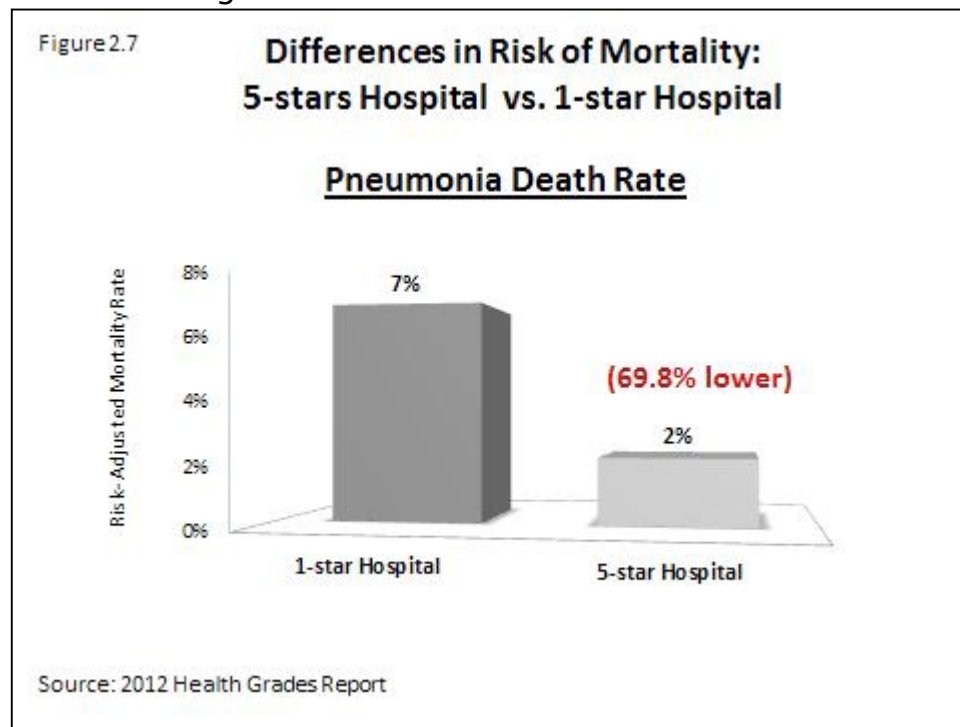


Not surprisingly, the same relative performance paths existed for pneumonia data in the Health Grade study. Those differences were fascinating, as well. Pneumonia is one of the hospital acquired infections

that happen most often to patients in this country. The success level variation for treating that disease is huge. As you can see from these charts, the best “five-star” hospitals only lose about two percent of those pneumonia patients. The one-star hospitals, however, lose over seven percent of the pneumonia patients. Being more than three times more likely to die is a very important difference in the survival rate if you personally are a pneumonia patient.

Again -- the business model we use today to buy care does not differentiate in any way between those differences in care outcome. If anything, the way we buy care today rewards the hospitals with the worst death rates because the pneumonia patients in those less effective hospitals tend to have their pneumonia longer than the cases in the best hospitals and they spend more time in the very expensive intensive care units.

We clearly need a business model for care that insists on making that kind of comparative mortality rate information available to patients who need those levels and categories of care. We also need a business model for care that pays hospitals more for higher survival rates and pays hospitals less for higher rates of death.





### We Need Care Delivery Innovation

We also need a business model for care that incents providers of care to be much more innovative in developing alternative care delivery tools and support systems.

As one example -- one important care delivery improvement that patients tend to appreciate and use is to give patients e-connections with their caregivers. E-visits can actually replace face-to-face visits for multiple levels of care. When people deliver care by the package, e-visits are easily included in the package. But when care is sold only by the piece, e-visits are rare and they are sometimes not available at all.

That makes economic sense for the caregivers because the current piecework payment model for care doesn't usually pay for e-visit, and that lack of payment penalizes any fee-based care sites that use e-visits and telephone connectivity as an efficient tool for delivering care. It penalizes those sites and those care teams because those electronic connections, information flows, and remote venues of care delivery are not paid for by the typical insurer or medical fee schedule.

That rigidity in payment decisions for those electronically connected levels of care is unfortunate because we need to design and implement care innovation approaches that use those new tools. It is a flaw in the business model we use now to buy care to not pay for improved connectivity. We obviously need a business model that supports reengineering the delivery of care to make it more affordable and more accessible using any and all of the new connectivity tools available to us.

We need to use the available sets of new connectivity tools to achieve a more flexible connectivity goal. Enhancing connectivity should be a very conscious goal. We need to fully and creatively use the new connectivity tool kit that is increasingly available to us through all of the new smartphones and internet connectivity devices so that we can deliver care in highly patient-focused ways in multiple care settings and deliver care that is both less expensive and much more patient friendly from a logistical perspective.

### **The Cusp of a Golden Age for Care Support Tools**

We are actually on the cusp of a golden age for health care support tools. If we take full advantage of the new tool kit that is being made available to us, we will be able to deliver better care with major improvement in the access to care and achieve a significant reduction for the overall cost of care in the process. These are exciting times for health care support tools. We are on the cutting edge of a connectivity revolution for health care. The new computerized connectivity revolution and an explosion in data purchasing capabilities and operational functionality has already transformed many work flows and has fundamentally changed many basic customer/vendor interactions and transactions in multiple other areas of the economy. That new connectivity capability is now reaching health care and if we use the new tools well, that connectivity revolution will change care as well. If we know what we are doing, we will change care significantly for the better.

### **Hospital Care Will Also Have Better Tools**

The new tools will make care better at all of the various sites we use to deliver care. The next generation of care delivery will have hospitals that are supported with great technology and with databases that will give hospital caregivers all of the information about each patient and their care needs.

Hospital care will get better with the new tool kit and it will become safer and more effective when hospitals adapt both continuous improvement approaches and data based core tracking as care competencies.

Hospitals are much more likely to do that work and use those tools well if the business model for care buys team care instead of piecework care and if the hospitals are allied as team members with appropriate caregivers for each patient.

So hospitals will still be a primary site of care. Hospitals will not disappear. If we design the entire process well, hospitals will be

increasingly embedded into a care team approach rather than simply continuing to be free-standing functionally unconnected care business units that deal with patients in the pure context of the patient's situational care needs.

### **Clinics Will Also Have Much Better Tools**

The second site of care that will survive and thrive, going into the future will be the clinics and doctors' offices where people have a direct face-to-face encounter with licensed caregiver who will provide needed elements of care.

Those clinic based sites of care will also continue to be needed for the foreseeable future. Those doctors' offices will also have much better technology and they should be supported with electronic information about each of the patients they serve if we put the right linkage in place. In many settings, the electronic data will come from an electronic medical record that are installed and operated at the clinical care site. In other settings, the electronic data will be available from patient focused electronic care registries and the data may be independent of any care sites. The goal for both approaches needs to be to have all of the needed data for each patient available at the point of care.

The patient focused medical homes and the Accountable Care Organizations that are described in chapter four of this book will both be a very powerful source of patient supported registry functionality. The medical homes and ACOs will need systems that anchor that data for care settings that do not have a full electronic medical record in place.

There will be variations relative to the patient data connectivity tools -- but we should be headed very deliberately for a functional future where all face-to-face care sites will have either EMRs or an electronic patient registry of some kind to support care.

The physician's office part of the care delivery system is clearly also destined to survive as a key element of future care delivery. There will be a growing level of variability in site size, site scope, site scale and functionality for those medical offices. At one end of the continuum, we

will see face-to-face care delivered at micro sites -- tiny care kiosks -- where licensed caregivers will see patients face-to-face in very small care settings.

Some of those settings will even be mobile. A number of care vans exist already and are being used to bring face-to-face care more conveniently to patient locations.

As we go forward to create team care and accessible care, even the micro care kiosks should be well supported with electronic medical records and extensive levels of patient information.

At the other end of the physician's office care continuum from the micro clinics will be a growing number of medical macro clinics. In a number of settings, care delivery organizations are building full service, full capability macro care sites -- mega care hubs. The care hub model has the potential as a medical group to provide almost all of the care needs of their patients in one very large care sites sometimes available to provide multiple levels of care in one visit.

Those care hubs will also be heavily supported by the new electronic tool kit. The care hubs will also be supported by extensive levels of connectivity tools that will allow for video links, team consults, and care connectivity levels that will allow key levels of care expertise to flow electronically to the patient rather than having the patient moving from one physical site to another.

The ability of really well designed care hubs to do that work well is already being proven. One of the large multi-specialty care settings is already using video consults so well that over 40 percent of their dermatology visits<sup>110</sup> are now being done by video from the office of the patient's primary care doctor.

The ability to redesign work flows and to build care delivery around the patient can be enhanced significantly by the use of those tools in a multi-specialty team care context and setting.

In any case, the doctors' offices will continue to be a major site of care -- in multiple sizes and permutations -- and those physician anchored sites will also have all of the information about each patient available electronically in real time.

For some elements of care -- like drawing blood, removing a cyst, setting a broken bone, or getting a tissue sample for diagnostic analysis -- sheer logistical realities will require physical medical office sites to continue to exist.

### **The Home Will Become The Third Site of Care**

One obvious problem with delivering care in either a hospital or a clinical care site is that the patient who is receiving care has to actually physically travel to those care sites. Travel can be inconvenient and sometimes difficult for patients. Any time a patient can receive appropriate care without having to travel to a care site to get that care, that approach to care delivery has the potential to make life easier for the patient.

If we really want to build care delivery around the patients and not around the business units of care delivery, the ability to receive basic care without travelling to a care site has obvious value and merit.

That fact -- combined with the fact that most of the care dollars spent in this country are spent on patients with chronic disease who generally benefit physically from consistent care monitoring and care support -- have caused quite a few caregiver organizations to conclude that the third primary site of care in the future should be and will be the home.

The new tool kit for care monitoring and care connectivity is already allowing the home to be the primary site of care for a growing number of patients. A whole array of in-home care support tools can already track key elements of a patient's physical status. In-home EKGs are now possible. Basic function monitoring can be now done relatively inexpensively from the home for an increasing number of patients.

Caregiver contact with the patient in the home can be very often video linked and tied to a blend of phone connections and email connectivity. That in-home care package already can replace many of the patient doctor encounters that have always required the patients to go in person to a clinic or a hospital for care.

In-home care can be far more convenient, significantly less expensive, and -- for many patients -- faster, more consistent and better care.

That in-home care support model works best in the context of accountable care and a care team. It's hard to do isolated pieces of care in a home. But team care makes sense for home care. The use of patient centered medical home team care approaches can create an easy to manage context for care delivery where in-home care is part of a total care package and a total care agenda for a patient instead of being an incidental, siloed, unconnected array of services that can be individually provided in the home as a site of care. Preventable care can also often be done remotely.

The best accountable care teams will also look at in-home care tools as a key and easy way to react quickly to patient needs when patient need quick interventions. The ability of care teams to monitor physical statuses of patient in their homes will be at a level that is far superior for many patients to the traditional monitoring that has happened in person when the patients have a monthly or even weekly appointment for a face-to-face care at a medical office.

The home could be the primary site of care for quite a few people -- and that will be most effective in the context of team care being delivered to those in-home patients.

### **The Internet Will Be The Fourth Site of Care**

In addition to those three increasingly well supported physical sites of care, we are on the cusp of seeing care delivery evolve very quickly to an entirely new care concept -- care everywhere.

Internet supported care can happen whenever an internet connection exists.

Care everywhere is clearly going to happen. There are thousands of computerized care opportunities already available on the internet that can do some levels of care diagnosis, care monitoring, and various kinds

of care consultations. Second opinions on the web are becoming easy to do. So are initial diagnoses for some conditions.

Health care apps already abound. Many elements of care that once required a face-to-face doctor's office visit can now be achieved on the internet. The new monitoring tools that exist on the web today can give patients the ability to track their activity levels, their food intake levels, and even their relative levels of heart activity or emotional status. Electronic tools to help monitor patients who are suffering from depression exist now. Monitoring for congestive heart failure patients is also available as a web tools. There are a number of tools now and more are being developed.

Group therapy session and individual counseling are even available electronically.

The new tool kit of care is exploding -- and it will transform care delivery.

### **We Need To Avoid New Electronic Silos**

That could be wonderful. It could also be -- for some patients -- dysfunctional and even dangerous. That new tool kit could also create entirely new data silos. It would be more than a little ironic if one consequence of using the internet as a care support tool would be to replace paper data silos with new electronic data silos that are equally segregated and equally dysfunctional.

As we look at the business models we need to use to buy care in the future, we need to make sure that those new business models embrace and support the best elements of this new world of care delivery rather than rejecting, derailing, defusing, or ignoring it.

Again -- building a level of accountability for the care of each patient can be a key thing to build into the new tool kit. If Accountable Care Organizations actually become accountable and are functionally responsible for the total care needs of a patient, we will need those ACOs to embrace team care, connected care and continuously improving care.

E-visits, done well, can replace some face-to-face office visits for the new care organizations and can both improve care and reduce costs. As noted earlier, quite a few existing care sites that could do various kinds of e-visits well do not do them at all today because the piecework business model we use to buy care pays well for a face-to-face visit and doesn't pay at all for an e-visit.

### **Patients Love E-visits**

Again, that perspective is not theoretical or hypothetical; that set of assumptions about what is possible when providers of care sell care by the package and not by the piece is based on direct observation of patient behavior and care delivery in settings where that model is used.

Kaiser Permanente is currently paid a lump sum today for all care as a care system. KP is not paid by the piece for care -- so Kaiser Permanente has already built electronic patient connectivity tools and uses e-visits today for many patients. Last year, there were over 15,000,000 e-visits in that particular care setting that would or could have been face-to-face visits in other care sites.<sup>111</sup> Over 30,000,000 Kaiser Permanente patients also received their lab results electronically -- with several million of those lab results going directly to people's smart phones.<sup>112</sup> In the past -- and in other care settings -- patients would need to visit their clinic to see their doctor in person to get those lab results.

Patients love that that electronic connectivity for e-visits and lab results. It doesn't happen in too many other care sites today because those electronic connections tend to replace a face-to-face billable event and any care redesign that eliminates a billable event is frowned on by people who rely on that cash flow for their livelihood.

We don't need care delivery built around entirely those kinds of billable events when other and better alternatives exist for meeting patient needs.

What does that tell us?



It tells us that the business model we use to buy care should very intentionally and effectively support the evolving delivery opportunities in care. The new ACO's and Medical Homes that are being worked to sell and deliver packages of care are highly likely to use that same set of tools and use them well.

Before describing what that new business model for buying care should look like, it makes sense to look at one more key issue that has a huge impact on health care costs in America. The next chapter focuses on that key issue -- the prices we spend for care. Any solution to health care costs that doesn't look at prices as part of the strategy to reduce costs is overlooking a major opportunity. So read the information in the next Chapter about the reality of prices in this country today and then look at various ways how we might change the way we buy care.