Organized Systems Of Care

A Vision of a Future Healthcare Delivery System

This article is condensed from a paper prepared by Carol Cronin, vice president of policy, and Karen Milgate, public policy associate, Washington Business Group on Health (WBGH). The paper reflects the comments of WBGH Organized Systems of Care Committee, chaired by Kathleen Angel, Digital Corporation; WBGH Board of Directors, chaired by John Burns, MD, Honeywell; and WBGH staff, headed by President Mary Jane England, MD. The paper was prepared as background for the WBGH invitational conference, the Future Health Care Delivery System, May 28-29, 1992, in Baltimore. WBGH is a not-for-profit health policy organization supported by large corporations.

Summary Policymakers no longer question that healthcare system reform will occur; rather they differ on the timing and direction of change. The Washington Business Group on Health envisions a future healthcare delivery system called an organized system of care (OSC). An OSC is an integrated financing and delivery system that uses a panel of providers selected on the basis of quality and cost management criteria to furnish members with comprehensive healthcare services.

The most important system attribute of the OSC will be the commitment of all involved to the *mission* of promoting the health of system members. To accomplish this mission, OSCs will incorporate the principles of continuous quality improvement.

Care will be delivered through care management teams, which integrate the physical, psychological, and administrative needs of the member. Such teams might be made up of primary care physicians, nurses, and mental health professionals. Although the entire team would be responsible for the OSC member, one team member would be assigned primary responsibility for overseeing and planning care with the member.

The American healthcare system is nearing a crossroads. Healthcare cost increases have persistently exceeded general inflation and may have reached unsupportable levels. At the same time, millions of Americans lack healthcare coverage at any point in time or experience some lapse of coverage over the course of a year. Many policymakers no longer question that healthcare system reform will occur; rather they differ on the timing and direction of change.

The Washington Business Group on Health (WBGH) envisions a healthcare system by the year 2000 that supports continuous improvements in the health status of Americans by making quality, necessary healthcare available to all at an affordable societal cost. Achieving this will require immediate fundamental reforms supported by a partnership of providers, government, purchasers, and users of healthcare.

Legislative attention to healthcare reform thus far has focused primarily on financing access for the uninsured. While this goal is extremely important, an equally fundamental concern is the type of healthcare delivery system to which we are providing access for all Americans, both the currently uninsured and the insured populations. WBGH believes that effective healthcare system reform must seek to change how healthcare is organized and delivered, along with how it is financed. Equally important is the need to better understand what works in medicine so that only necessary and appropriate care is delivered and reimbursed. Absent such restructuring and information, proposed cost control and financing solutions build the tremendous cost of inefficient healthcare delivery into their proposals.

The purpose of this article is to provide a vision of a future where healthcare is delivered to all Americans through competing organized systems of care. These systems would provide quality, cost-effective care and would serve as an organizing focus for the currently fragmented delivery system. Support of this vision will guide WBGH

involvement in the healthcare system reform debate.

As a delivery system vision, this article assumes that all Americans have access to healthcare and does not address the complex issues of financing access. Other work underway at WBGH addresses this area and will ultimately be integrated into an overall WBGH healthcare system reform proposal that addresses both access and healthcare delivery.

Paradigm Shifts

Paradigms give form to the underlying ideals and philosophies a society holds. They become the foundation that society uses to organize its thinking. Today's healthcare delivery system was built on ideals of individualism and a belief that doctors—not individuals with sickness—were primarily responsible for curing illness. These ideals have led to knowledge and technological improvements in healthcare delivery unmatched in any other nation. However, as several key healthcare measurements indicate, our nation has not organized and delivered these resources in a manner that has allowed them to reach their full potential. For instance, competition for technologically superior products has led to distortions in the balance between the supply and demand of

PARADIGM SHIFTS TOWARD ORGANIZED SYSTEMS OF CARE

Fragmentation to Integration

Individual practitioners currently deliver care without the benefit of standardized practice information or systematic knowledge of both the process of ongoing care or care outcomes, particularly if it involves multiple practitioners and treatment sites.

The development of new information systems, the maturing concept of management based on cooperation, and the potential integration of all healthcare partners will allow movement toward a unified system capable of combining a variety of heretofore isolated delivery system elements. The finance, administrative, and care delivery functions will be integrated. Treatment sites and healthcare practitioners will become integrated with the help of systemwide data that guide practitioners, patients, and purchasers on appropriate practice standards or guidelines, outcomes data, and treatment options. And, finally, future healthcare delivery systems will be integrated into their communities.

Passive Participation to Active Participation

Patients currently are expected to be passive participants in their treatment. Providers feel constrained by externally developed protocols, utilization review, and managed care policies. And, until recently, purchasers have passively paid premium increases every year or shifted costs to others.

The increase in knowledge and sophistication of all participants in the future healthcare delivery system, coupled with the speed of information transfer, will lead to altered roles. Patients will be expected to make informed choices about their care, work with practitioners to design and follow appropriate treatment plans, and take responsibility for preventing illness. Providers will actively use the system's information, respect patient preferences, and facilitate approaches to care that include overall health indicators. Purchasers will develop selective and evaluative criteria to provide better care for their members.

Paying for Services to Buying Value

The absence of comparable quality information in the healthcare delivery system has resulted in a competitive focus primarily on cost. In addition, healthcare facilities have competed with each other through better and more expensive technology; insurers and managed care companies have competed by cutting back benefits to keep premiums lower, negotiating discounted payments with providers, or excluding the sick through underwriting practices; and consumers of healthcare—whether individuals or purchasers—have little or no information on which to base their buying decisions.

Participants in the future healthcare delivery system will compete on the basis of value—that is, necessary healthcare at reasonable cost. Value begins with specifications that demonstrate that care is necessary and includes outcomes measured by comparing similar indicators across plans, including patient and practitioner satisfaction. To satisfy the cost-effective equation that defines value, quality outcomes will be balanced with the cost of providing the care.

Shifting Responsibility to Taking Responsibility

The present healthcare system encourages individual stakeholders to abdicate responsibility for their actions or lack of action. In the future, incorporation of continuous quality improvement techniques will strongly encourage providers, system members, and purchasers to "take responsibility." All will be expected to find new and better ways to improve care and to solve problems. Responsibility implies that members, purchasers, and providers are able to articulate expectations, agree on how to measure them, and agree to be held accountable for the results.

Focus on Sickness to Focus on Health

Current healthcare delivery is primarily centered around episodic care, with the entry point being either acute or chronic illness. A future delivery system focus on health will result in long-term partnerships that place a high priority on preventing illness, as well as treating it. The future system will also recognize that health is a dynamic state and that all individuals regardless of age or physical or mental capability have the capacity to improve their health.

healthcare products.

Five key paradigm shifts that underlie the movement toward organized systems of care reflect changes in the environment that extend beyond the healthcare setting and represent fundamental managerial, technological, cultural, and psychological changes already occurring in a variety of settings in the United States (see **Box,** p. 23).

Integration will be seen in the actual delivery of care to each OSC member.

Organized Systems of Care

Given the changed environment and resulting paradigm shifts, it is now possible to articulate a future healthcare delivery system—an organized system of care (OSC). An OSC is an integrated financing and delivery system that uses a panel of providers selected on the basis of quality and cost management criteria to furnish members with comprehensive healthcare services. An OSC incorporates continuous quality improvement (CQI) mechanisms and incentives to provide only appropriate and necessary care and is accountable to purchasers, patients, and others on the basis of cost, quality, and outcomes information.

WBGH believes that delivery of healthcare through OSCs should become the predominant mode of future healthcare delivery. The vast majority of Americans, regardless of how their healthcare is financed, should receive care through OSCs by the year 2000.

System Attributes The most important system attribute of the OSC will be the commitment of all involved to the *mission* of promoting the health of system members. All staff will know, understand, and be able to articulate the mission of the system. The development of shared values and a common vision will be a central tenet of the OSC culture.

To accomplish this mission, OSCs will incorporate the principles of CQI, which have successfully transformed many American manufacturing and service companies. These include a few basic characteristics:

- The quality of healthcare delivery is based on a careful understanding of the needs and expectations of "customers."
- The specification and improvement of the product or service is continuous, measurable, and never ending.
- Everyone in the organization is involved in improvement because everything can be improved.
- CQI incorporates statistical techniques that involve understanding the steps in a process and reducing variation where warranted.

The future OSC will have numerous "customers," including patients/members, payers, OSC employees, public overseers, the community at large, and investors. Assessing the needs and expectations of these different customers through such methods as marketing research, advisory boards, membership on OSC governing boards, focus groups, and other techniques will be important OSC functions. Even more challenging will be the need to manage conflicts that arise because different customers have different needs and expectations. The most successful OSCs will be those that can best align their delivery systems to meet the widest number of realistic customer expectations.

The focus on CQI differs significantly from the current model of delivering healthcare, which involves designing inspection systems focused primarily on poor performance. Although the underlying principle of protection against abuse is important, the application has resulted in troublesome levels of dissatisfaction on the part of healthcare practitioners, significant financial resources devoted to inspecting care, and a consuming public increasingly confused by how it all works.

A focus on customers will also make OSCs different from community to community as they reflect the differing demographic, ethnic, environmental, geographic, cultural, and socioeconomic mix of their communities. In some communities, a physical plant may define the OSC; in others the OSC may involve a series of contractual relationships involving linked information and accountability. OSCs will recognize that healthcare is ultimately delivered at the local level, while still supporting the need for national standardization across communities on certain aspects of the healthcare delivery system.

Embracing the principles of continuous improvement will result in an OSC that is structured differently from nearly all current delivery systems. The OSC will be marked by the integration of:

- Those who deliver care (e.g., clinicians, healthcare practitioners)
- Those who oversee the delivery of care (e.g., hospital and healthcare facility administrators)
- Those who administer and finance the delivery of care (e.g., insurers, managed care companies, purchasers)

Integration will also occur on a systemwide basis around such management functions as strategic planning, budgeting, human resource planning, and system support services. The integration will be symbolized by OSC leaders who will be trained in both delivering and managing healthcare.

Integration will also be seen in the actual delivery of care to each OSC member. Care will be delivered through care management teams, which integrate the physical, psychological, and administrative needs of the member. Such teams might comprise primary care physicians, nurses, nurse midwives, nurse practitioners, physician assistants, mental health professionals, and administrative support personnel. Although the entire team would be responsible for the OSC member, one team member would be assigned primary responsibility for overseeing and planning care with the member. In addition, allied health personnel and providers who practice a more holistic model of medicine will be integrated into the OSC and be available based on identified patient needs and preferences.

Integration will also be assisted by the development of linked information across all system components. Information on resource use, costs, and outcomes of care will be linked in ways that allow OSC management to truly understand the value of care delivered. The OSC computerized integrated medical record will provide the ability to track patients over numerous settings over time while ensuring continued patient confidentiality. The computerized integrated medical record will also promote continuity of care by linking care provided in one OSC to that provided in another. Information system design will incorporate the needs and expectations of different customers and will include new types of systems that capture customer preferences and satisfaction.

OSCs will oversee the provision of the full continuum of care, from prenatal to long-term care, through delivery sites that range from the technologically complex to the OSC member's home. The types of care received within the system and contracted out will vary depending on their proven necessity, availability, and cost-effectiveness. In some communities, members simply may go to another suite for follow-up care in a vertically integrated OSC model. In other communities, members may go to another facility for contracted specialty care (e.g., heart transplant) or disease-specific care (e.g., cardiac care). What will define the OSC is the level of cost-effective integration across these sites that ensures continuity of care for the OSC member.

Another key OSC attribute will be a culture that stimulates the intellectual curiosity and continued learning of all participants. In the same way that leading American companies support research and development, OSCs will view themselves as laboratories for generating new scientific, clinical, and organizational information. The emphasis on information collection and use will assist in this pursuit, as will possible linkages to practitioner training institutions.

New Health Partnerships OSCs will provide new models for partnerships among all involved in delivering, financing, and receiving healthcare. The patient will no longer be the passive possessor of an illness, but, as a member and partner with the OSC, will assume responsibility for his or her health. In addition, to maintain his or her health, the member will access the OSC at times other than when he or she is sick.

The systems will not consider prevention and education as optional benefits and services, but as central to the efficiency of the health plan and to the health of the member. Being informed, both about their own health and about options for care, is crucial for consumers if the delivery of care is to be provided as a member-provider partnership. Informed consumers will use the plan more efficiently by:

- Taking more personal responsibility for maintaining their health
- Identifying problems at early stages of development, thus making it easier for practitioners to treat problems
- Providing practitioners with more useful information on symptoms
- Seeking more targeted medical care
- Asking appropriate questions when in practitioners' offices
- Assisting practitioners in developing and monitoring an appropriate course of treatment
- Complying with agreed-on treatment regimens

The new health partnership will involve a clear understanding of the rights and responsibilities between the OSC and its members. Initial and ongoing communication around these issues will be crucial to managing expectations and achieving hoped-for outcomes. The new health partnership may also involve financial or other consequences for noncompliance with agreed-to responsibilities.

Readily accessible and easily understandable educational material will assist members in mak-

ing informed choices about their care. OSC members will be provided with information that will allow them to actively participate in treatment decisions, to plan for appropriate preventive medical procedures, and to make appropriate lifestyle changes because of a particular illness or for general well-being. To encourage practitioners to spend more time explaining options, traditional indicators of practitioner productivity need to be altered from the number of patients seen daily to a more qualitative measure of the type of care provided and overall outcome of the intervention. Traditional reimbursement structures may need to be altered to reward this change in measuring performance.

OSCs will have some degree of responsibility and financial interest to proactively seek out members who have not used their services. For members who are not as motivated to use OSC services or do not find them accessible, each organized system will develop an outreach program. Such programs could be particularly useful in rural and inner-city areas where lack of knowledge, coupled with transportation and cultural barriers, make it difficult for persons to access appropriate services. Care must be taken, however, not to punish the OSC for negative outcomes resulting from members who choose not to use the system, or use it inappropriately.

The development of partnerships will extend to other stakeholder relationships as well. Purchasers of healthcare, whether the government or private employers, will develop long-term relationships with one or a few OSCs. Healthcare practitioners and other OSC staff will also be involved in long-term relationships with one or a few OSCs. Indeed, financial arrangements with the OSC on the part of both purchasers and OSC staff will encourage long-term investment in the system, rather than short-term gain.

Information and Accountability The ability to collect and make available information on performance

COMPARING ORGANIZED SYSTEMS OF

The following case study illustrates how an organized system of care (OSC) manages a patient's needs. It then describes the hurdles a patient faces in the current healthcare delivery system.

The OSC Scenario

Mrs. L, 87, falls on her way to the bathroom and breaks her hip. She goes into the hospital that contracts with her OSC. It is 20 minutes away from her house. The physician on duty, who works for Mrs. L's health plan, checks her computerized record before examining her and realizes Mrs. L has broken her hip before. The physician advises the orthopedic surgeon of this fact, and the bones are set accordingly.

A care management team is assembled to discuss recovery plans, including a discussion on preventing falls. The team consists of the orthopedic surgeon, her usual primary care manager, a medical social worker trained in home healthcare management, a physical therapist, and an occupational therapist. This team meets with Mrs. L and her family (Mrs. L lives alone, but has two children who live 30 minutes away). In the course of the discussion, it became apparent that Mrs. L usually rushes to get to the bathroom beacause of an incontinence problem. Mrs. L expresses concern that her current limited mobility will make it even more difficult to reach the bathroom in time. She also expresses a strong preference for remaining at home if at all possible. Her children suggest that they are anxious to help, but their time is limited. They do cook three or four meals for her each week and help with laundry, cleaning, yard work, and bills.

The care management team, in consultation with the family, decides that Mrs. L needs more intensive home health assistance, but of an unskilled nature, at least after her condition stabilizes. Until she is more mobile, toileting, dressing, transferring, simple meal preparation, and homemaking could all be problematic. The family chooses to provide about one-quarter of the visits themselves to avoid the higher copayments that Mrs. L's plan requires if she chooses more than 24 hours weekly of unskilled home health assistance. The home health aide will change bedding or clothing as needed during his or her visit. The physical and the occupational therapists are assigned one visit weekly to teach Mrs. L exercises to improve her functional mobility and for self-care to monitor her progress. To assist her in meeting her urinary incontinence problem, a bedside commode is ordered, and she is advised to void her bladder every two hours to prevent any mishaps. It is suggested that, if her condition changes, she could benefit from one of the OSC day care or day treatment programs or one of the intermediate care facilities that the plan contracts with.

Scenarios from the Current System

Scenario 1 Mrs. L is on Medicaid and is brought into Medicare, through the qualified Medicare beneficiary program, but has never used any home health services through the program. In her state a 2176 Waiver program, which allows Medicaid to pay for home care on a budget-neutral basis (when it can be shown that an equal number of persons who receive reimbursement for home health services would otherwise have entered a nursing home), will cover her home health needs. However, there is a waiting list for this program, so Mrs. L's children decide to try to provide care themselves and wait for her to become eligible. She is eligible to receive skilled nursing services, so she is able to use the

to various constituencies, while respecting the confidentiality of the individual member, will be a fundamental feature of the OSC. Information will be used primarily to:

- Improve the performance of the OSC
- Facilitate OSC members' decision making and choice about their care
- Ensure accountability of the OSC to external parties

Information to improve OSC performance will mostly focus on internal management information systems. One hallmark of the OSC is the ability to link clinical and other administrative data. This will allow OSC managers and healthcare personnel to evaluate the necessity and cost-effectiveness of various treatments or processes. Another hallmark of the integrated data system will be components that identify problems or weaknesses within the system (e.g., underservice, overservice).

A second constituency for OSC information will be its members and potential members. Currently patients choose healthcare providers and make decisions about treatment options based on little or no comparable information, thereby calling into question the degree of real choice available. Practitioner proximity, family or friends' recommendations, or personal impressions are often used as criteria in physician or treatment selection.

The future healthcare delivery system will involve the development of comparable information to underlie member choice and decision making. There will be several points around which an individual will make decisions regarding the OSC. The first is deciding which of several competing OSCs to choose. Of particular importance here will be comparable information across OSCs regarding aggregate performance indicators. These might include information on OSC demographics, staff profiles, utilization, quality, member satisfaction, and cost to the member.

CARE WITH THE CURRENT SYSTEM

services of a physical and an occupational therapist.

After three months Mrs. L's children reassess the situation. It has become increasingly difficult for them to meet her needs. The physical therapist has helped her recover some of her mobility after the accident. However, because her incontinence was never diagnosed, no appropriate counseling or care plan was initiated. She generally makes it to the bedside commode but sometimes, particularly in the middle of the night, she wakes up disoriented and ends up with wet bedclothes. It is difficult for either of her children to come both in the morning and at night, so sometimes she goes all day without someone changing her bedding and undergarments. It is also upsetting to her for her children to take on this role. Not wanting to be a burden on her children, she suggests that perhaps she needs to be institutionalized. This would take the burden off her children and would be reimbursed by Medicaid. The children, recognizing the strain on their families and the possibility that their mother will probably need more intensive care in the future, agree to have her admitted.

Scenario 2 Mrs. L has been in her health maintenance organization (HMO) for 10 years, through Medicare, and has always been satisfied with the quality and accessibility of her care providers. The hospital that contracts with her HMO sets the broken hip. She is advised by both the occupational and physical therapist that in addition to their services, she will require homemaking assistance and a home health aide and, if her condition worsens, might need to be institutionalized. She is then referred to a social worker to discuss her options. The first question she is asked is about her insurance for long-term care needs. Mrs. L indicates that she does not have any; she has always used the HMO. It becomes clear that if she decides to get the help that is recommended, she will have to pay for and arrange it herself, although skilled nursing services are available, to be reimbursed by Medicare.

Mrs. L consults her children. They agree to chip in and arrange for minimal home health help, supplemented with their time. Mrs. L's children call the social worker and get the names of three or four home health services. Mrs. L and her children spend a lot of time deciding how much home health help they need, choosing the appropriate agency, and determining what they can afford to spend. However, they realize that this is a short-term solution, as both Mrs. L's children will need to deplete small savings accounts to pay for these services. They are hoping that Mrs. L will improve enough to achieve better mobility on her own. The issue of incontinence does not come up; Mrs. L is too worried about burdening her children further. She is hoping that she will be better able to control herself, and after all she does not lose control every time.

Mrs. L tries to hide her incontinence for several weeks, attempting to hold her urine. When she does have an accident, she does not tell her children or the aide. As a result, her condition worsens and she develops a serious urinary tract infection. She is treated for that condition and receives advice about how to manage her condition by voiding every two hours at a bedside commode. But at this point it is unclear whether these precautions or the present level of home health help will be sufficient. Mrs L's children remain concerned about the long-term feasibility of their arrangements. They hope they do not have to institutionalize her and also wonder how they would pay for it if they did.

To facilitate informed patient choice on entry into the OSC and to ensure continued compatibility between the member and the OSC, comparable information about OSC staff and operations will be made available to each member. For example, information about the following could be developed about the patient care teams: demographic profiles (e.g., training/credentialing, research interests), member satisfaction with the patient care team, statement about team treatment philosophy, utilization, and quality indicators. Armed with this comparable information, the member could then make an informed choice about which patient care team is most compatible with his or her needs.

OSC members would have information about the risks and benefits of various procedures.

Once chosen by a new OSC member, the care management team will be responsible for contacting the member and gathering baseline information. This process will ensure that each member has contact with the system before an episode of illness occurs, allow the member to meet the managers of his or her care, and give team members the opportunity to provide advice regarding potential health problems and preventive measures. The initial member contact will also provide baseline measures, which, when aggregated, will allow an assessment of the OSC's performance, as well as that of the care management team.

In addition, OSC members would have information about treatment options, including the risks and benefits of various procedures. This might include general information about outcomes, an understanding of the process of treatment, cost, and a more personalized assessment of the treatment, perhaps from other OSC members who have undergone the treatment. The process of supported decision making will recognize that each individual's decision is entirely personal but can build on the shared experience of others.

If the OSC member and his or her patient care team decide that specialty care is necessary, the member will also have comparable information about the specialty care provider, including information on the volume of procedures performed, risk-adjusted outcomes, and member cost.

Finally, OSCs will also be required to provide comparable aggregate information to other external parties responsible for monitoring overall performance. Recipients of this information might include public or private organizations that conduct the following functions: accrediting, certifying, monitoring, purchasing, collecting and reporting data, researching, overseeing financial solvency, and sanctioning. Information would be in the public domain and easily accessible by any interested party.

The process of deciding what types of information will be collected, how it will be collected, and how it will be released will include an understanding of and responsiveness to the needs of all OSC customers, including sensitivity to issues of member confidentiality. Although the process must be viewed as dynamic, given the continual evolution of clinical and technological knowledge, there also must be basic agreement on the parameters of information for which the OSC will be held accountable. Once these are clearly articulated and agreed to, the OSC will have wide latitude in managing its performance.

A Fundamental Change

Organized systems of care represent a fundamental change in the delivery of healthcare, one marked by an emphasis on CQI through information, long-term partnerships, and accountability. Although some organizations and healthcare plans incorporate various elements of this vision, the technological and clinical state of the art still precludes full implementation.

In addition, the development of OSCs involves a fundamental change in the relationships between healthcare providers, between patients and their providers, and between providers and payers. The transition to OSCs will therefore be marked by conflicts over authority, responsibility, resource allocation, information, and other obstacles. These obstacles, however, can be overcome if there is the leadership needed to implement the vision—leadership that includes all healthcare stakeholders. □