

Comments on Papers by Steven Shortell-Larry Casalino and Harold Luft  
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These two papers demonstrate the difficulty of tackling small pieces of the current, widely-disjointed and fragmented healthcare system in the United States. Indeed, one can argue that there is no system of healthcare in our country. It is difficult to analyze the value and practicality of individual proposals without having a context of a global vision for a healthcare system in the United States.

Attached is an outline of components for a healthcare system in the United States, the elements of which I will not discuss in this critique, but suffice to say, the recommendations of these two authors would fit into the category of paying for value (V). Indeed, their recommendations would also have an impact in driving towards integration (IV) and improving various models of healthcare under the rubric of the science of healthcare delivery (III). To have any of the recommendations come to fruition would require a true learning organization (I) either as an individual organization providing care or as a national organization in this country.

The topics these two authors touch upon are the relationships between the delivery system and how payments are made to providers. Luft is looking for ways to pay for value, while Shortell and Casalino are defining delivery systems which can create value. Shortell and Casalino seem to begin with the implied assumption that integrated care is better than disjointed care. They are then trying to describe the various delivery systems and estimating what might be the best types of delivery systems that provide the best value. Both authors describe some ways to encourage the development of these systems. Luft's proposal to pay for episodes of care would be one attempt at producing incentives for physicians, other providers, and healthcare organizations to integrate for the purpose of providing the best value specifically related to episodes of care.

All of this begs the simple question of should we pay for value and if so, how do we measure value? Value is quality of care over the cost of providing that care. The true cost is best measured over time (the leather shoe example) and can be related to the lifetime of an individual, an episode of care, or a condition over time. The numerator, quality, has the components of outcomes, safety and service. These components can be defined and measured. Viewed this way, value also equates to efficiency and to productivity in healthcare.

Specific points related to the Shortell-Casalino article:

The main issues they are addressing are what delivery system models create and continuously improve value and how to encourage their formation. An interesting extension of the Shortell-Casalino article would be to actually analyze current existing outcome, safety, service and cost data and align them with their table #3 to see which one of the five delivery system models provide the highest value according to the value equation. It should be noted that the value equation does not include process measures. Many of the current pay for performance models and concepts in the United States are oriented around process and not really related to outcome, safety or service. It is implied,

perhaps mistakenly so, that compliance with process will lead to better outcomes, safety and service, but that has not been a proven linkage in all cases. Process for its own sake is not what we strive for, nor what patients want. There is a real purpose of process and that is to produce the better value (improved outcomes, safety, service at lower overall costs) we all want. Indeed, when we look at tables 4.1 and 4.2, there are approximately 105 items, most of which deal with process. Indeed, it is quite likely that individual medical centers will be able to comply with some or all of these items, but is that really our goal?

The suggestion from Bob Smoldt and I would be to assess the performance of the five delivery system models in relationship to value equation. Rather than looking at long laundry lists of process measures focus on selected outcome, safety and service indicators, relate them to cost and see if it's possible to verify which of the five delivery organizations do provide the best value. Indeed, it might even be of interest to look at the five different categories of delivery system models and find the top value providers in each of those categories. Then find out what processes they use to accomplish higher value healthcare. This analysis might lead to defining the common features of the best performing organizations in each of the five delivery models. This could help develop a roadmap for future tactical recommendations that might stimulate the creation of more value-driven organizations. A hypothesis worth testing could be that the higher value organizations have some fundamental and key common features that lead to high value healthcare. Some features might include: integrated models of delivery; evidenced-based medical practice; electronic information systems; education programs; clinical research; emphasis on new models of healthcare delivery; financial rewards for quality, safety and service; transparency within the delivery organization; a focus on the patient as their core business. There are sources of information through the Medicare data bases, and the university hospital consortium data that would help in this assessment.

In all discussions about redesigning a healthcare system for the United States, I am continually struck by everyone's attempt to actually look for increased value by saying, "we would like to get what we pay for." The simple minded proposal by Mr. Robert Smoldt and me is to pay for value and perhaps we will get it.

## Components of a Health Care System in the USA

### I Learning Organization

#### 1. Professionals

Practice, Teamwork

Education

Research

#### 2. Information: accurate, timely, and reliable

#### 3. System Engineering

### II Science of Healthcare Delivery

#### 1. System, process, project engineering for increasing the value of health care

#### 2. Models of Health Care and Preventive Care delivery

#### 3. Safety reporting, transparency

### III Individualized Medicine

### IV Integration

### V Pay for Value = Quality/cost over time (episode, condition) where quality = outcomes, safety, service

### VI. Insure everyone

Costs, choice, mandates are the challenges