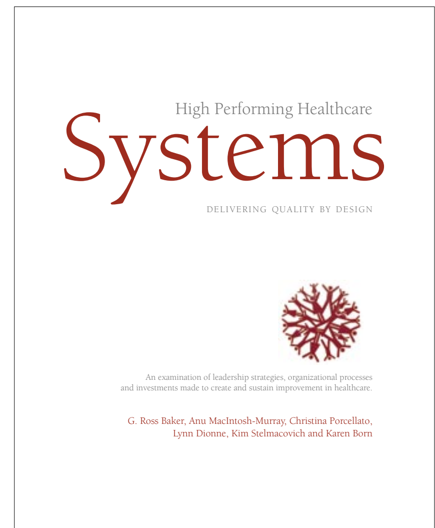
High Performing Healthcare Systems

DELIVERING QUALITY BY DESIGN

Chapter 5
Commentary



Citation Information

Roger, R. 2008. "Commentary: Intermountain Healthcare." *High Performing Healthcare Systems: Delivering Quality by Design*. 179–184. Toronto: Longwoods Publishing.

To view more please visit:

http://www.highperforminghealthcaresystems.com

Commentary: Intermountain Healthcare

Rick Roger, Senior Editor, *Healthcare Policy*
Former CEO, Vancouver Island Health Authority

It is the energy generated by my first exposure to Brent James that sticks with me. The acknowledged champion, architect and major builder behind the Intermountain Healthcare (IHC) success story was presenting at an early 1990s gathering of the Quality Management Network, an extension of the American National Demonstration Project on Quality Improvement in Healthcare. Attendees were treated to a substantial treatise on the measurement and management of quality. Inspired and brimful with new learning to share, I carried a dog-eared version of *Quality Management for Health Care Delivery* (James 1989) for years thereafter, drawing on it with each opportunity to discuss quality with medical or managerial colleagues.

James is IHC's vice-president of medical research and continuing education and executive director of IHC's Institute for Health Care Delivery. For two decades we have listened to his provocative voice and, during that time, James has become a compelling influence rooted in statistical quality control. At that meeting in Boston so many years ago, I thought I witnessed a true force for systems understanding and change – not an economist or an accountant, but a research- and quality-oriented physician moving far beyond the traditional healthcare finance textbooks of the time.

James' work, outlined in the quality, utilization and efficiency (QUE) studies mentioned in the case, featured division of measured costs and observation of input variation and possible waste into physician-related and generic organizational components. Back on the ground in Victoria, we started to augment our own experimentation with *patient*-specific resource consumption profiles with *physician*-specific utilization patterns. These were expressed in numbers or units of nursing workload, commissioned treatments and diagnostic tests. Introducing what we knew of outcome-based analysis, we briefly enjoyed improved relationships with an engaged medical staff leadership. As this portrayal of extended reach illustrates, James had significant influence beyond Utah and IHC, a classic "power of one" situation. This was a case of solid, cause-driven effort combined with the will to make good, witnessed long before Jim Collins popularized the phrase "level 5 leadership" (Collins 2001) to describe exceptional dedication and accomplishment.

Fast forward and we still find Dr. James on healthcare blogs demystifying the connections between quality and cost. Sadly, the thrill of learning for many of us is often coupled with disappointing grades. As Canadian health service providers, do we not find ourselves all too often stuck in a performance management rut, quite unable to achieve the results expected of us? Why, we ask ourselves, have we been unable to connect "will" with "way"? Where and how did we lose traction while IHC and a select few other organizations motored ahead? What are the vital few things we must do better? How can we apply lessons learned? Surely these are among the questions that motivated the University of Toronto researchers to investigate strategy deployment and sustainable improvement.

What mysterious ingredients are necessary for a breakthrough in achievement? Arguably, strong organizational leadership, clear goals, constancy of purpose, good governance, sound organizational tactics, aligned incentives and committed staff members are the most important constituent elements. The IHC case study identifies most of these elements in play, leaving us to wonder: Is it a baseline level of synergy among these factors that sustains progress, or is there more to appreciate in the picture?

As the case study authors acknowledge, it is a daunting prospect to disentangle interwoven tactics, situate observed strategies in context and clarify connections between and among adopted strategies, sanctioned targets, primary tactics and supporting resources. And this might be the most important consequential challenge for us: that is to say, finding ways to draw on the time, intellectual honesty and emotional energy needed to look deeply into our own organizations and the managerial interventions of recent years in order to assess our performance objectively and to view ourselves as others see us. Unfortunately, "we suck" is not quite the engaging mantra sought for our annual reports, or that all-so-important conversation starter with our board chairs.

Spurred by advances in evidence-informed medical practice, a concurrent movement to strengthen the evidence base of managerial decision-making has developed. Although there are formalized approaches available, our immediate purpose here may be better served by the work of Sir Douglas Black. Clinician, statesman and author of a renowned report on inequities in health 35 years after the establishment of the United Kingdom's National Health Service (NHS), Black was known for his sense of humour (one obituary quotes him professing, "My secret is never to retire; I enjoy committees") and respected for his ability to grasp and communicate the material essentials of highly complex undertakings (Tucker 2002). I have adapted Sir Douglas' "daft laddie" questions, initially addressed to advocates of new medical interventions as well as defenders of established practice (White 1992), as a frame of reference:

What is the aim of managerial intervention or set of interventions in question?

The case study authors note several interventions, including structural realignment, the integration of physicians in management, the identification and nurturing of sustaining organizational champions, the development of tools and measures, the formalization of incisive strategy, clear messaging, coalition building, incentive alignment and targeted educational programs. These constructive measures were implemented at IHC in parallel with information system advances focusing on clinical outcomes, procedure management, quality charting, point-of-care communication, patient involvement and cost assignment. Evidence-based clinical process modelling was enabled, in part, by information system technology that was, in turn, improved by the process model prototypes. Fundamental to the observed success, all of this activity was seemingly directed with unwavering purpose at the consistent further improvement of patient care, becoming "ever better" (not necessarily bigger) in response to the vision adopted by trustees early in IHC's history.

Does the intervention do any good? Does it make a discernible difference to anyone?

Coupled with validated results, the awards and distinctions received by IHC clearly indicate that the measures introduced did make a discernible difference. The problem for those looking on is to establish with some degree of rigour what in particular worked, which interventions are best combined with others and what sequencing would be most appropriate in other organizational contexts. More than once during my years as an adherent, I have heard James answer the question "What should our organization do first to gain traction and establish a pattern of positive results?" James' response most often involves developing knowledge and skills using a variant of his advanced training program, which brings in improvement projects and new clinical champions as inevitable by-products. In essence, engage, start the journey and reap

the benefits. So, yes, Dr. Black, a set of interventions worked at IHC, but we are not all that certain which of the ingredients flavoured the stew, and which stimulated and then satisfied the appetite for sustained effective practice.

How many people are potentially able to benefit? What portions of these people actually get help? What system determines who gets this help?

This grouping of Black's questions starts to bring the subject matter home to a Canadian audience. We know from the case study that IHC's market share has stabilized at a level where it provides a substantial – but not a universal – base of coverage, hardly a surprise given that the United States regulatory environment discourages continual growth in regulated markets. IHC does offer financial assistance to qualifying patients and no doubt works to not threaten competitors while responding to community needs. Might it be, though, that what we are observing is a system capable of delivering superior results, but only for a subset of the population? This is not a comfortable possibility for those schooled in the Tommy Douglas tradition. A pragmatic consideration also emerges: How do we start to understand the generalizability of observed results to broader populations? Factors other than care quality enter the equation, but the thinking behind Black's insightful questioning challenges us to address the population scale impact as a primary consideration. No one knew better than Black that the NHS, hardly alone among national health schemes, failed to meet the initial expectation of delivering the greatest health benefits to the least-favoured members of society.

What does the intervention or set of interventions cost? Are there potential substitute interventions at different cost levels? Who pays?

IHC contends that "because of cost-cutting and quality-control efforts, Intermountain's average in-patient charges are 19% lower than the Utah average, according to 2003 Utah Department of Health data, and 27% below the national average" (Intermountain Healthcare 2007). The case study documents efforts to drive out unwarranted cost and to increase affordability, but we are left uncertain as to the cost of the enabling interventions. For instance, although efforts to develop a first-class information system for the enterprise are well described, missing is any attempt to quantify what must be a substantial cost, or to express this as a percentage of the cost per case. The new electronic record under development with General Electric will add to both cost and value, but the hard facts necessary for cost–benefit analysis are not available to us. Conversely, the clinical program regional management team structure is well detailed, and imputable costs appear quite reasonable for this component. Finally, there can be little doubt that the Advanced Training Program has paid for itself several times over with realized savings and cost recovery. Surely Dr. Black would be highly impressed with Dr. James' constructive efforts in this regard.

What impact might the intervention make on the demand or effectiveness of other activities, procedures or services?

Comprehensive analysis of any clinical intervention will document unintended as well as intended consequences as referrals flow from instigating and enabling tests, screenings and treatments. Migrating from the clinical to the managerial world, the answer to the "impact question" emerging at IHC is intriguing to a Canadian audience. The case study provides evidence that IHC's set of managerial interventions is not only working now, but also positioning the organization well for future effectiveness and ongoing accomplishment. The impact elsewhere in the IHC system is readily contemplated: international recognition, more subscriber interest in IHC's associated insurance plans and contracts, easier access to capital, a sustainable critical mass of activity, a shot at improved staff retention and sound medical staff relationships. Outside the organization we should suspect ongoing reactive behaviour from competitors in both the care delivery and insurance markets. All good for IHC, but all very market driven and aimed more at competition than collaboration. Could Dr. Black, were he still with us, conclude anything else?

Upon considering the case study's findings we are left to ponder what they all mean for Canada. What might we learn and what can we adopt? What might we best avoid and where is the roadmap needed to move the agenda forward?

Puzzled by the intricacies of the issues, and with vision clouded by past experience, I am drawn again to James and Black, mapping mind-only dinner conversations with the passionate twosome, one sadly departed for some five years this past September. Unusual guest choices perhaps (ancient philosophers and contemporary entertainers are the predominantly cited candidates in magazine interviews), but the potential understanding gained from the mythical meeting of minds is of great intrigue. It would be such an enriching opportunity to examine the quality implications of contemporary Canadian approaches to primary health, demand management, supply management, incentives and sanctions, technology appraisal, workforce sustainability, end-of-life care, service integration, coordination and patient/client involvement. Although the list of discussion topics is endless, nothing would be more important than to consider the impact of alternative models of medical staff engagement and compensation.

And as my fictional dinner conversation draws to a close, I fancy myself distributing recent press clippings from just about any province, and attempting to steer the conversation to the environment in which we hapless Canadians attempt to engender quality improvement. What must we do to avoid further movement toward what Jim Collins (2001) describes as a "doom loop" with ever- changing executives, destabilized middle management, a shifting array of overlaid strategies, dissatisfied staff members

and questionable results? James would be well positioned to respond with a discourse on the benefits of dedicated effort focused within an overriding and well-understood sense of mission. From Black, I would hope to hear a reminder that, upon honest reflection, well-organized systems based on principles of essential justice and fairness are strong enough to survive any threat. James would no doubt reiterate the importance of education and shared learning. I would be disappointed not to be the recipient of some very straight talk from Black on aboriginal health, housing the homeless and the importance of targeting services to disadvantaged populations within a comprehensive system dedicated to universal accessibility. And somewhere over the evening of conversation, I would seek an assurance from both distinguished guests that we do indeed have enough time remaining still to start doing more of the right things the right way more often than not.

References

Collins, J. 2001. *Good to Great: Why Some Companies Make the Leap ... and Others Don't.* New York: Harper Collins.

Intermountain Healthcare. 2007. *Affordability: Reducing Costs.* Salt Lake City, UT: Author. Retrieved October 30, 2007. <http://intermountainhealthcare.org/xp/public/about-intermountain/affordability/reducingcosts.xml>

James, B.C. 1989. *Quality Management for Health Care Delivery.* Chicago: The Hospital Research and Education Trust of the American Hospital Association. Retrieved January 4, 2007. <http://intermountainhealthcare.org/xp/public/documents/institute/articles_qmmp.pdf>

Tucker, A. 2002, September 12. "Obituary: Sir Douglas Black." Retrieved November 1, 2007. <http://www.guardian.co.uk/obituaries/story/0,3604,791819,00.html>

White, K.L. 1992, September 24. "Health Care Research: Old Wine in New Bottles." Paper presented at the University of Virginia's History of the Health Sciences Lecture Series. Retrieved October 9, 2007. <http://historical.hsl.virginia.edu/kerr/documents/OldWine.pdf>