

# **Reforming the Healthcare Delivery System**

Presented to

Committee on Finance

United States Senate

By:

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April 21, 2009

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**Statement of  
Glenn D. Steele Jr., MD, PhD  
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Thank you for the opportunity to submit this statement for your Roundtable on Reforming the Nation's Healthcare Delivery System.

At Geisinger Health System, we serve a population that is poorer, older and sicker than the national average. Most of our patients have multiple chronic diseases, such as diabetes, high blood pressure and lung disease. Our patients have difficulty navigating through a complex healthcare system. They need help and we have made a concerted effort to put into place electronic and other innovative methods that will provide them with the assistance to maximize their ability to get care.

At Geisinger, we hold ourselves to high standards of assuring quality outcomes in serving these patients. For example, if a patient is readmitted to a hospital after a procedure or an in-patient stay, we believe we have failed that patient. Consequently, we have committed significant resources and have worked aggressively to bring value to healthcare and eliminate failures by redesigning how we provide care.

The innovations we have instituted at Geisinger that bundle payments for acute care procedures, enhance support for primary care physicians and their care teams, better manage chronic disease and the transitions of care for patients from caregiver to caregiver, have produced significant cost

savings and improved quality. Admissions for our patients with multiple chronic diseases have been reduced by as much as 25% and readmissions following discharges decreased by as much as 50% in community sites. I believe that what we have accomplished can be adopted nationally and will achieve similar cost savings while improving quality. This would result in significant positive consequences for large payors, particularly Medicare.

## **BACKGROUND**

I am Glenn Steele, the President of the Geisinger Health System, an integrated healthcare organization located in central and northeast Pennsylvania. Before coming to Geisinger, I spent 20 years as a practicing cancer surgeon at several Harvard hospitals and served as a Chairman of the Department of Surgery at the New England Deaconess Hospital. I then became Vice President for Medical Affairs and Dean of the Division of Biological Sciences and the Pritzker School of Medicine at the University of Chicago. Consequently, I have firsthand experience with patients, their access (or lack of) to care, issues that affect physicians and other caregivers in providing adequate and timely care, and the difficulties in juggling medical education and research, while facing ongoing changes in healthcare reimbursement.

In 2001, I came to central Pennsylvania because Geisinger offered the potential as an integrated healthcare system of developing cutting-edge approaches to increasing efficiency, value, and quality in healthcare. In short, we could attempt to transform healthcare using both our healthcare insurance product, and our clinical delivery system working together to benefit our patients.

We serve a population of 2.6 million located in central and northeastern Pennsylvania. And we have an electronic health record (EHR) that was implemented 14 years ago with now more than

3 million individual patient records. Geisinger has been named as “Most Wired” by *Healthcare’s Most Wired* magazine six times. We have our own health care insurance product - Geisinger Health Plan - that has nearly 235,000 members, 35,000 Medicare beneficiaries, 18,000 empanelled physicians, 90 hospitals (not including our Geisinger hospitals) and spans 43 of Pennsylvania’s 67 counties.

We also lead our area’s regional electronic health information sharing platform<sup>1</sup>, called the Keystone Health Information Exchange, with (currently) ten hospitals and approximately 700 private practices sharing valuable medical information. This secure, patient-approved sharing of information means that our doctors, and more than 1,500 non-Geisinger caregivers can access patient information 24/7 from anywhere – a remote two-doctor primary care office, a multispecialty clinic, an operating room, or at 3:00 am from home.

Our patients access their own electronic health record. They can see their lab results, radiology results, request prescription refills, and email their doctors, nurses, and staff with questions anytime. And, they schedule their own appointments on-line.

Geisinger has a large number of elderly patients (many greater than 80 or 90 and more and more now exceeding 100 years of age). Most have multiple chronic diseases and have family living outside of our area who follow their parents’ care through the electronic record (with appropriate patient approval).

Geisinger employs about 800 physicians who see patients in more than 50 clinical practice sites; 38 of which are primary care sites in local communities. As clinically appropriate, physicians in these clinical sites admit their patients to nearly 20 local community hospitals - ensuring that

patients receive most of their care near where they live. Only if necessary, are Geisinger patients treated at one of our three specialty hospitals.

Geisinger's innovation<sup>2</sup> is intended to attack fundamental flaws in our country's payment for and delivery of healthcare. The U.S. suffers from a variety of reimbursement and care delivery issues that do not produce good clinical outcomes. There is wide and unjustified variation in care. Fragmentation of care is rampant; our "hand-offs" (that is, transferring important medical and family information as patients are moved from one environment to another) are disjointed and most often result in patient care that is not coordinated and is confusing to the patient. We have a perverse method of payment – one that rewards units of work regardless of patient outcome. At Geisinger, we invest in quality and pay accordingly. Doctors who have better clinical outcomes are rewarded (financially and by recognition) and we constantly measure our outcomes against our peers, both within Geisinger and nationally. Physician, staff and site incentives are built into our system. And we reward quality and value, not just numbers of patients seen or numbers of procedures performed.

### **GEISINGER'S ACUTE EPISODIC CARE PROGRAM (THE "WARRANTY")<sup>1,2</sup>**

A great paradox in U.S. healthcare is that we get paid for making more mistakes. For example (with few exceptions), if a patient develops a post-operative complication that might have been avoided by proper care, we often receive more reimbursement for that case than for a comparable case without a complication. This does not happen in other industries. Why are healthcare services an exception?

Consequently we believe our care design should be based on best evidence. In 2006, we started tackling the perverse payment incentives noted above by redesigning how we provide elective

cardiac surgical care – what is known as coronary artery bypass grafts (or CABG)<sup>3</sup>. CABG is an episodic acute event – an event with a determined time frame from diagnosis through rehabilitation and recovery (unlike chronic disease, which stays with you for life). Our cardiology service line reviewed the American Heart Association and the American College of Cardiology guidelines for cardiac surgery and translated these into 40 verifiable best practice steps that we could implement with each patient undergoing this surgery. We hardwired these into our electronic health record so that we would be prompted to meet each identified step – or document the specific reason for any exception.

We then established a package price that included costs of the first physician visit when surgery was deemed necessary, all hospital costs for the surgery, and related care for 90-days after surgery, including cardiac rehabilitation. We named this program “ProvenCare”, since it is based on evidence or consensus of best practices by our heart experts. Pre-operative, post-operative and rehabilitation are part of the single charge. And we take the financial responsibility for any associated complications and their treatment.

While our cardiac surgery outcome was already well above the national average, (and near the top of Pennsylvania’s PHC4 data set) upon initiation of this program only 59% of patients received all 40 best practice steps. Three months into the study, 86% were receiving best care. We raised that to 100% and, with few exceptions, have kept it at that high rate.

As a result of implementing this “warranty” program, our patient care was better – using comparative, standardized data from the Society of Thoracic Surgery. We had a reduction in all complications of 21%, sternal infections were down 25%, and re-admissions fell by 44%. Costs for treatment fell, too. Our average length of hospital stay decreased by half a day<sup>4</sup>.

For other high volume, hospital-based treatments, we have now considered every step in the patient's care flow. For instance, in orthopedic surgery, why should one doctor use one set of surgical instruments and prosthetic devices and another insist on a different instrument set-up for the same procedure? That type of variation often has no medical justification, results in unnecessary costs that are passed off to third party payors (such as Medicare) and, we believe, compromises patient outcome.

We have expanded our experience with heart surgery to “warranty” programs that include: hip replacement, cataract surgery, obesity surgery, prenatal care for babies and mothers (supported by the March of Dimes) – from an infant's conception to birth, centrally- managed, evidence-based use of high cost biologicals, such as EPO (erythropoietin), and heart catheterization.

We have improved outcomes and have reduced costs. This is because we have systematically researched how best to deliver care, hardwired the process steps into our electronic health record to prompt us on what best practices are, decreased unjustified variation, and taken financial risk to decrease related complications.

### **PROVENCARE – CHRONIC DISEASE**

In reforming how we deliver care at Geisinger, it isn't enough to simply address acute episodic care. The major challenge of healthcare in the U.S. is now chronic disease treatment and “secondary prevention”. We identified the most common chronic diseases – diabetes, coronary artery disease, congestive heart failure, kidney disease – and have applied evidence or consensus-based best practice thought to limit disease progression. Called “bundled” care, we have designed each of these steps into our care pathways and strive to achieve as close to 100% adoption as medically appropriate and feasible. In the case of diabetes, we began to track how

we performed in meeting 100% of the expected “bundle” of best care for diabetic patients three years ago. Our primary caregivers have chosen to receive compensation based on how many of their 25,000 diabetic patients reach optimal levels in the practice “bundle”, not solely on how many patients are seen each day or how many tests are ordered.

### **PROVENHEALTH NAVIGATOR (ADVANCED MEDICAL HOME)**<sup>3,4</sup>

Geisinger’s patient-centered medical home initiative (called ProvenHealth Navigator) combines traditional medical home models with patient engagement and is designed to deliver value by improving patient care coordination throughout the system. Our Advanced Medical Home currently covers 30,000 Medicare recipients and 3,000 commercial patients, with plans to expand this base.

We understand that navigating through the complexities of any healthcare system is not easy, so we have invested in programs and staff to help support each patient’s journey, placing dedicated nurses in each targeted outpatient clinic. Over 200 Geisinger primary care physicians diagnose and treat their patients locally in 38 community practice sites. Our “embedded” nurses are paid for by the Health Plan, becoming critical members of the community practice team and, with the physicians, are expected to know the patients and their families, to follow all of their care, help them get access to specialists and social services as necessary, follow them when they are admitted to a hospital, contact or see them when they are sent home to confirm that they are taking the appropriate medication dosages, and be available for advice 24 hours a day.

Importantly, we don’t just ask these community-based clinicians to “try harder” or “work faster”; we use resources from our health plan to help redesign their work. And, we pay incentives for getting the job done. In our best practices, our sickest chronic disease patients’ admissions were

decreased by 25%, days in the hospital decreased by 23%, and readmissions following discharge decreased by 53%. The payback for the health plan occurred within the first year. The benefit to patients and their families avoiding multiple hospital admissions was immeasurable!

For these patients with multiple chronic diseases, transport to and from the hospital or clinic, choosing which doctor should be seen, coordinating their numerous prescriptions, getting their pills, making sure they take their pills at the right time – all of this is what our ProvenHealth Navigator work redesign accomplishes. Increased quality for the patient and their families actually lowers healthcare costs.

## **SUMMARY**

Building on what we have done at Geisinger, I have these recommendations for your consideration:

- payment reform is needed to encourage integrated health care organizations and other providers to be accountable for results and resources
- primary care and patient-centered medical homes need to be rewarded
- a global fee covering hospital, physician, and other services including 30-day follow-up for acute episodes of care is needed
- consider capitation payments linked to quality outcome measures for prevention and chronic care services
- help fund enabling information technology but insist on non-proprietary interoperability

- help hospitals and communities establish transitions of care programs to reduce unnecessary admissions and readmissions.

Thank you again for the opportunity to submit this statement for your Roundtable on Reforming the Healthcare Delivery System.

### **References**

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