Discussion A on Article 4: Rethinking Healthcare

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It is hardly surprising to come across one more study documenting the serious shortcomings in healthcare services. The methodologies for these studies usually entail using interviews, survey instruments, and various statistics to analyze the problems found in the work environment. The findings often show incorrect medical diagnoses, insufficient and incorrect treatment plans, and similar attributes of a badly managed care system. Added to this is the frustration of poor communications, long waits for treatment, and low staff morale. Obviously, the conclusion is that something must be done to better coordinate and orchestrate the relationship between patient and care provider.

The researchers’ logical and appropriate response to these findings is to call for the development of work-flow management tools, integrated patient care databases, and communication networks to link medical services. They also call for new integrated organizational structures to humanize the work environment, adding quality circles, team coordinators, and patient care managers. This approach is very much along the lines of tackling the operational issues in patient care by adding technical tools and supervising and coordinating personnel. Given the complexity of the problem — high case loads, a lack of funding, and the demand for increasingly sophisticated treatments — most people would be happy with modest changes or improvements.

On the other hand, some researchers look to a complete overhaul as the only way to address a potentially failing system. The rationale is that while technical tools such as integrated databases and work-flow scheduling tools are necessary, they are not sufficient. A more integrated solution is needed: one that addresses all stakeholders, from patients and medical staff to hospitals and insurance providers. This is an optimum case for reengineering.

For healthcare reengineering to be successful, each of the stakeholders must become active participants in the strategic realignment of medical services. One successful example of this strategic repositioning is Kaiser Permanente (KP), a huge health maintenance organization in the U.S. KP is a healthcare provider in that it owns hospitals and clinics, employs physicians and hospital staff, and also provides healthcare insurance for millions of patients. It is therefore in a unique position to change the work environment and reengineer services to all stakeholders.

The following data provides a brief summary of the numbers and scale of Kai-
Permanente, which is comparatively the size of a small country:

- 8.2 million members
- More than 11,000 physicians
- 134,000 employees
- $25.3 billion in annual revenues

The KP model builds an integrated care management environment from the perspective of its major stakeholders. It uses information technology to identify and target groups at risk. By measuring and analyzing medical outcomes for these groups, it can establish a database of evidence-based medicine. This medical data set is then available throughout its healthcare network and provides the basis for stakeholder accountability.

This can be illustrated by turning to one of its principal database findings: Chronic illness drives medical care costs. The 6% of the care population with multiple chronic conditions generate 33% of total care payments. Knowing such facts, KP focuses attention on critical populations and justifies the investment in training, personnel, and IT systems. The financial incentive of reducing costs is clearly one of the driving forces of this model.

Similarly, the integrated IT database system helps define and identify evidence-based medicine and successful practices. These become KP’s medical guidelines, which help to deliver care more intelligently. The practical outcome is to lessen the trauma to the patient, shorten the hospital stay, eliminate causes for malpractice suits, and reduce the overall financial outlay by as much as 30%. An example of this would be the area of preventive medicine, where early diagnosis and focused treatments can dramatically improve a patient’s health and drive down associated costs of treatment.

It is in the self-interest of the stakeholders to participate in the development and active use of new systems and procedures that change the care environment.

In essence, the KP model provides the IT resources for accountability, communications, and coordination. Within this core, demonstrated quality practices such as preventive medicine become the norm. KP works on medical grounds as well as on financial ones since statistically proven medical practices often prove to be the most cost effective. This coherent policy justifies the necessary capital investments, staffing modifications, and work-flow improvements. In turn, the KP model shares the financial outcome in the form of lower premiums to patients and higher bonuses to medical staff.

The KP model does not just address work-flow issues or patient management issues, but the overall processes. If you build a narrow system, it solves narrow problems, and sometimes these problems move to other areas. There is also a greater return on the investment in hardware and software when these resources address the overall care environment, from the early stage of preventive medicine on to the management of chronic disabilities. The efficiency and effectiveness of the healthcare system is therefore measured and evaluated by its accountability to its stakeholders.

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