REDESIGNING CARE: Jamie Robinson Interviews Virginia Mason CEO Gary Kaplan

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By James C. Robinson and Gary S. Kaplan

Editor's Note*: Why have so few provider groups undertaken the self-analysis that the Virginia Mason Medical Center (VMMC) entered into through its use of the famed Toyota Production System, even before Aetna and large employers began to push VMMC to cut costs? This is just one question posed by James C. Robinson, Berkeley economist and incoming* Health Affairs *editor-in-chief, in his interview of Gary S. Kaplan, the chairman and CEO of VMMC, for the* Health Affairs *Blog. In the interview below, Kaplan discusses VMMC's efforts to re-engineer care as well as structural and cultural obstacles to system-wide quality improvement. For more on the VMMC experience, read the* Health Affairs *Web Exclusive* *published today [2-week free access] and the issue brief published by the Center for Studying Health System Change.*

James C. Robinson: The description of the Virginia Mason (VM) program, published in *Health Affairs*, emphasizes the role of the insurer (Aetna) and the large employers in the Seattle area as the driving force behind the transformation. **But VM was engaged in its self-analysis using the Toyota model before Aetna developed its high-performance network strategy and before the employers became aroused.** What was the value added, from your perspective, of having a health plan participate in this as distinct from Virginia Mason alone continuing down its path of self-analysis and process improvement on the Toyota Model?

Gary S. Kaplan: The interest of Aetna in the work we were doing and the development of their Aexcel network was quite serendipitous. We were already well along the path of improvement utilizing our management method, the Virginia Mason Production System [VMPS], modeled after the Toyota Production System, which we had adopted in 2002. **Our focus has been on taking waste out of all of our processes.** The Aetna data were presented to us and, as our teams assessed the data through the VMPS lens focused on waste reduction, it was obvious to many that we could and should be able to remove waste and perform better in terms of the Aexcel data.

Robinson: Do you think, in retrospect, that the primary contribution of Aetna was in the form of better data of the type that you didn't have internally or, rather, that it was more the risk of losing the Aetna contract, at least for some services, and therefore potentially losing patients?

Kaplan: I think that for our clinical teams it was really a combination of factors. We were fortunate in that we had identified new ways to respond to marketplace issues such as those being presented to us. Rather than defaulting to the usual conventional resistance of many physician groups, including historically our own, by challenging the data or attempting to use market clout or prominence in the community to pressure the insurer, we actually decided to roll up our sleeves, apply our VMPS tools and form a unique partnership with the plan and the employer community.

Role Of Specialty Care Clinics

Robinson: Could you discuss the role of specialty care clinics at Virginia Mason? There's a lot of discussion around the country concerning the internal reorganizing of hospitals, health systems, and medical groups along specialty service lines. There may be a trade-off between the virtues of focus and specialization, on the one hand, and the virtues of coordination across specialties and service lines, on the other.

Kaplan: Our philosophy at Virginia Mason is that both are critically important. We talk a lot about team medicine at Virginia Mason, and that's really a description of the way we've approached care delivery virtually since the beginning of the organization in 1920. As you probably know, we were one of a small group of clinics formed in the years between 1915 and 1925 in the Mayo Clinic model. Teamwork and collaboration as cornerstones of multispecialty group practice have been very much part of our roots since the beginning. We have traditional departments of medicine, surgery, radiology and other specialty care services, like most institutions. This is the traditional academic model and most hospitals and medical centers with physician training programs like ours have been structured this way for many years. But we also, increasingly, are developing a mindset focused on service lines.

As part of our VMPS work we consider the entire "value stream" from the perspective of our patients, our customers. We consider how the patient enters the care-delivery system with a particular diagnosis, and the components of the value stream that may or may not be value-added. What we found in our work, as is described in the *Health Affairs* article, is that **for many**

diagnoses, the value stream has included a lot of waste — a lot of non-value-added diagnostics and therapeutics.

Revamping The Payment System

Robinson: And as you move down the road along this specialty clinic or service line path, what is your view of changing payment methods away from fee-for-service and towards an episode of care or outpatient DRG [diagnosis-related group] model?

Kaplan: Anything that better aligns reimbursement with the value-added diagnostic and therapeutic elements of care makes sense. How that occurs and the economic implications are critical. Today the fee-for-service payment system doesn't do that.

You used two examples — fee-for-service and episode-based care — I don't know if those are the only two options. I'm not trying to dodge the question and **I do think that we have to find a better way to get paid. I think that fully funded capitation that was better aligned with delivering value would be one way; DRG-based care, if determined to be fair payment, would be another.** The current fee-for-service payment system and the current way of valuing services needs to change if value-based care delivery is to be embraced by physicians and hospitals across the U.S. **Most conventional pay-for-performance, as I think about it, is going to pay incrementally a relatively small amount for doing the right thing, as opposed to incentivizing us to not do the wrong thing** — not to do the things that are a tremendous amount of waste in the system — **and I think that's where the big savings in care and the biggest opportunity lies.**

Robinson: The Virginia Mason experience is the best example of the pathology of fee-for-service payment, which essentially levies a 100 percent tax on improvements and efficiency. Capitation works well where it works well, and being from California I see where it works well. But a lot of physician organizations such as Virginia Mason found capitation did not work for them and went backwards towards fee-for-service. What have you inferred about capitation from a Virginia Mason perspective?

Kaplan: For a period of time we had our own health plan, from 1985 to 1997 — and that was a capitated plan. But being in the insurance business, although eventually profitable for us was not our core business. In terms of taking capitation, we had clear reimbursement issues with our own

plan and others with whom we participated at that time because our AAPCC [adjusted average per capita cost] was not good. We were penalized for our longstanding cost-effective care patterns in the Pacific Northwest.

Robinson: **Medicare pays most to the least-efficient providers.**

Kaplan: Right and we know that commercial insurer payment rates usually shadow Medicare. For us it was more a level of funding than the philosophy of capitation. Today, as we've come to think of care along the value stream, **I think a fully funded capitated product would really better align incentives.**

Robinson: **America has been on a drunken fee-for-service binge over the past five years**, and now we are seeing what you get from incentives to do more and more and more…

Kaplan: …And there is the added impetus to cost escalation of new technology and the ever-increasing expectations of our patients.

Physician Groups And Self-Analysis

Robinson: Is there some irony to the Virginia Mason experience — and as other health plans push the strategy of high performance networks — that insurance companies are using data and incentives to push the providers to look at themselves, when one would hope that the physicians would be doing that as part of their core practice? This self-analysis is what Virginia Mason was engaged in through its Toyota experiment. But as we look around the country, there are unfortunately few other examples. **What do you think it is about the culture of some physician groups or independent practice associations [IPAs] that makes them act more like guilds, protecting themselves, rather than as entities engaged in self-analysis and self-improvement** of the type that Toyota modeled?

Kaplan: Well, that's a complicated question. The history of modern medicine has been characterized by innovation and scientific discovery, so I wouldn't want to say that we haven't been focused on many of the right things. Yet we haven't had organized systems of care to the extent that we could. **The percentage of physicians in this country that are in multispecialty group practices with an infrastructure to really support improvement is still a small minority.**

I think much of our training, socialization — you used the term guild system — the liability climate, expectations of patients and other factors have spawned the feeling amongst physicians that autonomy is critical. This is an issue that works against continuous improvement and collaborative work. **At times this has fed the notion that one's personal economic interest was paramount and this is certainly not what American medicine should be about.**

Our Toyota work, just to put it in perspective, is really the management method of our entire institution and this has been the case for the past six years. I just came back from Japan this morning along with another Virginia Mason team of physicians, nurses, managers, and leaders to further our training, and it continues to be a very powerful experience.

Consumerism And Employer Activism

Robinson: One of the buzzwords of today in health care is consumerism, the role of the individual consumer — more informed and spending more of his or her own money on healthcare. Your example of process improvement and quality improvement was driven, however, not by individual consumers, but by the insurer, and, behind the insurer, by large sophisticated purchasers. What is your thought about the importance of the large purchasers as an ongoing process in stimulating efficiency improvement in healthcare?

Kaplan: At the present time, and you would know the statistics, the employer community is a major driver of care. Over fifty percent of employers still provide some healthcare insurance for their workforce and so they are a critical part of the care delivery system. I think that employers bring a lot of resources and creativity.

One of the things that characterize our project, which is described in the *Health Affairs* article, is unprecedented collaboration with employers including having their representatives from top management — human resources and employee benefits — involved on our Kaizen teams and very much at the table in this work. That was a very powerful influence and helped our physicians and care delivery teams enormously. So it seems there is a more constructive role they can play that could help mitigate the trend toward more cost shifting to employees or employers opting out of providing insurance altogether for their workforce. That's not to say that one way is better than the other, but I do think the employer marketplace will continue to be critical and represents a great opportunity for innovative partnerships. Dr. Robert Mecklenburg at Virginia Mason has been

leading much of this work with employers in our marketplace and the results have been quite gratifying.

Robinson: **Your experience is a word of warning to some of the policy pundits on the far left and the far right** of the political spectrum who fantasize about a healthcare system without employers playing any role whatsoever, and with the individual or the government doing everything.

Kaplan: There are enlightened employers like Howard Schultz, for example, at Starbucks — he feels that every barista is entitled to healthcare and of course he and his management team are still very concerned about the line-item expense for healthcare.

A Culture Of Efficiency And Improvement

Robinson: Switching back to Virginia Mason itself, we've talked about the role of external incentives and payment methods for influencing the organization. How do you compensate your physicians internally to support and sustain a culture of efficiency improvement?

Kaplan: First of all, we select people in our recruitment process who are interested in improvement and making a contribution to their specialty and to the improvement of care delivery. We have a strong ethic around teamwork, academics and improvement. We have incentives, both time and money. **People get credit for a variety of improvement activities**; committee work that allows that to happen; and participation on VMPS rapid process improvement workshops and in workgroups such as the Kaizen teams that focus on low-back pain, migraine, and cardiovascular work. We work hard to ensure that we are not disincentivizing things that we as an organization highly value.

Robinson: To what extent is Virginia Mason able to promote the use of guidelines and other standardized approaches to care to reduce the variation of practice patterns within the organization?

Kaplan: I think that is a core competency of our model of group practice. Frankly, we believe our structure is a competitive advantage. It also helps us to accelerate our work to do the right thing and to help transform healthcare. This is something that we at Virginia Mason very much want to do.

I also think that in addition to being structured right, we're sized right. We're not talking about transforming specific care delivery patterns for a mega-hospital system, but for a multispecialty group practice and a single medium-sized hospital. We have committed leadership at all levels of the organization, and not insignificantly we have a method. The method is the VMPS and it really has taught us to see in different ways, to focus on our customers and understand our value streams. That's how we think about care delivery and **it is becoming quite clear that there is great opportunity to provide only those services which truly add value for our patients.**