



James L. Reinertsen, M.D.



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Questions were provided by: Drs. Brent Asplin, Lee Beecher, Abdhish Bhavsar, Donald Jacobs, James F. Peters, Frank Rhame, Janette Strathy, and Peter Wallskog.

What are you most optimistic about when it comes to health care reform over the next 10 years?

Politicians and policymakers now are faced with trying to explain why we should continue to send two to three times as many Medicare dollars to Miami as we do to Minneapolis, with the same or even worse outcomes. I'm optimistic that, over the next 10 years, the work of Wennberg, Fisher and others will finally bring about a fairer, more sensible distribution of the resources we already have.

How do you envision our future health care systems managing the increasing needs of patients with complex/chronic diseases?

The Wagner Chronic Disease Model would appear to be the best blueprint available for caring for patients with chronic, complex diseases. Wagner's model works. Chronic disease patients get better outcomes when informed, activated patients interact with prepared, proactive practice teams, especially when those interactions between patient and care team rest on a base of self-management support, registries and other information system tools, and redesign of the care system to focus on chronic, rather than acute problems.

Do you think that primary care specialties will have roles in future health care models?

The Wagner chronic disease model provides a good case example of the pivotal, but different role that the primary care physician might play in the future: as captain of a multidisciplinary team (but perhaps not as an authoritarian "captain of the ship"). The quality of relationships that are built between primary physicians and patients has always been, (and to my way of thinking, will always be,) the most powerful determinant of whatever it is that makes ours a healing profession. But we can't do it all by ourselves. We must organize a system of care that makes the highest and best use of everyone involved—patients and families, as well as professionals at every level and type of training—if we're going to care for the oncoming demographic wave of elderly patients with chronic conditions.

If you had to pick one change in our health care system that would make a difference, which would be your first priority?

I've often asked this question of others, so I suppose it's fair that I should have to give my own answer. If I were king (which, thankfully, I'm not) my first health care decree would be to create universal coverage for all evidence-based preventive and catastrophic services, as a right of citizenship, supported by a broad-based tax. In other words, no American would get a preventable illness because of lack of ability to pay, *and* no American would lose all her savings, or the family farm or the small business, because she got really sick and piled up big bills. I might be simple-minded, but that's what I think of when I hear the word "insurance."

I think we could pay for those two items (preventive and catastrophic insurance—the latter on some sort of sliding scale based on income) with less money than is currently going into the health care

system. And as king, I'd make it a royal service—i.e. a single national payment method—to minimize the ridiculous administrative expenses and complexities that plague our current system.

And what, (you might ask) would His Majesty do about all the other services that aren't either preventive or catastrophic? For example....

- The knee that aches after you walk around Lake Calhoun, and for which you think you ought to get an MRI “just to see what's going on?”
- The headache that worries you, especially since your neighbor had a brain tumor, and you aren't really reassured by your primary MD's examination so you want to see a neurologist?
- The springtime hayfever that causes two weeks of sneezing and eye-watering, so you want to get allergy shots?
- Etc.

I'd suggest that all these non-preventive, non-catastrophic “nice to have but not absolutely necessary” services either be borne as personal expenses, or be part of a private insurance system.

In my kingdom, no one would have to get a preventable illness, no one would go broke or lack access to care if they got really sick, and the public could make value judgments with their own money on everything else.

Many physicians see attempts to standardize care as “cookbook medicine.” How do you view these standardization efforts and what suggestions do you have for physicians who continue to struggle with them?

I find it fascinating that when physicians (e.g. cardiologists and cardiovascular surgeons) start their own specialty hospitals, one of the first things they often do is to require that all the physicians rigorously standardize to one method for many common processes. They quickly learn that doing common things in a common way reduces complexity, decreases errors, improves workflow, reduces “rework” and personal hassles through the day, and improves patient outcomes. Yet, the same physicians resist standardization as “cookbook medicine” when it's promoted by a hospital administrator or a health plan medical director.

I don't think standardization is a bad thing. In fact, I think that if physicians got together and decided on one way to do sliding scale insulin, and “start heparin,” and other common hospital orders, and developed similar common methods for using common outpatient procedures and treatments, we would save precious time in our day, produce fewer errors, and get better results for our patients. The data are very clear now, from a number of different types of institutions, that standardized medical staff-wide standing order sets are a key component to improving quality.

We can't standardize everything. Every patient's care requires some custom-crafting. That's the art of medicine. But we can standardize within the science of medicine, and we should. Our patients' lives, and well-being, are at stake.

I heard an interesting statement from a nurse/quality leader in a Southeastern U.S. hospital recently. When one of the physicians on staff was resisting using a standing order set for acute MI because he saw such order sets as an infringement on his autonomy, she asked: “So am I to

understand that your autonomy is more important than your patients' outcomes?” I am beginning to think that her question might be the best response to those MDs who are struggling with this issue.

If you were the Dean of a medical school, what key changes would you initiate to prepare physicians for managing patient care into the future?

The best current blueprint for preparing physicians not only to work in but also on the system of care has been provided by the ACGME under the leadership of David Leach. If I were the Dean, I would ask “How can I prepare my students to be ready to ace the ACGME requirements they'll have to pass when they do their graduate medical education?”

Do you favor Minnesota legislation allowing for-profit insurance plans and HMOs into the Minnesota marketplace? Explain.

The genesis of my answer can probably be understood by reading the “If I were King” answer above. The quality of care that's delivered is primarily determined by the care delivery system in which you get your care—not by which plan you belong to. So I find it hard to believe that it would make much difference one way or the other for the quality of health care in Minnesota if for-profit plans came to the state. On the cost side, however, two things that take dollars from care would go in the wrong direction: administrative costs (mainly on the provider side, because they'd have to deal with more plans, more fee schedules....) and advertising budgets (for all the plans). So on that basis—no, I wouldn't favor it.

Do you favor the development and use of physician report cards based on adherence to clinical care guidelines, such as ICSI's? If so, who will pay for them? Could they be reliable and valid?

I have long felt that physicians should be held accountable for those quality attributes they can control. I think the two main aspects of care that are under physician control are their knowledge of their craft, and the quality of relationships that they and their office teams build with patients. So I'd be OK with report cards on board scores, say, and patient satisfaction, by doctor.

Adherence to guidelines, on the other hand, is more of a group practice, or office, or hospital, or “system-level” attribute than an individual physician attribute. Physicians have a lot to say about how systems perform against measures like “percentage of diabetics who get a HbA1c measurement” but these guideline adherence measures are also powerfully influenced by the presence or absence of an electronic diabetes registry,

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a prepared nurse and office team where all members are working from the same standardized method, and other factors that go well beyond the reach of any individual physician. I think we should have report cards on adherence to guidelines, but they should be reported by offices, or groups, not by individual physicians. Wisconsin provides an excellent model for this sort of reporting. (See <http://www.wiqualitycollaborative.org>)

Given the impending shortage of physicians predicted in the next few decades, a condition usually associated with higher consumer costs in a market driven system, how do you foresee the financing of health care systems into the future?

Health care economics bear little or no relationship to anything like a market driven system, so I really can't answer the question as framed. In health care, a shortage of physicians predicts lower costs, and high numbers of physicians are associated with higher costs! This is because we have created a system in which one of the primary features is so-called "supply-driven demand."

If any aspect of the financing system has to change, it would be the current perverse practice (exemplified best by Medicare) of sending even more money to oversupplied areas of the country, thereby attracting even

more physicians to practice in those areas, thereby driving the total costs even higher...in an endless sort of upward cost spiral.

In this age of increasing consumerism, do health care organizations still have the same responsibility for stewardship over health care spending? If so, how do providers balance the tension of providing both what the patient needs and what the consumer wants?

Consumers have access to enormous amounts of health care information—some valuable, some worthless. Often, this information creates requests for services—again, some valuable, some worthless, some even harmful. The physicians who hear these requests are put into a variety of difficult positions—from the temptation to render a desired, unnecessary, but highly remunerative service for one patient, to the role of having to say “no” to the exact same service for the next patient, who is identical in every respect to the first patient except for a different type of plan coverage and physician payment contract.

From my perspective, the only way to deal with these issues is to create the “King” scenario described above in which there would be a real marketplace for those services which fall between preventive and catastrophic. In other words, the person requesting these “nice to have but not absolutely necessary, or marginally valuable, or not even indicated” services would also be the person who was paying for them. So the “consumer” would become a value-conscious “customer,” and the physician would become a value advisor to the patient.

The role of value advisor would still be a stewardship role, in a way. It's just that it would be the patient's money that the physician would be charged with spending wisely, not the health plans'. I think that would make all the difference.

By the way, I do not believe we could, or should, ever create a marketplace for preventive or catastrophic services. The evidence suggests that people put far too low a value on preventive services to pay for them years in advance of whatever they might prevent. And when you're desperately ill is the very worst time to become a value shopper. It's in the “middle zone” between basic prevention and catastrophic services that market forces might have the best chance of improving quality and value in health care. ⇒