EDITORIAL

California’s Integrated Healthcare Association

David B. Nash, MD, MBA

Once in a very long while, we all attend a medical meeting that changes our long-held beliefs about a particular subject or process. I recently had the privilege of addressing the Integrated Healthcare Association (IHA) in Northern California. Formed in late 1994, the IHA is a 36-member leadership group of California health plans, physician groups, and health care systems along with at-large representatives of academic purchasers, consumers, and pharmaceutical companies. Beau Carter is the group’s very able executive director.

According to the IHA’s own materials, its official mission is “to promote the continuing evolution of integrated health care supported by financial mechanisms that align the incentives of purchasers, payers, and providers as the best means to achieve positive outcomes for the patient and the general public.”

In carrying out this mission, the IHA plays four additional complementary roles, including policy development, education, project management, and convener of cross-cutting health care issues. I attended just such a convener-type meeting in Oakland, California, regarding the future of disease management in the U.S. Now this might seem like a fairly dry academic exercise, but when you gather around the table such key national leaders as Peggy O’Kane, from the National Committee on Quality Assurance; David Lansky, president of the Foundation for Accountability; Paul Wallace, executive director of Kaiser’s Care Management Institute; senior physician leaders from more than 10 large California multispecialty group practices; and Ian Morrison as the moderator—you get a volatile mixture!

At the Oakland meeting, I saw remarkable results, particularly from Kaiser Permanente, based in Northern California. This company’s innovative approach to the implementation of guidelines, presented by Dr. Eleanor Levin, a key physician leader and a cardiologist, demonstrated that we might be able to reduce cardiovascular mortality in a population of nearly three million people. She displayed the pilot program’s patient-integrated logs, outreach efforts, and tracking system, which enable patients to reduce their low-density lipoprotein (LDL) levels, raise their beta-blocker levels, and increase their aspirin use. Slide after slide showed that Kaiser Permanente’s beneficiaries were reducing their burden of coronary disease through the rigorous implementation of national practice guidelines—something I know every hospital and managed care organization across the country is attempting to do. It was remarkable to see how such a large population, through a dedicated, coordinated effort, has been able to push the population health envelope.

P&T committees would be well served to examine the work of Drs. Levin and Wallace at the Care Management Institute in California. Over the past two years, these leaders have been applying many of the tools and techniques discussed in this editorial. They are, in a word, closing the performance gap between what we read in the peer-reviewed literature and what we actually accomplish in the day-to-day, hurly-burly practice of medicine.

I challenged the IHA to consider some key issues for the future. For example, although large systems such as Kaiser Permanente’s can reduce the burden of illness in the population, what about the perspective of hospitals on this issue? Many hospitals are alarmed by disease-management programs because their agenda attempts to decrease the number of patients admitted with key diagnoses such as congestive heart failure, diabetes, and asthma. We are faced with a situation in which patients are being driven out of the hospital from one arena, with the appropriate economic incentives, while other patients are being driven back into in-patient beds in the same geographical area. During the conference, I felt that any knowledgeable outside observers would look at the deliberations of this group and pull out their hair!

Finally, at this conference, we were introduced to the work of the California Healthcare Foundation and its report on the electronic management of disease.

This report energized me as I began to better appreciate how we might harness the Internet and other tools, such as electronically based health-risk appraisals.

After the IHA conference, I wondered how we could make integrated and effective programs, like the ones discussed earlier, work outside of California. Despite lingering questions, I was heartened to see, with my own eyes, the future possibilities.

It is difficult for me to transmit the enthusiasm, generated at a small meeting with very articulate participants, into this column. The lesson for our readers is to keep their environmental radar on high-acquisition mode while searching for better ways to begin the task of integrating health care across the continuum. Even if we tackle only one diagnosis at one hospital or managed care organization at a time, I think this is the way to make progress. After all, all change is incremental in nature.

Many observers believe that social change flows from the west coast to the east coast. It was fun for me to go “back to the future” to see what might be coming our way soon.

For more information about the IHA, visit www.iha.org. Of course, I am always interested in your views. You can reach me at my e-mail address, david.nash@mail.tju.edu.

REFERENCES