

Virtual Mentor

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Geisinger: An Insider's View

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The nationally recognized Geisinger Health System is often viewed as a leader for innovation in cost reduction while simultaneously improving care quality. Many of its programs, such as a so-called “warranty” for patient outcomes, have generated keen interest not only among clinicians and hospital administrators but also among many of the political persuasion. Due to the system’s policy of implementing care standards across the board, critics can point to the possibility of a loss of professional autonomy—“cookbook” medicine, so to speak. Or is the opposite contention true? Champions of Geisinger’s approach cite a reduction in unnecessary care variance and a path to the implementation of solid, evidence-based medicine as worthy of imitation. And is Geisinger’s success replicable for other health systems? I will draw on my experience as an internist in the system’s main academic hospital and a 20-year tenure on its ethics committee to reflect on these questions.

It may be helpful to understand the background and culture that have animated Geisinger for decades. The vision of philanthropist Abigail Geisinger, the hospital opened in Danville in 1915. Danville, to this day, remains a quintessential rural Pennsylvania town. The presence of a tertiary teaching hospital in a community that celebrates a mega gas station as a major attraction is undoubtedly unique. From its beginning, including Mrs. Geisinger’s recruitment of its first physician-chief, Dr. Harold Foss, the hospital had a closed staff, employed its physicians, and emphasized specialty care. It should be no surprise that Dr. Foss trained with the Mayo brothers in Rochester, Minnesota, at the turn of the last century. A combination of strong physician leadership, small town friendliness, and a uniquely loyal employee base has formed what is often referred to as the “Geisinger family.” From this culture, with visionary leadership, there developed many of the programs that have led to Geisinger’s national prominence.

Geisinger is diverse in its mission and clinical enterprise. It includes several hospitals, a large multi-group physician practice, and the largest rural health maintenance organization (HMO) in the country. By aligning all elements of its system, Geisinger strives to embody its mission statement: to heal, teach, discover, and serve.

In theory, successful management of chronic disease states will improve the financial standing of the system’s health plan which in turn can lead to financial support for other clinical enterprises (hospital, clinic, etc.). Everyone in the system benefits and the health of the community is enhanced and protected.

ProvenCare

An example of how this works is Geisinger's ProvenCare initiative, an insurance offering that guarantees successful health outcomes and retains liability for preventable complications. If a preventable complication occurs after surgery, the health system will not pass the cost back to the patient's insurer. For a number of months I have served on a committee to develop a "medical guarantee" for elective lumbar fusion surgery. Input from orthopedic and neurological surgeons was crucial, but physical therapists, pharmacists, physician assistants, nurses, and information technology experts were also core participants in the project. The processes were transparent, literature-based, and, when necessary, open to areas of personal surgical preference. At no time was cost or financial risk a major topic of discussion. It is my contention that the Geisinger culture, with its history of cooperation between clinicians, allowed for such a collaboration to be successful.

The project is now expanding to include not only surgery but the management of chronic diseases. Early data we have collected suggest that employing evidence-based protocols reduces variability and error and, surprisingly, may reduce overall cost.

Physician Payment

Like most other multi-group practices, Geisinger sets a baseline of work activity for its clinicians, but 20 percent of a physician's salary is reserved as an incentive to be obtained by achieving a number of goals. The goals set forth in my own compensation plan have required compliance with deadlines for medical records, maintaining patient satisfaction ratings, participating in academic and educational activities, and meeting quality benchmarks such as improving diabetic control or hitting higher vaccine rates for an at-risk population. I cannot see any ethical objection to these goals—they are clearly patient-oriented—and they are consistent with the behavior of what I consider the "virtuous" physician. However, I have concerns about the all-or-none requirements for certain measures and a potential unwillingness on the part of leadership to stray from set quantitative guidelines. I have described the entire interaction as being much like a dreaded IRS audit. It provides a sense of equity and accountability, but of course the risk is that professional life may degenerate into a database of quantifiable achievements.

When I first joined Geisinger, a "softer" reimbursement model existed, much more dependent on a clinical leader's "gestalt" of a physician's performance. It remains unclear if the newer quantitative model is a better way to gauge overall competency, commitment, and work effort. Perhaps it is the most reproducible structure, but it may not be the most inspiring. It is my hope that our group practice will move forward with a compensation system that values clinicians primarily for their service to patients, excellence in practice, and example of compassion to students and colleagues—things that can perhaps be measured by patient satisfaction scores, participation in communication workshops, observation by one's supervisors, evaluations by colleagues, and so on. One cannot know all the motivations that attract one to a career in medicine, but one hopes salary is not the prime reward. The

Geisinger reimbursement model is laudable in that it is not fully dependent on productivity and therefore less prone to compromises in sound ethical principles.

Conclusion

I think Geisinger's way of doing things can teach us much about the advantages of caring less about production and more about outcomes. Geisinger's progress can show empirically that good care can lead to lower costs. Yet replicating Geisinger's success would be difficult, I think, given its unique development and demographic situation. Certain elements, including a robust electronic health record, group practice model, and "medical warranties" can be incorporated anywhere. Its rural location, static local population, and "employed physician" culture would be much harder to export. It must also be emphasized that, for much of its history, there was scarce competition in the way of other rural referral centers. Time will tell if other health systems can reproduce what Geisinger has achieved.

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