Intermountain Health Care Case Study

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As the IMH organization began to implement their clinical integration protocols, naturally there was some trepidation among the physicians and nurses. Change is always a difficult journey to embark upon, especially when the providers do not see the value of the proposed changes. During Dr. James' presentation regarding the benefits of clinical integration protocols, one nurse replied, "We aren't making widgets here." A swift response from Dr. James was "oh yes we are." Well in fact they are both correct, however they are looking at this through different lenses. The physicians and nurses want to provide the best possible care for each patient, as does the administration. The health care provider's autonomy is threatened being hard-pressed to following clinical protocols, while thinking how can some computer program treat my patients better than I can? Well, the answer is, yes it can; according to many studies we have seen that clinical outcomes have improved when one follows these protocols or guidelines.

Is this cookbook medicine? In some ways I suppose it is yet that does not mean it is necessarily a bad thing. I would view these protocols as an adjunct to traditional medicine. As the providers see outcomes improve they will become more comfortable with this system. Think of the physician as the chef, the computer has the list of ingredients (clinical data) and the computer recommends directions for putting the recipe together. There may be some variation in the ingredients and this is where the chef tweaks the recipe and puts it all together. Along with the implementation of the EMR and protocols came discharge goals. Physicians treating patients with heart disease, had a the compliance rate for discharging patients with the appropriate medications over 90 % along with a decrease in the re-admission rate within one year.

The attempt at physician management of clinical operations has failed twice at IMH. The premise was that the management system was to provide the physicians with the tools and business training, so that they could mange the clinical aspects of the organization. The idea was promising, yet it failed. One of the reasons it failed is that the physician's focus is ultimately patient care, while the business people focus on the overall operations and finances of the organization. The ultimate goal is that the institution provides excellent patient care while running a successful business; both share the same goals, yet have different pathways to achieving them.

The goal of the new management system is to be more patient and physician centered, while looking at quality and clinical processes as well. Who knows if this will be successful, what will be the measures of success? If these measures and goals are met, then it is successful. If quality and clinical outcomes improve that is successful from a clinical standpoint; however, will this provide financial success as well? Not always as seen in with Community Acquired Pneumonia (CAP), where clinical outcomes improved while financial reimbursement declined resulting in a net loss to the organization. Once this system is proven to be successful, and evaluation can be undertaken to determine areas of duplication and consolidate these areas, while keeping the essence of the separate systems.