

PERSPECTIVE

Taking Steps Toward Integration

By putting patients' needs first, health care providers can take steps toward achieving a cohesive delivery system.

by Denis Cortese and Robert Smoldt

ABSTRACT: If patients are to be at the center of health care, then providers should work diligently to better organize the delivery system. In this Perspective, two Mayo Clinic leaders provide their views on why it is necessary for physicians and hospitals to set aside their differences and work together for the good of their patients. They cite successful enterprises nationwide that combine hospital and physician control. Many of them have been recognized as examples. [*Health Affairs* 26, no. 1 (2007): w68–w71 (published online 5 December 2006; 10.1377/hlthaff.26.1.w68)]

No man is an island, entire of itself; every man is a piece of the continent.

—John Donne, 1572–1631

THE SEVENTEENTH-CENTURY poet John Donne points out a simple truth that can guide our country as it undertakes the difficult task of reforming the health care system: No one is self-sufficient. Physicians need hospitals; hospitals need physicians. And, most of all, patients need their providers to work together. A 2006 Commonwealth Fund survey found that more than 40 percent of Americans have experienced “poorly coordinated, inefficient or unsafe care” at some point during the past two years. The survey also found that, across the board, adults endorse the importance of well-coordinated care.¹ Integration will also help us reach a common vision articulated by the Institute of Medicine: health care that is safe, effective, efficient, timely, equitable, and patient centered.²

Some have proposed that health care be of-

fered in a “focused factory” setting—a carve-out facility where physicians focus on providing heart care, for example.³ We believe that this approach is inadequate for patients with complex, multisystem health problems. In *Remaking Health Care in America*, Stephen Shortell, a leading health services researcher who has dedicated his career to studying organized delivery systems, and his colleagues ask, “How are the needs of a mother with breast cancer who cares for a mother-in-law with chronic obstructive pulmonary disease and has a child at home with attention deficit disorder served by a focused factory?”⁴

At medicine's best, health professionals create teams of experts that deliver appropriate care to patients throughout their lifetimes. They share a common electronic record; they consult with one another; they provide the care that is appropriate and no more. When providers aren't working together, they provide uncoordinated, expensive, unsafe, and substandard care. Unfortunately, this is common in the United States. Studies show that

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nearly half of physician care is not based on best practices.⁵ And at least 98,000 Americans die of a medical error each year.⁶

In their papers, Elliott Fisher, Robert Berenson, and their coauthors present a dichotomy of what we believe is desired (integrated health care) and current reality (difficult physician-hospital relationships). Using claims data, Fisher and colleagues found that the majority of Medicare patients receive most of their care in a “relatively coherent local delivery system comprising physicians and the hospitals where they work or admit their patients.”⁷ The authors suggest that measuring performance at this level—instead of at the individual physician level—may improve quality and reduce health care costs. In contrast, Berenson and colleagues, using data from the most recent Community Tracking Study, found that in many communities, the physician-hospital relationship is actually eroding.⁸ Possible reasons include competition over services, waning physician interest in taking emergency department (ED) call, and legal policies that make integration more difficult.

Uncoordinated hospital-physician relationships are common in other industrialized countries, too. An *Economist* analysis on improving the cost-effectiveness of care in industrialized countries concluded the following:

One of the biggest failings of modern health care systems is that they so seldom provide integrated medical care. In emergencies, patients head for the local hospital; for minor illnesses they consult their family doctor. But for chronic conditions such as diabetes and cardiovascular diseases, which are becoming increasingly prevalent, they require care and advice both from their primary physician and from the hospital. Effective coordination of this care results in better and cheaper treatment, yet too often it does not happen.⁹

■ **Building an integrated delivery system.** Much of the health reform discussion has

centered on providing insurance and defining a standard benefit package, with less emphasis placed upon on how care is provided.¹⁰ It's time to turn our attention to this important matter. Structurally, there are at least three ways to better accomplish hospital-physician cooperation.

Physician-led, multispecialty group practices that also own a hospital or hospitals. Examples, in addition to Mayo Clinic, range from the West Coast to the East Coast with organizations

such as Virginia Mason in Seattle, Washington; Scott White in Temple, Texas; Ochsner Clinic in New Orleans, Louisiana; Carle Clinic in Champaign-Urbana, Illinois; Cleveland Clinic in Cleveland, Ohio; and Lahey Clinic in Boston, Massachusetts. Recently, *Modern Healthcare* reported that Carilion

Health System in Roanoke, Virginia—a typical not-for-profit health system—will be converted into a physician-run operation.¹¹

Jay Crosson, executive director of the Permanente Federation, notes that there is compelling evidence to support the advantages of multispecialty group practice.¹² Studies show that larger prepaid groups are more likely than nongroup physicians to adopt evidence-based care processes.¹³ Larger groups are also more likely than smaller groups or solo practitioners to use information technology (IT) to coordinate care effectively.¹⁴

Hospitals that own physician groups. Intermountain Healthcare in Salt Lake City, Utah, is an outstanding example. Intermountain has been cited by Jack Wennberg and colleagues, who publish the *Dartmouth Atlas of Health Care*, as providing effective, efficient care. Using the atlas database, researchers compared every region in the country to three regions that provide high-quality/low-cost care—one of which was Salt Lake City. They found that Medicare could save billions of dollars—and achieve the same outcomes—if every region in the country had used hospitals and physician services in a manner similar to practice patterns in Salt

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Lake City (served extensively by Intermountain).¹⁵ Sentara Healthcare in Norfolk, Virginia, is another example of this organizational model.

Physician-hospital organizations (PHOs). PHOs are joint ventures between hospitals and physician groups; Advocate Health Partners in Oak Brook, Illinois, is an example. The PHO was born decades ago as a potential way to manage capitation contracting by presenting a united front to payers. PHOs peaked in the late 1990s and have been on the decline. But with more quality reporting and pay-for-performance (P4P) approaches that make hospital results dependent on physician practice style, there could be a renewed interest in this organizational structure.¹⁶

■ **Incentives.** At least two elements—the business environment and payment policies—should be addressed, to motivate providers to adopt one of these models.

A more supportive business environment. In their paper, Berenson and colleagues note that “policymakers need to examine the degree to which various existing policies are inadvertently contributing to the deterioration of physician-hospital relationships” (p. w41). We agree that there should be in-depth review of restrictions against gain sharing between hospitals and physicians, restrictions on hospitals providing IT support, self-referral restrictions, and reimbursement structures. Revising current federal policies could help foster the teamwork that is sorely needed.

Payment policies. In our view, the development of reimbursement approaches that reward (rather than punish) integration will be the most fruitful catalyst for change. Combining lump-sum payments for a delivery system that includes both the hospital and physician fees should provide incentives for these groups to work as a team. Fisher and colleagues suggest that accountability for quality care and cost might be feasible at a hospital level. Reimbursement at this level could also be a goal.

We strongly believe that the payment system should reward groups that are providing value: good outcomes, safety, and service at a reasonable price. Fisher and colleagues identify a similar approach when they define “high-performing hospitals” as those with the lowest risk-adjusted one-year mortality and lowest risk-adjusted one-year costs. We recommend adding patient satisfaction and safety scores to round out what constitutes a high-value, high-performing hospital: Value equals patient out-

comes, safety, and service, divided by cost over time. The good news is that some standard, case-mix-adjusted data are now available that would allow us to get started with a value equation to identify these high-performing groups.¹⁷

■ **Let the patient be our compass.** The healthy body—a complex orchestration of intricate systems—is

the epitome of integration. Health care in the United States should be redesigned to emulate this synthesis. If health care providers put the needs of the patient first—ahead of individual hospitals or individual physicians—then we will be on course to create a more cohesive delivery system.

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NOTES

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