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PERSPECTIVE

The Delivery System Matters

Today's multispecialty group practices are a promising model for the improved health care system of the future.

by Francis J. Crosson

ABSTRACT: To meet the quality, affordability, and access challenges of today's health care system, the Institute of Medicine's (IOM's) *Crossing the Quality Chasm* report described the critical competencies of a twenty-first-century health care system. A growing body of research suggests that the nation's multispecialty group practices most nearly meet the delivery system challenges set forth by the IOM. A variety of current public and private initiatives and potential policy options could act as catalysts for the development and spread of group practice-based, accountable delivery systems that are effective and efficient.

Few informed observers would disagree that the U.S. health care system is experiencing a profound crisis of value, characterized by escalating costs; inconsistent, suboptimal care; and diminishing access. The uninsurance rate is now 15.6 percent, or forty-five million Americans.¹ Meanwhile, despite all this spending, Americans are not getting the quality of care they deserve.² Unwarranted variability in quality and efficiency and underuse of appropriate care seem to be the stubborn status quo.

Public and private stakeholders have advanced an arsenal of innovative and often useful solutions: low-premium, high-cost-sharing benefit designs; pay-for-performance demonstrations; disease management programs; "focused factories"; evidence-based medicine; shared decision making; and tiered networks, among others. The list of actual or proposed interventions is testament to the creativity (and perhaps desperation) of purchasers, plans, providers, and policymakers.

A sustainable framework for system improvement that seeks to promote greater overall value must confront these critical chal-

lenges: (1) creation of medically, socially, and financially sound, consumer-centered benefit designs; (2) evolution of evidence-based technology assessment linked to coverage policies; (3) optimization of the use of health information technology; and (4) development of more effective, efficient, and accountable health care delivery systems.

The first three of these challenges are the focus of more extensive commentaries in this issue of *Health Affairs* and other policy forums.³ I address the fourth challenge.

In 1932 the Committee on the Costs of Medical Care, funded by the Milbank Memorial Fund and other private foundations and chaired by Ray Lyman Wilbur, former president of the American Medical Association (AMA), called for a major expansion of U.S. group practice.⁴ That opportunity has been largely unrealized but is still available to the country. Here I propose that such change, although difficult, could be accomplished by expanding existing multispecialty group practices by including smaller practices in geographic proximity and by creating new ones through the evolution of hospital-based

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physician staffs. I also suggest ways in which public and private policymakers and purchasers could move today's health care "system" toward that end, yielding something that more clearly deserves the name "system."

Delivery System Organization Via Multispecialty Group Practice

The challenge lies in the reengineering of the delivery system, as stipulated by the Institute of Medicine's (IOM's) *Crossing the Quality Chasm*. Its detailed description of key delivery system characteristics can be seen as a virtual blueprint for expansion of the multispecialty group practice model. The report envisions a delivery system capable of meeting six challenges: (1) evidence-based care processes; (2) effective use of information technology (IT); (3) knowledge and skills management; (4) development of effective teams; (5) coordination of care across patient conditions, services, and settings over time; and (6) use of performance and outcome measurement for continuous quality improvement and accountability. A care system's ability to meet these challenges is viewed as the necessary condition for unleashing a host of benefits.⁵

Evidence about the degree to which different types of delivery systems—group versus solo practice, multispecialty versus single-specialty, capitated versus fee-for-service—are capable of meeting the challenges, and thus enabling the benefits, is not complete. Most research has focused on comparisons of managed care and fee-for-service, without exploring differences in physician group organization. Valid comparisons between groups and non-group providers also are hamstrung by the lack of a systematic means of collecting data on the disaggregated physician community, in contrast to the ability of groups to collect and report data as a function of their integrated quality monitoring and improvement systems.

Nonetheless, with regard to most of the six challenges, there is compelling evidence in support of the advantages of multispecialty group practice. Groups—particularly larger, prepaid groups—are more likely than non-group physicians to adopt evidence-based care

processes.⁶ A 2004 California physician survey found that those in Permanente Medical Groups have adopted system-level care management tools more than physicians have in independent practice associations (IPAs) or "cottage-industry" practices.⁷

Large groups are also better able than small groups or solo-practice physicians to make effective use of IT.⁸ Eighty-seven percent of physicians in large groups have electronic access to test results, compared with 36 percent of solo-practice physicians. Other information technologies follow a similar pattern. Physicians in large groups are more likely than solo practitioners to use electronic medical records (EMRs), receive electronic drug alerts, use e-mail to communicate with colleagues and patients, and practice in a "high-tech" office.⁹

Also, larger groups are more likely than small groups or solo-practice physicians to practice in teams and to use performance and outcome measurement for quality improvement.¹⁰ Group practices are uniquely capable of coordinating care across conditions and settings, and the dissemination of knowledge and skills management is inherent in their sizable investments in the infrastructure and processes of evidence-based medicine.¹¹

Obstacles (Real Or Imagined)

Despite the positive evidence, legitimate questions inevitably arise: Why isn't group practice more widespread? Is it viable outside large population centers? Why aren't more physicians rushing to join groups? And what about the collapse of all those would-be groups in the form of physician-hospital organizations (PHOs) in the 1990s?

Larry Casalino and colleagues have addressed the key barriers to the formation of large medical groups, including the traditional physician culture of autonomy, the lack of capital for group formation, the lack of physician leadership, and difficulties associated with managing capitation.¹² Although the tradition of physician autonomy remains a strong aspect of physician professionalism, it is notable that in regions where group practices are thriving, community physicians are increasingly over-

coming their resistance to groups and joining them in growing numbers.¹³ Anecdotal evidence suggests that one of the reasons for this is likely related to the desire among a new generation of physicians to avoid the increasingly complex work of operating a small business and a preference for the full-time practice of medicine.

The need for strong physician leaders remains a critical issue, but here, too, there are signs of progress. Since the early 1990s the number of university-based physician-executive training programs has grown, including a sixfold increase in the number of MD/MBA (medical doctor/master of business administration) programs.¹⁴ Attacking the leadership issue from another direction, the medical directors of thirty-two of the leading U.S. group practices have recently formed an organization called the Council of Accountable Physician Practices (CAPP) under the auspices of the American Medical Group Association to bring the case for multispecialty medical groups forward more directly and in concert.¹⁵

As for the lack of capital and physicians' inability or unwillingness to invest in group formation, this is likely to remain a barrier, but it should begin to erode as solo-practice and small-group physicians face the inevitable need for implementation of expensive clinical IT—a need that will be most effectively and cost-efficiently met in organized group settings.

The barriers related to capitation were strongly associated with the era of pervasive managed care, and they may be less relevant in today's very different health care environment, because the shifting of unmanageable risks, which caused the demise of many nascent groups in 1990s, has become uncommon. Also, although the advantages of group practice are greatly enhanced by prepayment, they are not solely dependent on payment methodology; many large groups today excel at producing value in the fee-for-service environment, and those that still operate under capitation or a mixture of payment models use newer, more sophisticated methods to manage financial risk.

Regarding the geographic distribution of group practice, here too the facts are encour-

aging. The growth and reach of the Mayo Clinic in Minnesota, Wisconsin, and Iowa; the Geisinger Clinic in eastern and central Pennsylvania; the Dean and Marshfield clinics in Wisconsin; and Kaiser Permanente in Colorado Springs all suggest that group practices can integrate and collaborate with smaller community practices with relative ease, particularly with the help of clinical IT systems. Indeed, nearly every county in Wisconsin now has access to physicians associated with a multispecialty group practice. Nearly 200 large multispecialty group practices are present in most U.S. regions, providing important models for replication.¹⁶ In some areas such as New York City, where large groups have not been a presence, there is a different potential path to group formation: the group practice-based reorganization of medical staffs of large hospitals and academic medical centers. This has recently happened in Boston, and it could spread to other cities given appropriate conditions.

How Do We Get There From Here?

If one assumes that the IOM's vision is largely correct and that the previously discussed obstacles can be overcome, then the policy question is: What can be done to accelerate movement toward more integrated, accountable, group practice-based delivery systems?

■ **Direct legislative action.** Congress has created legislation expressly designed to change the way the health care system is organized and care is delivered—for example, the Hospital Survey and Construction Act of 1946 and the HMO Act.

It is unlikely in the current political and fiscal climate that similar legislation designed to grow or create multispecialty group practices will be forthcoming. On the other hand, the Bush administration has expressed interest in public mechanisms to promote the development and use of clinical IT.¹⁷ Congressional leaders have proposed model legislation to this end. These efforts to promote the diffusion of clinical IT could have the indirect effect of stimulating more integrated forms of physi-

cian practice, including multispecialty group practice, because groups represent an efficient way of spreading the high implementation costs. Also, physicians could take better advantage of publicly financed grants and loans if they band together in some organized setting.¹⁸ Solo and small-group-practice physicians often have neither the time nor expertise to determine the best route to computerization.

Even for physicians unwilling or unable to take advantage of public grants and loans for clinical IT, the need to respond to the proliferation of new pay-for-performance reimbursement systems, which are likely to include measures of IT-supported functions, will create an incentive to computerize. In fact, in its March 2005 report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that Medicare adopt such IT-related pay-for-performance measures.¹⁹

Finally, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 instructed the secretary of health and human services (HHS) to craft exceptions to Stark II and to antikickback laws to allow electronic information to be more easily organized, supported, and employed between hospitals and independently practicing members of the medical staff. Such capabilities could lead to the development of more hospital-centered group practices, as suggested above. Similarly, the current debate about restriction of physician-owned specialty hospitals could lead Congress to grant the HHS secretary the authority to allow now-prohibited gain-sharing arrangements between physicians and hospitals, as called for in MedPAC's March 2005 monograph.²⁰ Regulatory relaxations could further stimulate the development of hospital-centered multispecialty group practices, because gain sharing is less potentially problematic at the physician group level.

■ **Purchaser-based approaches.** As noted by Len Nichols and colleagues, few expect managed competition to return any time soon as a solution to the nation's health care woes.²¹ However, many health plans and some large self-funded employers are experimenting with tiered-network designs to provide finan-

cial incentives for patients to seek care from efficient delivery systems. High-quality, efficient group practices should seek inclusion in the most advantageous tiers. In fact, plans and large employers should pursue long-term partnerships with such group practices. Under such arrangements, innovative full and partial prospective payment mechanisms would likely evolve, leading to further efficiencies and accountability for quality and affordability.

As noted, the current interest in pay-for-performance is likely over time to stimulate the development of more group practice arrangements. Many more measures of quality and efficiency are possible at the group level than at the individual provider level. This is simply a function of the number of patient encounters needed to provide for statistical significance within the time frame required. Further, the kinds of practice changes necessary to improve performance on many measures are easier for physicians to accomplish in an organized practice setting. Therefore, over time, pay-for-performance may disproportionately reward physicians in group practice compared with those in solo and small-group practice. In California, just such group practices have recently been at the vanguard of, and profited from, the pay-for-performance initiative of the Integrated Healthcare Association.²²

In the Medicare arena, the Centers for Medicare and Medicaid Services (CMS) is experimenting with incentive plans through the Physician Group Practice Demonstration (authorized by the Benefits Improvement and Protection Act of 2000) and appears ready to extend this interest through the authority granted by Section 646 of MMA. Section 646 allows the HHS secretary to designate new performance-based reimbursement systems involving a range of new and existing local and regional provider organizations and to analyze their impact on cost and quality of care. Paul Harrington of the Vermont Medical Society recently stated that Section 646 could fill a need for "examples for nationwide improvement in the development of population-based integrated health care systems."²³

In addition, the CMS should consider, es-

pecially if it determines that requisite authority is available under Section 646, creating new organized practice incentives under Medicare fee-for-service physician payment. In this system and under current law, the annual volume-control mechanism commonly known as the sustainable growth rate (SGR) formula, which is scheduled to create negative physician updates from 2006 to 2011, appears to be politically unrealistic. To more effectively and practically control the volume of unnecessary Medicare services, the CMS could authorize, on a pilot basis, additional SGR target pools for future physician payment updates, as recently discussed by MedPAC.²⁴ Alternative SGR target pool mechanisms, available to regional consortia of physician groups, for example, could reduce unnecessary increases in the volume of services and so result in future higher payment updates for physicians in the target pools. In time, this would have the effect of creating a strong incentive for physician integration, to have access to more favorable payment updates.

The Need For Physician Leadership

Physician leadership in many quarters has been largely in a defensive mode, attempting to shield the profession from the impact of a rapidly changing and financially challenging practice environment. It is time for physician leaders—especially leaders of large and well-known multispecialty practices—to assume more active leadership in the public realm.

Physician leaders must address, in understandable ways, the professional ethical responsibility that all physicians have, not only for individual patients' welfare and autonomy (as required by the Hippocratic Oath), but also for social justice in health care delivery, including a fair distribution of resources. These responsibilities have been spelled out recently in a "Physician Charter," which states that "while meeting the needs of individual patients, physicians are required to provide health care that is based on the wise and cost effective management of limited clinical resources. They should be committed to working with other physi-

cians, hospitals, and payors to develop guidelines for cost effective care."²⁵ Leaders of U.S. group practices believe that responsibility for resource stewardship and for providing high-quality, coordinated patient care is best met in the setting of multispecialty group practice, particularly when financing mechanisms support the provision of efficient services.

THE POLICY DIRECTIONS suggested in this paper are neither easy nor likely to yield quick results. On the other hand, to borrow from a 2004 National Academy of Sciences symposium, "delivery systems matter."²⁶ No long-term solution to the U.S. health care cost and quality crisis is likely without the kinds of improvements in health care delivery called for by the IOM. Effective and efficient multispecialty group practices take time to create, but once established, they tend to survive, thrive, and produce value. The question is whether the country can learn to recognize this value, create financial systems that would support and extend group-practice capabilities, and so create the necessary environment for a truly effective and efficient twenty-first-century health care delivery system.

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