CHAPTER ONE

INTRODUCTION AND VISION

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Introduction

As this book goes to press, the United States is in the midst of a multiyear struggle to design and implement comprehensive health care reform. As a nation, we have embarked on a journey of sensibility and equity that has been too long delayed. The end of this journey is obscure, but before it is over and a new equilibrium established, the journey will engage nearly every person and institution in the country. This book is an attempt to describe one important element of that eventual equilibrium—the physician-hospital relationship—and by doing so the authors hope to speed along the journey itself.

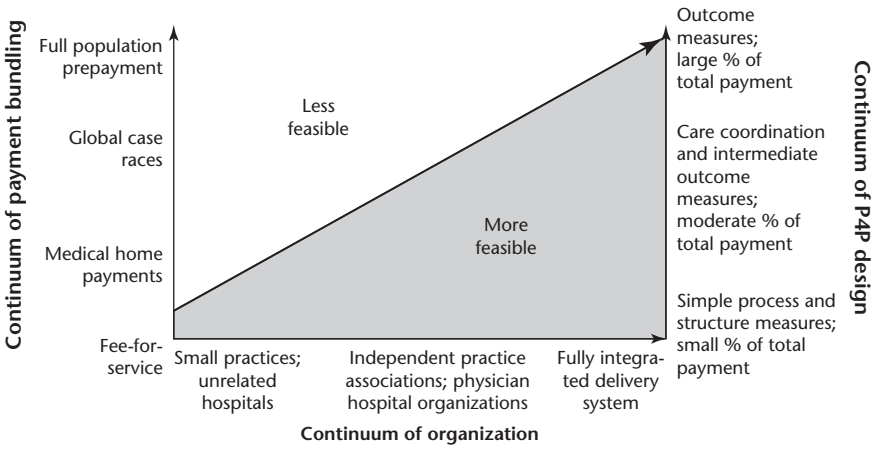
It has been estimated that expansion of health care coverage to 90 percent or more of U.S. citizens will cost in excess of one trillion dollars in the first ten years. This figure may prove to be a significant underestimate. Higher than expected costs from the Massachusetts near-universal coverage experiment have contributed to a potential four billion dollar budget shortfall in that state for 2010. For U.S health care reform to be politically successful, individually affordable, and nationally sustainable, it must contain the elements necessary to constrain cost growth. This will require a reduction of the annual average health care cost increase from more than 2 percent above the annual growth in gross domestic product (GDP) to between zero and 1 percent above GDP growth. The alternative is a significant increase in federal revenues through taxation. Although this

task might not seem daunting when expressed in terms of a 1 or 2 percent change in the rate of expenditure growth, such a change will involve billions of dollars of cost reductions annually and have a major impact on all parts of the health care industry.

Any approach to sustained cost reduction in health care must involve hospitals and physicians. Hospitalizations are the most costly form of care delivery, and conventional wisdom is that physician care decisions directly drive over 80 percent of total health care costs. Accordingly, there is a growing consensus that changes in payment incentives to hospitals and physicians are required, and that such changes must be more than superficial.[1] Most such payment reforms involve either prepayment for services to be rendered, with some form of risk sharing, or episode-based payments such as case payments to physicians and hospitals together.

But there is a problem. As seen in Figure 1.1, advanced payment methodologies are most feasible in an environment of highly organized providers.[2] Such payment methodologies are much less feasible in the disaggregated delivery model that exists in much of the United States today. Most small physician offices are not capable of managing prepayment risk, nor should they be. Capitation of small

FIGURE 1.1 ORGANIZATION AND PAYMENT METHODS



Source: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, "Organizing the U.S. Health Care Delivery System for High Performance" (New York: The Commonwealth Fund, August 2008), Exhibit ES-1, p. xi, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Aug/Organizing-the-U-S--Health-Care-Delivery-System-for-High-Performance.aspx. Reproduced with permission of The Commonwealth Fund.

physician groups was shown to be unstable in the 1990s and presented significant ethical concerns. Similarly, few U.S. hospitals have sufficient integration with their physician staffs to be able to accept episode-based payments without considerable rancor and physician opposition, and potential violations of several federal regulations (see Chapter Six).

The solution to the problem is a coordinated set of delivery system reforms that involve changes in both payment and incentives and in the structure of how hospitals and physicians are organized to provide care. The changes must address the chicken-or-the-egg dilemma that has impeded progress in delivery system integration in many parts of the country. Without payment reform, there is little motivation for disaggregated physicians to do the hard work of forming larger organizations and to work with hospital administrators. Conversely, without the existence of greater numbers of integrated organizations, payers (including Medicare) have gained little traction in developing advanced payment methodologies because so few entities are capable of receiving them and succeeding with them.

Over the past eighty years, there have been a number of carefully constructed calls for delivery system integration (or *organization*, as shown in Figure 1.1). In 1933, the Committee on the Costs of Medical Care recommended that the United States seek to create many more group practices (modeled after the Mayo Clinic), because such practices were more efficient and less costly than solo practices.[3] More recently, the Institute of Medicine, in its report *Crossing the Quality Chasm: A New Health System for the 21st Century*, identified six "redesign imperatives" for future care delivery in the United States: redesigned care processes; effective use of information technologies; knowledge and skills management; development of effective teams; coordination of care across patient conditions, services, and settings over time; and use of performance and outcome measurement for continuous quality improvement and accountability.[4] The strong implication of the report was that significant structural change was needed in care delivery to achieve these process characteristics.

Finally, in its landmark report in 2007, *A High Performance Health System for the United States*, The Commonwealth Fund Commission on a High Performance Health System called for "the U.S. [to] embark on the organization and delivery of health care services to end the fragmentation, waste, and complexity that currently exist. Physicians and other care providers should be rewarded, through financial and non-financial incentives, to band together into traditional or virtual organizations that can provide the support needed for physicians and other providers to practice 21st century medicine."[5]

The goal then, in the context of Figure 1.1, is to move through both payment changes and delivery system changes over time from the "southwest" corner of

the figure to somewhere closer to the "northeast" corner. There are many ideas about how to do this, discussed throughout this book. Virtually every one of these ideas for change will require increased collaboration or integration between hospitals and physicians. The purpose of this book is to describe what will need to change in the relationships between these providers to drive movement from disaggregation through collaboration to integration.

Delivery System Reform Proposals

In 2009, anticipating some type of national health reform, various stakeholders developed delivery system reform proposals to achieve the goals referred to earlier. Most of these require changes in the relationships between hospitals and physicians to be effective. Here, we will discuss three of these proposals:

- Clinical integration, as envisioned by the American Hospital Association (AHA)[6]
- Bundled payments to physicians and hospitals, as recommended by the Medicare Payment Advisory Commission (MedPAC)[7]
- Accountable care organizations (ACOs), as conceptualized by MedPAC, the Brookings Institution, and others[8]

Clinical Integration

Most U.S. physicians practice medicine, at least in part, within a hospital setting but without a direct legal or financial relationship with the hospital. There are some exceptions to this model. In integrated delivery systems, such as Kaiser Permanente, the Mayo Clinic, and the Geisinger Health System, most physicians are employed by the group practice, which either owns or has a financial arrangement with the hospital or hospitals. Similarly, in physician hospital organizations (PHOs), the hospital and its associated physicians create a joint financial entity through which revenue is distributed. Recently, hospitals have begun to employ physicians directly in a variety of specialties. Some of this change has come about because of hospitals' difficulty in finding physicians willing to cover emergency services after hours and because of the rapid growth of hospitalist programs.[9]

In each of these settings, there is usually a sound structural, financial, and legal basis for physicians to work closely together to improve care quality and reduce unnecessary costs. For example, in Kaiser Permanente, orthopedic surgeons regularly analyze the success rates of various artificial hip devices, determine which ones are best for patient care, and agree to use only those devices. In turn, this

agreement allows the hospital to achieve economies of scale on the purchase of these devices.

In the more common setting, where the physicians and hospitals are not part of a single economic entity, the situation is quite different. In some states, the "corporate practice of medicine bar" prevents hospitals from hiring physicians (except in certain specialties such as pathology), even if the physicians wish to be employed. In addition, a broad range of federal laws and regulations inhibits physician-hospital interrelationships, including antitrust provisions, tax-exempt organization regulations, laws intended to prevent limitation of services to Medicare beneficiaries, and "anti-kickback" and "Stark" provisions.[10] These regulations, as well as possible mitigation approaches, are discussed in detail in Chapter Six.

To improve physician-hospital collaboration in settings where physicians and hospitals are not part of an economic entity, the AHA Task Force on Delivery System Fragmentation recommended that the AHA seek ways to integrate clinical care across providers, across settings, and over time.[11] The task force called for the federal government to "establish a simpler, consistent set of rules for how hospitals and physicians conduct their working relationships. The complexity, inconsistency and sometimes conflicting interpretations of federal laws and regulations affecting physician-hospital arrangements are a significant barrier. Few arrangements can be structured without significant legal expense."[12]

Subsequent AHA-sponsored work has identified a number of goals for clinical integration:

- Foster collaboration to improve quality of care.
- Improve quality and efficiency for independent providers.
- Enable providers to perform well in pay-for-performance and other public reporting initiatives.
- Gain experience in forming provider organizations responsible for an entire episode of care or population of patients.
- Provide a vehicle for a hospital to work more closely with members of its medical staff.
- Provide the means whereby providers can obtain greater reimbursement to cover the added costs of their efforts and that recognize the increased value of the services they offer.[13]

In response to the AHA efforts, the Federal Trade Commission (FTC) held a workshop with the AHA to examine the topic of clinical integration and the potential for changes in federal laws and regulation that could remove perceived barriers to such integration efforts. However, in late April 2009, FTC

Commissioner Pamela Jones Harbour told the AHA that the FTC would not be issuing clarifying rules, or "safe harbors," regarding clinical integration but would continue to issue case-by-case judgments.[14]

On the other hand, MedPAC has recommended to Congress that it enact changes to existing laws and regulations to allow *gainsharing* between hospitals and physicians for specified activities intended to improve quality and increase efficiency.[15] As part of the Deficit Reduction Act of 2005, Congress authorized and the Centers for Medicare and Medicaid Services (CMS) subsequently implemented two gainsharing demonstration projects, which are still pending completion and evaluation.

Were there to be a significant "relaxation" of the laws and regulations that now inhibit financial arrangements between otherwise separate physicians and hospitals, it is possible that more formal integrated structures such as those that we will discuss later in this chapter might be less necessary. However, the pace of such regulatory changes is likely to be too slow to foster the type of systematic reorganization that appears to be called for now, as part of health care reform. Therefore, other, more complex proposals are under consideration.

Bundled Payments

Currently, physicians and hospitals that are financially independent of each other are paid separately. For example, Medicare pays most acute care hospitals through the Medicare Part A Prospective Payment System (PPS), based upon case rates known as diagnosis-related groups (DRGs). Physicians are paid for services provided in both the hospital and office settings through the Medicare Part B resource-based relative value scale (see Chapter Four).

The incentives inherent in these two payment systems are not aligned. Once a Medicare beneficiary is admitted for care, the hospital, which is to receive a fixed payment for that hospitalization, has an incentive to deliver services efficiently and to avoid unnecessarily prolonging the hospitalization. The physicians caring for the beneficiary, on the other hand, will be paid by Medicare for each service they deliver, irrespective of the complexity of the service or the length of the hospitalization. Thus, there is no financial incentive for the physicians to be efficient, and as noted earlier, generally the hospital is prevented by law from providing such incentives. In addition, there is no financial incentive for physicians to work together during the hospitalization to avoid duplication of services.

To address this problem, some payers have tried to combine payments to physicians and hospitals in a model known as *bundling*, or episode-based payments. Payments can be bundled for multiple services delivered by one provider, such as a payment that covers admissions and readmissions for the same condition.

Payments can also be bundled for services provided by multiple providers, such as physicians and hospitals. It is this latter form of bundling that we address here. In the early 1990s, Medicare created the Medicare Participating Heart Bypass Center Demonstration, which bundled hospital and physician payments for cardiac bypass graft surgery (see Chapters Four and Five). The payments covered readmissions within seventy-two hours postdischarge and related physician services for a ninety-day period. Although the demonstration was considered successful, it was not renewed because of opposition from some parts of the hospital industry. However, more recently, the Geisinger Health System in Pennsylvania instituted a similar bundled payment initiative called ProvenCare, which resulted in a 44 percent drop in readmissions over the first eighteen months.[16]

In its June 2008 report, MedPAC, having studied the issue for more than a year, made three unanimous recommendations to Congress regarding bundling. These recommendations were as follows:

- **Recommendation 4A**—The Congress should require the [U.S.] Secretary [of Health and Human Services] to confidentially report readmission rates to hospitals and physicians. Beginning in the third year, providers' relative resource use should be publicly disclosed.
- **Recommendation 4B**—To encourage providers to collaborate and better coordinate care, the Congress should direct the Secretary to reduce payments to hospitals with relatively high readmission rates for select conditions and also allow shared accountability between physicians and hospitals. The Congress should also direct the Secretary to report within two years on the feasibility of broader approaches, such as virtual bundling, for encouraging efficiency around hospitalization episodes.
- **Recommendation 4C**—The Congress should require the Secretary to create a voluntary pilot program to test the feasibility of actual bundled payment for services around hospitalization episodes for select conditions. The pilot must have clear and explicit thresholds for determining whether it can be expanded into the full Medicare program or should be discontinued.[17]

The MedPAC commissioners had three behavior changes in mind in making this set of recommendations. First, the commissioners believed, based on research regarding geographic variation in the frequency of physician inpatient visits during hospitalization, that bundling could provide the incentive and opportunity for physicians to reduce the number of hospital visits without harming quality.[18] Second, they intended that a bundled payment pilot would remove legal barriers that currently keep hospitals from compensating physicians for using fewer resources during a hospital stay. Third, depending upon the structure of the

bundled payment, physicians would be encouraged to focus on posthospital care and the prevention of readmissions. (The MedPAC commissioners found that up to 80 percent of Medicare readmissions might be preventable with better coordination of acute care and postacute care services.)

MedPAC envisioned that bundled payments could be "virtual"; in other words, physicians and hospitals would receive separate payments that would be equally adjusted up or down based on their collective performance relative to national or local benchmarks. Actual bundled payments would be tested on a voluntary basis through a pilot program, in part because these payments require the creation of an agreement between physicians and hospitals regarding how the payment is to be divided. Such arrangements would be difficult to mandate. On the other hand, actual bundling is a stronger model precisely because it forces a close working relationship between the hospital and the medical staff.

Whichever model proves to be the best, this type of incentive change is difficult. As noted by Glenn Hackbarth, MedPAC's chairman, "MedPAC is under no illusion that the path of policy change outlined here is easy. Unforeseen consequences are likely, and midcourse adjustments will be needed. But a continuation of the status quo is unacceptable. The current payment system is fueling many of the worst aspects of our health care system, leaving beneficiaries' care uncoordinated, and increasing health care costs to an extent that strains many beneficiaries' ability to pay their health bills, the nation's ability to finance Medicare, and the ability of a large segment of the non-Medicare population to afford health insurance."[19]

Following the recommendation by MedPAC, the Secretary of the Department of Health and Human Services authorized the creation of the Medicare Acute Care Episode Demonstration, which began in 2009. Five hospitals in the states of New Mexico, Oklahoma, Texas, and Colorado volunteered to receive bundled payments for specified cardiovascular and orthopedic services. Gainsharing between the hospitals and the medical staff is allowed, and there are beneficiary incentives in the form of reduced out-of-pocket expenses. Further, at the end of 2009 it appeared possible that Congress would require bundling of payments to participating Medicare hospitals in 2014 as part of larger health reform efforts.

Accountable Care Organizations

In 2003 the physician leaders of thirty-four of the nation's largest multispecialty group practices formed the Council of Accountable Physician Practices (CAPP) to focus attention on what they believed was the most successful delivery system model in the United States.[20] These groups included, for example, the Permanente

Medical Groups, the Mayo Clinic, the Geisinger Health System, the Henry Ford Health System, and Intermountain Health Care. Most of these group practices either owned hospitals or had close working relationships with one or more hospitals. In addition, they were strong believers in the improved performance possible with physician-hospital integration. Over the next five years, CAPP sponsored research into the relative performance in quality and efficiency of such groups compared to disaggregated practices.[21] In 2008 Tollen reviewed the literature on the subject and found that, in general, there was a positive correlation between practice organization and better performance.[22]

In light of the experience of the CAPP medical groups and the developing data that supported claims of better results, in 2005 Crosson called for the inclusion of structural reform of the delivery system, similar to such integrated delivery systems, in any future attempt at comprehensive health care reform.[23] The obvious problem was that there were not enough such delivery systems in existence to cover more than a fifth of the U.S. population, and most were concentrated in the West and Midwest regions of the country.

In 2006 Fisher and colleagues proposed a solution to this problem.[24] Noticing that most Medicare beneficiaries received most of their care from a single primary care provider and the hospital(s) in which that provider most often practiced, the authors proposed that integrated delivery systems could be created quickly by having payers "assign" patients to hospitals and their "extended medical staffs" based upon such usage patterns. They called the resulting virtually integrated system an accountable care organization (ACO). In 2008 Shortell and Casalino sought to broaden the model under the term *accountable care systems* (ACSs) and called for payment reforms to create incentives for more such organizations.[25] In 2009 Fisher and colleagues refined the ACO model and laid out a five-year reform schedule for Medicare to institute payment to ACOs.[26] Note that this book will use the term *accountable care organization* in a general sense to refer to the broad concept of an entity that is clinically and fiscally accountable for the entire continuum of care that patients may need, rather than to any specific ACO model that has been proposed. (Any exceptions to this usage have been noted by the authors of individual chapters.)

In its June 2009 report to Congress, MedPAC reported on more than a year of study and analysis of the ACO concept, laying the groundwork for potential legislation that would move the Medicare program in this direction.[27] As the report states, "By giving physicians and hospitals a way to increase their income through ACO-wide quality improvement and reducing unnecessary services, the Medicare system would gain a way to constrain spending other than through the blunt instrument of lowering FFS [fee-for-service] updates. . . . For Medicare to become sustainable, the delivery system has to change.

ACOs could prove to be an important catalyst for delivery system reform by creating incentives for increased organization and joint decision making."[28]

At the end of 2009 Congress seemed intent on creating robust pilot testing of ACOs and accompanying payment changes as part of a reformed Medicare program. However Congress and the Secretary choose to support and implement ACOs in the future, physician-hospital integration will be required to make the model work. The more comprehensive the reform and the faster the change in payment incentives evolves, the more important will be the development of the knowledge base for making this change successful. As noted by Crosson, "a successful movement to the availability of ACOs will require substantial changes in how physicians and hospitals relate to and seek to integrate with each other. Integration must occur at the operational, financial, and cultural levels, each of which faces a number of barriers."[29]

Physician-Hospital Integration as Central to Delivery System Reform

Whether the AHA model of clinical integration, integration driven by a more widespread use of bundled payments, or the evolution of ACOs becomes the predominant reform dynamic in the next five or so years, there is little question that change is coming. The well-known *Dartmouth Atlas* data have made it abundantly clear that health care services are unnecessarily expensive and of poor quality in many parts of the country.[30] There are really only two ways to reduce those costs, either through progressive fee-for-service payment reductions to physicians and hospitals or through reorganization of care delivery and changes to payment and incentives. It is likely that only the latter choice has a simultaneous chance to improve quality.

So the best hope is the most radical—to restructure and integrate. But are U.S. physicians and hospitals capable of proceeding successfully through such changes? The old medical staff model seems to be failing, for reasons discussed later in this book. Some institutions, such as the multispecialty group practices mentioned earlier, are ready and waiting to thrive on new payment models. But most hospitals and their medical staffs are not. Some remember all too well the failed attempts to "integrate" in the mid-1990s to prepare for managed care prepayment, which never materialized. Many nascent organizations failed or disbanded as a consequence. Hard feelings and financial losses were the result. Currently, in many institutions, physicians and hospitals are at loggerheads over control issues or are in frank competition for patients needing complex, profitable procedures.

A first step in breaking down this negative environment is to analyze what is wrong and how it could be different. There are many aspects to solving this problem—clinical, legal, financial, psychological, and cultural, to name a few. These various aspects of the problem and solutions to them have not been brought together in one place before. That is the goal of this book.

About This Book

Some of the needed experience and knowledge to bridge the physician-hospital divide exists in the health care academic community, among individuals who have devoted their lives to gaining understanding, teaching, and creating new knowledge. Some of the needed experience and knowledge exists in the practical fact base of delivery system leaders, who have devoted their lives to building and improving real-world institutions of care delivery. This book is designed to be read by, and to be of value to, members of both these constituencies. Accordingly, the authors have been selected from among the most distinguished individuals in both of these disciplines. The book is intended to contain both academic analyses and real-world examples of successful change. The book can be read as individual chapters, but it is intended, ideally, to be read as an entirety—to tell a story of change that is multifaceted and difficult but also necessary and possible.

In Chapter Two, "History of Physician-Hospital Collaboration: Obstacles and Opportunities," Lawton Burns, of the Wharton School of Business, Jeff Goldsmith of Health Futures, and Ralph Muller of the University of Pennsylvania Health System review the changes in physician-hospital relationships during the twentieth century. Based on their analysis of this history, they argue that the major provider-based competencies called for in health care reform may best be satisfied by hospitals rather than physicians. They also note that hospitals' past attempts to collaborate more closely with physicians have relied heavily on structural mechanisms, such as salaried employment, leadership roles, and contracting vehicles. However, there is little evidence that the use of these mechanisms has helped the pursuit of value. As a result, hospitals and the physicians with which they work will need to carefully consider the factors that have prevented more significant behavioral change. These factors, each explored throughout this book, include real and perceived legal barriers, differences in culture between hospitals and physicians (and among physicians), and major differences in governance structures.

In Chapter Three, "Achieving the Vision: Structural Change," Stephen Shortell of the University of California, Berkeley, Lawrence Casalino of Cornell, and Elliott Fisher of Dartmouth describe the range of proposed structural or

organizational models for promoting greater alignment and integration between hospitals and physicians. They call these models, collectively, "accountable care organizations." They begin with an overview of the aspects of institutional culture that differentiate hospitals from physician organizations, describing the inherent conflict between bureaucracy and professional autonomy. Next, they analyze four models of accountable care systems: the integrated delivery system, the multispecialty group practice, the physician hospital organization, and the independent practice association. Each of these models has varying potential for promoting greater collaboration between hospitals and physicians. The key is the extent to which they can take advantage of possible new payment incentives to develop commitment to shared goals and the capabilities to realize those goals. In conclusion, the authors discuss the need for supportive financial incentives and changes in the regulatory or legal environment to foster the development and success of accountable care organizations.

In Chapter Four, "Achieving the Vision: Payment Reform," Stuart Guterman of The Commonwealth Fund and Anthony Shih of IPRO analyze a range of payment reform proposals designed to encourage the type of structural integration between hospitals and physicians described in the previous chapter. Their chapter describes how the evolution of payment methods and other market factors have affected the "traditional" hospital medical staff model. This is followed by a discussion of payment methodologies that are viewed as potentially useful in appropriately aligning hospital and physician incentives with the patient's best interest. These include hospital pay-for-performance, shared savings, blended payment for primary care, and episode-based payments. Ultimately, the authors suggest that payers should adopt a flexible payment approach—one that offers an array of alternative payment models that incentivize quality and efficiency through various levels of bundling matched to the capabilities of the current organizational structures.

In Chapter Five, "Achieving the Vision: Operational Challenges and Improvement," Bruce Genovese of the Michigan Heart and Vascular Institute outlines the operational value and clinical capabilities of highly functioning integrated organizations, as well as the obstacles to such capabilities that exist in many delivery sites across the country today. He describes potential solutions for such obstacles, including common clinical information technology platforms and common performance measurements and goals. Genovese also provides a case study of a successful physician-hospital collaboration in Michigan (Saint Joseph Mercy Hospital's participation in the Medicare Participating Heart Bypass Center Demonstration), focusing on the operational enablers and benefits.

The change to ACOs, which will be built on physician-hospital integration, is likely to be a ten- to fifteen-year proposition. It will face a series of barriers, any

one of which could derail such change. We know this from observation of the failures, as well as the occasional successes of the physician hospital organization (PHO) movement in the 1990s. In the next three chapters, the authors describe these barriers and potential solutions to or pathways around them.

In Chapter Six, "Overcoming Barriers to Improved Collaboration and Alignment: Legal and Regulatory Issues," Robert Leibenluft of Hogan and Hartson and William Sage of the University of Texas, Austin, focus on the extent to which legal change is necessary for significant health care reform. The chapter begins with an examination of federal antitrust laws and their perceived and real impact on physician-hospital collaboration. The authors discuss potential barriers to the formation of ACOs and also some of the antitrust issues that might arise if a particular ACO became dominant in a given geographic area. Next, the authors examine two other important federal issues: fraud and abuse, and tax exemption. They discuss several state laws that affect hospitals' and physicians' ability to improve collaboration, including health professional licensing and scope of practice, the corporate practice of medicine doctrine and physician employment, medical staff credentialing, insurance regulation, and medical malpractice. The authors conclude with a series of key questions regarding the legal environment that should guide the health care reform debate.

In Chapter Seven, "Overcoming Barriers to Improved Collaboration and Alignment: Governance Issues," Jeffrey Alexander of the University of Michigan and Gary Young of Boston University review the historical development of hospital governing boards and medical staffs, and discuss how regulation, reimbursement, and competition have shaped relations between the two groups. The chapter next considers internal and external factors that have impeded alignment between hospital governing boards and medical staffs. Next, the authors analyze several strategies to enable hospital and medical staff governing entities to take a leading role in promoting alignment between hospitals and physicians. These include development of "workaround" organizations such as physician hospital organizations (PHOs), foundations, and joint ventures. The chapter concludes with several policy recommendations. In addition, James DeNuccio of the American Medical Association and John R. Combes of the American Hospital Association provide brief perspective commentaries.

In Chapter Eight, "Overcoming Barriers to Improved Collaboration and Alignment: Cultural Issues," Katherine Schneider of AtlantiCare uses her experience in creating the physician hospital organization at Middlesex Hospital in Connecticut (the only non-group-practice entity to qualify as a Medicare Group Practice Demonstration site) to explore the range of human dynamics that have prevented closer collaboration and innovation between hospitals and practicing physicians. She also describes what she calls "rules for

engagement" for hospitals hoping to entice physicians to enter into new collaborative ventures, asserting that physicians will not allow their time and attention to be diverted from patient care unless the proposed collaboration will do at least one of the following: save them time, add value to their patients' experience, increase their income or improve their quality of life, or add to their professional satisfaction. Conversely, there are rules for engagement on the hospital side as well. Schneider notes that in order for engagement with physicians to be worth administrators' efforts, the activity must be consistent with the organization's mission, vision, values, and strategy; result in improvement in a key measurable outcome, without adversely affecting another measure; and result in increased happiness of one key stakeholder without resulting in ire from another one. Further, the operational requirements and implications of the activity must be adequately identified, and it must be possible to accommodate them. Schneider concludes with a series of recommendations for bridging the cultural divide between hospitals and physicians to encourage collaboration for quality and efficiency.

Not all hospitals in the United States are the same. Among other differences are variations in geography, financial base, and mission that separate institutions. Such differences can create particular strengths and weaknesses relative to physician-hospital integration. The authors of the next two chapters explore the special issues of safety net providers and explore special issues for safety net providers and academic medical centers in the context of the goals outlined in this book.

In Chapter Nine, "Special Issues for Safety Net Hospitals and Clinics," Benjamin Chu of Kaiser Permanente, formerly of the New York City Health and Hospitals Corporation, examines the special issues of public health care providers, especially those in large city environments. He focuses on two real examples of physician-hospital integration in safety net institutions, Denver Health and the New York City organization that he led and improved. Chu generalizes from these examples to a set of principles that can help guide other such institutions, as well as non-safety-net providers that are seeking to change in a similar fashion.

In Chapter Ten, "Special Issues for Academic Medical Centers," David Posch of Vanderbilt University Medical Center addresses, in similar fashion, the range of considerations facing academic medical centers that seek to create "group practices" out of disparate clinician/teacher/researcher physicians at such institutions. Drawing on his experience at Vanderbilt, he provides recommendations for the future of academic hospitals. Darrell Kirch of the Association of American Medical Colleges provides a commentary on this chapter.

Finally, in Chapter Eleven, "What Needs to Happen Next?" Francis Crosson draws from and highlights the knowledge brought forth in the preceding chapters. In collaboration with the other chapter authors and the information gleaned from

a set of workshops that accompanied the creation of this book, he describes a cascade of potential legislative, regulatory, voluntary operational, and market-driven changes that could, in combination, bring about the development and success of new models of physician-hospital integration, as part of a reformed, twenty-first century health care system.

Notes

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