In the Literature

CREATING ACCOUNTABLE CARE ORGANIZATIONS: THE EXTENDED HOSPITAL MEDICAL STAFF

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Prompted by concerns that the U.S. health care system suffers from serious gaps in quality and widespread waste, many reform efforts have focused on holding individual providers accountable through performance-measurement and pay-for-performance programs. By focusing on individual clinicians, however, such efforts may overlook quality problems attributed to poorly coordinated care.

A new Commonwealth Fund-supported paper explores an alternative approach to performance measurement and payment reform, one that considers the continuum of patient care: the development of "accountable care organizations." Dartmouth College's Elliott S. Fisher, M.D., M.P.H., lead author of "Creating Accountable Care Organizations: The Extended Hospital Medical Staff" (*Health Affairs* Web Exclusive, Dec. 5, 2006), believes these virtual organizations—which comprise local health care delivery systems and the physicians who work within and around them—should be a focal point for quality improvement initiatives.

Why Do It?

Because seriously ill patients receive care from many clinicians in many care settings, proper coordination among these professionals is critical to ensuring that no significant gaps in quality occur. That is why reform efforts focused solely on holding individual providers accountable for the care within their direct control may do little in the end to improve the overall quality of care. A potential solution, say Fisher and colleagues, is to foster *shared accountability* among providers. Previous efforts in this direction have targeted traditional health maintenance organizations or multispecialty group practices. But these groups represent only a tiny share of the current market: most U.S. physicians are employed in solo or small group practices.

The researchers instead propose hospitals as the focal point. To assess the feasibility of such a model, the researchers "assigned" physicians to hospitals by two methods. Using Medicare claims data, they determined that 62 percent of physicians perform inpatient hospital work. These doctors were assigned to their primary hospital—where they do most or all of their inpatient work. This left 38 percent of physicians who do not perform inpatient work. The researchers assigned these doctors to hospitals where most of their patients were admitted. In doing so, they created an "extended hospital medical staff" or, in essence, a hospital-associated multispecialty group practice.

The Potential Advantages

The most important advantage of this system, say the authors, is that it can help establish accountability for local decisions about capacity. The authors' prior work has indicated that differences in capacity (e.g., the numbers of specialists employed or the supply of acute care hospital beds) are a major determinant of differences in spending across regions and hospitals. Measuring quality and cost at the hospital staff level could therefore help pinpoint examples of overuse of services that would not otherwise be identified. Bringing these

instances to light can help hospital leaders initiate activities that lead to improved quality and lowered costs, such as investing in care management, reducing acute care capacity, and forgoing unnecessary specialist recruitment. There are also advantages in terms of performance measurement. Hospital-based measures focus on the longitudinal experiences of patients (e.g., total costs and health outcomes), as well as measures that directly address the problem of fragmentation of care. In addition, public reporting on an aggregated, rather than individual, basis may alleviate some physicians' resistance to the process, the authors say. And in terms of administrative complexity, it can be less daunting than collecting data from individual doctors.

Finally, hospitals or large medical groups are in much better position than physicians in solo or small group practices to invest in systems to improve care and lower costs—like health information technology, care management protocols, or ongoing quality improvement initiatives.

Challenges: Culture and Market Forces

The authors acknowledge that there are barriers to implementing the extended hospital medical staff approach. Recent market trends—including a payment system that effectively encourages entrepreneurial physicians to compete with hospitals—work against the integration of physicians and hospitals. Culturally, physicians have long operated with a high degree of professional autonomy, and many will resist the notion of accepting some responsibility for the care of all patients within their local delivery system. In addition, there are legal, political, and practical obstacles to overcome.

Moving Forward

Despite potential barriers, the authors argue that the new approach is worth pursuing, particularly because the alternative of focusing on individual providers' performance risks "reinforcing the fragmentation and lack of coordination that characterizes the current delivery system." Performance measurement and public reporting at the extended hospital staff level is the logical first step to implementing such a system and could begin nationwide relatively quickly, the authors say. Data on Medicare beneficiaries are already being collected and could be augmented by surveys to assess patients' experiences and outcomes. In addition, payment system reform to reward improved performance of the hospital and its medical staff is already the focus of current and planned Medicare demonstration programs.

The hospital and its extended medical staff provide a natural organizational setting within which to improve quality of care, conclude the authors. By focusing on this model, providers and policymakers can help alleviate deficiencies in our health system related to fragmented and poorly coordinated care.

Facts and Figures

- The average U.S. hospital has an extended medical staff of 88 physicians per 100 beds.
- On average, 62 percent of physicians perform inpatient work; the proportion is slightly greater in smaller and rural hospitals.
- For physicians who do any inpatient work, 90 percent or more is performed at one primary hospital.
- The Institute of Medicine has called for efforts to foster shared accountability among providers for the quality and cost of care.