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By Owner

“He who would trade liberty for some temporary security, deserves neither liberty nor security.” – Benjamin Franklin

By the time this article appears in the June edition of the DMJ, we will be a couple weeks away from the most anticipated Supreme Court decision impacting the healthcare delivery of this nation. No matter your views on this subject and no matter what decision is rendered, to borrow from Winston Churchill, this is just the end of the beginning of this process of health system reform, not the beginning of the end. A multitude of decisions remain to be made at the federal, state and local governmental and regulatory levels that will shape how healthcare delivery ultimately will manifest. Perhaps the most important of these decisions will affect the relationship between hospitals and physicians. “Physician-hospital alignment” is the new catch-phrase dominating our industry, and how this integration will be promoted and permitted will have a dramatic impact on the physician-patient relationship and the timely access to quality, cost-effective health care. Physician-hospital alignment is most frequently represented by the employee-employer relationship. But is also is reflected in the whole hospital physician-ownership model, and every variation and permutation in between, including joint-venture partnerships, and service line management. The Supreme Court decision could have a dominant transformative impact on this relationship. Embedded in this legislation (and subsequent regulatory rule making) is language that helps define and restrict how physicians and hospitals will be permitted to interact and partner, especially in anticipation of the emerging world of bundled payments and accountable care organizations.

The impending Supreme Court decision affords a good opportunity to revisit some of the views that were circulating about models of physician-hospital alignment before the Patient Protection and Affordable Care Act passed in December 2009. Consequently, I have made the presidential decision to plagiarize myself and use an article I wrote for the October 2009 journal *Cardiology* (Volume 38, Number 10, page 9). I believe that the vision and arguments are as valid now as they were then, and, depending on the SCOTUS decision, may be prosecuted anew.

Bending the Cost Curve: A Fork in the Road

There’s been a lot of discussion and debate recently over the best way to “bend the cost curve” in a reformed healthcare system. I think most would agree that the best way to do this would be to develop new incentives in payment that reward better outcomes with evidence-based medicine. I think most also would agree that physicians should play a pivotal role in developing these incentives and in the integrated health systems that emerge.

How best to develop these new incentives and what system – or systems – can or should be used as models appears to be where we’ve hit a fork in the road. Some would argue that integrated systems such as at Cleveland Clinic or Mayo are the path to the future. These large systems use EHRs to coordinate care across sources and sites of care. Their physicians are salaried and, some would argue, more motivated toward coordination of care and quality.

I would argue that physicians are best positioned to serve as advocates for patients in our pursuit of quality when serving as partners and owners of the system, rather than as salaried employees. The Centers for Medicare and Medicaid Services for the first time ever in July 2009 released results of a risk-adjusted comparative survey of approximately 4,700 US hospitals looking at the Medicare population from July 1, 2005, through June 30, 2008 (<http://www.hospitalcompare.hhs.gov>). Some of the more popular brand-name physician-salaried hospital systems that routinely are promoted as the ideal model

for hospital-physician integration by **The New York Times** (Mayo and Geisinger) had CHF readmission rates that were “No Different” than the US national rate, with a notable one in particular (Cleveland Clinic) finishing in the “Worse” category (bottom 5 percent of the nation). This is significant because, up until that point, the administration had been promoting 30-day heart failure readmission as the prime example of waste in healthcare delivery. Out of the four risk-adjusted cardiac clinical outcomes studied in this survey, physician-owned models were ranked No. 1 in the nation for lowest MI mortality (Austin Heart) and for lowest CHF readmissions (Baylor Heart and Vascular Hospital). In Texas, the top two hospitals for lowest CHF readmissions and MI mortality are physician-owned integrated models. Furthermore, the Median Medicare Payment by Medicare-Severity DRG for these physician-salaried facilities were more than 15 percent to 25 percent higher than the physician-owned facilities that finished number No. 1 in the nation in terms of quality. Physician-hospital ownership represents an alignment of interests between the hospital and physician in the pursuit of timely access to quality, cost-effective care. In the future world of Accountable Care Organizations, where reimbursement will be bundled by DRG to an integrated system, a physician-owned hospital is, in my opinion, exactly the form of physician-hospital integration that will be most effective regarding quality, cost and timely access.

I am not advocating that the physician-owned model be the only model that is proposed for healthcare reform, but it should not be left out of the discussion. You cannot have a discussion about healthcare reform and the most effective physician-hospital integration model and not mention a model that ranks first in the nation in two out of the four cardiac outcomes categories studied, and with lower costs. In a July (2009) **USA Today** article about Baylor and its No. 1 ranking, ACC CEO Jack Lewin, MD, said, “The best-quality health care in America is certainly not the most costly care I would be very frustrated if our health reform agenda doesn’t emphasize these kinds of opportunities.” Quality health care is inherently cost-effective. Judging by the recent CMS survey, I don’t agree with the blanket statement that in general, salaried physicians at integrated institutions using EMRs provide superior quality and are more affordable.

If timely access to quality, cost-effective health care is as simple as having salaried physicians in an integrated hospital model using EMRs, then why are Congress and other groups bothering with proposing pilots? The US government already operates the largest, nationwide hospital organization of salaried physicians under one roof in an exquisitely integrated system of healthcare delivery using EMRs, and has done so for decades. Why are Congress and others not promoting this example as THE model of physician-hospital integration in this grand debate of healthcare reform? I think some already suspect an answer.