

Doctor, Heal Thyself: Why Reorganizing the Physician Practice Could Help Cure What Ails American Health Care

Lawrence Casalino, M.D., Ph.D.

Although medical research has made incredible advances in the last 100 years, one aspect of health care remains largely unchanged: the doctor-patient relationship. In the age of genomic medicine, magnetic resonance imaging, and laser surgery, the fundamental interaction between patient and physician in 2006 is the same relatively unadorned affair it was in 1906.

A person gets sick or has some other complaint, makes an appointment, sees the doctor, and the doctor prescribes a course of care. And although today there might be a follow-up phone call or email, that is usually the extent of the encounter.

Few of us would question this dynamic. But after a couple of decades as a physician in a family practice, Lawrence P. Casalino, M.D., Ph.D., became increasingly interested in the over-reliance of the patient experience on what is usually a single, brief exchange.

“So much of the quality of care that patients receive depends on what physicians do for them while they are literally right in front of them,” he says. “That’s something that has not changed in a century, even though, in the rest of the health care system, there has been a lot of change.”

Research shows that Americans receive the right health care only 50 percent of the time. Casalino believes that failure is linked to the way that physicians organize their practices. With support from a Robert Wood Johnson Foundation Investigator Award in Health Policy Research, Casalino, now an assistant professor of health studies at the University of Chicago, has focused his scholarly energies on the role of the physician in the U.S. health care system.

When he was in practice, Casalino recalls, physicians believed that the way to improve care was to simply work longer hours. “For me that meant I rarely got home before 9 at night because I was at the office making follow-up phone calls to patients.”

But now, after nearly 500 interviews with physician leaders nationwide, he is convinced that there is a better way.

Building a Better Doctor’s Office: It’s Not Just about the Appointment

Casalino differentiates between two approaches to quality. The traditional “individual physician approach” as he calls it, hinges on what a physician does for whatever patient happens to be in front of him or her at a given time. Contrast that to the “organized process approach,” in which quality is determined by “what everyone in the practice—physicians and non-physicians—does collectively on an ongoing basis for a population of patients.”

For example, a practice could seek to better serve chronically ill patients by adopting specific “care management processes,” or CMPs, such as those promoted in the Chronic Care Model developed at Group Health Cooperative of Puget Sound. Among other things, care management processes might include:

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- a registry organized to identify patients who have a chronic condition such as asthma, diabetes, heart disease or depression;
- case management programs in which a nurse or other non-physician medical professional stays in close touch with chronically ill patients to help coordinate their care and teach them how to manage their illness;
- other education programs that teach patients how to manage their disease on a day-to-day basis;
- systematic feedback to physicians on the quality of care they provide.

Casalino says that in order to ensure high-quality care, both approaches are needed. “We want individual physicians to take responsibility, to feel that they are ultimately accountable for the care that their patients receive,” he says. “But we also need to recognize that there’s only so much that any one physician can do. By correctly identifying and organizing processes of care and distributing tasks throughout the entire practice, physicians can live saner lives, and, most important, patients will get better care. It’s win-win.”

Currently, though, most practices rely quite heavily on the individual approach, with little or no emphasis on an organized process approach.

Creating a Market for Quality

Casalino says that physicians are interested in improving quality, and many like the idea of implementing CMPs. “But these changes cost money, and most physicians don’t see a ‘business case’ for quality. For the most part, health insurance plans and Medicare don’t reward physicians for providing high-quality care.”

If CMPs are to become more prevalent in the physician practice, health plans and government agencies need to adopt policies that compensate physicians for adopting processes that improve care.

“Right now, the payment system encourages individual physicians to run a ragged race from patient to patient,” Casalino says. “The more patients they see, the more they get paid. Meanwhile, they get nothing for doing a lot of things they would like to do or should do to provide high-quality care.”

With colleagues at the University of California, Berkeley, Casalino examined physicians’ use of CMPs in a national survey of 1,040 medical groups and independent practice associations (IPAs). The researchers found that physician groups that had external incentives for using CMPs—such as higher pay for higher quality measure scores, or public reporting of quality scores—used CMPs more than groups that had no outside incentives.

Clashes over Price-Fixing Produce Policy for Quality

Recently, Casalino has been involved as a consultant or expert witness on four intriguing cases likely to have a far-ranging impact on how physician practice is organized. Managed care gave health insurance plans the ability to determine the prices they pay for physician services. In response, many physicians in small practices joined together in IPAs to negotiate prices collectively with health plans.

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Ordinarily, an attempt by independent businesses (such as physician practices) to come together to negotiate prices is considered price-fixing—a serious violation of U.S. antitrust law. But as long as IPAs accepted some financial risk for the costs of patient care—for example, by signing capitated contracts with health plans—the Federal Trade Commission (FTC) considered them to be “financially integrated” and therefore not at risk for prosecution. During the past decade, the use of capitated contracts has declined, yet many IPAs—including some that aren’t integrated financially—have persisted in their attempts to negotiate with health plans. In response, the FTC has stepped up its enforcement activities, conducting approximately 25 public investigations of physician groups in the past six years.

However, the FTC has given IPAs a new safe harbor: They are unlikely to be investigated if they are “clinically integrated”—that is, if they are using organized processes to improve quality. But which processes? And how many constitute clinical integration? Casalino has been involved in helping to answer these questions.

“If the FTC sets the bar too high,” Casalino says, “IPAs that are capable of improving quality will go out of business. On the other hand, if the FTC is too lenient, physicians will be able to jointly negotiate for higher prices without having to do anything to improve quality. This will create an unlevel playing field in favor of IPAs that aren’t serious about quality improvement.”

Casalino is working to convince IPAs to do more to implement organized processes to improve quality, and to convince the FTC to give its blessing to those IPAs that are clearly making an effort to improve quality. Meanwhile, he says, the FTC should weed out those practices that are trying to raise prices while doing little or nothing for patients.

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Disease Management Services: Coming Soon to a Patient Near You

The more time that physicians take to consider whether to revamp their practices, the greater risk they face of being overtaken by events. Casalino points to a rapidly growing industry sector of disease management companies that focus on dealing directly with patients, rather than relying on physicians to improve the quality of care for patients with chronic illnesses. They use innovative information technology systems and disease modeling software to identify and track chronically ill patients, and employ specially trained staff to monitor patient conditions and assist with everything from diet and exercise to proper use of medicines.

Casalino warns that if physicians don’t move now to reorganize their clinical services, they stand to lose both influence and income to these increasingly popular companies, which generate nearly \$1 billion in revenue annually, up from \$85 million in 1997. Furthermore, disease management providers have attracted the attention of Medicare, which is conducting randomized controlled trials involving more than 200,000 patients in eight disease management programs. Congress has instructed Medicare to expand disease management nationally if these demonstrations succeed; that roll-out could begin as early as 2008. Yet physicians generally have little or no awareness of disease management.

“If disease management companies can do good things for patients that physicians don’t or can’t do, more power to them,” Casalino observes. “But we don’t know what physician groups can do best, what disease management companies can do best, or whether and how their activities should be organized and coordinated.”

And unless physicians take the initiative to begin improving quality in a more organized way, “we may never know,” he adds.

About the Investigator

Lawrence Casalino is an assistant professor of health studies at the University of Chicago whose background includes 20 years as a family physician in private practice. He holds a doctoral degree in health services research, with a focus on organizational and institutional sociology and economics.



Dr. Casalino's research focuses on the organization of physician practice, and, in particular, the kinds of organized processes physicians use to improve the quality and control the costs of medical care. He is also exploring questions around the forms of relationships that physicians have with hospitals and health plans; the effects on quality and cost of the varying types of physician practice organization; and the influence of public and private policies on the ways that physician practice is organized.

Dr. Casalino is currently studying disease management, outpatient medical errors, physician views on quality measurement and pay for performance, and clinical integration in relation to federal antitrust regulation.

He has published in a number of journals, including the *New England Journal of Medicine*, *Journal of the American Medical Association*, *Health Affairs*, *Health Services Research*, *Journal of Health and Social Behavior*, and the *Journal of Health Politics, Policy and Law*.

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