Bundled Pay for Care Coordination Proposed

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — The U.S. health care delivery system should be overhauled to organize medical practice around "integrated care cycles" that are coordinated by a central physician and to reward physicians for providing value, Michael E. Porter said at a media briefing presented by the Journal of the American Medical Association.

The proposals are a shortened version of a book written by Mr. Porter, the Bishop William Lawrence University Professor at Harvard Business School, Boston, and his coauthor, Elizabeth Olmsted Teisberg of the University of Virginia's Darden Graduate School of Business, Charlottesville.

Mr. Porter and Ms. Teisberg said a value-based system has three principles: providing value for patients, organizing delivery of care around conditions and care cycles, and measuring results, preferably risk-adjusted outcomes that are measured over the full care cycle, not just a single care episode (JAMA 2007;297:1103-11).

The authors do not advocate a single-payer system, stating that competition is healthy but the current system supports the wrong kind of competition.

"Physicians focused on value for patients will no longer see themselves as self-contained, isolated actors," the authors wrote. "Instead, they will build stronger professional connections with complementary specialists who contribute to patient care across the care cycles for their patients."

The authors pointed out that they do not advocate a single-payer system. They say instead that competition is healthy but the current system supports the wrong kind of competition.

It rewards physicians and health plans for taking patients away from one another or for shifting costs onto a competitor, rather than for providing value for the patient in the form of improved clinical outcomes, said the authors.

Physicians are in the best position to change the delivery of health care, they said. "Physicians have to get out of the bunker," Mr. Porter said at the briefing.

He said they could lead by becoming part of a care team and agreeing to accept a piece of a payment that would be bundled for the episode of care, not for an individual service. And they can take the lead in defining outcomes measurements, Mr. Porter said.

In the article, the authors said that pay for performance models are also going down the wrong track, because they are aimed only at getting physicians to comply with processes of care. That will not provide value to the patient and, with more and more such measures, will likely lead to micromanagement of medical practice, they said.

A study published the same week in the New England Journal of Medicine found that pay for performance proposals under Medicare aren't likely to work well under the current system, because patients' care is not being coordinated by a single provider. In fact, beneficiaries are seeing multiple physicians—typically seven physicians in four practices in a given year—which "impedes the ability of any one assigned provider to influence the overall quality of care for a given patient," wrote the investigators, who were with the Center for Studying Health System Change and the Memorial Sloan-Kettering Cancer Center's Health Outcomes Research Group (N. Engl. J. Med. 2007;356:1130-9).

Mr. Porter and Ms. Teisberg envision a future in which most physicians are allied in partnerships or working for large group practices or staff-model managed care organizations, so that the care can be delivered more efficiently.

Their model is similar to the medical home concept that's being promoted by the American College of Physicians and the American Academy of Family Physicians. Under the concept, insurers would provide a bundled payment to a physician to coordinate care and there would be a pay-for-performance element based on patient outcomes.

Medicare will pay for a 3-year, eight-state demonstration of the medical home, and ACP and AAFP are working with IBM on testing such a program with its employees in Austin, Tex. ■