

A “No Apologies” Approach to Clinical Integration

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Five premises underpin the observations and advice in this column:

1. Quality and efficiency outcomes can be improved throughout the patient care delivery system in the U.S.
2. Medicare and other payers will shift from volume- to value-based payment in an effort to improve outcomes.
3. Value-based payment success requires greater clinical integration among physicians and between physicians and hospitals.
4. Hospital employment of physicians may enable, but clearly does not guarantee, clinical integration.
5. Most hospital-employed physician groups need dramatic improvements in operations. Failure to achieve them will undermine progress towards clinical integration.

Given these premises, we believe that greater clinical integration is in every hospital's and every physician's future and that directors, executives, and physician leaders (i.e., senior leaders) must recognize and prepare for this. It is what it is and there is no reason to apologize for it, but there are reasons to set the stage for the journey and specific steps to take towards implementation.

Setting the Stage: Six Steps

Senior leaders need to prepare their organization for the transition from volume-based payment based on transactions to value-based payment based on episodes of care and outcomes. This will require a wholesale change in patient care processes. Before launching this initiative, the entire organization, including the medical staff, needs a “heads up.” Senior leaders must:

1. **At all times be transparent regarding your vision and rationale.** There is no reason to apologize (you didn't create this environment) and no benefit to secrecy. Encourage civil debate about the future but arm yourselves with facts and make it clear that the status quo is not an option when patients, employers, and payers are demanding change.
2. **Identify the assumptions that new payment algorithms mandate a transition to greater clinical integration.** For example, Medicare's new payment algorithm will be: value = quality/cost + utilization management. Other payers are also moving in this direction and some (e.g., Blue Cross Blue Shield of Massachusetts and Independence Blue Cross of Pennsylvania) are not waiting for direction from the Department of Health and Human Services. In Boston, at



least, the tectonic plates of the healthcare infrastructure have already begun to shift and it's not clear when the seismic shocks will end.¹

3. **State your assumptions regarding the future of physician employment.** For example, “For the foreseeable future physicians will receive their paycheck through a variety of mechanisms. Some will be ‘hospital employed’ while others will remain ‘independent’ in a multi-specialty group, a large single specialty group, or a small single specialty practice.” If you expect the hospital-employed group to grow, be clear about that as well. (*Note to skeptics:* witness the mass migration of cardiologists to the employment model when CMS cut their reimbursement in 2010.)
4. **Express your assumptions regarding the future of physician collaboration.** For example, “Regardless of who signs the paycheck it will be important for physicians to be organized for a variety of reasons including joint contracting with payers and collaborative development of clinical protocols. We value our patient care partnership with independent physicians and will continue to seek ways to work together.”
5. **Communicate your vision for the future.** For example, “Our ambition is to function like an integrated delivery system² within seven years.” Note that some will argue this is too long—it's not. Field experience suggests it will more likely take 10 years.

- 1 For example, a large multi-specialty group diverted its hospital referrals from one prestigious academic medical center to another; a suburban IPA pressured a community hospital to transfer its affiliation with a world-class specialty hospital to a lower-cost hospital in the IPA's preferred payer network; and Cerberus purchased the six-hospital Caritas Christi Health Care System as the foundation for its, self-described, “Southwest Airlines approach” to healthcare delivery in Eastern Massachusetts.
- 2 The goal is to create an organization that achieves the clinical integration of the integrated delivery systems associated with the Council of Accountable Physician Practices (e.g., Kaiser Permanente, Henry Ford, and others). See www.amga-capp.org.

6. **Remind everyone of the organization's mission.** “As a non-profit organization we have a fiduciary duty to the community. In rank order, our priorities are to the a) patient, b) community, c) hospital, d) medical staff, and e) individual physician.”

Board members, in particular, have an integral role in maintaining transparency, developing assumptions, articulating the vision, and adhering to the mission.

Structuring the Physician Component: 10 Steps

Clinical integration is the purposeful fostering of patient care collaboration among independent and employed physicians and a hospital(s) in order to improve quality, patient satisfaction, and efficiency of care.³ Examples of large-scale clinical integration initiatives include Brown & Toland Physicians (San Francisco), Advocate Physician Partners (Chicago), Greater Rochester Independent Practice Association (Rochester), and Partners Community Healthcare, Inc. (Boston). Organizations focused on the more limited integration required for Acute Care Episode demonstration projects in cardiology and orthopedics include Exemplar Healthcare (Denver), Baptist Health System (San Antonio), Hillcrest Medical Center (Tulsa), Lovelace Health System (Albuquerque), and Oklahoma Heart Hospital (Oklahoma City).

Senior leaders need to ensure that the rights steps are taken to properly prepare and implement a clinical integration plan. While the boards' role here is predominately one of oversight (are the structured steps being followed on a timely basis?) there is also an advisory function (is the board visibly supporting the clinical integration effort?). Senior leaders developing a clinically integrated group of physicians should:

1. Determine the size of the population to be served at some point in the future, say seven years out. If the nascent integrated delivery network with 50 percent market share of 100,000 lives wants to grow to 60 percent in 2018 then the goal is to build a virtual multi-specialty group (V-MSG) to serve a population of 60,000. The V-MSG includes both employed and independent physicians.
2. Given the population, run the algorithms to estimate the number of physicians by specialty that the V-MSG will require; then

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- 3 This definition was inspired in part by *Getting from There to Here: Evolving to ACOs through Clinical Integration Programs*, Kaufman, Hall & Associates, p. 3.

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- develop a recruitment and retention plan that also accounts for retirements. Remember that newly trained physicians are anticipated to work, on average, at approximately 65 percent of the productivity level of the generation ahead of them.
3. Determine the physician nucleus around which the V-MSG will be built. For some this may be the existing employed group, for others an existing physician-hospital organization; some may be starting from scratch.
 4. Check with legal council to make sure your V-MSG qualifies under the FTC definition of “integrated.”
 5. Create a V-MSG leadership council composed of selected independent and employed physician leaders. Work with this group to establish a clear charter and accountabilities. In particular, task the leadership council with identification of a minimal set of criteria for participation in the V-MSG. These might include agreement to participate in:
 - An interoperable EMR
 - Clinical protocols
 - Payer contracts tied to performance and/or bundled payment
 - Lean Six Sigma initiatives
 - Utilization of hospitalists
 - Utilization of intensivists
 6. Sustain the “no apologies” attitude. Among other things this means physicians not meeting the requirements for participation in the V-MSG will not be included in it or may not be retained during re-credentialing.
 7. Create an operating council for the hospital-employed group with a specific charter, clear areas of accountability, and a defined policy setting authority.
 8. Dramatically improve the operational performance of the hospital-employed group:
 - Recognize practice management is a unique business that can’t be successfully managed as a hospital department. To be successful the group needs appropriate coding, financial, scheduling, and staffing systems. It also needs operational policies (e.g., human resources) appropriate to practice management versus a hospital.
 - Identify the ancillary contributions of the group in internal financial reporting.
 - Eliminate non-value-adding overhead allocations in internal financial reporting.
 - Continue to refine and improve compensation models tied to productivity and other key metrics.
 9. Proactively work with Blue Cross or another private payer on your own demonstration project in, for example:
 - Cardiology and/or orthopedics (Piggy back on the criteria in the Medicare Acute Care Episode demonstration project.)
 - Diabetes (See Advocate Physician Partners on the Web for examples of benchmarks.)
 - Other chronic disease(s) (See the IHI collaborative series on chronic disease.)
 - A switch to generic drugs (e.g., pilot a free “first fill” program with a retail pharmacy.)
 10. Recognize that clinical integration is more of a journey in continuous improvement and culture transformation than it is a destination. It will take time and it will require change management skills, patience, and fortitude. In the end, patient care will be improved and no one should apologize for that. ●