Alice G. Gosfield

clinical integration and the CFO

The concept of *clinical integration*—loosely defined as "physicians working together systematically . . . to improve their collective ability to deliver high-quality, safe, and valued care to their patients and communities"[a]—has been bandied about as a critical component in the transition to a more value-driven healthcare delivery system.

Virtually everything that happens in a hospital is derived from the work of physicians, in part because physicians have plenary legal authority—the broadest scope of clinical authority under law. They admit and discharge patients. They order services. They perform the most critical and intimate procedures patients will experience. They make referrals. They are the patient's portal to the healthcare system when they are sick.

There are many things hospitals can do to improve efficiency, safety, and value, but unless they actively engage physicians—whether employed or independent—they will not be able to achieve optimal results.

In the past decade, forward-thinking hospitals and health systems have worked to more effectively engage physicians in quality improvement. But the organizations can no longer be the sole drivers of this effort and expect to meet the demands of a value-based business environment. Rather, physicians and hospitals together will have to transform their relationship in much more fundamental ways to achieve clinical integration—not episodically, not project by project, not when the surveyors are coming soon, but in a systematic way, deploying well-thought-out and articulated principles of engagement. Physicians and hospitals also will have to share not only the risks and rewards of changed processes, but also accountability for measured results of care.

How CFOs Can Promote Integration

To move care delivery beyond the status quo, healthcare CFOs and other senior leaders must have a vision of what full clinical integration for their organization will

AT A GLANCE

Healthcare CFOs should consider five strategies for promoting clinical integration:

- Seize the opportunity to work with physicians in demanding credible payment models from payers.
- Collaborate with physicians in redesigning compensation models and processes of care.
- Establish financial relationships with physicians who are not employed by the hospital or health system.
- Develop data-sharing relationships with referral sources.
- Become actively involved in creating an articulated, transparent approach to capacity control.

a. Gosfield, A., and Reinertsen, J., *Achieving Clinical Integration with Highly Engaged Physicians*, whitepaper, November 2010, gosfield.com/PDF/ACI-fnl-11-29.pdf.

CFOs' involvement in coordinating the multiple moving parts of a clinical integration strategy will be key to limiting financial risk while allowing new initiatives to flourish.

look like and understand what it will take to achieve that vision. They also must regularly measure performance and be transparent about their results with physicians, other clinicians, and the communities they serve.

CFOs should undertake five strategies to promote clinical integration within their organizations.

Work with physicians in demanding credible payment models from payers. CFOs should engage with physicians in demanding that payers base quality incentives on metrics that can be easily measured, and in ensuring that upside reward and downside risk are clearly defined in contracts—in ways that physicians can clearly understand. CFOs also should carefully consider how many risk-based contracts their organizations would be willing to enter altogether, how much risk their organizations could afford to assume in such arrangements, and how much reserves their organizations will require to take on downside risk, in particular.

Collaborate with physicians in redesigning compensation models and processes of care to deliver better value. How physicians are compensated will affect the success or failure of a hospital or health system's clinical integration strategy. Many organizations are moving away from pure work-relative-value-unit compensation models and are placing increased emphasis on measures that reflect quality of care, efficiency (e.g., using length of stay as a hospitalist compensation measure), and productivity. Unfortunately, most hospital-physician employment contracts are nowhere near as refined as they will need to be to support clinical integration that works. In many instances—particularly in cardiology and neurosurgery—hospitals not only are paying physicians more than the physicians were making in their own practices, but also are not taking action to support and motivate them to deliver better value. More than that, if CFOs do not actively engage and collaborate with employed physicians to move to true clinical integration, such employment arrangements will not be financially viable over the long term.

For example, CFOs should engage physicians in the design, implementation, and measurement of the results of initiatives focused on improving quality of care while reducing cost. They also should work with physicians in designing models that discourage overuse of services—a strategy that will be key to the long-term survival of hospitals and health systems, even though it may be counterintuitive to the "heads on the beds" philosophies of the past.

Establish financial relationships with physicians who are not employed by the hospital or health system. Financial relationships with independent physicians are also a critical aspect of clinical integration and can be varied. Comanagement contracts with medical staff members for service lines—or even, in some instances, of the whole hospital—offer the opportunity to integrate independent physicians in improving performance while motivating them to become more fully engaged in improvement initiatives. In addition, paying independent medical staff members for improved hospital quality performance is explicitly permitted under the Stark law. Joint ventures with physicians also can enhance the organization's ability to work with and motivate physicians in improving results in key areas. CFOs' involvement in coordinating the multiple moving parts of a clinical integration strategy that incorporates such elements will be key to limiting financial risk while allowing new initiatives to flourish.

Develop data-sharing relationships with referral sources. The extent to which the clinically integrating entity shares data with referral sources, including financial data related to performance and payment models, is important where broader collaboration is sought from otherwise independent providers. An increasing

number of hospitals have begun to engage with referral sources around matters of common interest and even pay them for time spent in such endeavors (e.g., primary care physicians who do not admit patients, but who sit on hospital committees to provide insight and information) to support clinical integration. The CFO has a major role in how such referral sources are included or dealt with in broader accountable care organization-type initiatives.

Become actively involved in creating an articulated, transparent approach to capacity control. Diagnostic and treatment technology arms wars are no longer viable strategies and will be even less so for the foreseeable future. CFOs should lead efforts to align capital budgeting with their organizations' goals of clinical integration, with significant involvement from the physicians to ensure transparency. This shift in thinking also will incorporate a focus on margins, rather than revenues, as the organization moves toward adopting a culture in which "value becomes a value."

Seeds of Change

Strategies that connect directly to clinical integration will inevitably require and produce significant culture change in hospitals and health systems. The greatest power from these strategies will result from intense involvement with physicians who help to articulate a vision of what the organization could become with senior leadership support.

CFOs' understanding of the new roles for physicians in these strategies and their involvement in engaging physicians around these issues will be critical. In the last analysis, alignment strategies that motivate physician employment and engagement with independent medical staff physicians and others should be seen as part of a far broader and deeper culture change. Such culture change is the purpose of clinical integration. ●

Alice G. Gosfield, Esq., is principal, Alice G. Gosfield and Associates, P.C., Philadelphia (agosfield@gosfield.com).