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Crossing the bridge to the corporate world: Getting clinicians involved

an interview with Nancy Beckley
President, Nancy Beckley & Associates LLC

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by Alice G. Gosfield

How clinical integration lowers fraud and abuse risks

» Clinical integration can only begin with physicians working with each other.
» The standardization in clinical integration can lower false claims liabilities.
» Clinical integration requires that the collaborators adopt "value" as a value.
» The Stark regulations allow hospitals to offer free compliance training to staff members with continuing education credit.
» Hospitals that employ physicians will not succeed if they do not help their recruits to clinically integrate.

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It has now become almost a truism that for providers to survive in the changing healthcare environment, clinical integration will have to become widespread. Yet few have taken the opportunity to articulate what clinical integration ought to mean and how it can be accomplished. Even less well understood is how clinical integration can lower fraud and abuse risks.


Gosfield

Essential concepts

Although many make the argument for physician engagement with institutional providers, in the last analysis, if physicians do not engage with each other around changing both their clinical processes of delivering care and the administrative mechanisms to support those changes, facilities such as hospitals and nursing homes that seek physician engagement will confront chaotic, individualized behaviors which will not advance the common goals at work in the healthcare system. A practical, fundamental definition of today's sought-after clinical integration would be:

> Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.[1]

The key words here are (1) "systematically"—not episodically, not from time to time, not when the surveyors are coming, but as part of an organized, ongoing cultural change; and (2) "collective,"—that the success of all will matter, especially as payment models change and physicians are more accountable for care delivered to more than just their own patients.

As the architecture within which physicians' collective activities alter, the fundamental need to clinically integrate remains, regardless of setting. This is true, whether physicians act in a stand-alone group practice, within the hospital's organized medical staff, in a newly forming accountable care organization (ACO) structure, as hospital or system-employed physicians, or in a network which has come together just to participate in a bundled payment model. They cannot integrate with others, especially within complex institutions and organizations, without having a driving sense of what they are doing with each other.

Attributes of clinical integration

Across a range of contexts, there are common factors to take into account in developing a

clinical integration strategy. These can be seen through a framework of the "Four Fs":

- the Form of the enterprise,
- its Function,
- its Finances, and
- its Feeling or culture.[1]

To get from the status quo to a more fully clinically integrated undertaking, it is essential to start with an assessment of where things are. Two tools have been created to facilitate this work for the physicians who would seek to come together, as well as those who would seek to work with them. One has been developed for medical groups, employed physicians, the organized medical staff, and a newly forming ACO-type entity. The other is for otherwise independent providers to join together in a network. For each of 17 attributes, the tools postulate what it would look like if the participants were barely in the game, to making an effort, to committed and capable. The tools give participants a vehicle through which to contemplate specific actions that would have to be taken to move from the left side of the chart to the right.[2]

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Among the Four Fs are attributes not particularly relevant to fraud and abuse concerns. Included under Form and Function are the clarity of mission, confidence in management and leadership, expectations regarding leadership and followers, and patient centeredness. Finance and Feeling include far more that touches on the fraud and abuse pitfalls that clinical integration can mitigate.

The extent to which new payment models predominate (including bundled payments, bundled budgets, episode rates, capitation, or full risk), rather than the fee-for-service model is a primary marker of clinical integration. There is now agreement among more clinically integrated entities that they do not want fee-for-service payments.[3] That shift moves the participants considerably away from the type of fraud and abuse risks associated with documentation of services and their medical necessity, and toward the use of delivery models such as group visits, which are barely recognized in fee for service. Next, where physician compensation models within the integrating entity reflect external market drivers for efficiency, economy of resources, patient satisfaction, and quality performance, the venture moves away from the traditional emphasis on either high work Relative Value Unit (wRVU) services, or a high volume of services to meet productivity measures, thereby decreasing risks of over-utilization.[4]

How physicians engage with others financially in joint ventures, co-management arrangements, or other forms of explicit collaboration is an attribute of clinical integration as well. The more clinical collaboration among them the better, but when payers bolster these arrangements with support, as they increasingly are doing,[5] the integration gets stronger while the false claims liability and Stark-type referral worries decrease. Another significant theme of clinical integration is standardization: (1) to guidelines, clinical protocols, and the evidence base; (2) in to whom referrals are given and from whom referrals are taken; (3) in documentation; (4) in deployment of non-physician

practitioners; and (5) in implementation of electronic health records. Where the expectations are that physicians, other clinical team members, and those with whom they work will all be following the same musical score, using standardized techniques, the false claims risks that come from idiosyncratic practice styles, particularly in Medicare and Medicaid, are significantly lowered.

To know that standardization is occurring depends on measuring performance. Being transparent with the results is part of the concerted data-sharing policies that provide the foundation for clinical integration. The whole point of clinical integration is to increase quality performance while lowering costs. Unlike a fee-for-service driven setting, it is hard to imagine a truly clinically integrated enterprise where cardiologists would be criminally charged with over-stenting patients who did not need the procedures. At the same time, clinical integration can help avoid the pitfalls of new forms of "quality fraud" in terms of both improper care and inaccurate reporting of care and results.[6] In addition, a principal tenet of clinical integration is to make "value" a value of the collaborators. Of necessity, this means confronting both capacity control and utilization, which will be increasingly important as the fraud and abuse enforcers focus more and more on over-used procedures and waste.

Although the primary emphasis in this consideration has been on physicians integrating with each other and in relationship to hospitals, nursing facilities, and other organizations, many of the same issues will have to be confronted in a collaboration among all the parties focused around the institutional manifestations of the attributes of integration. Because so many of them depend on physician engagement and the clinical integrity of the decisions made, the self-assessment tools can serve as a conversation starter as the parties come together in new ways.

Practical considerations

How to get started has confounded many physicians who would like to come together to change the way they conduct business. One of the major positive supports that institutions could offer in these contexts is education that the physicians can apply, even in their own practices. In fact, the Stark regulations have provided a safe method to permit what they refer to as free "compliance training" for which the hospital can make continuing medical education credits available as well. The training can extend to family members of the physician along with office staff, as long as the physician practices in the entity's local community or service area and the training is held in the local community or service area. When the regulation was published in 2007, there was a relatively bounded concept of what compliance training entailed. For purposes of the regulations:

> Compliance training means training regarding the basic elements of a compliance program (for example, establishing policies and procedures, training of staff, internal monitoring or reporting); specific training regarding requirements of Federal and State health care programs (for example, billing, coding, reasonable and necessary services, documentation, or unlawful referral arrangements); or training regarding other Federal, State or local laws, regulations, or rules governing the conduct of the party for whom the training is provided.[7]

Seven years later, with the passage of the Affordable Care Act and multiple other regulatory initiatives, the education that could be made available is far broader. Clinical integration itself could be the subject of education, as could standardization and other techniques, under the compliance training rubric. These approaches can be a significant bonding strategy for hospitals with their staff physicians

or community-based physicians, but where hospitals employ physicians, the movement towards formal clinical integration among them is just as important.

Many of the recent hospital employment relationships into which physicians and their employers have entered have done nothing to help physicians come together to work better. Because the impetus to many of these employment relationships was the desire for financial security from highly compensated specialists, many of the employment transactions have little core content to them.[8] Implementing the Clinical Integration Self-Assessment Tools in the employed physician context can begin the process of creating more value in these transactions. The transactions will be unsustainable if all they do is offer physicians increased compensation with no change in their behavior.[9]

Conclusion

The fraud and abuse enforcement environment is unquestionably heating up. New focuses on overuse, inadequate quality, and inaccurate data reporting join the traditional fee-for-service-based false claims liabilities that have long plagued physician practices and those doing business with them. The purpose of clinical integration is to improve the quality and value of services rendered. The mechanisms by which those changes can be achieved entail significant standardization as well as careful attention to the financial context for the operations. A deliberate focus on a clinical integration strategy can lower fraud and abuse risks. Above all, however, it can improve the health of patients.

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