Clinical Integration: Getting From Here to There

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Although "clinical integration" arose as an antitrust term, the broad principles of clinical integration have become central to any conversation about hospital-physician alignment. Hospitals and physicians face powerful new financial incentives to improve quality, reduce harm events such as infections and readmissions, and improve value, and virtually every strategy to succeed would require significant levels of clinical integration—particularly as we define it:

> *"Physicians working together, systematically, with or without other organizations or professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities." (*Gosfield and Reinertsen, "Achieving Clinical Integration with Highly Engaged Physicians," November, 2010, http://uft-a.com/PDF/ACI-fnl-11-29.pdf.)

Many hospitals are intently pursuing structural approaches to this challenge, by purchasing primary and specialty practices, aligning with large multispecialty groups, and forming "accountable care" organizations. It is our view that these structures are at best a partial solution to clinical integration, and at worst a major distraction, as various players jockey for money and power.

We believe that any health system that seriously intends to become more clinically integrated must have a clear idea of the functional, financial and cultural requirements necessary for success—not just the structures. A good way to initiate a conversation among the medical staff and the hospital about these matters is to ask them to do a frank self-assessment of where you are, and where you need to be, in terms of some very specific attributes of clinical integration.

A Clinical Integration Self-Assessment Tool

To help hospitals and health systems have a productive conversation with their doctors, we have developed a Clinical Integration Self-Assessment Tool [http://uft-a.com/CISAT.pdf] (Note: this tool is freely available to all, with no strings attached of any kind.) We identified 17 attributes of clinically integrated entities, cutting across governance, leadership, payment, compensation, standardization of operations, teamwork, capacity control, and cultural focus on "value as a core value," and developed descriptions for each attribute of what an organization would look like at the most primitive levels of clinical integration, as well as at mid-stage and at fully-developed

clinical integration. It proved useful to divide the descriptions into two categories, based on whether the physicians are employed (e.g. in a multispecialty group and hospital-employed practices) or independent "free-range physicians" (e.g. the organized medical staff of a hospital that is trying to bring the physicians into an ACO.) The example shown in Figure 1 shows how the tool is laid out for the attribute "Control Capacity of Services."

How to Use It

The principal use of this tool is as a generator of meaningful conversations among physicians, and between the hospital and its medical staff. We have observed such conversations to give clarity to the obstacles present in the current patterns of behavior, operations, and other attributes of any given system. It can also engender a clearer picture of where an organization is headed, in a way that gives everyone a realistic view of what is needed to succeed. A good procedural method is to ask physicians and administrators to quickly scan the tool individually, and circle the descriptor that appears most apt for their situation. They then share their assessments in small groups, and discuss differences of opinion about various attributes of integration, and in particular, where it needs to go. We have found that it might be helpful to leave the "fully committed and capable" box blank for a few attributes, and to ask groups to fill in their own desired future states.

We do not believe that our descriptions are in any way necessary evolutionary stages. We also recognize that the 17 attributes that we singled out are by no means a complete set, and we encourage local modification and improvement of the descriptors and attributes. In addition, we hope that others will share their applications of the tool. We already have one refinement of our work applied in a Canadian academic setting [http://uft-a.com/CISAT.pdf].

Making it Real

It's obviously not enough to have conversations. If clinical integration is to become real, conversations must be translated into physician employment contracts, medical staff bylaws and compacts, the privileging criteria used to evaluate the medical staff, operating processes and systems, compensation system designs, co-management contracts, human resource policies, and many other physical manifestations. The self-assessment tool doesn't make this work any easier—but it does give everyone a clear, shared idea of what the work of clinical integration is, why it needs to be done, and where it is ultimately headed.

Figure 1: Self Assessment Tool Descriptions for the Attribute “Capacity Control”

	Not Really in the Game	Making an Effort	Committed and Capable
We are either a multi-specialty group practice, or we are hospital-employed physicians	Our physicians like to be on the cutting edge with new technologies. Wherever possible, we buy and use the latest imaging and other technologies, because they increase our group’s revenues. We wonder if some of our doctors are over-utilizers, but we don’t have any data on this.	Because of RAC audits on medical necessity, we document very carefully. We are beginning to track utilization patterns of our doctors, but take no action. We rarely say “no” to a new technology, especially if we or our physicians can bill for it.	We make our decisions on new technology based on “best value for patients” rather than “highest revenue opportunity for us.” This includes our recruitment decisions as well; we don’t bring in doctors who appear to be major drivers of overuse of technical procedures that are lucrative for them, but of little added value to our patients..
We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We acquire technologies to keep our physicians happy and increase our revenues. We will buy the expensive diagnostics the cardiologists can’t bill for anymore, even though the higher co-pays are bankrupting our patients. We haven’t found a titanium implant or other new technology we don’t like. If we build it, they will come.	We’ve started to be concerned about the technology use of some of our medical staff, especially in their offices. Our concern is partly about our cost profile to purchasers, but it’s also about internal competition. With what’s in the hospital plus our physicians’ offices, we have more MRI capacity than most small nations. We know that’s a problem, but are struggling to do anything about it.	We’ve revised our recruitment and capital planning processes with the explicit aim of controlling the capacity of overused services in our community. For example have actually said “No” to the acquisition of a urology practice that wished to continue office radiation therapy. We have sent a clear signal that members of the ACO must clear it with the ACO board before acquiring expensive new technologies.

To read more about Alice G. Gosfield, Esq., click on her CHG biography

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