

# Informed Consent to the Ties that Bind: Clinical Integration

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## In this article...

If you're already aboard or about to board the physician/hospital integration train, take a moment to ask some critical questions and consider the consequences.

A major hospital and its physician leaders are considering closer alignment as a “clinically integrated” system. The situation is complicated:

- The hospital’s medical staff is largely made of up independent “free-range chickens” who are also on staff at several competing hospitals in the area.
- Among the medical staff there is a 110-physician multi-specialty group, 28 physicians who are employed by the hospital in one role or another (hospitalists, ER, etc.), and several single-specialty “cartels” that dominate those specialties across the region (colorectal surgery, anesthesia...)
- Recently, a surprising number of physicians, in specialties such as orthopedics and cardiology, have come quietly to the hospital to express interest in becoming hospital employees.
- Preliminary meetings with the leaders of the multispecialty group, and other key physicians, uncovered a good deal of interest in coming together to form an “accountable care organization (ACO),” although there is uncertainty as to what that is. The main attraction for the doctors appears to be the prospect of better reimbursement rates.
- The hospital has engaged a consulting firm to help form something, and the first big meetings are scheduled for next week. In early conversations, the consultants have estimated that the potential costs for the IT development, salary guarantees, and other initial investments and ongoing expenses to create and operate the virtual equivalent

of a large medical group will total as much as \$30 million over the next five years.

As a physician or a hospital executive do you know what you're in for? Have you been fully informed as to the complications and risks of the procedure you're about to undergo? Have you signed an “informed consent” to have this surgery?

## Now in theaters

This movie, or a variation, is playing right now in almost every community in the United States. Prodded by impending health reforms, hospitals are racing to form medical groups, to employ physicians and to clinically integrate with their medical staffs.

Rattled by relentless reimbursement reductions, many doctors who have remained proudly independent for years are now seeking financial shelter and security. All the players want to position themselves well for whatever imagined health reform scenarios unfold, including bundled payments and a new emphasis on value rather than volume.

All reform scenarios raise the importance of being able to deliver value—and specifically, measured performance on quality, safety, and coordination of care, with control of cost growth (primarily, reduced overuse).

Reining in costs is critical if the uninsured are to be covered. Otherwise, the Centers for Medicare and Medicaid Services’ only alternative is to reduce the rate of payment. If doctors can’t change their current behaviors and fee schedules are cut further, the only way to maintain income is to run faster and faster on the fee-for-service treadmill.

Many of us think we saw this movie in the mid-1990s. Much feels the same—e.g., hospitals competing to purchase primary care practices. But this is a new movie, not a remake. It was almost unheard of in the ‘90s for cardiologists and orthopedic surgeons to seek employment.

The prospect of bundled provider payments seems much more real today than it was 15 years ago. Performance measurement of quality and safety has evolved substantially. And perhaps most importantly, awareness of the enormous impact

of unexplained regional variation in cost and utilization of services has opened everyone's eyes to the quality problem of overuse.<sup>1</sup>

So, while this is not the 1990s, many hospital leaders would rather not relive the massive financial losses, shattered trust, and nasty aftertaste that resulted from that last great spasm of organizational integration.

## Flashback

The last time this phenomenon appeared, the hospitals' main interests were control and ownership to command good payment rates. Today, the market emphasis is far more on clinical results and value and far less on structure and consolidation for its own sake. This difference increases both the options available as well as the complexity of the undertaking.

Still, many tout the acquisition/employment technique as the easiest way to produce results,<sup>2</sup> often referring to the Mayo Clinic, Intermountain Health and the Cleveland Clinic, among others, as examples. But this simplistic analysis does a disservice to all, including misperceiving the core distinctions of the cited exemplars. Mere employment of physicians is hardly the whole story of their success.

If you are feeling propelled toward some sort of clinical integration today, we believe you should pause, and ask your consultants, and yourselves, some key questions. These questions are based on the authors' experience of both successes and failure over the past three or four decades: in one instance, as a leader of large, complex, multifaceted clinically integrated systems, and in the other, as a lawyer advising physicians and hospitals through endless varieties of relationships and situations, including many versions of clinical integration.

It is our intent that by asking these questions, and by considering some of the common answers, you might gain the equivalent of an



**If doctors can't change their current behaviors and fee schedules are cut further, the only way to maintain income is to run faster and faster on the fee-for-service treadmill.**

# It is not only legitimate to work on reducing costs, it is mandatory.

“informed consent” to this procedure—clinical integration—that you’re about to undergo.

By the way, the concept of clinical integration itself is not fixed. It emerged in 1996 as an option under the antitrust rules to allow otherwise competing physicians to stay independent, organize themselves around standardized procedures and improved quality, and still be able to bargain together for fees.

But many stand-alone group practices are now learning to clinically integrate within their own practices and others are integrating with their hospitals. The new drivers of quality, value and changed care processes are the hallmarks of the new clinical integration. Today, antitrust is secondary.

## Why is this procedure necessary?

When we ask the question “Why are you—hospitals and physicians—tightening your bonds?” we are hearing some answers that make us nervous, and in our mind, should cause you to ask the nurse to stop the gurney before you’re wheeled into the operating room.

- **Herd mentality: “Everyone else is coming together.”**

The “everyone else is doing it” answer wouldn’t make you feel very comfortable about undergoing painful surgery, and it doesn’t stand up as a reason for doing clinical integration, either. There are many subtle versions of this rationale—often unspoken—but watch out for it. Did it work in the 1990s?

- **The Tooth Fairy argument: “We’ll be so much more efficient.”**

The notion that you are going to get “administrative efficiencies” by creating large networks of doctors that work together with each other on quality problems, devise clever new compensation schemes, and negotiate and implement successful complex deals with various payers—is laughable. If there are any such economies of scale in health care, we haven’t seen them.

- **Fear: “The alternative is even worse.”**

One of the ways that hospitals were able to choke down the huge losses associated with the purchase of primary care practices in the 90s was this peculiar rationale: “We’ll lose lots of money if we buy these practices, but we’ll lose even more if we don’t.” Fear tends to drive bad decisions, both for doctors, and for hospitals. This time around, the fear appears to be stronger on the doctors’ side of the equation, but it’s a bad rationale, either way.

- **Anabolic steroids: “We need to bulk up quickly so that we can negotiate contracts. We’ll worry about actually delivering on the contracts later.”**

This is perhaps the scariest of all the rationales for clinical integration currently being voiced. Many advisors say “You shouldn’t do this just to be able to negotiate contracts.” But their strategies and actions—especially, their emphasis on quickly getting to size and scale in a given market—should tell you what their real strategy is. And just

like anabolic steroids, this strategy will build an impressive appearance on the field in the short term, and leave a legacy of toxic side effects in the long term.

- **Blind trust: “The lawyers say this is the only way to deal with the doctors.”**

There are, indeed, many legal issues, including Stark, antitrust and Medicare reimbursement, that must be considered. But we see far too many situations where a law firm is marketing its newest solution, or the lawyers have hijacked the strategic planning with overly restrictive guidance. Lawyers are advisors, and should never run the show.<sup>3</sup>

Here are some better answers from the surgeon, before going forward with this operation.

- **Professional aspiration: We can deliver better, safer care for our patients, and our community, by working together rather than separately.**

The vast majority of people—even doctors—has a deep-seated need to improve what’s not working well. We know our patients and communities want a better care system—better outcomes, a better experience using the system, and lower costs. Real clinical integration—not just structural revision—offers an opportunity for doctors, and hospital leaders, to be part of what’s right, rather than what’s wrong, with American health care.<sup>4</sup>

- **Realism: There are some hard things that need to be done to fix the care system: we will either have to do them for ourselves, or someone will do them to us.**

Designing and operating a better care system is going to require a great deal of give and take, and a lot of changes in longstanding



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behaviors. One strong appeal of clinical integration is that it offers participants the opportunity to lead these changes themselves, rather than to be the passive recipients of changes designed and ordered by others. For example: A clinically integrated system might take hard steps to reduce overuse of imaging services and elective procedures—involving a good deal of pain, and reset expectations, for some providers—but this change might avoid otherwise inevitable blunt force rate cuts for all providers.

- **Stepping up to leadership: We're tired of just working in the system. We want to work on the system.**

By coming together in meaningful forms of clinical integration, doctors have the opportunity to work on some of the things that frustrate them the most—particularly, wasted time and poor clinical outcomes—caused by poor communication and coordination of care across the boundaries of practice sites and facilities.

The idealized solo community practitioner of long ago was a doctor both for individual patients, and for communities—with influence on resource allocation, design of care systems, and oversight of public health and hygiene. Clinical integration, in a peculiar way, offers individual doctors a return to some aspects of that second role—as responsible designers of care systems, not just workers in care systems.

## What are the core values and principles?

No organization succeeds over the long term without establishing clearly shared values that guide everything from daily behaviors to big strategic decisions. When you ask your consultants about core values, here are

some answers that should make you nervous.

- **Ignorance: “What does that touchy-feely stuff have to do with success?”**  
Few would actually say this out loud, but their body language and actions might. Run, do not walk, from the operating room of this “clinical integration-ologist.”
- **Structural emphasis: “We need to put everyone in the right boxes first. Then the clinical initiatives can emerge.”**  
Whatever you are doing should be about changed clinical processes for improved outcomes and better value. Governance matters, but a good approach to the future is not going to be about who owns what within which four walls, but about what clinical work gets done by whom and how.
- **Patronizing procrastination: “We’ll have a retreat about that after we get all the legal and structural stuff worked out.”**  
No, actually, your “legal and structural stuff” are precisely the sort of major decisions that should be driven by your values.
- **Protectionism and historical preservation: Our bedrock principle will be “holding on to the last bastion of American free enterprise in medicine.”**

Some doctors appear to be attracted into clinical integration based on the false premise that “If you join up with this thing, you can continue to practice pretty much as you always have, and we’ll go to bat for you and protect you from all those who wish to impose on how you practice.” If protecting individual professional autonomy is a core value—spoken or unspoken—of whatever you’re planning to do,

it won’t be clinical integration, by definition, and, this surgical procedure is going to go very badly. You probably won’t even get out of the operating room.

In our view, these are some much better answers to the question “What values will guide us?”

- **Our patients are the only customer.**  
One of the major flaws of the current delivery system is that in all too many instances, it is designed to serve the doctor as the primary customer—not the patient. Successful health care providers will focus everything on serving the needs of patients and families.
- **Value as a value: We’re responsible for delivering quality outcomes and high levels of service at a reasonable cost.**  
It is especially important for doctors to accept that it is not only legitimate to work on reducing costs, it is mandatory. For too long, many have regarded cost reduction as a necessary evil. The successful “clinically integrated thing” will regard the creation of customer value—including reducing costs while maintaining quality—as a core value of the organization.
- **Learn, grow, and change:**

Being clinically integrated will mean massive change for doctors and administrators—in individual levels of autonomy, in ways of working, in how services are organized, in the daily routine of work, in the economics of the practices—in everything. Before anyone joins the party, it would be useful if they were told...“If you sign up, you will be expected to change and improve—every day, every month, every year and in many ways.”

## Who will play?

This is perhaps the most important question of all—but it can only be answered after struggling with the first two questions about why you’re forming something new and what its core values will be.

If your primary purpose is simply to negotiate better contracts, or if one of your core values is physician protection from change, then it doesn’t matter that much who you invite.

Here are some examples of the dilemmas that leaders are facing:

- Will you invite groups to join, or will you invite individual doctors within groups? It is not unusual to find a group of six doctors in which five wish the sixth had never joined them—because he’s not a team player, doesn’t take call responsibly, and is an absolute terror to staff and sometimes even to patients. Do you sign up the whole group or do you invite the five you want, but not the bad apple?
- How much will you spend to get what you need? You do not want to reprise the “cash for clunkers” program of the 90s that had to be undone when purchased practices failed to perform as advertised. Do you really need to buy anyone? Clinical integration can produce results without ownership, merger or consolidation. It is about clinical collaboration among the participants and not ownership. Direct employment of the physicians alone guarantees nothing about value or quality results.
- If you decide to invite only individual doctors who share the new core values, how will you evaluate whether they actually share the values or, more importantly, can actually live those values? Who will decide whether they meet your criteria for membership?

If you ask these sorts of questions of your “integration-ologist,” there is one particularly prevalent answer that raises our eyebrows:

- Our first priority is to get everyone possible into the tent so our footprint is big enough that payers will take us seriously. If docs don’t fit because they don’t follow protocols, or cooperate with others or treat patients and families with respect, or run up huge costs with unnecessary procedures, we’ll sort them out later. Basically, if you’re on the medical staff, you’re welcome.”

If you’re actually trying to create something with new capabilities, this approach is absurd. The bar for medical staff membership has generally been set fairly low compared to what true clinical integration will require. But is your hospital’s medical staff bar high enough for what you’re now setting out to do? In most hospitals, it doesn’t come close.

There’s another very practical problem associated with this “we’ll sort out the problems later” approach: lots of legal fees. The most difficult problems of medical groups are caused by bad hiring decisions. Your best shot at getting something done right is at the beginning. You are condemning yourselves to mediocrity, and nasty legal battles with poor performing, disaffected physicians, if you don’t address this upfront.

A much better answer to this question would go something like this:

- “We are going to form our clinically integrated organization around a small, committed nucleus of doctors and administrators who share our values, and we’ll build it from there.”

ACOs such as Mayo, and Geisinger, didn’t get built in a few months. And they certainly didn’t take the “everybody into the tent and we’ll

sort the wheat from the chaff later” approach.

We’re aware that there is a real tension here from time pressure. To succeed you must get to some reasonable scale faster than it has taken to build the Mayo Clinic. But that doesn’t mean that you can’t have explicit, written, high standards for what it means, professionally and culturally, to be a member of your new enterprise, and that those who sign on are absolutely clear about how those standards translate into expectations for behavior and practice.

Neither does it mean that you can’t demonstrate, with early, high-visibility examples, that you are absolutely serious about removing those who don’t share your values, even though they signed their membership papers.

And, while we’re talking primarily about hospital/physician relationships, clinical integration is also an opportunity for many longstanding multispecialty groups to reflect on these same questions. Some of these organizations provide superb examples of the very highest value health care, when doctors work together as a team, in a strong organizational system.

But too many others are basically fee-splitting and overhead-sharing schemes, rather than real group practices. They need to reinvigorate strongly shared values of patient-centeredness, value creation, and commitment to ongoing learning and change. Perhaps leaders of all multispecialty groups might ask: “Are we really all that clinically integrated ourselves?”

## In the end

What is the endpoint? Are we going to be a hospital that happens to employ most of its physicians in some sort of a group? Or is it going to be a physician group that happens to have an inpatient care facility in its midst? Or....?

**What Doctors and Administrators Might Say to Recruits, or in Parking Lots, or in Depositions, About Your Clinical Integration Five Years from Now**

**Best Things**

One of the best decisions I ever made. Nobody else in town can do what we're doing for patients. I love coming to work.

We own and control our own destiny. It's not easy, but we do the hard things for ourselves, rather than wait for them to be done to us.

I never thought I'd say this, but our administration is actually helpful! They fix things that go wrong, and make it easy for us to do things right.

We get paid fairly for what we do and we do better as a clinically integrated team than we did when we practiced in our own silo. Our performance commands respect and recognition.

We have a real sense of True North around here. Everything revolves around the answer to this question: "What is the right thing to do for our patients?"

**Best**



**Worst Things**

Nothing I say matters. This is just a job, and not a fun one at that. I've checked out, emotionally. I'm still here, but I'm just going through the motions.

This clinical integration thing was just a scheme to enrich a few doctors, who are in cahoots with the "suits" at the hospital. I got screwed.

The administrators are green eye shades who only care about money. None of their promises are worth a nickel. I never should have trusted them or anyone else.

The administrators cheat us at every possible turn. They keep everything for the hospital and make us fight for every penny. This is worse than every bad fee schedule a payer ever gave us.

I know a lot of things that aren't too savory about how this clinical integration thing came to be and I'm thinking of blowing the whistle.

**Worst**



There isn't necessarily a single or right answer to this potentially uncomfortable question that brings up very deep-seated issues about ownership, control and identity. But we think that it should be raised, early and often, because it will define many aspects of what unfolds: how decisions are made, resources allocated, and services designed.

Hospital administrators argue, with some justification: "We're underwriting this whole adventure—paying consultants, guaranteeing salaries,

hiring administrators. No way are the doctors going to run the show."

And doctors say, with some justification: "The most successful examples cited—Mayo, Geisinger, Kaiser Permanente—are run by doctors. The vast majority of the cost decisions are made by doctors. Eighty percent or more of the care is delivered in clinics and doctors' offices, not in hospitals. So it makes sense for the doctors to own and operate these entities."

Rather than resolve this tension, we have a cheeky proposal: As you

pick your way along this path, have this conversation in a public room, surrounded by patients and families in your community. The conclusion isn't foregone, but we do believe that the presence of patients would silence some of the more self-serving arguments that might be put forward, and would drive a better degree of give and take among the parties.

However you answer this question, we believe that you must agree on the long-term vision of this new thing that you're creating—and that

it has to be more uplifting than just being able to negotiate better with payers and maintain market share for the hospital!

What can you learn from those who've undergone this procedure before you? What complications did they have? Are they happy with the results?

The longest experience in clinical integration has been in large multi-specialty groups. Consider some of the best and worst things that doctors have said about those settings. What follows is a composite from our combined experience of working with these entities for over 30 years:

So, we've asked a lot of questions, and we'll finish by asking two more:

1. Do you think you have been educated about and have truly considered all the risks, so your consent for this clinical integration operation is truly informed?
2. Are you ready to be wheeled into the operating room?



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