CLINICAL integration is back

How you can take charge in the quality-driven health reform environment

Many physician groups don't employ clinical integration in their own operations.

They should.

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"The essence of clinical integration is the interdependence among healthcare providers. Put simply, each provider must have a vested interest in the performance of the other providers, such that their financial and other incentives are closely aligned to meet common objectives. In addition, physicians are more likely to conform their behavior to network goals when their performance is judged by objective standards, in comparison to their peers."

Commissioner Pamela Jones Harbour, Federal Trade Commission, speaking April 27, 2009, to the American Hospital Association[1]

As proposals for "accountable care organizations" and other forms of provider bonding have emerged on the policy landscape, we have heard again about clinical integration. Clinical integration first appeared as an antitrust concept in joint statements published by the Federal Trade Commission (FTC) and the Department of Justice in 1996.[2] Since then, although the FTC has settled multiple price-fixing cases in which nonintegrated physicians bargained together, the agency has produced only three advisory opinions approving proposed clinically integrated networks.

However, the antitrust implications of clinical integration are really beside the point today. Clinical integration has far greater significance as a management technique in a more quality-driven, waste- and cost-controlled context, rather than as an excuse for physicians to bargain for higher fees.

The real principle behind clinical integration is for providers — whether physicians on their own or physicians with hospitals — to come together to standardize

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their clinical behavior for better, more efficient patient care. Clinical integration ought to have nothing to do with whether anyone pays more money to the engaged participants. If clinical integration is real, those physicians can bargain for fees together. Of more importance in some ways, though, is the fact that many physician groups don't enjoy clinical integration in their own operations. They should.

Historical integration

The federal government published antitrust safety zones just after the Clinton health-reform plan failed. The American Medical Association pushed for physician unions; integrated delivery systems were purportedly coalescing around the country. Group practices "without walls" were forming. Single-specialty megagroups were coming together to gain access to ancillary services compliant with the Stark statute that forbids physician self-referral. Hospitals sought to acquire physician practices — predominantly primary care — and created multientity systems. These structural integrations would permit multiprovider fee bargaining.

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Financial integration was difficult and often unsuccessful. In many geographic areas, independent physicians didn't have the option of financial integration because health insurance plans wouldn't contract that way. The messenger-model individual practice association was weak — the network/independent practice association is not permitted to negotiate fees. It can convey to its physician members the fees offered by the payer, or it can "message" the payer the rates that the individual participants are willing to accept. Actuarially based risk models such as global capitation and percent of premium proved unmanageable, as the 1998 bankruptcy of Pennsylvania's Allegheny Health System and other health organization failures demonstrated.

Today's environment

Today, unlike the health reform environment of 15 years ago, we see far more emphasis on quality measurement and transparency. Everyone gets measured. Reporting is public. Scoring well matters because it affects payment. This inevitably leads to the potential for clinical integration to have nothing to do with bargaining for fees.

Physicians in group practice struggle daily with the loss of time and touch with their patients.[3] Demands to meet the practice's administrative burdens and manage pharmacy needs and hospital duties, among other things, get in the way of optimal care. Physicians contribute to their own inefficiencies with defensive medicine, cumbersome documentation, poorly equipped and designed office environments and more. Time is money, and improving margins is critical.

The more physicians in groups find ways to standardize their care, compare themselves to learn what works best and reclaim time and energy, the more successful they will be financially. They will provide a better quality of care. When otherwise competing physicians come together with similar goals across practices, or physicians join with hospitals in these efforts, major improvements in care and efficiency can result.

Integrating within a medical group

As much as smaller physician groups might want to come together for improved quality and a better bargaining position with payers, it's surprising how few practices have sought to standardize and streamline their own clinical processes — and measure their results. Measurement is an integral part of clinical integration, since part of the point is to improve. Three oft-heard quality truisms

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pertain: You can't improve what you do not measure; what gets measured gets done; so be careful what you measure.

The use of clinical practice guidelines and templates for clinical documentation based on those guidelines represents one way to approach measurement. You can further the effort by standardizing other aspects of the practice, such as exam-room design and equipment, use of ancillary clinical personnel, standing order sets and responses to typical clinical complaints, such as drug reactions and treatment responses. Electronic health records and electronic prescribing aid this kind of clinical integration. Physician groups can compensate physicians more for higher-quality performance.[4]

Unfortunately, time and again, medical practices allow the idiosyncratic behaviors of individual physicians to dominate the chance for a better-organized context. Many techniques of clinical integration can save physicians time in their day. Practices such as Park Nicollet in Minneapolis have saved their physicians eight or nine hours a week with standing order sets that cross borders from the practice to the hospital.[5] Physician groups need to focus more energy on these kinds of activities, perhaps even before they look outward. However, clinical integration with competitors can also yield benefits.

Integrating with others

The first step is to identify with whom you want to integrate your medical practice. Be careful not to include too many people lest you create a monopoly. Ideal participants are those who are well-motivated, well-organized and have good reputations.

Next, identify whether any performance measures are already at work in the market — in report cards or pay-for-performance programs — for the relevant specialties involved in the clinical integration. Integrating around those measures will bolster the positive effects. The integrating practices should collaboratively identify a few conditions on which to base documentation standards. It's difficult to measure performance without common documentation to produce data. Then, select applicable national clinical practice guidelines from which to work. Figure out what clinical processes have to change to implement the guidelines and agree on what those will be.

After a month of using the guidelines, pull five to 10 records from each participating physician and determine whether they adhered to it. Based on data, identify the high performers (good outcomes, high guideline conformity, lower costs, saved time) and the low performers. Analyze why the high performers did better. Develop processes to improve the low performers. Keep going and add more guidelines.

Once you have done this a number of times for a number of conditions on an ongoing basis, you will have a partially integrated network. You must have some infrastructure to analyze the data and report to the participants — infrastructure as low-tech as a nurse and a pencil, or as sophisticated as Web-based technology and a medical director and staff.

Data analysis is essential. Sharing your data with payers will form the basis for bargaining opportunities. Clinical integration

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What the FTC says

In three positive advisory opinions and one review after a settlement, the FTC approved approaches to clinical integration that include several common elements:

- The use of clinical guidelines or pathways;
- Web-based interchange of data;
- Benchmarking performance;
- Stating targets for improvement; and
- Investment in infrastructure to profile, monitor and engage in discipline of the membership.

When these factors exist among otherwise competing providers, the FTC has indicated that the fee bargain is ancillary to the reason to come together — and therefore the agency will not enforce what would otherwise be collusive bargaining. This is in stark contrast to the many settlements the FTC entered into with purported networks that were not integrated, either clinically or financially.

can bolster case rates and episode payments, as well as enhanced fee-for-service payments. Although you need not form a legal entity, you should at least have written principles of behavior for the participants, whether in a formal contract or a simpler compact. You may wonder how much integration your operations need before you can bargain with payers. There is no firm answer to this question, but without meaningful data, a payer has little reason to take a group of physicians seriously. You may want to seek legal review to determine whether your organization is integrated enough to bargain.

Conclusion

There is no one way to clinically integrate — whether within a group or with other medical practices. Legal pitfalls exist when integrating with competitors, but so does positive potential. The real point is that the antitrust issues are secondary to true clinical integration, which is about improved quality, greater efficiency — and most likely better margins.

join the discussion: Is your practice integrated internally? Tell us at mgma.com/connexioncommunity or connexion@mgma.com

Notes

1. "Clinical Integration: The Changing Policy Climate and What It Means for Care Coordination," FTC, Remarks of Commissioner Pamela Jones Harbour, American Hospital Association Annual Membership Meeting, Washington, D.C., April 27, 2009.
2. Statements of Antitrust Enforcement Policy in Health Care Issued by the Justice Department and Federal Trade Commission, Aug. 28, 1996.
3. Gosfield A, Reinertsen J. Doing well by doing good: Improving the business case for quality. June 2003, www.uft-a.com.
4. Gosfield A. Physician compensation for quality: Behind the group's green door. Health Law Handbook. 2008 ed. Westgroup, pp. 3-44, www.gosfield.com/pdf.publishedchapter1.pdf.
5. Personal communication with James L. Reinertsen, MD, former Park Nicollet CEO, Jan. 25, 2007.