The Case for Clinical Integration

BY LLOYD A. DARLOW, M.D., FAAFP

The passing of the Affordable Care Act (ACA) was a distinct wakeup call for our industry, and it certainly has generated plenty of dissenting opinions and criticism. The historical culture of patients blaming payers, payers blaming doctors, etc., isn't going to solve this complex problem.

Along with those perspectives came those who are willing to take "what works" from reform and use it to change from within. Whether we agree with the means used to get there, many in the industry agree that now is the time to fix our broken healthcare system. As an industry, we know that changes are coming, but it is ever more important for healthcare providers to be the drivers of that change. Fortunately, there is a distinct opportunity right now to take charge of our own destiny as both physicians and leaders.

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Healthcare costs haven't skyrocketed as a result of one distinct area within the healthcare industry—whether it's payers, providers, or medical device and pharmaceutical companies. A lack of accountability across the entire system has left us vulnerable to waste and inefficiency. In my opinion, physicians can be the key enablers of this process by working on the solution in concert with their communities and other organizations that are directly and indirectly involved in patient care.

Driving the Momentum

Clinical integration is one model that has potential to drive this forward momentum toward real change. Clinical integration creates a local healthcare system that promotes interdependence and collaboration among participating physicians. Early Clinically Integrated Networks (CINs) have demonstrated real potential in driving more efficient, high-quality health care while holding the line on the costs of that care.

Clinical integration can also create new opportunities for physicians to maintain sustainable independent practices. Financial and administrative burdens have driven many physicians—and in some cases, entire specialties—into a position where they can't conceive of independent or traditional private practice. Yet, the thought that all physicians need to move away from their independent practices into an employed model is a disconcerting notion. There will always be a need for practices, especially in the primary care disciplines, that can personalize their models to work for their patients while addressing their own business needs. And the truth is, physicians may take a slightly different approach to health care based on who is writing their paycheck. Forcing all physicians into an employed model is really counterintuitive to the idea of patient-centric care. However, today's commitments to Meaningful Use, value-based purchasing, and other payment

reforms are going to be an incredible strain on these independent doctors. Clinical integration provides an alternative that allows physicians to maintain their autonomy by sharing resource insight and increasing accountability to each other as well as their patients.

Taking the Leap

In the case of my organization, the Cayuga Area Plan (CAP), we were ready for change and willing to take this leap. We didn't want to end up "fighting for scraps" as the market becomes more competitive and consolidated. As a result, in 2010 CAP, a classic physician-hospital organization (PHO) partnership between Cayuga Medical Center at Ithaca (NY) and the Cayuga Area Physicians Alliance, began rolling out a robust plan for clinical integration. Ours is a mixed model that includes both employed (approximately one-third of our network) and independent physicians, who make up the remaining two thirds. Our aim was to bring together these physicians along with our medical center to create an atmosphere of collaboration and trust. Along with these cultural considerations, we needed to build a technology and operational infrastructure that would support better quality and patient outcomes, improve the care of high-risk patients, and reduce the overall costs of care.

Today, we are one of a select number of healthcare systems in the nation that have made the transition to clinical integration. Now that we are further down the road in this process, I understand some of the hesitancy in the industry toward making this shift. It's not easy. In fact, it was far more difficult and costly than we had imagined. But in asking ourselves, "What better options exist?" the answer was clear—CAP needed to clinically integrate. The next question was, "How?"

Our organization has chosen to build out this structure in manageable stages, and we're still in the midst of much of this transition. Along the way, we've had our share of lessons learned, but the new opportunities have far outweighed the challenges.

Two Core Objectives

CAP's foundation was truly built on two core objectives. Being a physician-led organization, we understood that engaging our physicians and maintaining transparency throughout this process would be key.

Our health system did not want to employ all of the providers necessary to make this transformation happen. We knew that we could bring independent physicians to the table and offer them distinct advantages in terms of getting the data, technology, and processes in place for them to deal with the new world created by health reform. We also wanted to develop a structure that supports interdependence while maintaining autonomy for physicians in the community.

In many cases, physicians see the hospital's interests as contrary to their own. It was important for us to align these interests and create an environment of mutual benefit and accountability. This required a great deal of relationship building and a governance structure that bridged the gap between these stakeholders.

To that end, we established very active and ongoing committees that report to the PHO board. These include groups that deal with operational and clinical as well as information systems issues. These committees meet weekly and, although physicians are not compensated for committee participation, we have seen a high level of interest from our physicians. Their goals are to develop a system that supports interdependence and accountability—not just to the network's employee clients, payers, and patients—but among physicians themselves. As a result, there are high degrees of integration among these areas. For example, our performance and process improvement committee works closely with the clinical guidelines committee to jointly develop clinical and evidence-based medicine guidelines and implement them. This integrated governing structure has created an atmosphere of cooperation that we would never have thought possible just a few short years ago. As reform has brought rapid changes and shifts in the healthcare industry landscape—technical as well as clinical—CI has brought us an essential degree of flexibility and agility in dealing with these changes.

Our Tech Partners

Because of the diversity of our network, we have had significant challenges around the sharing of electronic medical records (EMR) and analytics. A mixed-model like ours means that not every physician is on a common platform. We engaged technology partners to help us navigate this complex landscape. Currently, we have made progress in pulling clinical data from disparate electronic (and a few paper-based) systems to gain a better view of our overall population and stratify patients by risk. This process of viewing quality data and reporting is just the first step in a complicated transformation, and it has already provided insights that empower our physicians and leaders.

We are also working on developing a technology infrastructure that will support quality at the point of care by offering clinical decision-making support for our physicians. This process will not happen overnight, but as the technical landscape seems to be changing rapidly, it is my hope that we will soon have the ability

to truly connect physicians and drive true collaboration across the continuum of care.

Bringing the Team to the Table

Our transformation required significant investments in time, resources, and dollars. As a result, we knew that we needed to bring local employers and payers into the fold early on to ensure that we were creating a system that worked for all stakeholders while offsetting some of these costs. From day one, we included payers in the conversation and brought our model to them in its infancy. We wanted to keep our dialogues open and honest and be sure that we could maintain a positive relationship over time.

To accomplish this goal, we changed the conversation from cost-savings to value. Employers and payers understand the value proposition around member engagement, increased productivity, and improved health. These were commitments we could deliver on, even if the returns on cost would not be immediately forthcoming. The truth is, no one else is coming to these organizations with an immediate plan for bending the cost curve. We are all dealing with some level of uncertainty around the future. However, if our model can help these entities maintain costs in the short-term while setting a foundation for long-term improvements, the added value of our efforts in terms of overall population health and wellness will offset these early investments.

A Viable Model

As a result of this approach, we were successful in getting all the key stakeholders—patients, payers, and employers—aligned with our mission and engaging our physicians through this transformation. While there is still much technology and infrastructure work to be done, I believe our progress is a testament that clinical integration can and should be a viable model to connect physicians, payers, hospitals, and the community within a system that supports improved care at a sustainable cost.

Lloyd A. Darlow, M.D., FAAFP, is vice-president, clinical integration, Cayuga Medical Center at Ithaca in Ithaca, New York; and president and chief medical officer, Cayuga Area Plan.