



ROUNDTABLE

Clinical Integration for Physician Alignment

Clinical integration allows independent/private practice and employed physicians alike to jointly develop clinical initiatives with hospitals or health systems, aiming at patient care that's higher quality, more efficient, and less costly. These agreements also allow providers and care partners to formally align and collaborate on the critical requirements of care coordination: evaluation and concrete improvement of clinical performance, reduction of unnecessary service utilization, and management and support of high-cost and high-risk patients. According to HealthLeaders Media research, an increasing number of health systems and physicians enter into clinical integration arrangements to gain expertise in population health management. As this trend evolves, health system leaders who are developing clinical integration networks say the strategy is helping align physicians, metrics, and goals of care, but planning on the front end is crucial.



PANELIST PROFILES



RICHARD LOPES, MD
Executive Vice President,
Chief Population
Health Officer
SCL Health
Denver



JOHN REILLY, MD
Jack D. Myers Professor
and Chair,
Department of Medicine
Senior Medical Director
for Population Health
UPMC
Pittsburgh



BRUCE SWARTZ
Senior Vice President for
Physician Integration
Dignity Health
Los Angeles



J.R. THOMAS
CEO
MedSynergies, Inc.
Irving, Texas



JACQUELINE FELLOWS
(MODERATOR)
Senior Editor-Physicians
HealthLeaders Media

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Roundtable Highlights

HEALTHLEADERS: *How does your organization define clinical integration?*

BRUCE SWARTZ: Clinical integration with our company is a way to align the independent physicians and employed physicians in a particular service area. It takes about a year to stand up a clinically integrated chapter, which is following the FTC guidelines. They develop a payer committee, a quality committee, and they select a board of managers. On that board of managers, there are nine seats, of which one is held by the hospital. The rest are all held by physicians, and that's by intent. This is a physician-led operation, not a hospital-led operation.

We deploy clinical integration models throughout our three-state enterprise. We have clinically integrated units in each one of our eight service areas. One area we're adamant about is that there has to be a common set of metrics. Eighty percent of the metrics have to be common across all eight service areas so you can begin to measure outcomes, and be of value to payers and employers, and most important, achieve consistency of delivery.

The last thing that's required is physicians have to agree to submit data against the metrics. The biggest challenge is how to extract and aggregate the data from multiple information systems and data sources.

RICK LOPES, MD: I would say we are in various states of development in urban, suburban, and rural markets, all of which present different challenges. We have Medicare Advantage plans. We have a shared-saving ACO. We have a Medicaid product on the [health insurance] exchange. The way we've approached it is to engage clinicians much more actively in the governance and operation of our enterprise. All of our primary care physicians are in a large IPA. We describe our physician groups, our medical groups that

are integrated, and our hospitals as codependent equals.

We've established governance structures in markets that are geographically consolidated beginning with that codependency, and that brings clinicians into the discussion very early on.

The actual network includes not just our employed or tightly integrated physicians, but independent physicians, and we tend to try to put those networks together with an expectation in the market that we will meet service-delivery needs across the continuum in a broader way.

We've gotten our start with the 27,000 associates and their family members, which we are fully at risk for as a self-insured employer.

JOHN REILLY, MD: Clinical integration has involved an evolution of the relationship between physicians and hospital leadership. I think the most tangible outside evidence of where we're going with this at UPMC is until last year we had a hospitals division, we had a physicians division, and we had an insurance company as three big components. The hospitals division and physicians division were merged into a health services or provider division, under single leadership, which I think is indicative of where the system is going.

We face the challenge that a lot of people do in that we're capitated and at full risk for some of our population, and we're fee-for-service for the other part of our business. Balancing the incentives of those two different reimbursement models is a challenge because we are a system that was built on fee-for-service medicine: high volume, high margin. For a long time it was the transplant capital of the world, and that was a huge economic engine.

Moving from there into population health, we have started most of the conversations around getting physicians and clinicians and people from the system together to talk about the best

evidence-based care for patients, and the data becomes very important: what the outcomes are, can you measure the outcomes and share those data. Getting to that data collection and transparency, I think, is going to be one of the big cultural changes at UPMC.



Richard Lopes, MD
Executive Vice President
SCL Health

J.R. THOMAS: A clinically integrated network is a critical aspirational goal to provide a local network of care providers where patients can navigate through those systems seamlessly. We think they have to be led by health systems. It's more about access, quite frankly, and quality measurements than it is the structure.

The challenge that we're all facing is that clinical integration is a market-by-market-driven phenomenon. So if you've seen one market, you've seen one market. Despite the fact that primary care doctors are the main aggregators of patients for a health system, we're seeing their operational financial pressures growing. They're essentially a small business, and that brings a whole host of daily pressures. The healthcare system requirements to be successful are the same whether you're a big system or a small practice. The fear is, "I don't have the patient base to support my practice." Patients [also] have fear of lack of access to doctors, and a clinically

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integrated network led by a health system in a market can marry those up.

We wonder, without managed care or capitation or fee-for-value transition, would clinically integrated networks have as much appeal? Most of the physicians that we see in big groups ask, “What happens if I’m excluded from a contract?” A lot of providers are concerned about access to patients.

HEALTHLEADERS: *What is your organization’s mix of affiliated and employed physicians, and how did you convince independent physicians to join your clinical integration network?*

SWARTZ: At Dignity, we have got about 9,000 physicians on our combined medical staff, and of that amount, 3,600 are participating providers in our clinical integration networks. We are well past the one-third mark in doing this, and the message is pretty simple: It’s doctors talking to doctors. It is not hospitals talking to doctors. There still is that distrust between the doctors and the hospitals, so this was why it had to be physician-led.



John Reilly, MD
Jack D. Myers Professor
and Chair
UPMC

The challenge we face, as many, many large integrated systems do, is breaking down the silos of care. When you’ve got 39 hospitals, you have a lot of different workgroups, and you want to make sure they’re being coordinated, because our whole focus is

on consistent outcomes across those hospitals. A lot of what we’re doing is putting physicians in lead positions.

We’ve been adamant about making sure that the independents are equally represented alongside the employed physicians. There’s always natural distrust because the independents think that the employed specialists get all the referrals, and we have worked with our hospital presidents and leadership to make sure that there are medical staff bylaws in place so that referrals are evenly spread.

LOPES: We have some very interesting markets, and honestly, Kaiser aside, our most successful clinically integrated networks were largely driven by physicians who were the consolidators. In the Denver market, we also have participated in, and our employed primary care physicians participate in, a large clinically integrated network that is made up of our employed physicians, some of our competitor-employed physicians from Centura, part of CHI, and a large cadre of independent physicians supported by a management company that they capitalized.

What we bring to the table in many markets is the capital to stand up the infrastructure. In less urban, suburban markets—for example, Mesa County, which gets a lot of press [because] it is one of the markets that Atul Gawande, MD, MPH, wrote about very early on as a clinically integrated network that was a collaboration between all of the providers and a health plan for the creation of a data management system and an infrastructure that supported care coordination in a much more dynamic way—we did bring capital to the table there, but also facilitated the development of the collaboration. We are now back in that market working to create a larger but narrower scope of service clinically integrated network. We, as the facility provider, have been driving that for many reasons, but most importantly are responding to payer and employer needs and desires to reduce their overall healthcare

spend. It’s also a desirable market that other providers would undoubtedly like to enter.

In Montana, we’re partnered with another large faith-based organization to create a clinically integrated network that’s intended to be a statewide offering. Together we bring expertise, capital, infrastructure to manage risk and well-coordinated provider groups in the larger markets. Our hope is that not only will we offer a high-quality, efficient network to larger employers and payers, but that it will be a structure to help support the participation of smaller provider organizations in the more rural parts of the state.

REILLY: UPMC has a clinical footprint in western Pennsylvania that extends from Erie through Pittsburgh and then east to Altoona. The ratio of employed physicians to independent physicians tends to vary inversely with your distance from Pittsburgh. When you’re in Pittsburgh, it’s heavily weighted toward employed physicians, and then as you get out to the more rural areas, it’s more independent physicians and fewer employed physicians. Right now the employed physicians at UPMC are responsible for about 70% of the hospital admissions, so 30% are coming from the community physicians.

This clinical integration process has actually given us an opportunity to engage more constructively with independent physicians, because it’s very easy to get doctors to come together and talk about the best way to take care of patients and what the evidence is. We have a large number of pathways at various stages of development across the system—a lot in cancer and probably about another 50 or so in other diseases. Having everybody sit around the table and come up with both an approach to taking care of those patients and an agreement about what the meaningful outcomes are to measure has been a valuable procedure.

I think, particularly for primary care physicians, the promise of this

clinical integration is you make primary care a better job. It's an opportunity to acknowledge the activities that are important in taking care of patients that they don't get reimbursed for because the patient's not there in the office, strictly speaking.

HEALTHLEADERS: *How are payers responding to clinically integrated networks?*

LOPES: Generally in most of the communities that we serve, payers and self-insured employers are looking for any opportunity to reduce their healthcare spend or the cost of their insurance offerings. An integrated network with a proven track record for delivering high-quality, low-cost care has a strategic advantage. Clinical quality outcomes, alone, doesn't yet seem to be the primary driver. So while we work very hard to deliver high-quality, evidence-based care, that is essentially a given, so doing it at a cost that is competitive is where we're focused with our networks.

In Colorado, we're a provider on the inpatient side to Colorado Permanente Medical Group and provide about 70% of their inpatient care. We've been a partner with that organization for many years, and in some ways it's much easier to translate a care model and/or a style of care delivery when you've had the opportunity to work side by side with a successful model for integrated care delivery. We also have Medicare Advantage and Medicaid programs that probably go back longer than two years. But in some markets, our networks are still forming.

One market includes a relationship with a payer that is participating in the development of the integrated network. That trend seems to be expanding in other markets as payers pick provider partners to form narrow networks around.

SWARTZ: We worked with Blue Shield, Hill Physicians, and our Sacramento hospitals designing a narrow network product for the CalPERS population. It

was a very successful venture, and we've continued it going forward.

We are launching our direct-to-business strategy. We already have a contract in place with a major tech company now, and we're going to be doing more of that.

Also in California, as of April, we're going to have a restricted Knox-Keene license to facilitate assuming global risk. I would like to see us getting into risk a lot faster. The biggest issue with fee-for-service is that I don't care how good the hospital gets on throughput and economies, they aren't getting rewarded for it, and the employers are asking for that. The employers that we're working with now on direct-to-employment, they are really sharp. They've been self-funded for a long time, they know what they're willing to pay for everything, and they are very adamant about the outcomes.

REILLY: We do direct-to-employer. About 15 years ago, UPMC made the decision to establish an insurance company to compete in the marketplace in western Pennsylvania [where] the demographics are good if you want to spend money on healthcare. It's an older population that's traditionally been a high-utilization, high-morbidity, high-comorbidity marketplace. Part of the health plan business is an ASO business where UPMC manages it, but the risk sits with the employers. In fact, the health plan's relationship to UPMC as an employer is that. So the risk for the UPMC healthcare cost doesn't sit on the health plan's books. It sits on the UPMC corporate books.

One of the advantages of having an insurance arm is not only the lives they bring, but the actuarial expertise. You know what the total cost of care is.

THOMAS: The hospital provides a way to shelter risk and also delivers some level of longevity, because at the end of the day, for example, Dignity is going to be there a long, long time. The problem that we see is, strategically, the

institution has to have a strategy for engaging physicians. I think that's predominant over managed care because insurance companies have more experience in managing risk. They have more skill sets without the delivery system.



Bruce Swartz
Senior Vice President
Dignity Health

We see that experience in how [you] build your network in your marketplace, whether it's employed or affiliated, that allows you to distribute patients, access, quality, and managed care. Once you have a network, the question is how can you get new patients? Most systems that are in the marketplace contract with most payers today anyway. If you take United, you take Aetna, you take Blue Cross, Medicare, and Medicaid, that covers the majority of the payer mix. So then the next question you run into is, "How can I use this performance network?"

You've got to figure out what you're going to do with physicians and what your strategy is to acquire patients. Then you have to move, because if you don't, there are non-health system groups and companies that are going to come into vibrant markets and push you through that system and force you to react.

HEALTHLEADERS: *Are the independent physicians who join the clinically integrated network precluded from joining another clinically integrated network from a competitor?*

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LOPES: If they're a primary care provider in an ACO, yes, because that's one of the requirements for patient attribution. In our other clinically integrated networks, we are generally seeing broader participation, particularly with specialists. Loyalty of the primary care providers is probably the most critical determinant of the network's ultimate success and attractiveness.



J.R. Thomas
CEO
MedSynergies, Inc.

SWARTZ: We've had some who have left because they thought the grass was greener, and then they come back. We've had one group that was part of our network in Southern California leave because they felt we were competing with them, but then they have come back. You have to expect that you're going to have some movement of people coming in and out of your network in clinical integration, but we never made promises that we couldn't deliver, and that's why it takes about a year. You're basically creating a whole new culture where you're putting the elements in place to be an approved clinically integrated network.

REILLY: In these networks, one of the critical leadership challenges is saying "no" to having people participate. You don't want everybody in your clinically integrated network. You want the good people, right? Then the issue is how do you measure who's good, and that's much harder.

HEALTHLEADERS: *This gets into metrics for clinically integrated networks, not just for patients, but for providers. Do these benchmarks exist yet?*

REILLY: We're getting there. I think the bigger issue for hospital systems is—and this comes up more, I think, with surgeons—are you going to privilege people for everything that they want, or are you going to demand that they have certain annual volumes and outcomes in order to have privileges to do [a certain] procedure at your facility? We're going through that now, and that's a big cultural change.

For the first time now, because we're in the shared-savings model for our employed primary care physicians, they are asking for utilization data about specialists. The insurance companies are nervous about sharing that, and so the latest dialog is, "You don't have to tell us who's bad. Just tell us who's good." [Physicians] want to be in the quadrant that's high quality, low cost. Obviously, if they're in the low quality, high cost, you don't want to be sending business to those people. The interesting discussion is the people who are high quality and high cost, because I've got a few of those in some of my subspecialty divisions.

SWARTZ: It's quality. And the most effective way that we're bridging that is through the best practices being led by a key physician in Arizona. He's put a group together with a multispecialty cross-diagonal team that covers all eight service areas, and through the chief physician executives—each region has a chief physician executive—that's how we're doing it.

When the physicians begin to see their first check come out of all this—it doesn't have to be a lot, it's acknowledgement for all they do—it means a lot. They all count on that to pay their personal expenses, and so there is a lot of pressure to not lose that. The next year they want to do more, and they begin to see how this all works. This clinical integration has been the

effective thing that we have done to really build an enterprise physician culture that we never had before.

LOPES: We're looking for more systems to manage claims, aggregate data, have more powerful analytics that are both retrospective and forward-looking as well.

We've been very active about engaging providers in not just the clinical integration governance, but also the operations of the care delivery continuum, including hospital service lines as well. They're actively engaged operationally and in governance, and that's, I think, probably a stronger glue and a better incentive than just capital.

One thing we've learned is these are capabilities and competencies that health systems felt like they had to have inside their walls. For us, it's speed to market; we're looking for long-term partners that bring specific expertise and proven experience.

THOMAS: One of the challenges that we hear is, "I want lower cost, higher quality." We do business with independent physicians as well, and when they think low cost, they consider, "What's my cost priority?" From a payer perspective, the cost of a payer contract is the revenue to the physician group, so there's an inherent tension there. That revenue to the physician group has virtually no relationship between their practice cost and delivery.

We were in a meeting with a major system, and they were talking about physician alignment, technology, and population health. One of the members said, "Well, why would we do that? All this revenue is leaving the hospital." I said, "Someone's going to do it, whether you do it or not." The second issue is that if you lose that patient out into the marketplace to an alternative provider, you lose everything. You don't get the opportunity to shift the chairs on the deck. ■

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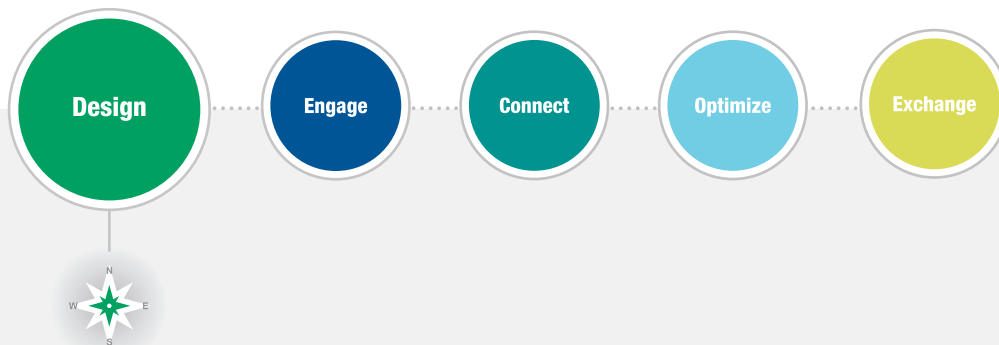


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