Achieving Clinical Integration with Highly Engaged Physicians

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and

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Foreword

Throughout the modern history of healthcare, physicians have often been among the strongest champions and leaders of improvement of quality and value. But physicians have also presented some of the most difficult challenges faced by those who wish to make changes that would improve patient care and reduce costs. When one considers certain key structural and cultural elements of the medical profession – a powerful place at the top of the professional hierarchy; a fierce attachment to individual professional autonomy; a deep-seated wariness of corporate structures; and lack of alignment of business interests with both other physicians, and with hospitals and other institutions – it is not surprising that many hospitals, for instance, have found the "organized medical staff" inadequate to the task of improving and assuring clinical quality of care.

Purely structural solutions have not proven the answer to these challenges. Despite the rapid growth of hospital-based employment of physicians,[1] the burgeoning of larger medical group practices, and ongoing existence of IPAs and other forms of physician "aggregation," there is little evidence these structural forms by themselves have improved overall value – i.e. high quality with contained costs. There are, of course, commonly cited and notable exceptions, such as the Mayo Clinic, Cleveland Clinic, Geisinger, and others. But these exceptions go far beyond mere employment contracts, and legal reorganizations. They are examples of true clinical integration with highly engaged physicians. The focus of this paper is on understanding the cultural, functional, financial and structural attributes that drive real clinical integration.

In an earlier Institute for Healthcare Improvement (IHI) white paper, we presented our views on how organizations – principally hospitals – might engage more successfully with physicians in a shared quality agenda, by understanding and applying six critical elements set into a useful framework.[2] That earlier framework continues to offer both insight and practical guidance on a variety of aspects of this challenge, but it is the aim of this paper to extend that approach significantly beyond the question "How do we get the doctors to engage in the quality activities of our organization?"

It is not that we don't believe that getting physicians to engage in quality projects is important. It is. But, we believe that this sort of project-by-project engagement, by itself, will ultimately prove insufficient to meet rapidly evolving demands of patients, employers, communities, and regulators for better value. To meet these demands, physicians and organizations will need to transform their relationships in much more fundamental ways in order to achieve true clinical integration. The question at the core of this transformation is not about how to get physicians to engage with organizations and their projects. Rather, the key question is: ***"How do we get physicians to engage with each other in improving quality, safety, and value?"***

[1] Lewis, "Physicians Choosing Hospital Employment." Medical Economics, July 9, 2010

[2] Reinertsen, Gosfield, Rupp and Whittington, "Engaging Physicians in a Shared Quality Agenda," Institute for Healthcare Improvement (IHI), 2007 (hereafter, "Engaging Physicians")
http://www.ihi.org/IHI/Results/WhitePapers/EngagingPhysiciansWhitePaper.htm

In this paper we (1) present our view of the power of true clinical integration to drive engagement among physicians, not for antitrust liability avoidance purposes, but for true clinical process redesign that can change culture and lead to lasting differences in the way care is delivered. We (2) address how health reform has changed the landscape and hastened the need for significant alteration from business as usual, for physicians themselves and those organizations which depend on them to be engaged. Next, (3) we discuss the potential role of the organized medical staff of hospitals in clinical integration. We then present a useful framework (4) – "the Four F's" – Form, Finance, Function and Feeling – as a roadmap for leaders who wish to achieve clinical integration. Finally (5) we call for physician leaders, in particular, to take a leadership stance, and to go forward with the difficult work that lies ahead, in order to create a better care delivery system for our patients and our communities.

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I. Clinical Integration: Form vs. Substance

What do engaged physicians sound like?

> *"When we started in the year 2000, our average hemoglobin A1C for the clinic was 9.4. At that time we had 1300 diabetics. By 2004, we had 2150 diabetics with an average hemoglobin A1C of 7.6. You know, that is impact. If you know that with every 1% drop in hemoglobin A1C you reduce morbidity and mortality by 20%, having a drop of 2%, has tremendous impact on these people's lives. That's very rewarding. It's very rewarding."*
>
> – Dr. Bechara Choucair, family physician,
> Crusader Community Health, Rockford, IL

> *"Since we started deploying all of our quality indicators and our quality mechanisms, it has changed everything for us. It has changed our attitudes. It has changed our communication internally because we are always looking for new ways of doing things. People come to us all the time internally asking "why don't we measure this or that?" It is like always renewing. This is the best of all times for me because I know I am doing something meaningful because I am doing something that is measurable. We can make a change in our own practice personally, every day in the quality of our care we give our patients. It changes our lives. It does get us up in the morning."*
>
> – Dr. William Jordon, oncologist,
> The Center for Cancer and Blood Disorders, Fort Worth, TX[3]

On their own, these physicians have developed systems to coordinate and improve care with their own colleagues, by standardizing their care to the evidence base, measuring their results, and taking action based upon that data. They have made it easy to try out new ideas. When the new ideas work well, they have explicitly made these "right things to do" the easiest thing to do, by simplifying and standardizing care processes. Culturally, they have worked collaboratively with their colleagues and staff. Although they might have labeled what they were doing "quality improvement," they could also be considered to have been *clinically integrating* their practices, in order to deliver optimal care to their patients. We would contrast their self-motivated approach with the history of health care delivery integration of the last fifteen years.

[3] Both of these quotes are from "In Their Own Voices" a 45 minute free, downloadable video sponsored by the American Board of Internal Medicine Foundation. We use a six minute excerpt from that video to illustrate both engagement and the deployment by physicians in actual practice of the techniques we address in our program for IHI and which are touched on in the 2007 white paper. Both versions of the video are available at http://www.abimfoundation.org/Online%20Community/Video/PQIP.aspx. We highly recommend viewing both. The videos are available on YouTube as well at "ABIM Foundation".

A. Past Integration Efforts

The concept of integration of health care delivery is not especially new. Back in the early 1990s, hospitals and physicians responded to reform plans, market pressures and managed care demands by entering a wide range of ownership, joint management, and employment relationships among professionals and organizations.[4] While there was considerable rhetoric regarding economies of scale and efficiencies, the focus was primarily on organizational, legal and financial integration. Much of the integration was designed to attract and manage the flow of capitation dollars from large payors through newly purchased primary care practices and then on into these integrated systems.[5] Lawyers were far more involved in the creation and implementation of these structures than clinicians were. Few of these transactions were motivated by a primary desire to improve clinical processes of care.

While some of those PHOs, mergers, practice purchases, and other arrangements from the 1990's have survived into the present, most did not work; and many generated serious dissatisfaction and distrust both among physicians, and between physicians and organizations.[6] As a result, the majority of these configurations were mothballed, dismantled, or sold off, often at fire sale prices. Even where parts of these purportedly "integrated and aligned systems" lived on, few could claim to have made meaningful changes and improvements in clinical processes. And very few generated the sort of true professional engagement demonstrated by Drs. Choucair and Jordon. Why not?

At the time these entities were forming there was a clear recognition that change in clinical processes – standardization to evidence, better coordination across different specialties and professionals, reduction in overused services – would be necessary if the delivery system were to respond effectively to the demands of the market.[7] But most of the organizational attention in these early efforts was devoted to negotiation and contracting strategies with payors – that is, on market share and fee schedules. Where health systems focused on a variety of economic integration strategies and even attempted to implement the then existing notions of clinical integration,[8] the evidence was weak that any of these efforts had much effect in terms of creating value and real clinical process change.

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[4] Shortell, Gillies and Anderson, "The New World of Managed Care: Creating Organized Delivery Systems" Health Affairs, (Winter 1994), pp 46-64

[5] For an excellent review of these developments, see, Gold, "Accountable Care Organizations: Will They Deliver?", Mathematica Policy Research, Inc., (Jan 2010). http://www.mathematica-mpr.com/publications/pdfs/health/account_care_orgs_brief.pdf

[6] Burns, Anderson and Shortell, "Trends in Hospital-Physician Relationships", Health Affairs (Fall 1993) pp 213-223 addressing conflict between physicians and hospitals, and Landon et al, "Evolving Dissatisfaction Among Primary Care Physicians", American Journal of Managed Care (Oct 2002), pp. 890-901, addressing dissatisfaction with health plans.

[7] "Our thesis is that these systems will be successful only to the extent that they achieve the requisite degree of service integration at the clinical level. *Clinical integration* is defined as the extent to which patient care services are coordinated across the various personnel, functions, activities and operating units of a system." Shortell et al, supra n.4 at p. 52.

[8] Burns and Muller, "Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration," The Milbank Quarterly 86:3 (2008) http:www.milbank.org/quarterly/8603feat.html. But their list of forms of clinical integration contains among others categorizations that are vague and almost entirely hospital-centric including credentialing of physicians, case management, disease management, clinical information systems, continuous quality improvement, demand management and clinical service lines.

B. Clinical Integration: The Successful Exceptions

As the most recent health reform debates unfolded, however, some of the organizations which had far longer histories of financial and clinical integration, and even some which had arisen during the 1990's, were cited as high value, cost effective and high quality, service delivery programs.[9] Most of these organizations directly employ physicians and therefore are referred to as "Group Employed Model" (GEM) organizations. In a meeting convened to elucidate what features of these organizations could be replicated in non-employment settings, physician leadership became the single most commonly cited factor which these organizations claim distinguishes them from those who do not achieve such positive results.[10]

> *The elements that leaders of such organizations identify as key to their success are physician leadership that promotes trust in the organization, integration that promotes teamwork and coordination, governance and strategy that drive results, transparency and health information technology that drive continual quality improvement, and a culture of accountability that focuses providers on patient needs and responsibility for effective care and efficient use of resources.*[11]

These are very different statements from the factors which were in play in the mid 1990s. The successes of these organizations are not so much about structures and employment contracts. They are about leadership, culture, and a focus on improving the core processes of delivering care. They are about *true clinical integration.*

For our purposes, we have chosen to define "clinical integration" as:

> ***"Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities."***

Underlying this definition are two primary driving forces:

- The intrinsic desire of physicians to make a meaningful difference in their patients' lives – it is the right thing to do from a professional perspective.
- The external pressures of markets and economies to reduce operating costs and improve margins – it is the smart thing to do from a business perspective.

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[9] Crosson, "21st Century Health Care: The Case for Integrated Delivery Systems." NEJ M 2009; 361:1324-1325

[10] Minott et al, "The Group Employed Model as a Foundation for Health Care Delivery Reform," The Commonwealth Fund, Issue Brief (April 2010) http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Apr/1389_Minott_group_employed_model_hlt_reform_ib_v2.pdf (hereafter, "Minott")

[11] Id at 1.

Neither of these forces alone can sustain true clinical integration. If doctors come together purely for personal financial reasons – e.g. to form larger groups to capture ancillary revenues or to form networks to bargain for higher fees – without creating any of the joy in professional work that comes from actively improving care, they may find themselves frozen out of actual opportunities to get business in the short term, because their value is unclear.[12] Moreover, in the long run, they will find themselves in constant internal competition for a finite pool of resources, and the result will be an organizational life that is "solitary, poor, nasty, brutish, and short."[13] This was the story of the failed PHOs, IPAs, MSOs and other solely economically motivated arrangements.[14]

On the other hand, doctors who "clinically integrate" purely for professional reasons of improving patient care and community health, with absolutely no regard for the business realities of practice, will have an organizational life characterized by noble statements, unrealized dreams, disillusionment, and bankruptcy lawyers. The only thing these idealists will have in common with those doctors whose motivation is purely about the money is that in both instances, their organizations' life will also be brief.

The goals of true clinical integration are demonstrably improved quality, better financial performance, and higher value to patients and purchasers. Studies show that physicians who are engaged in active quality improvement have lower stress levels and a perceived better quality of life.[15] The type of clinical integration we are talking about actually motivates physicians to sustain their efforts ***and*** it produces results. We offer four very different examples:

1. Institute for Clinical Systems Improvement

The Institute for Clinical Systems Improvement (ICSI) was founded in 1993 by a voluntary collaborative of large multispecialty groups, smaller physician groups of various sizes, an influential employer coalition, (Buyer's Healthcare Action Group, or BHCAG) and a health insurance plan (HealthPartners). The purpose of ICSI was to respond to a request from the employer coalition, which wished to purchase care from the functional equivalent of a fully integrated care delivery system across a broad geography – a system in which some 20 or more medical groups, including the Mayo Clinic, Park Nicollet, and HealthPartners would function as one system, at least from the standpoint of accountability for high quality, cost-effective, evidence-based care. ICSI's primary role was to develop practical, evidence-based guidelines for delivery of common services, and to help doctors to implement those guidelines in their own practices, with an overall aim of standardizing and improving the quality and value of care across the entire network.

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[12] Robeznieks, "Not a Big Deal… Yet," Modern Healthcare, August 9, 2010, http://www.modernhealthcare.com/article/20100809/MAGAZINE/100809934/1139#

[13] Thomas Hobbes: LEVIATHAN, 1651

[14] Burns and Pauly, "Integrated Delivery Networks: A Detour on the Road to Integrated Care," 21 Health Affairs, 128.43 (2002)

[15] O'Reilly, "Quality-of-Care Concerns Add to Doctors' Stress," AMNews, August 31, 2009, http://www.ama-assn.org/amednews/2009/08/31/prsb0831.htm

Membership in ICSI required a commitment from each medical group to involve its staff in guideline development and implementation, in return for which the medical groups might expect to achieve "preferred provider" status in an innovative contract with the employer coalition. Although both the business coalition and the health plan that administered the provider contract were important to the process, the primary engine that drove ICSI was the voluntary participation of physicians from medical groups, large and small. Medical group participation grew rapidly until at one point the medical groups in ICSI cared for over 90% of the population of Minnesota.[16]

What compelled doctors to participate in ICSI? Why did they get into their cars on cold, snowy Minnesota winter days, drive 100 miles to a meeting on, say, a hypertension guideline, and then drive home in the dark a few hours later, without any financial compensation? More importantly, what kept them coming back for more of the same, year after year? Was it simply the promise of some sort of special contract with the business coalition?

One of us (JR) had the opportunity to ask this question of dozens of doctors, and the answers provide a powerful insight into the core driving needs of these doctors, many of whom practiced in relative isolation from colleagues and peers, (even, surprisingly, in what otherwise appeared to be a "medical group"). (More on this below.) Their answers included statements such as:

> *"At the ICSI meetings, I sit at the same table as some of the best doctors in the world, from Mayo and the other big clinics, and I work as a respected colleague with them."*
>
> *"It's clear that ICSI is working to develop real world solutions for practices like mine. We're not developing guidelines that go into plastic binders. We're working on how to implement these evidence-based practices in everyday practice, taking into account the differences between practices in how they're staffed, what kinds of computer systems they have, and other factors."*
>
> *"When I'm driving home at the end of one of these long days, I have the satisfaction of knowing that I'm part of what's right, rather than what's wrong, with American medicine."*

It is noteworthy that as the ICSI collaborative grew and changed, the business reasons for doctors to participate faded, primarily because as the contract with BHCAG evolved, there was no longer any "special status" conferred to ICSI participants. Yet doctors continued to voluntarily lead the hard work of developing, improving, measuring, and implementing evidence-based practice guidelines, for a number of years.[17] ICSI is an enduring example of the power of professional, intrinsic motivation – to practice the best, most efficient medicine, and to spread those practices to others.

ICSI originally stood for "Institute for Clinical Systems *Integration."* It involved physicians across communities, not otherwise organizationally linked, coming together to improve care. It is a good example of our definition of clinical integration: *"Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities."*

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[16] Reinertsen. "Collaborating outside the box: when employers and providers take on environmental barriers to guideline implementation." Joint Commission J. of Quality Improvement. 1995; 21(11):612-618.

[17] Reinertsen and Mosser. "Collaborating outside the box: three years later." Joint Commission J. of Quality Improvement. 1998; 24(10):585-590.

2. GEM Organizations

Throughout the health care reform debates, a relatively small number of high value, high performing organizations were cited as having produced the kind of results the legislation would hope to stimulate throughout the country. In fact, there is some evidence that these organizations deliver higher quality care at lower cost than smaller physician practices.[18] These are large multispecialty physician groups which often have a hospital within them. They are many of the same groups cited in the GEM report.[19]

Their clinical integration stems from physician leadership which "is critical to supporting their ethos: collaboration and accountability". As they stated it, "Collaboration is essential for providing high-quality coordinated care; physician leaders can implement policies that promote teamwork and foster interconnectedness among physicians, and get buy-in from their medical staffs in assuming accountability for the results for their work."[20] These organizations also have strong histories of integration with hospitals – which tends to broaden their mission of accountability and coordination of care across both clinic and inpatient settings.

One critical feature of GEMs is their ability to be selective about which physicians they recruit into their groups. Successful GEMs have developed processes and systems for identifying physicians whose values fit within their organizational cultures. From a quality perspective, the most important values which GEMs seek in recruits are aspects such as

- Commitment to teamwork across all specialties and disciplines;
- Acceptance of transparency of data and practice records within the organization;
- Enthusiastic adoption of responsibility for improvement and change, using data-driven decision making;

Physicians in GEMs have a sense of accountability for professionalism and performance, not just for themselves as individual physicians, but also for all of their colleagues. Common among these organizations is continuous quality improvement based on focused, transparent metrics founded on relevant data. GEMs are a "public" rather than a "private" practice, inasmuch as each physician's care is "public" to all of her colleagues. This is one of the most important differences between doctors practicing in the same building in a true group practice and independent doctors who happen to all practice in the same medical office building or even merely the same corporate entity. In all successful GEMs, there is a pervasive theme of both individual physician and group accountability for patient care and practice patterns. We alluded to this shift of values in our first white paper as difficult, but essential to real change.[21]

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[18] Weeks, et. al. "Higher Health Care Quality And Bigger Savings Found At Large Multispecialty Medical Groups." Health Affairs, May 2010; 29(5): 991-997.

[19] The participants cited in the GEMs report were Bassett Healthcare, Billings Clinic, Cleveland Clinic, Geisinger Health System, Gundersen Lutheran Health System, Guthrie Health, Henry Ford Health System, Lahey Clinic, Marshfield Clinic, Mayo Clinic, Palo Alto Medical Foundation, The Permanente Medical Group, and Scott and White Healthcare.

[20] Supra n, 9. Minott at p. 3

[21] Engaging Physicians, Framework Element 2.2 (p. 11)

GEMs appear to take business realities into account as well. Part of what seems to characterize GEMs is their interest in providing high-quality medical care to their patients, while allowing their physicians to earn reasonable incomes. Discussions with GEM leaders resound with the terms "sustainability and fairness" not "risk and profits."[22] While many of these organizations were formed decades ago, and often in geographic areas with relatively little competition from other providers, that is not uniformly the case. Nor is it uniformly the case that only large multispecialty groups are capable of this kind of transformation and outstanding results.

And most important, we should emphasize that the structural features of multispecialty groups by themselves are no guarantee of high quality, high value, patient-centered care.

In other words, not every group practice is an exemplar of clinical integration. In our view, there are all too many medical groups – both single and multi-specialty – that share the same name, and split the overhead costs of occupying a building, but are barely "integrated" in the true sense of the word. They allow physician idiosyncratic clinical styles to flourish, with little or no sense of shared accountability, shared values, excellence and leadership of practice-wide improvement of quality and value. Forming a medical group gives leaders the tools (e.g. recruitment, performance feedback and management) to reinforce values, but it doesn't necessarily mean that those tools and systems will be used to reinforce the *right* values. Still further, we see very few settings where hospitals now employing physicians have confronted any of these issues specifically. In fact, we believe that existing group practice leaders who wish to succeed in the future (see Section II. The Health Reform Spur to Clinical Integration) – whether in private practice or hospital-based employment settings – would be well-advised to ask themselves the question: "How clinically integrated are we, really?" and to take steps to move beyond mere sharing of office space, support staff, and computer purchasing.

3. Consultants in Medical Oncology and Hematology

The burgeoning interest in the Patient-Centered Medical Home (PCMH) in primary care practices is a growing example of physician motivated, inter-disciplinary (e.g. physicians, nurse practitioners, physician assistants, nurses, case managers, medical assistants) clinical integration. The challenges of moving to this model are considerable:

> *"Key challenges faced by all practices when thinking about medical home adoption and implementation fall into three basic categories: structural changes (e.g., facility, personnel, technology), workflow/process modifications (e.g., team building, efficiency of operations, care coordination), and a focus on outcome improvements (e.g., quality, cost, patient experience). As if these goals were not difficult enough, complete transformation of a practice also requires several cultural shifts such as: (a) moving from a physician-oriented workflow to a patient-centered approach; (b) moving from a top-down command/control model to team-based decision making (ideally with input from patients and families); (c) encouraging individuals to practice to the level of their licenses, training, skills, knowledge and comfort levels – and no lower; and (d) accepting the concept of information sharing with patients/families."*[23]

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[22] Minott at 3

[23] Barr, "The Patient-Centered Medical Home: Aligning Payment to Accelerate Construction," Medicare Care Research and Review, 67(A) 492-499 (2010).

Yet, the number of PCMH practices is growing, and not just in primary care. Consultants in Medical Oncology and Hematology (CMOH) offers a ground-breaking example.

CMOH is a 10-physician independent hematology-oncology practice in Delaware County outside of Philadelphia. The oncologists of CMOH are affiliated with three health systems and do inpatient consultations at 7 hospitals among those systems, from a base of four outpatient office locations. In 2005, dissatisfied with their ability to get the attention of the local managed care plans to deal with them differently, they embarked on a program of collecting data that would demonstrate their value to the plans, measuring their performance on issues such as keeping patients out of the hospital, having efficient lengths of stay and producing high satisfaction scores.

When they implemented an electronic health record in 2006, they realized that they would be able to manage themselves better if they had more and better information about what they were actually doing. They created essentially a paperless office that was fully interfaced with the laboratory, radiology, pathology and medical records departments of their affiliated hospitals. They customized a 'wrap around' program to their basic oncology electronic medical record (MOSAIC) which could track patient-centric information, and provide standardized approaches to care

The hallmarks of their approach are intense collaboration among the clinical support/treatment team, adherence to evidence-based guidelines, prevention of complications of the disease as well as therapy, enhanced patient access to care with same day/next day unscheduled visits, and intense patient education to improve medication, evaluation and treatment compliance, early treatment of complications and promotion of patient directed goals of therapy.

Around the physician care delivery alone, they monitor and refine the process of care for all services based on evidence based medicine. They streamline and standardize physician responsibilities, including with standardized use of physician support personnel in the form of 'patient navigators' who facilitate the patients' interactions with the practice. Virtually every aspect of their care is measured and tracked, compared and refined. The physicians are measured on their adherence to evidence, waiting time for patients, document management, documentation of patient instructions, e-pharmacy utilization, screening and immunization compliance, hospice referral and patient satisfaction. The practice itself decides what the metrics are and they change them over time in a continuous improvement cycle.

These efforts are another superb example of what we mean by "true clinical integration:" *Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.* By 2010, the CMOH group's clinical integration garnered them the first oncology Patient Centered Medical Home designation by the National Committee for Quality Assurance.[24]

[24] Sprandio, "First Oncology Practice in the Nation Earns 'Medical Home' Recognition" Medical Home Vol. 2 No. 7 (July, 2010) p. 1

And their results are impressive. First, they have saved significant amounts of time in the physicians' day by developing software modifications explicitly designed to streamline and standardize care and documentation of it. They improved their financial margins, having lowered their staff FTE requirements by 10%. Their engagement with their patients has lowered the number of emergency room referrals year to year. Over the last five years the absolute number of emergency room evaluations for the entire practice has remained flat despite a 28.6% increase in the number of active patients. The practice's overall hospital admissions declined by 16% in FY 2009 and 9.7% in FY 2010. Their in office efficiencies improved to the extent that even as the practice grew over the same period of time, the numbers of patients seen within 24 hours of a telephone call increased five fold. By changing their treatment of gastritis in patients on chemotherapy, they lowered the C. Difficile rate at one of their primary hospitals by 50%! [25]

At the heart of their effort are a number of customized software programs – one in particular that essentially organizes all pertinent clinical information for their physicians at the time of the patient evaluation. This software facilitates the immediate creation of a document that thoroughly and completely organizes all aspects of the patients' care – updating current medications, assessing current clinical issues and details a thorough assessment and plan of care. This document is utilized to communicate with all involved parties with the goals of improving physician and patient compliance, clinical outcomes, economic outcomes and patient satisfaction.

In sum, CMOH physicians have transformed their mission such that, as a practice, they assume ownership of all the patient's cancer-related needs in a highly personalized way, leveraging technology and an enhanced care team to actively streamline, standardize and monitor treatment while optimizing outcomes. Their staff, their physicians and their patients are much more satisfied with the care they receive and deliver.

4. McLeod Regional Medical Center

But what about the more typical US hospital, with its largely independent medical staff? Are they excluded from this "true clinical integration" world? Can independent, "free-range chicken" physicians step up to leadership, and work together to systematically improve quality and value? We believe so, and McLeod Regional provides a strong example. We highlighted McLeod Regional Medical Center multiple times in the first white paper precisely because they are ***not*** a GEM organization. A 453 bed hospital in Florence, SC, McLeod has a predominately independent medical staff of 400 physicians. Their quality performance is spectacular, as recognized in their receipt of the 2010 American Hospital Association McKesson Quest for Quality Prize, among other accolades. The prize honors hospitals that: have committed in a systematic manner to achieving the Institute of Medicine's six quality aims – safety, patient-centeredness, effectiveness, efficiency, timeliness, and equity; can document progress in achievement of all six of the IOM aims; and provide replicable models and systems for the hospital field.

[25] Sprandio, Personal communication to Alice Gosfield, Aug. 30, 2010.

Medical staff engagement has been vital to McLeod's ongoing quality transformation. Those who have visited them marvel at the enthusiastic, effective leadership and participation of McLeod's doctors in quality, safety and value initiatives – without any significant financial incentives or payments. How have they accomplished this level of "clinical integration?" Much of their approach can be traced to one or more elements of our first paper, and the IHI Framework for Engaging Physicians. To summarize some of the specific elements of McLeod's methods for engaging and clinically integrating doctors:

- *McLeod has **asked** doctors to lead.* The overarching theme of McLeod's clinical effectiveness improvement work is "Physician Led, Data-Driven, Evidence-Based." In keeping with that theme, McLeod's leadership (Board, CEO) specifically invite a physician to lead each major improvement initiative, and expect that physician to report the results to the Board. (Note: we often hear hospital and practice administrators say "Our doctors don't step up and lead" but McLeod's experience makes us wonder whether these administrators have truly asked them to lead, in a meaningful and respectful way).

- *McLeod asks the doctors what **they** want to work on.* The first element of the IHI Engagement Model is to "uncover common purpose." Each year, McLeod charters approximately 12 major clinical effectiveness improvement efforts. The initial list of improvement opportunities is created by administration, but a leadership group of physicians makes the final recommendation to the Board as to what is chosen. The doctors' fingerprints are all over the improvement agenda. They are working on things that are meaningful to them, AND to the institution.

- *McLeod makes it easy for doctors to lead, and to participate. In particular, McLeod doesn't waste doctors' time*. When McLeod approaches one of its busy physicians and asks her to lead one of these 12 improvements, they are not inviting the physician into an endless series of pointless meetings and vague responsibilities. McLeod works on 4 improvements for 90 days, gets them done, and moves on. The physician leader's role is to lead 3 meetings over the course of 90 days. All the relevant data from McLeod's internal sources, and all the relevant literature from external sources, is gathered for the physician in advance. Quality support staff draft meeting agendas, contact committee members, draft schedules, keep minutes, record tests of change conducted… and the physician leaders (along with the other members of the medical staff who are working on the improvement) lead and guide the process, using their best judgment and their skills and experience as clinicians.

- *McLeod recognizes physicians who lead.* When an improvement project has been successfully completed (and some 10 out of 12 each year are successful), the physicians who participated are recognized in many ways – in newsletters, large photos in medical staff lounges and hallways, and in particular, by having the opportunity to present their work to the Board for approval and full-scale adoption.

- *McLeod backs up its medical staff leaders, with courage.* Occasionally, improvements recommended by physicians meet with resistance from other physicians – a fairly euphemistic characterization of a familiar, difficult problem in changing physician behavior as part of system process change. McLeod's leaders work through this resistance in a variety of ways, but they have also demonstrated, through several highly visible examples (as noted in our earlier paper at p. 25), that they will back the evidence-based, data-driven recommendations of their physician leaders for safety and quality practices – all the way to the board.

- *McLeod provides opportunities for its physicians to learn and grow.* Physicians are curious and like to learn. When the medical staff heard that the management team met at 7 a.m. each Monday, to discuss the next chapter as they read systematically through the management, leadership, and quality literature, the doctors started their own book club. There are now 2 or 3 such "clubs" that read and discuss books on quality, safety and human factors, leadership, and a host of other topics. All this is voluntary. McLeod just supplies the coffee and donuts.

This is hardly the whole McLeod story. But it emphasizes the essential features of engagement and integration – especially, the idea of doctors engaging with each other – to drive learning, quality, and professional satisfaction.

All of these examples involved physicians coming together in common purpose. And in the case of true clinical integration, what physicians want to achieve – their primary common purpose – ought not to be to bargain for higher rates.

C. Anti-Trust and Clinical Integration

In 1996 the Federal Trade Commission and Department of Justice, jointly first offered the opportunity for otherwise competing physicians to bargain together with insurance companies, provided that these independent groups of providers were "clinically integrated."[26] In the 14 years since the 1996 publication, very few clusters of providers have taken up this opportunity; there have been only four advisory opinions from the FTC, three of them positive.[27] The networks that passed muster with the FTC varied considerably in structure and other characteristics, but they had several key features in common:

- they used clinical practice guidelines or protocols to measure performance
- they used web-based technologies to measure care
- they evaluated their performance, and acted on findings
- they were willing to share data with payors.

The FTC's description of a network that would not be enforced against posited the use of guidelines or protocols, measurement of performance, investment in infrastructure with time and/or money, taking action against poor performing providers and sharing data with payors. In essence, the FTC indicated that if fee bargaining was not the primary reason for clinical integration – in other words the group did not come together just to bargain for rates, but to improve care – then otherwise competing physicians could bargain together.

[26] Statements of Antitrust Enforcement Policy in Health Care Issued by the Justice Department and Federal Trade Commission, August 28, 1996, BNA Health Law Reports, (8/29/96), pp. 1317-1321.

[27] http://www.ftc.gov/ftc/opinions.shtm

In a host of other settlements with physician networks and hospital-physician entities where the enforcers found improper behavior, the FTC has stated that if the physicians and their networks *had* been clinically integrated, they would not have been enforcement targets. But the FTC is fairly unwilling to define the boundaries of clinical integration, because they wish neither to stifle innovation, nor to encourage anticompetitive behavior. Even when the American Hospital Association asked for greater clarity in the FTC's views,[28] the FTC refused to be more specific.

> *"The essence of clinical integration is the interdependency among health care 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."*
>
> – Pamela Harbour Jones, FTC Commissioner, 4/27/2009[29]

Non-lawyers should understand that providers are under no legal obligation to obtain an Advisory Opinion from the FTC in order to engage in clinical integration. It is not even necessary to get FTC approval in order for otherwise competing providers to proceed with bargaining for better rates from payors. Complaints which have generated the FTC settlements usually arise from disgruntled payors who find themselves confronting physicians in networks engaged in price fixing, in the absence of any substantive efforts to improve quality, service, or cost.

A number of mythologies have arisen regarding the legal issues associated with clinical integration. For example, comprehensiveness is not an essential feature; one doesn't need to completely clinically integrate all service lines in order to bargain for fees. Similarly, it is not necessary to go to a payor first to describe what one is intending to do in order for clinical integration to proceed. Finally, it is not true that to begin to clinically integrate without any plans for fee bargaining will prevent the ability to bargain with otherwise competing physicians and payors later. We have found consultants and attorneys advising hospitals and health systems otherwise; and they are wrong.[30]

Regardless of the antitrust issues, we take the position that clinical integration among physicians is worth the effort even if no one pays the doctors more, because it will enhance their value to patients as well as payors. Moreover, we believe that if done correctly, (see the example of CMOH, above) good clinical integration can improve quality, lower physicians' practice expenses and improve their financial margins, even without bargaining for higher rates. We do recommend that legal advice be obtained if clinical integration strategies involve competitors – *which for independent physicians includes hospitals, especially if those hospitals employ the same type of physicians.* For clinical integration within groups, including among the physicians whom the hospital now employs, antitrust guidance is less of a problem. In the last analysis, we believe that the clinical, professional, and community value of clinical integration is far more interesting, and important, than the antitrust issue.

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[28] Hogan and Hartson, "Guidance for Clinical Integration," A Working Paper for the AHA (2007). http://www.aha.org/aha/content/2007/pdf/070417clinicalintegration.pdf

[29] Remarks of Pamela Jones Harbour to the American Hospital Assocation, "Clinical Integration: The Changing Policy Climate and What it Means for Care Coordination" (April 27, 2009), http://www.ftc.gov/speeches/harbour/090427ahaclinicalintegration.pdf

[30] Lawyers are important in the implementation of many strategies physicians and hospitals will pursue in the changes that are coming. But we see far too many instances of lawyers either hijacking or controlling what should be clinically driven initiatives. Alice Gosfield has written an article with practical guidance about how to assess the advice a lawyer is giving non-lawyers. Gosfield, "How to Listen to Your Lawyer," Trustee, (Nov/Dec 2009), pp 1-3. http://gosfield.com/PDF/Listen%20to%20Lawyer.,Trustee1109.pdf

II. The Health Reform Spur to Clinical Integration

Several key themes of the Patient Protection and Affordable Care Act of 2010 (ACA), many of which were clearly based on the national priorities for quality of care established by the National Quality Forum,[31] create a compelling set of drivers toward true clinical integration of physicians with each other, and of physicians with hospitals. Reform themes with particular relevance to clinical integration include:

- expansion and public display of performance results on measures of quality and efficiency for doctors and hospitals;
- expanded use of performance measures for payment of providers using "value-based purchasing";
- bundled payments for defined sets of patients with certain acute and chronic conditions;
- development of delivery systems accountable for the quality and cost of care to populations.

Measurement and transparency: The ACA greatly expands specification of, and resources for, quality measure development and public reporting of performance data. In specific, $75 million was allocated for each of fiscal years 2010 through 2014 to develop measures of management and coordination of healthcare across episodes of care and care transition. A separate provision calls for the Secretary of DHHS to develop and periodically update provider level outcome measures for hospitals and physicians including acute and chronic disease within 24 months on not less than 10 measures and for primary and preventive care within 36 months on not less than 10 measures. By January 2011, the Secretary is to publish a National Strategy on Quality Improvement, not limited to Medicare and Medicaid, and across federal and state government agencies. If physicians and hospitals wish to be positioned to perform well on the measures of acute myocardial infarction, stroke, CHF, cancer care, diabetes, and other conditions, they will need to be capable of delivering highly reliable, evidence-based care, across multiple aspects of the care delivery system.

The burgeoning measures are not solely about quality. ACA requires the Secretary to develop an episode grouper which will have the ability to bundle services into clinically significant episodes of care and compare physician resource consumption based upon that data. While individualized reports of resource consumption will be made available to physicians, aggregate reports with respect to physicians will be made public. These initiatives make it clear that physicians who can work together to make their clinical processes of care more efficient, their patients' experience of care exemplary and the quality of their care score well will be in a far better position than those who carry on with business as usual.

Value-Based Purchasing: The value-based payment programs prescribed in ACA will require hospitals and doctors to work closely together. For physicians, beginning on or after October 1, 2012, the Secretary will establish a value-based payment modifier to provide for differential payment based on composite scores of quality that reflect outcomes. By 2015, costs will be explicitly included in the scoring as well. In the same timeframe, and to be coordinated with the physician initiative, hospitals will be subject to value-based purchasing with incentive payments based on measures covering at least, acute myocardial infarction, congestive heart failure, pneumonia, surgeries to be identified, and consumer

[31] http://www.nationalprioritiespartnership.org/

assessment of care. By 2014, efficiency measures will be included for hospitals as well. Hospitals that do better than others will get a percentage "bonus" on their entire book of Medicare business, not just for those conditions which are subject to measurement. These are not pilot programs or demonstrations. These are wholesale changes in how Medicare will pay.

Note that there is no "new money" involved in these "bonuses." The funds come from scheduled reductions in overall payments to, as well as payment penalties for, low-performing hospitals in two categories: preventable hospital-acquired conditions such as infections and complications, and failures of coordination of care in the form of avoidable readmissions. Clearly, hospitals and physicians will need to work closely together to perform well on both hospital-acquired complications, and even more so on readmissions. The challenge of reducing preventable readmissions is particularly interesting because it requires "clinical integration" with physicians who would write the readmission order but who might not ever have any practice presence at all within the walls of a hospital.

Those mandatory programs ought to make hospitals and physicians together craft strategies for their mutual success, using the six elements set forth in the 2007 white paper. But simply working on quality 'projects' together will be insufficient to survive in the value-driven, chronic disease-coordinating, performance-measure reporting world that will be the prevailing reality by 2015. During the interim, the relative ambiguity and fluidity in the regulatory context is an opportunity for physicians and hospitals to forge new ways of relating around their new value proposition.

Bundled Payment: In addition to those mandatory programs, there are several voluntary and pilot projects which hold both promise and pitfalls for physician engagement. One that is significant for physician-physician, and physician-hospital relationships, starts out voluntary and ends up being mandatory: bundled payment – an initiative that has been identified in a comprehensive RAND Corporation study as the single most powerful method available for changing our national health care cost trajectory.[32]

This pilot will launch in January 2013, to establish and implement a payment methodology which will include payment for 'patient-centered functions' including care coordination, medication reconciliation, discharge planning, and transitional care service, all subject to quality measures. The Secretary is to select conditions which include a mix of chronic and acute care, surgical and medical, where there is evidence of an opportunity to improve quality, and where there is significant variation based on readmissions and amount of expenditures. And then, instead of paying individual specialists, hospitals, and other providers individually, under the pilot one check will be cut to cover acute inpatient services, physicians' services including inpatient and outpatient care and post acute services for a full "episode of care" (defined as three days before the admission, the admission and thirty days after admission). Example conditions might include hip replacement, or admission for acute MI. The "system" of providers receiving the check would be at risk for preventable complications, readmissions, overuse of services, and other avoidable costs.

The whole point of bundling payment is to align incentives between the disparate care delivery components. Succeeding under bundled payment models requires a high degree of clinical coordination and integration. Although the details of this program remain to be established, the ACA specifies that following the pilots, this sort of payment will be mandatory beginning in 2016.

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[32] Hussey, et al. "Controlling US Health Care Spending – Separating Promising from Unpromising Approaches." NEJM 361; 2109-2111, 2009

Accountable Care Organizations: Perhaps the most high profile element in the ACA is the pilot program for shared savings in 'accountable care organizations' (ACO). The idea arises from several roots: the experience of staff and group-model HMOs over many decades; the discovery of widespread variation in cost and quality among communities of practice that could be "attributed" to hospitals and their medical staffs; and even much of the thinking about "Accountable Health Plans" in earlier reform proposals. Under this voluntary program, a group of providers who have enough primary care doctors to be capable of delivering care for at least 5,000 beneficiaries, and who meet other criteria, can apply to become an ACO, which will allow them to pool and redistribute payments from Medicare Parts A and B in a variety of innovative ways. The ACO will not get to share in any savings generated, unless its expenditures for the beneficiaries assigned to it are lower than expenditures for the same beneficiaries over the previous three years before entering into the ACO pilot, which itself will last three years.

There is very little detail about the ACO program at this writing. Even the most current, enthusiastic advocates have put forward only the most skeletal outlines about payment models, assignment of "enrollees," and other critical features.[33] There are many skeptics about this concept.[34]

Nevertheless, numerous hospitals and medical practices are working hard to come together as "ACO's" in preparation for this program, in the belief that doing so will be critical to their longterm survival. It is our view that those organizations which have a long history of managing capitated payments and the associated actuarial risks (e.g. Kaiser Permanente, Intermountain Health Care) will have a leg up on those that are new at taking financial risk for the care of populations. In contrast, the history of those who have taken capitation risk without being prepared to manage it has not been pretty.[35] The Allegheny health system collapse was probably the worst example of this.[36]

For any providers who wish to become ACOs, however, we believe that true clinical integration, in the sense described in this paper, will be an absolute precondition for success.

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[33] Shortell et al. "How The Center For Medicare And Medicaid Innovation Should Test Accountable Care" Health Affairs 2010; 29: 1293-1298

[34] See Gold, supra n 4; Goldsmith, "ACOs: Not Ready for Prime Time" *Health Affairs* blog, Aug 17, 2009 http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/; Gosfield, "Latest Issues," (1)#64; Accountable Care Organizations, http://www.gosfield.com/newissues.htm#qual68

[35] Engert and Emery, "Integrated Delivery Systems: Non Fait Accompli", Managed Care Quarterly 1999, 7(1):29-328

[36] Burns et al, "The fall of the house of AHERF: the Allegheny bankruptcy" Health Affairs, January/February 2000; 19(1): 7-41.

III. The Organized Medical Staff and Clinical Integration

What role might the "Organized Medical Staff" (OMS) of the hospital play in clinical integration? This structure has been the traditional vehicle through which physicians relate to hospitals, and to each other, regarding quality of care for inpatients and other hospital-related services. Yet in many settings the OMS has languished. Barely able to scare up a quorum at meetings, many staffs have done away with regular meetings, relegating physician-to-physician interaction to the departmental level. As a result, many now see the organized medical staff as irrelevant, obsolete and moribund.[37] We take a more balanced view.

First, the organized medical staff is not going away any time soon. The OMS is required by law under many state hospital licensure regulations.[38] Second, Medicare's Conditions of Participation require that each hospital's medical staff must be "…well organized and accountable to the governing body for the quality of the medical care provided to patients."[39] Regardless of the mechanism by which a hospital satisfies this requirement (The Joint Commission (JC), Det Nordske Veritas (DNV), or direct Medicare certification). it is necessary to have a functioning, organized medical staff. In other words, the OMS is likely to persist into the world of ACOs and clinical integration; and it will be necessary to work either with it, or around it.

Secondly, the notion of a self-governing, organized medical staff turns on the oldest models of medical staff relationships instigated by the American College of Surgeons in 1917. This model provided a way for otherwise independent clinicians to come together solely in the interests of assuring high quality care for hospitalized patients. To accomplish this, the physicians had to have some sort of a structure, since they typically had no legal or other organizational affiliations with each other, except for their relationship to the hospital. In recognition of their unique expertise, they became "self-governing" (although this concept has always existed in some tension with the notion that the board is the ultimate authority on all matters in a hospital, including quality of care), and "organized" with bylaws, structures, and standards. Despite some serious questions about the concept of self-governance,[40] and about how effectively the OMS has discharged its quality obligations,[41] its long history has deeply imprinted physician culture. Those who wish to encourage true clinical integration must recognize and find ways to work with that imprint on how physicians view themselves and their role in hospital organizations, at the very least in the course of performing their own "degree of difficulty assessment." (See Section IV on page 20).

[37] Goldsmith, "Hospitals and Physicians: Not a Pretty Picture," Health Affairs 26: W72-W75 (Dec. 5, 2006); Smithson and Baker, "Medical Staff Organizations: A Persistent Anomaly," *Health Affairs* 26: W76-W79 (Dec. 5, 2006)

[38] For a discussion of the legal foundation for the medical staff see, Gosfield "Whither Medical Staffs: Rethinking The Role of the Medical Staff in The New Quality Era," HEALTH LAW HANDBOOK, (2003 ed.) WestGroup, a Thomson Company, pp. 141-217; www.gosfield.com/pdf/agg.CB%202003.ch4.pdf

[39] 42 §C.F.R. 482.22(b)

[40] Peters and Nagele, "Promoting Quality Care & Patient Safety: The Case for Abandoning The Joint Commission's "Self-Governing" Medical Staff Paradigm," 14 MSU Journal of Medicine and Law 313 (2010)

[41] Cortese and Smoldt, "Taking Steps Toward Integration," Health Affairs (Jan/Feb 2007) 26(1):W-68-71.

Thirdly, recent standards adopted by the Joint Commission, such as ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE), require medical staffs to assess their members in a far more evidence-driven, and robust manner than in the past. In particular, the new standards are a first step toward assessing and improving the cultural features of any hospital's medical staff, that is, attributes such as teamwork, interdisciplinary professional respect, and adherence to key safety rules. While the requirement to do so is clear, the standards against which such performance will be measured are not prescribed. We believe this constitutes a significant opportunity for the OMS to become a positive force for cultural change in medicine, and for clinical integration. For example, there is no inherent reason why the OMS couldn't develop and apply standards for "overuse" as part of its quality and safety activity. Similarly, there is no reason why an individual physician's pattern of apparently excessive readmissions (primarily a function of the coordination of care outside the hospital boundaries) couldn't trigger a FPPE. In other words, if the right values are built into the OPPE and FPPE standards, the OMS might become a positive force for clinical integration, rather than an impediment to it.

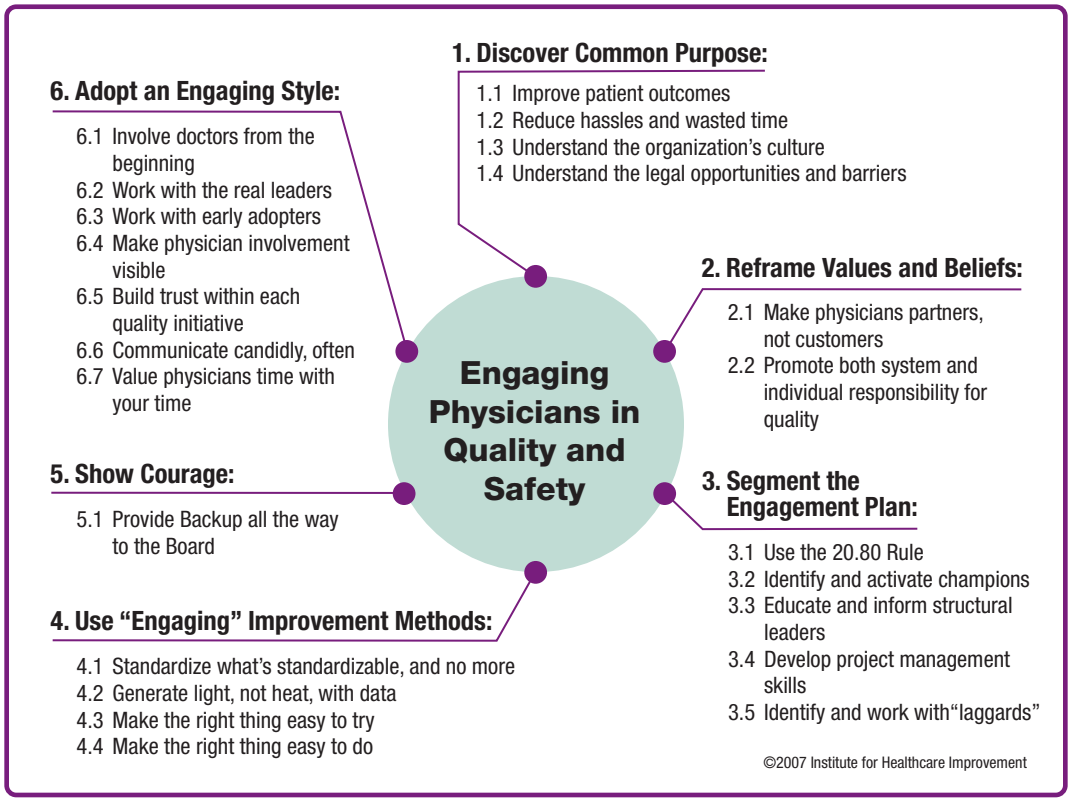
There is, of course, some real baggage that comes with the OMS, especially for those attempting to drive true clinical integration. Many medical staffs have neither developed nor applied high standards for teamwork and professionalism, because it is so difficult to take meaningful action against colleagues. Furthermore, even where high standards have been in place and enforced, the entire apparatus of the OMS is focused on the inpatient care environment and specialty care, whereas the most significant opportunities driving clinical integration – coordination of care for chronic disease and improved end-of-life care, for instance – are primarily outpatient, office, community, and primary care matters. And the mechanisms by which the OMS can give feedback to physicians on performance and take action against poor performers tend to be encrusted with due process and other legal overburden that makes them far more cumbersome to use than their counterpart mechanisms in, say, employment relationships. In sum, the OMS is not a very wieldy instrument.

It is not surprising, therefore, that when we have informally questioned leaders of organizations pushing toward clinical integration and ACOs, they rarely answer "Yes" to the question "Is the hospital OMS going to be the central or major mechanism by which you will manage membership and performance of physicians in your clinical integration plans?" In other words, they do not plan to manage the medical staff of their ACO using the same system by which they currently managed the medical staff of their hospital(s).

But it is our view that leaders of clinical integration can use the OMS as part of their overall strategy for bringing about needed improvements in processes that cross the in/outpatient boundaries, and for the deeper changes in culture that are required for success. In some settings, such as McLeod, the culture of the medical staff can evolve to a new and more vibrant functionality, working on far more meaningful things than most do now. At the very least, in virtually all hospitals, physicians will want to pay attention to the signals being sent by their OPPE and FPPE standards, and use those and other mechanisms of the OMS to drive, rather than oppose, the process and cultural changes of clinical integration. Leaders of clinical integration might fret about the cumbersomeness of the OMS, but they have to work with it, one way or another.

IV. Getting from Here to There

In our first white paper, we set forth a framework with six elements for leaders to consider, if they want to get physicians to engage in quality improvement.



As we have observed leaders applying this model, whether in hospitals or physician practices, we have noted that one of its most useful elements has been to understand one's starting point – specifically, to assess the "degree of difficulty" in effecting real change that is faced in any particular setting. We created a "Degree of Difficulty Assessment" which focused primarily on past hospital-physician relationships. We have revised that document over time and the most recent version of it is Appendix A of this White Paper.

The sorts of barriers to engagement that occur in hospitals – distrust due to failed past joint ventures, for example – are not unique. We think these kinds of factors within and among physician practices as well, must be considered and dealt with if doctors are to engage effectively with each other.

For example, while failed joint ventures or managed care strategies can poison the setting for hospital-physician engagement, the equivalent problems within a physician group would be failed managed care strategies, loss of a contract with a major payor or serious cash flow problems that require pay reductions. Mergers or acquisitions of other physician groups without attention to developing a group-wide shared culture can torpedo engagement of any sort. Unplanned and disruptive departures of physicians from the group, leading to a sense of instability and insecurity among the remaining physicians, can be a barrier to change. Difficult electronic medical record implementation or failed administrative changes can generate mistrust among physicians.

Compensation models which reward only production and RVUs, especially where ancillary services have been brought into the practice and now must be serviced with a volume of procedures or tests to make their presence worthwhile, can thwart the willingness to focus on overuse and value. It is especially noteworthy that in a number of the GEM organizations, there are well established programs of basing some physician compensation on quality results; and more organizations that seek to be seen as valuable are moving in that direction.[42] Virtually every organization that has adopted this approach reports that quality improved, but none of the reporters believed that the compensation model was the sole driver, or even the principal driver, of improvement. Rather they all described that the compensation model was a part of a broader strategy of quality improvement.

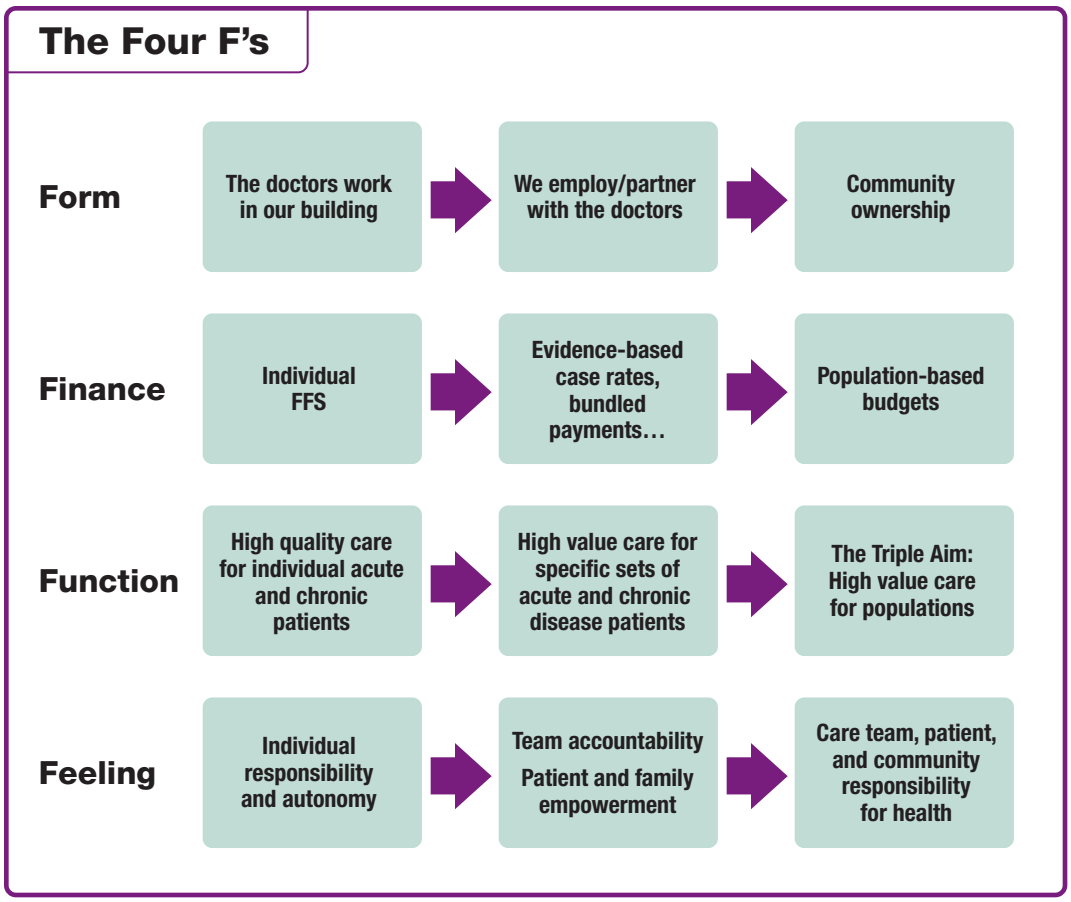
Entrenched group leadership with no apparent avenues for younger physicians to ascend to the privileges and perquisites senior physicians claim can stymie efforts to engage physicians at all levels. In the move to change culture, who invites or instigates or begins to lead in a new direction can be predictive of the likelihood of other physicians' willingness to take a chance to do things differently.

We do not have any magic wands to wave over these sorts of obstacles that lurk to some extent in every organization's past, and impede that engagement of physicians which is necessary to create a better future. But we do have a recommendation for leaders who wish to take their group practice, hospital medical staff, or other set of providers into true clinical integration: before you embark on this journey, surface and talk about your own historic and cultural impediments. Specifically, we suggest that you and some of your colleagues score yourselves on our degree of difficulty assessment, adding either the types of issues noted above, or historical facts specific to your circumstances. Then, sit down and have a long conversation about what has led you to this point in time. Clear the air of some longstanding issues, if you can. Talk about where you have been, and articulate and write down a vision of where you would like to be. And then move forward with true clinical integration. One way to organize that work is through the framework of The Four F's.

[42] Gosfield, "Physician Compensation for Quality: Behind The Green Door," HEALTH LAW HANDBOOK (2008 ed.) pp. 3-44. http://gosfield.com/PDF/Published.Chapter1.pdf

V. The Four F's

Frameworks are useful for leaders in any field who wish to think through major changes, and plan their actions with some sense of coherence. Frameworks act as a sort of scaffold on which to design and build specific elements of a new organization or system, as well as to plan communications that give meaning to those who are being asked to change. We believe that clinical integration, like any other major effort of this sort, would benefit from a framework. We have termed ours the "Four F's." Like virtually all frameworks, it is imperfect. But also like many frameworks, we believe the Four F's can be useful to leaders who are struggling with how to organize their clinical integration work. We offer it in that spirit.



The Four F's framework is a simple construct, with complex issues embedded in it. It is meant to convey, from left to right, the evolution of clinical integration in three broad stages represented by the vertical columns. At the far left is a starting point – perhaps distant history for an Intermountain Health or Marshfield Clinic, but a very current reality for most others. The central column is much more representative of where health care is, or will be going, over the next 5 years. The far right represents one version of where this might all be headed in the more distant future.

The rows – the Four F's – are four fundamental features that could be used to describe any care delivery system. "Form" refers to the structural elements of governance, management, employment, and other legal and organizational characteristics. "Finance" refers to the business model, predominantly driven by how doctors and hospitals are paid. "Function" describes the principal purpose of the system – the goals toward which it is focused. And "Feeling" relates to the key cultural attributes of the system – deeply shared habits, values, and patterns of belief that drive behaviors.

The Four F's typically don't move from left to right in lockstep. In other words, at any one point in its history, an organization may be more advanced on one dimension than others. For example, Form may be "community ownership" as in a 501(c)(3) organization, while the dominant cultural feature (Feeling) remains "individual responsibility and physician autonomy." (An example which many non-profit hospitals that have purchased physician practices might recognize.) This sort of dissonance among the F's ultimately causes tension, hampers performance, and eventually causes leaders to try to bring Form, Finance, Function and Feeling back into better harmony.

Progression from left to right on this framework is not inexorable, some sort of a relentless evolution. It takes leadership action to move from left to right. And there are a wide variety of approaches, programs, applied techniques, and initiatives that might be deployed by leaders to bring about more sophisticated levels of clinical integration.[43] We offer the framework as a way for leaders to organize and prioritize the work they need to do the work of clinical integration in their own settings.

With respect to the far left column, there isn't much to say about Form, at least with respect to the clinical integration history of hospitals and doctors. For a century or more, hospitals provided a workplace for doctors, and required little in return other than participation on the organized medical staff, and individual professional competence. By far the predominant payment model – "Finance" – has been fee for service (FFS), which has meant that volumes – number of RVUs, number of admissions – have driven business success. Providers have considered their job to be taking care of individual patients (Function). Moreover, the responsibility for taking *good* care of patients rested with individual doctors. If something were to go wrong, individual doctors would bear the blame, and as a result, physicians have insisted on a high degree of autonomy. The predominant cultural "Feeling" in the profession of medicine, has been "If I'm going to be held accountable for care quality, then I must have the autonomy to do what I think is right in each situation I encounter."[44]

True clinical integration requires that physicians (along with the organizations and payment environments in which they find themselves) move from the left to the middle column of the Four F's. Structurally, the forms of our organizations need to evolve to at least the informal partnership stage, including such approaches as co-management arrangements, if not to more formal relationships such as employment. The recent surge of employment of physicians in groups and by hospitals is a clear sign that "Form" is evolving at a very fast pace. The good news is that this creates the *potential* for use of sophisticated, powerful methods – human resources tools such as careful initial selection and recruitment, performance measurement and feedback, promotion and appointment, and yes, even "excommunication" – that have proved either cumbersome or impossible to apply to independent members of the "organized medical staff." The bad news is that many physicians and hospitals are rushing into these employment relationships without having first done the hard cultural work of defining the values and patterns of behavior that will be required under clinical integration.

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[43] Our earlier white paper offers techniques to advance quality projects, principles of engagement, use of data, and more which are applicable in these efforts. In addition, see Gosfield, "Avoiding Marriage: Hospital and Physician Non-Acquisition Financial Strategies." HEALTH LAW HANDBOOK, 2010 Ed., WestGroup, pp. 1-53 for a presentation of hospital-physician financial relationships which can support and bolster quality and safety. http://gosfield.com/PDF/Gosfield.AvoidingMarriage.pdf.pdf

[44] Reinertsen, "Zen and the Art of Physician Autonomy Maintenance." Ann Int Med 139; 993-995, 2003

FFS compensation has proven to be unsupportive at best, and toxic at worst, to the kind of redesign of services that will be necessary for true clinical integration. Those who wish to lead their organizations toward better coordination of care, reduction of care-acquired complications, and lowered overall costs should welcome developments such as bundled payments or budgets.[45] (Note: There is a lot of discussion about the possibility that the reform legislation might be substantially altered as a result of political changes. We believe that bundled payment is one feature that will ***not*** be changed, under whatever political circumstances, because it has such great potential for slowing the rate of cost growth in health care.)

But there is also a "Be careful what you wish for" aspect to these new, better payment models, especially for those who are attempting clinical integration without having a strong "Form" (e.g. something like a multispecialty group practice). Specifically, we are referring to the reform idea of "one check for all Part A and B services" that is central to the concept of bundled payments, as well as ACOs. Integrated systems like Mayo and Park Nicollet have a long history of learning how to distribute payments among doctors and hospitals. Fledgling "clinically integrated organizations" are bound to encounter a lot of tensions about what to do, once they get one check for total hip replacement, or a CHF admission. How much will go to each provider? Who will decide these things?

We believe that there will need to be a strong alignment between Form (who will decide) and Finance (how, and how much, each doctor will be paid). Those who want to move forward with clinical integration will need to keep these two features of the Four F's closely harnessed, and not get too far ahead on either one. It is of note as well that the Finance question isn't just between the hospital and the doctor, but also within medical groups too, where there are typically two phases to the Finance question: how the group gets paid; and, then how the doctors in the group get paid.

Moving to the third F: true clinical integration will require a major shift in purpose, or Function: from high *quality*, to high *value*. Delivering high value will require a systematic approach to correcting underuse of evidence-based services (giving *all* the care that can help patients) as well as eliminating overuse of service (giving *only* the care that will help) and misuse of services (preventing things that go wrong, even if the services intended are precisely the right ones). These are challenges even under the best of circumstances, but are made even more difficult because physicians historically have been highly suspect of efforts to reduce costs of care. They are especially sensitive to any reference to "overuse." For one thing, there is a widespread societal belief that less care must be worse care, and many physicians share that view. More directly, those whose services are targeted as "overused" are likely to lose revenues and will fiercely resist.

If this change in Function is to occur, it will help if Form and Finance are nicely aligned. For example, it is easier to imagine a redesign of the care plan for hip replacements that includes elimination of unneeded imaging services (overuse) when organizations employ their radiologists on a salaried bases, than if the radiologists were independent practitioners, paid on a piecework basis. We believe that over

[45] In the RAND corporation study supra n. 35, bundled payments were singled out as extremely promising to improve quality and contain costs. But the only program noted by name, PROMETHEUS Payment®, is not about bundled *payment*, where one payment is made to be shared among otherwise independent providers, it is about bundled "budgets", which make separate payments to providers, depending on their collective performance. See http://www.hci3.org for more information. We are using the term "bundled payment" to include both approaches. In the interests of full disclosure, one of us (AG) is a founding m ember of the PROMETHEUS Payment Design Team, the chairman of the board of PROMETHEUS Payment, Inc., now the Health Care Incentives Improvement Institute, Inc. (HCI3).

time, clinically integrated entities will move progressively toward salaried models, simply because any other physician payment models will put individual physicians at financial risk for redesign and innovation.[46] On the other hand, if salaries reflect the wrong incentives – as most physician group practice compensation models which largely reflect "productivity" or RVUs do – then salaries by themselves will not advance clinical integration. Unless salaries and bonuses reflect the values of clinical integration, including collaboration in teams, effective and timely use of ancillary personnel, deployment of communication systems, and techniques that permit patients to manage their care effectively, patient experience of care, and adherence to the evidence-base, the fact of a salaried arrangement will thwart the desired Function.[47] And leaders of clinical integration cannot afford to inhibit redesign and innovation if they are to deliver on the new requirements for Function.

It is our strong view that the single biggest challenge, as leaders attempt to bring about true clinical integration, will be culture, or Feeling – the fourth "F".[48] Marc Bard is fond of stating the reality that "Culture eats strategy for lunch." We agree. Feeling will trump Form, Finance, and Function.

Simply stated, if the physicians in your clinical integration effort believe strongly that…

- ***Physicians are responsible only for their own personal care decisions, and share no accountability for the performance of colleagues.***
- ***Physicians should focus only on quality. The cost of care is not only someone else's problem, physicians must also be alert to and resist any attempts to reduce costs.***
- ***It is unprofessional to take responsibility for the care of a population. A physician's only responsibility is for the individual patient in front of him.***
- ***Patients should be compliant, not question physicians' decisions, and should not be allowed to control the design of their own care.***

…your clinical integration efforts will fail, regardless of how cleverly you design and communicate your Form, Finance, and Function.

The good news is that culture is not an accident. It is not something that leaders simply accept and work around. Leaders can shape culture in a variety of ways, and those who wish to build clinically integrated systems will need to become adept at using as many of these mechanisms as possible. It is in the Feeling aspect of the Four F's that the values of the organization are made real. The successful physician leaders of the GEMs organizations have a very direct connection to the known, articulated values and cultures of these organizations. In contrast with hospital-centric organizations which now claim to "own" the doctors, these organizations say "we are the doctors." This is a statement about the cultural values that are the bedrock of their mission. In fact, they are speaking a shorthand regarding their deeply quality and data driven organizations which value clinical results and meeting their patients' needs above all. We strongly suggest that readers become familiar with Edgar Schein's classic list

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[46] Reinertsen, "The Tyranny of Piecework." Healthcare Forum Journal 1994; Jul-Aug: 18-24

[47] For an examination of physician compensation in light of new health care payment models see Gosfield, "Physician Compensation for Quality: Behind the Group's Green Door," HEALTH LAW HANDBOOK, 2008 ed., WestGroup, pp. 3-44. http://gosfield.com/PDF/Published.Chapter1.pdf

[48] Id. at p. 17

of primary and secondary methods by which leaders change and develop a culture,[49] if they wish their clinical integration – whether in a group practice, hospital employment, hospital/physician organization, ACO, HMO, or whatever – to succeed.

Edgar Schein's view of what leaders can do to change and develop organizational culture

Primary Mechanisms

- What you pay attention to, measure, and control on a regular basis
- How you react to critical incidents and organizational crises
- Observed criteria by which you allocate scarce resources
- Deliberate role modeling, teaching, and coaching
- Observed criteria by which you allocate rewards and status
- Observed criteria by which you recruit, select, promote, retire, and excommunicate organizational members

Secondary Mechanisms

- Organization design and structure
- Organization systems and procedures
- Design of physical space, facades, and buildings
- Stories, legends, and mythos about people and events
- Formal statements of organizational philosophy, values, and creed

From our perspective, the most difficult, and the most important of Schein's mechanisms for clinical integration leaders is the last one: observed criteria by which you recruit, select, and excommunicate organizational members. As hospitals and doctors gear up to clinically integrate, or to form ACOs, there is a strong temptation to be inclusive – for example, to invite all the doctors on the medical staff into the organization, or to employ all physicians who seek the cloak of the hospital's financial security. This might work, if the culture of your current medical staff is congruent with the culture you will need for successful clinical integration. But it will most surely fail if your medical staff culture is one of fierce attachment to individual autonomy, lack of transparency and defensiveness about performance data, and a belief that the physician, rather than the patient, is the primary customer. We believe that before you invite physicians to join your clinical integration efforts, you should make it absolutely clear that the primary values of your new organization – whatever its form – are going to be about professional accountability as a team, true teamwork, patient-centeredness, value creation, learning, innovation, and change. This requires the leader's ability to communicate clearly and enthusiastically the values that will drive the organization. This can, and should be, an exciting invitation, rather than a barrier. But it must also be crystal clear to all invitees that you intend to hold them accountable for upholding and living these values. Failure to explicitly define and develop your culture – e.g. to invite anyone who wants to join, and then sort out those who don't fit the culture later – will be an expensive road to failure.

[49] Schein, ORGANIZATIONAL CULTURE AND LEADERSHIP. Jossey-Bass, San Francisco. 1992

And what about the longer term future? The far right column of the Four F's model is one possible view of where Form, Finance, Function and Feeling might be headed, over the next decade. Structurally, we see the eventual ownership and governance of health care delivery resting neither with the hospitals, nor with physicians – but with the community. The Scandinavian model of ownership by Counties, and governance by County Councils, might sound far-fetched today, but would be nicely aligned with where Finance and Function appear to be headed – with population-based budgets, funding the "Triple Aim" of excellent care quality, superb access/service, and affordable cost. As for the Fourth F – Feeling – we believe that the most important cultural change that will be necessary to that future involves a fundamental shift in power, and accountability – from individual doctors, to teams and groups of providers, to entire communities.

Back to the present. We think the Four F's framework can stimulate leaders of clinical integration to think about their current status in each of these categories, and to carefully develop plans to move their organizational Form, Finance, Function and Feeling forward in a thoughtful way. And while each of these elements is important, it is even more important to make sure that one or another of the F's is not out of step with the others – that leaders pace and develop all Four F's in balance with one another. For example, it would be a mistake for an ACO to leap into population based budgets (global capitation) without having serious structural capability to manage enrollments and control the supply of beds, imaging centers, and specialists. Similarly, it would be impossible to take responsibility for community coordination of care for chronic disease, while continuing to pay everyone, including the hospital, on some sort of FFS basis. And in every case, leaders will need to carefully shape and develop the culture needed to succeed. How that begins is critical.

VI. The Leadership Stance: A Critical Requirement for True Clinical Integration

What makes the difference between so-called "medical groups" that are mere aggregations of professionals who share overhead expenses, and those which have clinically integrated with intention and purpose? What differentiates a hospital/medical staff partnership that is making rapid progress toward higher value, more patient-centered care, from one that is still wallowing in yesterday's approaches to professional and business success?

We believe that the essential differentiator is leadership. Effective physician leaders of clinical integration enable physicians to engage with each other around common purpose, and then channel their collective volitional energy into useful work for improvement of quality and value.[50] The elements of effective leadership are a much broader subject than this paper can address.[51] But one element is foundational to all leadership work: ***effective leaders of clinical integration and physician engagement take a leadership stance.***

It is common for practicing physicians to feel beleaguered and hassled, under-resourced and underappreciated. As a result, the prevalent tone of many physician conversations today is negative, or even whiny. Even leaders are tempted to join in. When faced with the challenge of true clinical integration, many would-be leaders lapse into "If Only" thinking, which goes something like this:

- If only we had a better computer system…
- If only we had a different Chair of Surgery'…
- If only we had more time to do this work…
- If only we had more support staff to track the measurements…
- *…Then we could make meaningful changes in clinical quality and value.*

All leaders indulge in "If Only" thinking from time to time. But effective leaders do not let themselves wallow in it. They instinctively realize that "If Only" thinking is really a way of rehearsing their excuses for failure, and ultimately, is a first step on a slippery slope that leads toward victimhood – the antithesis of leadership. The leaders in organizations such as GEMs, ICSI, COMH, and McLeod did not appear to waste a lot of time in "If Only" thinking. Instead, they acted with purpose, focus, energy and determination. There is evidence that creating a culture of performance excellence and accountability for results – high quality, high value organizations, is made real through "a disciplined and persistent focus by leadership on execution and implementation to achieve… lofty goals."[52]

[50] Reinertsen, "Physicians as leaders in the improvement of health care systems." Ann. Int. Med. 128: 833-838, 1988

[51] Yonek, Hines, and Joshi . "A Guide to Achieving High Performance in Multi-Hospital Health Systems." Health Research & Educational Trust, Chicago, IL. March 2010.

[52] Id.

Effective leaders take a leadership stance – a realistic, but essentially positive attitude toward the challenges that they face. Instead of joining in and contributing to whatever complaints and excuses they hear, real leaders say: "OK, those are the realities. You're right, we have limited resources, and we've got some challenges. Now, how can we use the resources we ***do*** have in order to make clinically and financially meaningful improvements?" Effective leaders of clinical integration are able to unite physicians around what they want to achieve, rather than what they wish to complain about.[53]

Atul Gawande has eloquently captured the essence of "taking a leadership stance" in his 5 suggestions to physicians who wish to become "positive deviants" at the conclusion of his book *better*.[54] In particular, his explanation for the admonition "Don't Complain" constitutes excellent advice for those who would lead their colleagues toward clinical integration: complaining doesn't fix anything, and it just makes everyone – including the complainer – feel worse.

We recommend Gawande's book for other reasons as well. He tells the stories of physicians in many settings – the battlefield, small towns in India, a large urban children's hospital – who, through curiosity, self-motivation, and a drive toward excellence, sometimes against great odds, stepped up to make care measurably better for their patients and others. His highlighting the humanity of these efforts ought not be forgotten in the sometimes dauntingly complex efforts to change American healthcare. Physicians still have a unique call to do this work.

> *"To live as a doctor is to live so that one's life is bound up in others and in science and the messy complicated connection between the two. It is to live a life of responsibility. The question then is not whether one accepts the responsibility, just by doing this work, one has. The question is having accepted the responsibility, how one does such work well."* [55]

We think that true clinical integration, as we define it, is a means toward that end.

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[53] Reinertsen and Gosfield: "Informed Consent to the Ties That Bind," ACPE Journal Jan/Feb 2010, 6-13. http://gosfield.com/PDF/Informed%20Consent..pdf

[54] Gawande. better, Metropolitan Books, 2007.

[55] Gawande, supra n.53 at p. 9.

VII. Conclusion

Together and separately, in other work[56] and this paper, we have focused on the role of physicians in changing healthcare delivery because we continue to believe that they play a unique role in how and what care is delivered. In our writings and live programs, we elucidate how physicians are unique. While those understandings are important to non-physicians who work with physicians in improving the quality, value and safety of healthcare, it is also important for physicians themselves to understand how their status confers what we now see as a new professional responsibility to engage more effectively with each other in the new work that the altering environment commands.

This paper is intended to help non-physicians and physicians understand that through diverse models of care delivery, clinical integration as we have defined it –

> *Physicians working together systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities."*

will be essential to achieve optimal quality and patient safety results and likely is fundamental to surviving in the new economic realities of health care.

Our earlier framework of the six steps to engage physicians continues to offer useful techniques to deploy in this work. The Four F's framework offers a filter through which to plan and design the work of clinical integration, taking into account the key elements of Finance, Form, Function, and Feeling. These elements appear to us to be critical to successful clinical integration, whether in some new organizational idea such as an ACO, or within a revitalized group practice, or a re-visioned medical staff. We would call on physician leaders – no matter their work setting – to embrace their unique responsibility and opportunity in this new context to work with each other. Through true clinical integration, engaged physicians can have enormous impact for positive change.

[56] See, www.uft-a.com/publications

Appendix A

Engagement Degree of Difficulty Factors

Score your hospital. **1** = Easier, **3** = Harder			
Physician Involvement	Very high attendance at medical staff meetings; intense interest in hospital work; widely shared. **1**	Physicians primarily relate to their departments where they do attend meetings and perform committee work; not so much interest in the medical staff activities as a whole. **2**	A small group of physicians get called on to do everything; tough to get a quorum at the medical staff. **3**
Departmental Cross Border Issues	Very few issues with cross-department privileges. **1**	There are some departments and specialties where cross-departmental boundaries are being crossed and there are struggles. **2**	There is open hostility among specialties regarding turf battles. **3**
Medical Staff-Hospital Vision	The medical staff is clear about the hospital's quality vision and mission. *(Same measurement among group practice members within a group. Substitute 'group' for 'hospital')* **1**	The medical staff understands the hospital has an interest in improved quality but does not understand its role in achieving it. **2**	The medical staff has no idea what the hospital's vision of quality is. **3**
Hospital-Physician Ventures	If the hospital engages with physicians in a variety of arrangements which provide medical directorships, gainsharing, joint ventures, payment for medical staff service or leadership or other relationships of financial support, those arrangements are doing well. **1**	The hospital has a few relationships with selected physicians; some of these are secret. **2**	The hospital has or has had JVs and more which failed or are failing and the taste lingers. **3**
Physician Competition	The physicians see the hospital as their significant other and do not create competitive services outside of the hospital setting. **1**	There have been limited forays into competition (e.g, ASCs, endo suites, imaging) but no real trouble. **2**	The physicians openly compete. **3**
Physician Employment/ Acquisition	Physician employment and acquisition strategies have gone smoothly with open communication and little concern from other medical staff/group members. **1**	There is some restiveness among still independent medical staff members (or resistance to mergers in groups) as other physicians are employed and/or acquired and seen as competitors. **2**	There is significant hostility to acquisition, merger and/or employment strategies and foment among medical staff members. **3**
Integration Infrastructure	CPOE and EHR have been easily accepted and are widely deployed among all staff and group members. **1**	Still in transition, there are pockets of acceptance and use but still pockets of resistance. **2**	Initial efforts failed and there is considerable skepticism about new initiatives. **3**
Management Stability	There is a high degree of confidence in management and leadership. **1**	Management or leadership has changed recently or there are beginning rumblings of trouble. **2**	There have been no confidence votes, terminations, and upheaval in management. **3**
Currency of Medical Staff Bylaws	Bylaws are dynamic, up to date, reflect reality. **1**	Bylaws revised in some measure in the last few years to reflect reality. **2**	Bylaws have not been amended in years to reflect current state. **3**
Medical Executive Committee Authority	Balanced: MEC is the Supreme Court for the staff; resolves inter-departmental feuds; procedural presumption it acts effectively. **1**	MEC "represents" the medical staff: Board doesn't cede 'too much' power; approves officers and chairs; credentials committee reports to Board. **2**	Civil Libertarian: individual physician rights dominate; high levels of due process; reactive and formalistic. **3**
Board Engagement with Medical Staff on Quality	Direct Board-Medical Staff involvement, high input from medical staff, early role in quality activities. **1**	Board watches quality, depends on administration for monitoring and surveillance of medical staff to be reported. **2**	Board thinks quality is purely a medical staff responsibility; no real engagement. **3**