4 pitfalls to clinical integration

Mistakes commonly made when pursuing clinical integration can significantly prolong implementation or derail the initiative altogether.

For more than a decade, research has shown that the fragmented nature of our nation’s healthcare system has hurt the value of healthcare services. A lack of communication and coordination across providers and sites of care has led to escalating healthcare costs and suboptimal outcomes.

Many healthcare policy experts—and more recently, politicians—have advocated for greater clinical integration among healthcare providers. This advocacy is reflected in the final regulations for participation in the Medicare Shared Savings Program as an accountable care organization, which have raised the concept of clinical integration to top-of-mind status for physicians and healthcare administrators across the country (“Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations,” Federal Register, Nov. 2, 2011).

Recently, providers spanning the continuum of care have attempted to educate themselves on models for clinical integration by scrutinizing Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) guidance, studying healthcare organizations and provider networks that have relied on clinical integration strategies to establish a value-based market position, and consulting with vendors (including business, legal, and IT advisers) to determine the right approach. Although due diligence is a key exercise for any organization considering clinical integration as a strategy, this process often results in confusion or misinterpretation.

How can healthcare providers expedite implementation of a clinical integration initiative and succeed in an environment of accountable care? There are four pitfalls that healthcare organizations and physicians should avoid.

**Level of Ambulatory EHR Adoption**

The first pitfall is the notion that the clinical integration model’s potential is limited if there is a low level of ambulatory EHR adoption among the organization’s affiliated medical staff. It’s a common fallacy that a successful clinical integration program relies upon widespread adoption of an EHR. Clearly,
if an EHR is implemented appropriately, it can be a powerful tool to help coordinate patient care. However, the meaningful use of an EHR is not the cornerstone of successful clinical integration efforts from either a legal or a practical perspective.

From an antitrust perspective, the FTC and DOJ have defined clinical integration as “an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among physicians to control costs and ensure quality” (“Statements of Antitrust Enforcement Policy in Healthcare, Statement Eight: Enforcement Policy on Physician Joint Ventures,” U.S. Department of Justice and Federal Trade Commission, August 1996).

With the government’s repeated attempts to offer incentives for EHR adoption, it is easy to draw the conclusion that the FTC and DOJ require clinically integrated providers to use an EHR to track, monitor, and report upon provider performance. In reality, the FTC and DOJ have been hesitant to tell providers what specific steps they should take to achieve meaningful clinical integration. These agencies look favorably upon EHR adoption as part of a clinical integration effort because the adoption of this technology shows an investment of time, effort, and capital by the network’s providers and signifies that the network has a long-term commitment to the model. However, no specific threshold for EHR adoption appears within the decade of FTC and DOJ guidance on establishing meaningful clinical integration.

From a practical perspective, EHRs can be powerful tools that enable providers to appropriately manage patients at the point of care, but having such a tool is only part of the clinical integration equation. Clinical integration also requires providers to audit their performance and proactively manage populations of patients. It requires data aggregation across various providers and IT platforms as well as sophisticated data mining, analysis, and reporting capabilities that the current generation of EHRs tends to lack. As a result, many successful clinical integration programs have downplayed their focus on implementing EHRs in favor of deploying comprehensive clinical registries to fill their business intelligence gaps.

Promoting EHR adoption should be a part of any clinical integration program’s long-term strategy because it will increase the ease and accuracy of data collection for providers and their office staff. That said, providers with low levels of EHR adoption should not delay the start of their clinical integration efforts simply because they have not yet achieved meaningful use of an EHR. Clinical registries can serve as a bridge to a fully integrated EHR and enable providers to begin their clinical integration efforts well before achieving meaningful use.

**Ambulatory Support of Clinical Integration**

The second common pitfall is the erroneous decision to delay development of ambulatory services that support clinical integration. The reason hospital and health system executives often make this mistake typically derives from two factors that influence their decision to support and dedicate resources to clinical integration programs, motivating them to focus initially on inpatient services.

First, because much of the inpatient value equation—namely physician behavior and decision making—lies outside of the control of hospital and health system leaders, the impending implementation and expansion of value-based purchasing programs by both governmental and commercial payers presents a growing liability to many organizations’ balance sheets. This situation applies particularly to healthcare organizations that depend on independent providers. Clinical integration provides healthcare administrators with a means to effect change through influence—or, more accurately, incentives—in lieu of direct authority.

Second, many hospitals and health systems self-fund their employees’ healthcare benefits. Just like any other self-funded employer, these organizations are seeking innovative ways to curb escalating health benefits costs. Many hospitals and health
systems have become early adopters of the clinical integration model as a means to manage their own employees’ healthcare needs efficiently.

Because hospitals and health systems have a vested interest in the success of their clinical integration programs, it is not surprising that many programs’ initial efforts are skewed toward optimizing inpatient care. The inpatient setting presents significant opportunities for reducing waste, so it can seem quite reasonable to begin the clinical integration effort by embarking on a three- to five-year strategy focused on this area.

In addition, a hospital’s or health system’s inpatient information systems can provide data and resources to enable the emerging clinical integration program to achieve early wins in its first few years of operations, thereby helping the program prove its business case, attract payers and employers as long-term sponsors, and decrease its reliance on hospital or health system funding over time.

The problem is that hospitals and health systems are not the sole stakeholders in clinical integration programs. Despite the important role these organizations will always play, the long-term “sponsors” of such programs should be payers and employers. Once these second-generation stakeholders become engaged, outpatient and ambulatory care will become increasingly important value drivers for clinical integration. Payers and employers will realize their full value from a clinical integration program when the program effectively decreases incidence of acute illness or injury, prevents or slows the progression of disease, optimizes the clinical resources utilized across the continuum of care, and ensures that transitions in care are smooth and safe.

Developing these capabilities can take years of sustained effort, so it is not wise to delay this effort. Clinical integration leaders should begin identifying, securing, and developing the appropriate ambulatory resources from day one to ensure that the program is not derailed when the opportunities to improve value on the inpatient side dry up. At the same time, hospital and health system sponsors should be aware that successful clinical integration is likely to redefine the organization’s role within the healthcare value chain. They would be wise to begin implementing strategies from the very start that mitigate the

**STEPPING STONES TO DEVELOPING A CLINICAL INTEGRATION MODEL**

**Legal and Successful**

- “Valuable” provider for, and viable competitor of, health plans
- Willing and able to directly compete for and manage self-funded employer contracts
- Consistently outperforms the market (providers and health plans) in terms of quality of care
- Consistently outperforms the market (providers and health plans) in terms of cost of care

**Legal**

- A network of physicians committed to improving the value of care has been established.
- A set of quality, cost and utilization initiatives/metrics has been developed to promote value creation by all participating physicians.
- A system has been put in place to track and monitor physician performance (IT infrastructure).
- A process for addressing performance issues has been established.

**Per- Se Illegal**

- A group of independent physicians promotes itself as “clinically integrated,” but has made no real effort to integrate (i.e., modified messenger model).
potential long-term financial impacts of efficient outpatient care throughout the clinical integration process.

Education of Office Managers and Staff
The third pitfall comes from believing that knowledge of clinical integration initiatives will passively diffuse through the ranks. Some organizations believe there is a trickle-down effect related to knowledge of clinical integration initiatives—that the education provided to hospital and physician leaders related to the initiative will diffuse through the ranks via organizational osmosis. Unfortunately, what tend to diffuse through the ranks are hearsay, rumors, contradictions, and confusion.

Recruiting a governing body of respected physician leaders and C-suite administrators and educating them on the nuances of the clinical integration model is a critical success factor. These leaders set the direction and vision for the organization. They are the ones who will motivate potential providers to adopt the clinical integration model, and they will lend credibility to the program as the business case for clinical integration is built.

But the extent to which participating physicians and administrative support staff understand the impact of clinical integration on their day-to-day activities is a much stronger predictor of the long-term success of the program.

When physicians and their office staff are not well educated on their roles and responsibilities under a clinical integration model, their lack of education can significantly prolong or derail the recruitment phase of the initiative. Worse, the inability of participating practices or hospital departments to operationalize clinical integration into their respective workflows can doom the program to years of lackluster performance.

Once the organization’s governing body understands how the initiative will work, resources should be dedicated to educating both potential physician participants and staff on the model. Hospital support staff should develop plans to build clinical integration activities into their departments’ existing routines. Physician office staff should receive training at the same time as physicians.

Providing early and ongoing education to these key participants will make the difference between a good conceptual model and a highly marketable, value-driven network.

FTC/DOJ Approval of the Model
Organizations stumble into the fourth pitfall when they attach too much weight simply to obtaining FTC/DOJ approval of the clinical integration model. Developing a clinical integration program that will receive a favorable response from the FTC and DOJ is no small effort. Even for organizations with significant human and financial capital at their disposal, the process of taking clinical integration from concept to implementation can span nearly a year. Thus, it would be easy for organizations to assume that a positive response from the FTC and DOJ regarding their plans for clinical integration is a significant predictor of the long-term success of their initiatives.

The fact is that FTC and DOJ approval is merely a qualifier for employing a clinical integration strategy. Although a favorable response from these agencies reduces the legal risk for a clinically integrated network as it tries to sell clinically integrated services, it does not obligate payers or employers to purchase these services. If a clinically integrated network attempts to make purchasers feel obligated to do so by wielding its market power or using other anticompetitive measures, it will still be subject to antitrust review.

At the end of the day, the success of a clinical integration initiative will be based on the network’s ability to deliver upon its value-driven business case. Establishing perceivable, value-based differentiation in care and service will attract patients, employers, payers, and high-value providers to the network and ensure its long-term sustainability. Doing the bare minimum to ensure legal compliance is likely to result in a
generic, easily replicated, and expensive program that is unlikely to provide a positive return for its stakeholders.

When developing a clinical integration network, it is critical to ensure that the network will not only meet the expectations of the FTC and DOJ, but also exceed them. Leaders of a clinical integration network should scrutinize the details of the initiative to ensure that the program both complies with FTC and DOJ guidance and addresses the needs of its key stakeholders, including employers, payers, sponsoring hospitals and health systems, and provider participants.

The devil is truly in the details. Successful clinically integrated networks are prepared to substantiate their accomplishments with reliable, quantifiable data.

Achieving the Full Potential of Integration

Despite a number of misconceptions related to the development of a clinical integration program, the model remains a viable means for hospitals, health systems, and direct providers of care to succeed in an accountable care environment. Providers that fall into any of these four pitfalls associated with clinical integration are likely to experience significantly prolonged development processes and, in some cases, will be more prone to abandon the model early in the development process. Providers that avoid these pitfalls will be more likely to expedite the implementation process, develop marketable and value-based business cases, and realize sustained financial returns from their clinical integration programs.

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