CLINICALLY INTEGRATED NETWORKS: THE SECRET SAUCE TO SUCCESS

by Jamie Orlikoff

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So Why Have ACOs and CINs Been Such A Hot Topic?

- Dartmouth Atlas showed that costs and quality could be attributed fairly accurately to the “community of practice” defined by hospital service areas, and that performance varies widely from one hospital community to another
  - McAllen v Grand Junction
  - Miami v Minneapolis
  - Los Angeles v Sacramento
- So....if cost and quality can be attributed to hospitals and their “extended medical staffs” perhaps they could be held accountable.
- And if they could be held accountable, and share in the savings from their lower costs, then many communities would somehow perform a lot like Geisinger, and Kaiser, and Mayo....then a miracle would happen!
1. Old Delivery Model

2. Then a Miracle Occurs

3. New Delivery Model

"I think you should be more explicit here in step two."
Let’s Hear from The DOJ and the FTC in 1996

CI is an active and ongoing program to evaluate and modify practice patterns by the CI network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.
Let’s Hear from The DOJ and the FTC

Clinical Integration:

- Establishes mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality of care.
- Selectively chooses CI network physicians who are likely to further these efficiency objectives.
- Utilizes investment of significant capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.
WHY CLINICAL INTEGRATION?

Collective bargaining by physicians that compete with each other is considered anticompetitive and is prohibited except when physician networks are financially or clinically integrated.
In a clinically integrated network, employed and affiliated physicians can negotiate collectively with payers on reimbursement arrangements. It is a key step for networks, though a Medicare Shared Savings Program (MSSP), Accountable Care Organizations (ACO) are exempt from these requirements.
A Clinically Integrated Network must generally:

- Show that they improve quality and efficiency
- Deploy consistent clinical protocols across the network with the goal of achieving measurable targets
- Monitor physician and network performance
- Have a collective financial investment in a reporting system
• In a Clinically Integrated Network, physicians collectively invest in IT infrastructure, such as disease registries, clinical performance management systems, and predictive analytics, as well as funding staff dedicated to performance improvement.

• Participating physicians also commit "sweat equity" to improving performance—serving on committees as well as changing their day-to-day clinical practice. And they create explicit plans for how the network will improve care outcomes and efficiency.
• In exchange, the physicians can negotiate collectively with insurers for better payment rates (in recognition of their superior quality) or for bonuses based on quality and cost improvements. This collective bargaining would otherwise be illegal, but properly-designed clinical integration arrangements create a “safe harbor” from antitrust rules.

• Hospitals often play a role in organizing clinical integration networks; however, the networks are led and operated by physicians.
Today, other than extensive direct physician employment, a clinical integration program is the most effective way to create the incentives, management, and infrastructure for health systems to improve quality and efficiency.
Though CINs bring the advantages of being part of a group of physicians, they don’t require doctors to give up their individual practices—though there are some CINs consisting of employed physicians.
Captain Obvious Says:

For some physicians accustomed to independence, having their performance monitored by and being accountable to the CIN isn’t easy.
True Clinical Integration:
A Requirement for Success under Accountable Care and Population Health

“Physicians working together systematically to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.”
Jumping The Curve From:

“Eminence Based Medicine”
Making the same mistakes with increasing confidence over an impressive number of years.

~BMJ, Vol. 1 Sept 2001

“Evidence Based Medicine”
Rapidly integrating individual clinical expertise with the best available external clinical evidence from systematic research.
“The most meaningful cost reduction strategies will involve standardization of clinical care and elimination of variation in patient procedures. This will be a multi-year, ambitious journey requiring strong physician, management and board leadership"
Anatomy without Physiology don’t mean a thing!

"I gave it a healthy dose of denial, but it didn't help."
WHEN THE PIE GETS SMALLER, THE TABLE MANNERS GET WORSE!
TYPICAL MEDICAL STAFF DISTRIBUTION
TYPICAL MEDICAL STAFF DISTRIBUTION

LEADERS

$\bar{X}$

2.5%
TYPICAL MEDICAL STAFF DISTRIBUTION

LAGGARDS 2.5%  X  LEADERS 2.5%
TYPICAL MEDICAL STAFF DISTRIBUTION

- LAGGARDS: 2.5%
- EARLY ADOPTERS: X
- LEADERS: 15%
The 7 Samurai of CINs
Three Basic Requirements for “Accountable Care” Success

1. Collect, analyze, and understand performance data on quality and cost, for episodes of care, and for total cost of care for populations

2. Manage clinical quality and cost performance across diverse settings for episodes of care, and/or for populations

3. Govern the whole operation
Leaders must emerge who regard themselves as defenders not of organizations but of the underlying purposes that have temporarily created those organizations in their current forms. **Leaders will have to be willing to unmake the very organizations they hold in trust.** That’s a big job. It requires a kind of courage that is rare among human beings, including organizational leaders.”

Don Berwick MD

“Seeking Systemness,”
Healthcare Forum Journal, March/April 1992
“The currency of leadership is attention.”

Heifetz
CHALLENGE of LEADERSHIP

IN A STABLE ENVIRONMENT
KEEP THINGS THE SAME,
INCREMENTAL IMPROVEMENT

IN A REVOLUTIONARY ENVIRONMENT
“THE JOB OF LEADERSHIP IS TO RE-DEFINE REALITY”

Max DePree Leadership is an Art
Types of Leadership

**Transactional**
- Exchange
- Within current frame of values, habits, beliefs
- Incremental change
- Political skill

**Transformational**
- Conversion
- New frame of values, habits, beliefs
- Revolutionary change
- Authenticity
Leadership and The Adaptive Challenges

Leadership (mobilization of resources)

Technical Problems
(fits the current experience base and decision-making logic; we know who to fix these problems)

Authority (power to deliver services)

Adaptive Challenges (zone of inexperience / uncertainty; new terrain, and nobody knows the answer – often the problem is not well defined)
## Leadership and Adaptive Challenges

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<tr>
<th>Principle</th>
<th>Adaptive Challenge</th>
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| Get on the balcony                    | • Should we be in the field or in the coach’s box?  
• What patterns might we see from the coach’s box? |
| Regulate distress                     | • What is the level of distress?  
• What is the cause of distress?  
• What are the pluses and minuses of high stress? |
| Frame the adaptive challenge          | • What is the adaptive challenge?  
• What is the problem we are trying to solve?  
• Is this individual or collective work? |
| Maintain disciplined attention        | • Are those responsible for the work doing the work?  
• How do we avoid work? |
| Give the work back to the people      | • Where is the locus of responsibility for work in the organization?  
• Have we framed the challenge in relevant terms?  
• Is there conflict? If so, what is the source of the conflict?  
• What, if any, norms or deeply held beliefs are unproductive? |
| Protect the voices of leadership from below | • Are we listening to dissenting voices?  
• What are we hearing/learning?  
• Are we acting on what we hear/learn? |
A leader is a person or group that people will follow to places where they would not otherwise go by themselves.
Stolen from Jim Conway, who Stole it from Cathy Trower, Harvard Graduate School of Education
Leadership in a learning organization starts with the principle of creative tension. Creative tension comes from clearly seeing where we want to be, our 'vision', and telling the truth about where we are, our 'current reality'. The gap between the two generates a natural tension.

Creative tension can be resolved in two basic ways:
- by raising current reality toward the vision, or
- by lowering the vision toward current reality.

Individuals, groups, and organizations who learn how to work with creative tension learn how to use the energy it generates to move reality more reliably toward their visions.

THE FALLACY OF COMPOSITION

• WHAT IS GOOD FOR THE INDIVIDUAL IS NOT GOOD FOR THE GROUP

• WHAT IS GOOD FOR THE GROUP IS NOT GOOD FOR THE INDIVIDUAL
1. Every System is Perfectly Designed to Produce the Results it Gets.

2. In Order to Optimize the System, One or More Parts Must Be Sub-Optimized.

3. If Each Part is Optimized, the SYSTEM Will Be Sub-Optimized.

4. Complex Adaptive Systems are Not Like Complicated Machines, They are More Like a Flock of Birds.
Laws of Systems

There are Three Ways to Achieve a Better System Number:

1. Improve The System
2. Sub-optimize the System
3. Cheat

As Leaders Put More Incentives on “Achieving the Number”, The Likelihood Increases of More of 2 and 3.
Maternal-mortality rate, per 100,000 Live Births

Maternal Deaths

2009 – 5 deaths (18.5/100,000)
2010 – 4 deaths (16.4/100,000)
2011 – 1 deaths (4.3/100,000)
2012 – 3 deaths (12.8/100,000)
2013 – 0 deaths (0.0/100,000)
2014 – 0 deaths (0.0/100,000 plus the brain dead MVA patient)
Mandatory OB 22 hour CME training for both physicians (to maintain credentials) and nursing (to maintain job) with incentive for early completion

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Physicians today must absorb three messages:

1. Quality is measured not by volume, diligence, or even skill. Quality is measured by **Results**.

2. Cost does matter. **“Value”** in health care means achieving good outcomes as efficiently as possible.

3. **Teamwork** is required (coordination, information sharing, goal setting, accountability).
Clinical integration is

Integration of Physicians with each other (and often with a hospital or hospital system) on a Clinical basis to

- Determine the right and best ways to practice medicine
- Commit to practice that way
- Commit to mutual accountability
- Develop active performance improvement programs to enhance healthcare quality and efficiency

Aligned Incentives
CI Practical Requirements

- Leadership group of physicians is key
  - Willing to be measured and improve (a direct appeal to the ethos of physicians)
  - Able to communicate
  - Respected
  - Collaborative

- Clinical Performance Improvement Projects
  - PQRS, attestation for meaningful use, Medicare levy, performance measures
  - Ambulatory pathways and protocols
  - Hospital quality, safety and cost efficiency projects
    - Choose wisely—doable projects with clear benefits
    - Patient centered
MHMD agrees to:

- Maintain primary **loyalty** to physicians
- Negotiate well to **align incentives**
- Include physicians in work and decision making
- Provide **clear and timely information**
  - Membership Criteria, Quality Measure Scoring
  - Accountability / Improvement Process
  - Contract, Financial Performance
- Provide physicians with information, services, and education to ensure high quality and ease practice burdens
- Seek feedback from its physicians
- Maintain confidentiality
- Communicate, communicate, communicate
- Make meetings worthwhile and engaging
- Create leadership training programs
Physicians agree to:

- Practice evidence-based medicine
- Uphold regulatory, quality, and safety goals
- Report quality data
- Meet CI criteria
- Come to meetings and performance feedback sessions
- Pay attention to information from MHMD
- Accept decisions by physicians in MHMD committee settings
- Be flexible, share ideas
- Collaborate with colleagues and hospitals
- Behave as professionals
Clinical Integration takes effort!

- Participating physicians must participate
  - Participate in selecting quality measures
  - Participate in reporting performance measures
  - Participate in determining what level of performance is the goal (setting realistic goals)
  - Participate in committee work, performance feedback, and quality improvement activities
  - Time, effort and IT infrastructure all required

- Those who do not participate even after remediation, must be removed!
Three Common Stages of Evolution to CIN

**AGGREGATION**
- Mostly defensive
- Transactional, one-off deals
- Disparate offices/systems
- No consolidation of offices
- Pure productivity-based comp.
- No organization or code of conduct
- Escalating investment

“I do my part seeing patients. In return, the system needs to support me and my income. Finding the resources to do so is their problem.”

**CONSOLIDATION**
- Consolidation of locations
- Common name
- Central, shared governance
- Hierarchy w/performance evaluation
- Standard offices/systems
- Single blended comp. plan
- Budget discipline
- Referral management
- Investment is stabilized

“My role is to see patients and support system initiatives so the system has enough resources to support me and my income.”

**INTEGRATION**
- Standard clinical work
- Common culture/vision
- Shared incentives
- Team-based care
- Commitment to redesign for better quality and efficiency
- Investment yields return

“I am the system, my income depends on the collective performance of me and my colleagues.”

Nate Kaufman, Kaufman Strategic Advisors
“At Virginia Mason… we understand that healthcare is impeded not facilitated by the notion of physician autonomy.”

~Dr. Gary Kaplan MD, CEO Virginia Mason, January 11, 2014
Big Questions:

• What values are the primary influence of the culture, structure, and processes of your physician group (or, hospital’s medical staff)?

• Will the values of your proposed medical group, ACO, or other “clinically integrated thing” need to be different from the values of the current physician group/medical staff?
Who should we invite to be members of our “clinically integrated thing?”

• The answer that should make you nervous
  – “Our first priority is to get everyone possible into the tent. If docs don’t fit because they don’t follow protocols, or cooperate well with other docs, or treat patients and families with respect, or run up huge costs with unnecessary procedures, we’ll sort them out later. Basically, if you’re a member of the physician group or on the medical staff of the hospital, you’re welcome.”
A much surer, (but slower) strategy about “Who”

“We are going to form our clinically integrated organization around a small, committed nucleus of doctors and administrators who share our values, and we’ll build it from there.”

Dr. James Reinertsen
Stages of Facing Reality

• Stage 1  “The data are wrong”
• Stage 2  “The data are right but, it is not a problem”
• Stage 3  “The data are right; it is a problem but, not my (our) problem”
• Stage 4  “I accept the burden of improvement”
If you’re really going to be accountable for the quality and cost of care for a population…

- You’ll probably have to be driven by both upside and downside risks.
- You’ll have to know who’s in the population.
- You’ll have to find some way to align provider incentives with your business model.
- You’ll have to know how to reduce waste.
- You’ll have to control capacity, especially for overused services.
- You’ll have to have good information, and USE IT!
- You’re going to have to be really clear about your guiding values.
“In Times of Change, Learners Inherit the Earth, while the Learned find themselves beautifully equipped to deal with a World that no longer Exists”

Eric Hoffer

(Stolen from Gary Kaplan; his Favorite Quote)