Q: What is “clinical integration”?
A: Clinical integration is an agreement among physicians, often in collaboration with a hospital or health system, to develop active and ongoing clinical initiatives to control costs and improve the quality of delivered care. The agreement involves the acceptance of common care guidelines, data sharing and often performance tracking of providers and patients against the agreed upon guidelines. Participation in an effective clinical integration program provides all participating physicians, whether they are employed or independent to a health system, the ability to contract collectively with health plans without violating antitrust laws.

Q: What are the defining elements of a successful clinical integration program?
A: A successful clinical integration program (1) provides measurable clinical improvements for patients (2) common metrics used to evaluate physician performance and (3) results cost reductions or changed economics for physicians.

Q: What does a clinical integration network look like?
A: In many instances, a clinical integration network involves both employed and independent doctors on the medical staff of the same hospital or hospital system who join together in an organization (often a PHO or IPA) that allows them to: (1) collectively agree to and adopt clinical protocols for the treatment of particular disease states or patients (in both ambulatory and acute settings) (2) develop reporting platforms to measure adherence to the adopted protocols (3) collaborate with the hospital or hospital system to encourage compliance with inpatient performance improvement processes and protocols, and (4) enter into “pay-for-performance” and other contractual arrangements with payers to financially reward physicians’ successful efforts to improve health care quality and or lower costs. In some cases the clinically integrated network designs the programs and “pitches” the program to payers, in others payers may have already established such programs, and the clinically integrated network is formed in part to take advantage of them.

Q: Who is typically involved in the development and leadership of a clinically integrated network?
A: Often a hospital of health system bands together with a PHO or IPA to create the clinically integrated network. Often the hospital or system side is represented by a senior executive with responsibility for physician relations, network development or clinical improvement. The physician side, whether an IPA or PHO or more loosely affiliated physicians, is often governed by a board led by doctors, and operates for the explicit purpose of implementing a clinical integration program, on the basis of which the network negotiates “pay-for-performance” arrangements with the hospital or health system and payers to share in the savings generated by improving quality and reducing costs.

Q: What do participating physicians within a clinically integrated network typically need to do?
A: Often physicians are asked to do most, if not all, of the following:
• First, membership is usually optional (at least at a practice level if not an individual physician level). So, physicians who decide they will participate in a clinical integration program usually sign some form of Network Participation Agreement.
• Second, physicians are required to collaborate with their physician colleagues and the sponsoring hospital or health system in adoption of the clinical integration program, inclusive of clinical guidelines, and care protocols.
• Third, the physicians are often required to adopt technology and data sharing practices that allow for the proper measurement of adherence to the collectively agreed to guidelines and protocols.
• Fourth, physicians hold themselves and each other accountable for compliance with the guidelines and the protocols, including its disciplinary and remediation efforts should physicians not meet the benchmarks set by the clinical integration program.
Q: What clinical areas does a clinical integration program typically include?
A: Often clinically integrated networks seek to improve:
• Chronic disease management
• Care coordination after an acute episode
• PQRI reporting
• Communication among primary care physicians and specialists
• Community case management
• Quality-based credentialing

Q: What technologies and/or information are typically involved in a clinical integration effort?
A: The more comprehensive the data used in a clinically integrated network, the more effective that network can be. Typically, the following data sources are utilized in clinically integrated efforts:
• Inpatient EMR and CPOE information
• Ambulatory EMR information
• Ambulatory practice management information
• Claims data (from the practice, clearinghouse and/or the payers)
• Disease registries
• Immunization registries
• PBMs
• Labs

Q: Does participation in a clinical integration program change the way physicians practice medicine?
A: By definition, yes. Participation in the quality such programs require physicians to adhere to certain collectively agreed to guidelines and performance measures with the goal of improving quality and reducing costs. If the status quo of care quality and costs were acceptable to the participants there would be no reason to adopt a clinical integration program. By changing/improving the way they practice, physicians can provide better, more consistent care, at a lower costs, and as a result realize financial benefits. Often, the size of financial incentives is dependent upon an individual physician’s performance and the performance of the program holistically.

Q: What role does technology play in clinical integration?
A: Technology provides the backbone for a clinically integrated network, allowing various data sources to be pooled to create a full clinical record of a patient, as well as apply the agreed upon guidelines to the consolidated patient data in such a way that non compliance or gaps in care are readily apparent. An ambulatory EMR is NOT A PREREQUISITE for the development of clinical integration, though it can help. While a common EMR across all participating physician practices can certainly accelerate and strengthen a clinical integration program, most (if not all) successful models of clinical integration nationwide do NOT depend on an ambulatory EMR for data on physician performance. Many, if not most, clinical integration programs began their efforts to measure, analyze and evaluate physician performance through claims data, existing hospital data, disease registries and chart audits.

Q: Why are physicians motivated to engage in clinical integration networks?
A: Physicians have several reasons for joining clinically integrated networks including: (1) Enhancing the quality of the care provided to patients (2) Legally and legitimately negotiate with payers as a network and reap financial rewards for improving quality and reducing costs (3) to respond to health system or health plans that are under tremendous pressure to use “report cards” to grade physicians (4) to gain access to technological and quality improvement infrastructure that will provide physicians their own data sets to argue against these “report cards,” (5) to allow networks of physicians and hospitals to market themselves on the basis of quality.

Q: Is it lawful for a network of clinically integrated physicians to collectively negotiate with healthplans when the FTC is actively investigating and prosecuting physician networks for negotiating PPO contracts?
A: The FTC views clinically integrated physician networks as an opportunity to create efficiency and quality in care that outweighs any restraint on trade. However, the FTC will continue to prosecute those networks that fail to demonstrate the elements of true clinical integration. For those reasons, physicians are encouraged to work with proven consultants and partners to establish clinical integration networks.
Q: If a physician delegates his or her contracting to the network, how will that affect his or her current managed care relationships?
A: Typically physicians will only be asked to delegate their contracting for agreements entered into by the network. Often those agreements will not impact their existing managed care contracts.

Q: How are contractual arrangements usually negotiated?
A: The network usually has a contracting committee, led by physician members of the network, who determine the parameters of any contractual relationship. Physicians are required to treat patients under these arrangements in the same manner as any other managed care relationship.

Q: What benefit do hospitals or health systems provide in the development of clinical integration programs?
A: Partnering with a hospital can provide distinct advantages to a network of independent physicians in the development of clinical integration. In instances where the hospital shares the same quality vision as the physicians, the hospital can be a powerful ally in program development by: (1) collaborating with the physicians in the development of clinical integration initiatives based on existing inpatient quality measures (2) lending financial and technological assistance and personnel in the implementation of inpatient and outpatient initiatives (provided they create true community benefit and are not tied to the volume or value of referrals) and (3) demonstrating to payers and the community as a whole that the clinical integration program is both legitimate and valuable.

Q: How can I receive more information regarding clinical integration programs?
A: Valence Health consultants and experts are available for free informational discussions. Contact us at: information@valencehealth.com or 888-847-0250