5 WAYS TO **SUPPORT**

CLINICAL INTEGRATION

By Laura Ramos Hegwer

In an era of increased partnership and affiliation, healthcare leaders are leveraging their collective strengths on the path toward clinical integration. The success of these efforts depends on healthcare executives' commitment to investing in the infrastructure needed while allowing physicians to take the lead.

Healthcare leaders cite the need to achieve clinical integration as one factor spurring the wave of innovative affiliations and established partnerships among providers across the country. The degree to which geographically separate hospitals, physicians and other healthcare entities or personnel are clinically integrated—coordinating their activities for the benefit of patients—is key to success in an era of value-based business models and increased consumerism in healthcare, according to Rob Schreiner, MD, FACP, FCCP, managing director, Huron Healthcare Consulting, Dunwoody, Ga., and an ACHE Member.

But in spite of the importance of clinical integration, healthcare leaders often are hard-pressed to articulate what clinical integration looks like, Schreiner says.

To a patient, clinical integration might be viewed as the ability to be seen by a physician more quickly, gain improved access to specialty care and encounter a more seamless care experience across the continuum. To a CEO, clinical integration might take the form of increased market share. To a health system or facility CFO, it might equal higher margins by service line and lower supply chain costs. To a quality officer, it might mean higher Health Effectiveness Data and Information Set scores. To the marketing officer, it might look like an opportunity to leverage the organization's branding power.

Even with its potential advantages, clinical integration presents a prioritization challenge for healthcare CEOs, Schreiner says. "It's the CEO's conundrum: How much should I invest to build the infrastructure for value-based payment today versus next year or the following year?" he says. "Healthcare leaders recognize they need to build their capabilities before payers insist on this transition."

How can healthcare leaders effectively support—but not control—clinical integration from the C-suite? Healthcare

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leaders for three organizations that have demonstrated success in integrating care across the continuum share five lessons for success.

Lesson No. 1: Commit the Resources for a Long-Term Approach

The capabilities needed to support clinical integration include IT and analytics tools, although Schreiner believes their role in driving clinical integration is often overstated. "Analytics and IT are enablers of clinical integration, but they do not create it," he says. "Clinical integration is really about changing operations and opening up access to the right level of care. Changing workflows and the organization's culture is more important than having the right analytics and reporting platforms."

Schreiner believes increased data transparency—specifically around physician performance—can help drive the cultural changes that need to occur at the physician-practice level to improve individual and group performance. "Physicians behave differently when they believe they are accountable to one another," he says. "That accountability is an important cultural leap for a practice, and it is more important than the tactical issues such as bolstering an organization's IT capabilities around business intelligence or care management."

Today, many healthcare organizations are facilitating clinical integration through the development of networks, which permit legally separate healthcare providers to form a combined entity that allows single-source contracting without running afoul of antitrust laws, Schreiner says. They also enable providers to jointly invest in the infrastructure needed to support clinical integration.

In 2013, CHI St. Vincent, a 447-bed hospital in Little Rock, Ark., formed a CIN that has become the backbone of its accountable care and population health management strategy. Called the Arkansas Health Network, this CIN received a $1.9 million bonus payment through the Medicare Shared Savings Program during its first performance year in 2014. Leaders at CHI St. Vincent say their success is based on aligning with committed physician partners and investing in the resources needed for clinical integration—including care managers, population health coaches and new technologies.

"Clinical integration is not a short-term commitment," says Polly Davenport, DSc, FACHE, president, CHI St. Vincent. "You have to dedicate the resources and commit for the long haul."

Although leaders at CHI St. Vincent are still searching for the right mix of technology, they have found value in a risk stratification tool that identifies the physician practices whose patients are most likely to use the health system's services at a higher-than-average rate in the coming year.

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"We have been very intentional about placing our care managers and population health coaches in clinics where they are likely to have the greatest impact," says Rachel Kahn, manager, strategy and governance. "As a result, we've seen a lot of improvement, particularly in our chronic obstructive pulmonary disease and end-stage renal populations. At the same time, we've seen an overall decline of inpatient costs and utilization and a shift toward care delivered in primary care settings."

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Leaders at CHI St. Vincent structured the governance of the CIN so that it reflects the appropriate mix of community and employed physicians (less than half of Arkansas Health Network's 1,200 providers are employed). An 11-member board composed of five independent physicians, three employed physicians, administrators and community members leads Arkansas Health Network.

Driving CHI St. Vincent's clinical integration efforts is a commitment to becoming better partners with physicians and other providers in the community, Davenport says. Increased partnership is the premise behind CHI St. Vincent's five-year agreement with Conway Regional Hospital, a 154-bed community hospital in Little Rock. Under the deal, CHI St. Vincent will manage the operations of the hospital while Conway Regional maintains its local governance and autonomy, Davenport says.

"We believe there is going to be continued consolidation across the state," says Tadd Richert, CHI St. Vincent's CFO. "We also understand there are community-based providers across the state that are looking for some type of support. Through the alliance, we can develop relationships and support each other in different ways, through purchasing supplies or providing physician support where needed. Together, we can create a network that works not only as a clinically integrated model, but also as an operating model that will be more sustainable in the future."

Lesson No. 2: Have a Strategy for Onboarding Physicians

The healthcare CEO should be the key executive sponsor of any effort to make the organization more clinically integrated, Schreiner says. Too often, though, CEOs and other healthcare leaders get caught up in trying to get physicians "on board" with clinical integration, as if it were a top-down strategy. The best approach: Use mutual patient-centered goals in seeking physician buy-in, Schreiner says.

"Tell physicians you need their help with clinical integration because patients deserve highly reliable, humanistic, empathetic and easily accessible care, and clinical integration will enable the health system to achieve that desired state for the good of the communities you serve," he says. "Doctors will sign up for that."

Onboarding physician practices is critical to the success of clinical integration initiatives. To do so successfully, healthcare leaders should consider hiring practice facilitators, says Patrick Wright, MD, senior vice president, quality and patient safety, Cone Health, Greensboro, N.C. Practice facilitators support the 1,200 physicians (60 percent independent, 40 percent employed) who make up Cone Health's CIN and accountable care organization, Triad HealthCare Network. "Our practice facilitators work behind the scenes with physicians and office staff to further our clinical integration initiatives," Wright says.

Specifically, practice facilitators—who are typically registered nurses—are responsible for helping physicians achieve various clinical and financial benchmarks that are part of THN's payer agreements. As of January 2016, THN will be managing 77,000 lives through the Centers for Medicare & Medicaid Services' Next Generation ACO Model, several commercial Medicare Advantage plans and its own MA plan.

When a new physician practice joins THN, a practice facilitator educates the physicians and office

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staff on resources provided by the CIN such as a list of the practice's patients who have exhibited high utilization and who are at risk for inpatient admission or readmission. The practice facilitator will help office staff close care gaps for these patients and keep physicians informed on treatment protocols in high-priority areas, such as chronic obstructive pulmonary dissease and heart failure. The practice facilitator also may recommend process changes in the practice to improve access or efficiency. They may even help office staff implement new software or tools, such as a point-of-care dashboard. This dashboard displays a patient's most recent diagnoses, medication list, upcoming screenings and other interventions needed so physicians can refer to it during the office visit. It also includes a utilization section that shows per-member-per-month cost data.

Wright believes leadership education for physicians can make or break the success of clinical integration efforts. "Clinical integration can't come from the C-suite—it has to be physician driven," Wright says. To that end, Cone Health provides courses on leadership designed specifically for physicians. The health system also has developed an effective infrastructure of physician-led committees. THN's operating committee, which includes nine independent physicians and eight employed physicians as well as Cone Health administrators and a patient representative, oversees the CIN's day-to-day operations. Under the operating committee, there are five subcommittees: credentialing, quality, contracting and finance, health information exchange and medical management, which review cost information and provide dashboard data to physicians on their performance.

Improving quality is often the central rallying call for physicians involved in clinical integration, but finding the right way to engage providers may take time. For example, THN has moved away from its early attempts to improve quality by service line. "That worked well for about a year, but what we found was that the approach was a bit too siloed, and we were producing a number of process-based metrics that weren't moving the needle on population health," Wright says. Instead, leaders at THN redesigned the health system's quality subcommittees around key outcomes for population

Rachel Kahn, manager, strategy and governance; Tadd Richert, CFO; and Polly Davenport, DSc, FACHE, president, CHI St. Vincent, work collaboratively on clinical integration.

David (Clint) Matthews, president and CEO, Reading Health System, believes physician education is vital for clinical integration.

Flo Spyrow, RN, JD, FACHE, interim CEO, Hammond-Henry Hospital (pictured at right), shares plans with Penny Park, RN.

Patrick Wright, MD, senior vice president, quality and patient safety, Cone Health, says hiring practice facilitators can help support clinical integration efforts.

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health. They also have formed teams around readmissions, sepsis, surgical-site infections, COPD and heart failure, to name a few.

Wright recommends engaging physicians in just six to eight major quality initiatives at a time. "Sometimes, you can get so overwhelmed with data that it paralyzes you," he says. "Clinical integration is really about connecting with people who can improve care across the continuum."

Lesson No. 3: Develop Multiple Partnerships to Fill Gaps When Needed

In an environment of increased competition and consolidation, maintaining independence can be difficult for rural and critical access hospitals, particularly as leaders consider their clinical integration options, says Flo Spyrow, RN, JD, FACHE, interim CEO, Hammond-Henry Hospital, a 25-bed community hospital managed by HealthTech Management Services in Geneseo, Ill., part of the Quad Cities area.

"Rural and critical access hospitals have neither the patient base nor the revenue necessary to make managing population health feasible on their own," Spyrow says. "They also may not have access to all levels of care, including specialty care, home care and nursing home care, in their communities, so they have to reach out and develop more partnerships. The challenge for rural and critical access hospitals that wish to maintain their independence is finding the right balance between clinical integration and providing patients with a seamless experience across the continuum of care without getting de facto aligned or becoming part of another system."

Spyrow believes the best strategy for healthcare leaders in rural and critical access hospitals is building multiple partnerships, rather than working with one large health system, to gain access to the services or resources they do not have under their own roof. That has been the strategy at Hammond-Henry, which has partnered with two health systems: UnityPoint Health-Trinity, a regional integrated delivery system that operates four hospitals in Illinois and Iowa, and Genesis Health System, a five-hospital system that serves a 10-county, bistate region and is part of the University of Iowa Health Alliance.

For instance, Hammond-Henry joined UnityPoint Health-Trinity's ACO last year. "We have fewer than 20 Medicare and commercial patients who are attributed to us, and these patients would be difficult to manage on our own," Spyrow says. By joining the ACO, Hammond-Henry has been able to leverage UnityPoint's care pathways and other resources to help care for these patients across the continuum and better manage costs across an episode of care. Hammond-Henry also recently entered into an agreement to participate in Genesis' ACO. "This will help us broaden our patient base and increase our learning in the future," Spyrow says.

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Lesson No. 4: Keep Physician Recruitment Strong

One way in which leaders at Hammond-Henry have supported clinical integration is by honing the hospital's long-range physician recruitment strategy. "You have to

be able to recruit and retain high-quality physicians to become more clinically integrated," Spyrow says.

The hospital has partnered with UnityPoint Health-Trinity to identify medical students and physicians early in their careers who are interested in rural healthcare. Leaders at the system are building relationships with medical students who grew up in the area and others who are interested in completing a six-month medical rotation in a rural community. They also collaborated with the health system and various residency programs to identify and attract residents who are interested in rural care but desire to be part of a larger system of coordinated care.

Healthcare executives and physician leaders also are investigating ways to provide financial support to residents in exchange for a commitment to work in the area later on. For instance, physicians at Hammond-Henry have raised more than $50,000 from their own pockets to improve recruitment efforts.

Lesson No. 5: Consider a Collaborative

Some healthcare leaders are taking clinical integration to the next level by forming large-scale regional collaboratives. One example is AllSpire Health Partners, which includes seven healthcare systems covering New Jersey, New York, Maryland and Pennsylvania.

"Our seven systems have common goals in working with our physicians as we all move into risk sharing and value-based payment," says David (Clint) Matthews, president and CEO, Reading (Pa.) Health System, and an ACHE Member. Specifically, the collaborative is focused on sharing best practices to improve clinical outcomes and developing shared services to reduce costs.

A regional focus on population health management has gradually evolved at Reading Health System, which includes a 647-bed acute care hospital and a rehabilitation hospital. In 2012, Matthews and his team decided to implement a CIN. For the first year, they focused on educating the board and medical staff on why the health system needed such a network. "Rather than jumping immediately into shared savings, we needed to develop the infrastructure," Matthews says. Healthcare executives also wanted to make sure they were following the 1996 rules governing CINs from the Federal Trade Commission and the U.S. Department of Justice. "We actually went to the FTC and presented our network to them to make sure we were meeting all of the requirements," Matthews says.

After scaling the legal hurdles, the health system named its network Reading Health Partners, which today includes 650 physicians in 50 specialties. The CIN has played a pivotal role in the health system's risk-sharing agreement with a local self-insured employer, East Penn Manufacturing. Based on its success with the East Penn population, the CIN is in talks with other employers as well as payers to enter into risk-sharing agreements.

Matthews says the most challenging aspect of working on clinical integration has been overcoming physician skepticism and distrust, which leaders achieved through regular communication.

"Whether physicians are employed or independent, they are threatened by the changes in our industry," Matthews says. "Sometimes, the health system can seem like the common enemy. That's why it is important to educate physicians on how clinical integration can help them work together for the purpose of improving quality and access as well as managing the cost of care."

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