CHAPTER 15

A Platform for Collaboration

INTRODUCTION

Clinical integration (CI) offers hospitals and physicians the opportunity to coordinate patient interventions, manage quality across the continuum of care, move toward population health management, and pursue true value-based contracting.

The pillars of CI include shared governance (with strong physician leadership) focusing on the transformation of health system culture and the achievement of clinical outcomes—the key drivers toward value-based care (Marino 2012). This requires a mindset of interfunctional collaboration, sharing information, managing utilization, and providing proactive care. Communicating the value of CI, employing innovative care delivery models, and tracking clinical quality outcomes all create incentives for joint accountability, mutual commitment, teamwork, and engagement across the continuum of care.

ALIGNING INCENTIVES

It is essential that clinically integrated networks develop interdisciplinary structures that align goals and incentives. Incentive plans

that encourage productivity across the entire spectrum of care must reward physicians' efforts to achieve quality care and reduce cost.

Strategies and decisions must be shared and communicated to the entire organization and resources must be available to support the goal of integration. A key priority is to develop a risk-based cost model that links patient care costs to interventions and quality outcomes. Chief financial officers will need to engage with payers to explore and negotiate risk-based contracts and develop appropriate physician performance incentive programs.

CLINICAL PROGRAMS

Effective coordination between providers and optimization of care transitions will improve patient outcomes and help reduce costs. They will do so by eliminating redundant testing and providing better management of patient care. Important areas of focus include high-risk patients (e.g., patients with diabetes who also have comorbidities such as hypertension or heart failure), cost-control opportunities (e.g., generic drugs, review of magnetic resonance imaging usage), and prevention programs (e.g., smoking cessation and depression screening).

Developing appropriate clinical performance measures is imperative. For example, an asthma care program could track asthma control rates, screening frequency, and currency of asthma action plans. The program could also track cost measures such as drug expenses, physician visits, and emergency department visits.

Clinical programs should also develop care plans that define care protocols for various conditions. Dyad leaders can use process mapping to create care pathways that encompass ambulatory, inpatient, post-acute, and home health interventions. Healthcare process mapping is an important form of clinical audit that examines the patient experience from the patient's perspective to identify problems and suggest improvements.

Creating Value Through Process Mapping

The largest health system in Illinois, Advocate [Health Care], comprises over 250 sites of care, including 12 acute-care hospitals. In developing a process map of the Inpatient Stay care segment, we followed these steps:

1. *Identify a care segment that has opportunities for improvement.* Specific areas . . . include identifying non-value-added clinical and administrative tasks. For each task within a care process, we ask ourselves, "Is this something that a lower-cost resource could be doing, instead of the high-cost alternative?" . . .
2. *Develop a first draft of a care segment process map by interviewing experts—that is, the people involved in the process.* . . .
3. *Start with Post-it notes, then convert to electronic.* . . . [This] surfaced missing steps, highlighted misunderstandings, and allowed us to refer back to it for improvement opportunities.
4. *Observe the care segment twice to validate the process map.* . . . Repeating the observation can catch variations in practice.
5. *Close the loop with the experts after the observation.* . . . Not only does it highlight opportunities for improvement, and identify non-value-added processes, it idenitifies gaps in processes that that subject matter experts and manager believe are occurring all the time, when in reality there are barriers that may lead these processes to only be occurring 30–50% of the time.

Of course, delivering reliably excellent care across teams, units, and sites takes more than creating a process map. Changes to medical practice, such as adjusting staffing skill mix, require negotiation, engagement, and support from physician champions and key leadership.

—Kevin Little and Mike Barbati, as told to IHI Multimedia Team (2015)

Proactive medicine is key. The success of CI hinges on the physicians' ability to anticipate and prevent patient problems. To do this, clinicians need to incorporate care gap reports into clinical care and adopt new processes—for example, by assigning a nurse to call patients with high-risk diabetes to ensure hemoglobin A1C is reported according to the defined diabetic clinical treatment protocol.

TECHNOLOGY INFRASTRUCTURE

Investments in technologies that support population health make hospital–physician alignment quite attractive, although the peril of overspending on technology infrastructure and underdelivering on functionality must be closely monitored. The key to avoiding these problems is to invest in an electronic health record (EHR) system that connects ambulatory electronic medical records (of both employed and independent physicians), the hospital's data, pharmacy information systems, and labs. The goal is to create a longitudinal patient record that allows physicians, nurses, and other providers across the care community to track patient care in every setting.

A clinically integrated organization needs to be able to aggregate and analyze clinical data to identify performance gaps and develop improvement plans. The key is to incorporate tools that allow the clinically integrated networks (CIN) to run performance analytics on clinical programs, care settings, provider performance, and cost utilization. CINs should also invest in technologies for connecting patients. Patient electronic engagement—via patient portals and secure messaging—is an important requirement under meaningful use or interoperability programs. In fact, the Centers for Medicare & Medicaid Services distributes incentive payments to healthcare providers that effectively implement EHRs and use them to improve quality of care coordination and patient engagement.

BENEFITS OF CLINICAL INTEGRATION

Regardless of the strategy, when designed and implemented appropriately, CI offers tremendous potentials for efficiencies and improvements in healthcare quality and patient satisfaction. Here are ten benefits to consider when exploring the feasibility of CI and options for achieving it (Marino 2019):

1. *Increase collaboration.* The use of cross-functional teams helps to address gaps in the care continuum and implement a CI program effectively.
2. *Improve efficiency.* CI eliminates non-value-added activities and redundancy, allowing health systems to deliver seamless care.
3. *Integrated systems*. CI programs provide health systems with monitoring and enforcement tools, including financial incentives for participating physicians.
4. *Payer partnerships.* As CI improves the quality of patient care and clinical processes and reduces costs, health systems are able to achieve market differentiation that can serve as a lever for further partnerships.
5. *Improved care management.* The goal is to achieve the best clinical and cost outcomes for both patient and provider. This goal is most successful when case managers are able to work inside and outside of coordinated care.
6. *Integrated continuum of care*. CI care management teams collaborate with adult day care, independent living, assisted living, and skilled nursing facility partners to efficiently assess, document, communicate, and meet patient needs.
7. *Clinical data systems*. An integrated health system must also have an integrated technology platform. Information technology should facilitate communication across the care continuum and provide information that measures service,

performance, quality, and outcomes, at the levels of both individual provider and network.

8. *Patient-centered communication*. Reducing barriers to communication and improving doctor–patient communication to help increase patient satisfaction and retention.
9. *Improved pharmaceutical management*. CI improves pharmaceutical management by identifying gaps in the medication management process and allowing hospitals to take actions to help make patients safer.
10. *Improved community health*. CI emphasizes wellness initiatives such as outreach programs and classes to empower patients to participate actively in their care. This restructuring is not a project with a defined endpoint, but an evolution that requires proactive medicine, continuous improvement, dedicated resources, and the combined strengths of dyad leaders.

KEY TAKEAWAYS

- Changes to medical practice (e.g., adjusting staffing skill mix) require negotiation, engagement, and support from physician champions and influential leaders.
- Incentive plans that encourage productivity across the entire spectrum of care must reward physicians' efforts in achieving quality care and reducing cost.
- A key priority is to develop a risk-based cost model coupled with clinical performance measures that link patient care costs to interventions and quality outcomes.
- Dyad leaders can use process mapping to create care pathways that encompass ambulatory, inpatient, post-acute, and home health interventions.

- Proactive medicine and investment in EHR software that connects ambulatory medical records, pharmacy information systems, and labs help sustain CI efforts.

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