Hospital Executive A: We’ve officially taken the plunge. We’ve woken up and smelled the proverbial coffee, and now we’re moving toward clinical integration.

Hospital Executive B: Fabulous. We’re also sitting on Go, ready to start our own integration efforts, but we’re looking for a role model of sorts. How is your effort going?

Hospital Executive A: We started with our physicians, of course. It just makes sense to build a physician-focused entity around physicians, as they’re both the most challenging element of an integration effort and, at the same time, its very foundation.

Hospital Executive B: Amen to that. I suppose putting a strong administrative structure in place comes next, right?

Hospital Executive A: Indeed. We’ve done that, too. Now we’re looking at the final phase, actually aligning our clinical products and services. Wish us luck!

Nothing about clinical integration is really new or fundamentally difficult. But it is a process that takes focus, effort, and extreme tact. The phases of clinical integration are what you would expect: Assemble your frontline providers and establish them in important leadership positions; put an overall administrative infrastructure in place; and then integrate your clinical products and services. Do not be intimidated—each step in the process is achievable. Just be aware that new structures of governance, management, and operations will need to be created, and old ones will need to be modified or discarded.
In Chapter 9, we looked at the environmental underpinnings of the healthcare industry’s move to clinical integration and at what makes up a clinically integrated organization (CIO). In this chapter, we provide a brief overview of how to construct a CIO. Building a CIO generally occurs in three phases and with four discrete projects (see Exhibit 10.1).

A physician organization project is part of the first phase, which gives physicians insight into how the operating entity would be structured and, most important, helps physicians see the need for combining forces and collaborating with one another and the sponsoring organization (usually a hospital or health system). A CIO administrative project makes up the second phase. The third phase, the pure clinical integration of previously less-connected product lines and services, includes a medical staff collaboration project and a clinical model (we call this the “model of the future” project because it represents the ultimate end goal structure).

**PHASE ONE**

The first phase of CIO development includes numerous levels at which hospitals and physicians can collaborate (see “Levels of Clinical Integration”); given the changes occurring in healthcare, market drivers and reimbursement shifts will push the delivery system toward greater clinical integration. Readers will note the use of the word *collaborate* rather than *integrate*. The authors contend that past efforts to integrate often suggested that physicians lost their identity as they became integrated and were converted into cogs in the corporate healthcare enterprise. This situation created much of the distrust and contentiousness we have seen over the past several years. In the world of clinical integration, this is not the case; in fact, physicians lead the process.

<table>
<thead>
<tr>
<th>Levels of Clinical Integration</th>
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<tbody>
<tr>
<td>1. Contractual ties</td>
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<tr>
<td>2. Payer contracting</td>
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<tr>
<td>3. Key practice support</td>
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<tr>
<td>4. Joint ventures and comanagement models</td>
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<tr>
<td>5. Full clinical integration</td>
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<tr>
<td>6. Physician employment</td>
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<tr>
<td>7. CIO</td>
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</table>
### Phase One: Physician Organization Project: The Intro

Getting physicians ready for the new operating entity, helping them see the changes ahead, and engaging them in supporting the development of the ultimate clinical integration model

- Education
- Engagement
- Deciding whether to develop a formal physician organization
- Attention to the aligned and nonaligned physician dynamic

### Phase Two: CIO Administration Project: The Form

Transforming health systems into value-based CIOs, getting the legal and administrative i’s dotted and the t’s crossed, and developing the infrastructure that will allow the physicians to participate

- Legal structure
- Organization
- Governance
- Committee structure
- Care delivery transformation
- Infrastructure development
- Budgeting and financial modeling

### Phase Three: Medical Staff Collaboration Project: The Substance

Getting the physicians actively involved in the formal process, signing them up as participants in the corporate structure, and getting their buy-in to participate in quality and cost data sharing

- Education
- Engagement
- Discussions around the proper structure for collaboration
- Delegated functionality

### Clinical Model: The Model of the Future

Designing and implementing the final organizational structure and using data to enhance quality and efficiency, picking up the first contracts, and getting the feet wet with quality and financial performance

- Provider compensation
- Clinical transformation
- Technology enablement
- Contract negotiation
- Mobility of care elements in nontraditional settings
In the most basic level of integration, collaboration means contractual ties only—say, where physicians serve as medical directors and provide clinical and quality guidance in patient areas. In general, specialists are more involved at this level than are primary care physicians (PCPs). The contractual ties are specific to a single physician or group for designated services. The strategic value of the contractual ties is low, as is the level of complexity and risk. Fee-for-service reimbursement dominates.

In the next level of integration, providers join together for payer contracting. This strategy is a move that is designed to increase providers’ negotiating strength but has become increasingly ineffective. These types of collaborative relationships—which often take the form of a physician–hospital organization (PHO)—generally involve a mix of PCPs and specialists. The level of complexity and risk from this model increases proportionally as the market share of physician and hospital services increases within a discrete geographic area. Fee-for-service reimbursement continues to dominate.

The third level of integration involves key practice support ties, including management services organizations, loans, and recruiting support designed to assist independent physicians and group practices. PCPs tend to be better represented in such ties than specialists. The level of complexity and risk continues to focus on market share contracting concentration and “fair market value” for any services provided in this integration model. The strategic value of these relationships and services remains of value to the mutual parties (physicians and hospitals). Fee-for-service reimbursement still dominates.

The fourth level of integration involves joint ventures or comanagement models, such as imaging centers or ambulatory surgery centers, with specialists. Joint ventures are economic partnerships in which the assets or services are jointly owned by the physicians and the hospital. The level of complexity and risk is noticeably higher than for the other types of collaboration, and the strategic value is quite a bit higher. A comanagement model is essentially an arrangement in which hospitals enter into management agreements that have physicians manage hospital service lines. A comanagement model provides incentives for physicians in the development, management, and improvement of quality and efficiency and also in making the service line more competitive in the market. Fee-for-service reimbursement dominates, but glimmers of value-based reimbursement may be seen in especially sophisticated specialty comanagement arrangements.

The final level for clinical integration is a full-fledged CIO (see “Accountable Care and Clinical Integration”). A CIO is a physician–hospital alignment entity involving specialists and PCPs that enables clinical integration needed for value-based contracting and for passing Federal Trade Commission (FTC) review. The
level of complexity and risk is much higher than it is for the other levels of integra-
tion, and the strategic value is higher as well.

At the high end of the integration scale is physician employment—by the hospital,
a larger physician group, or a related organization, such as a payer—and its vari-
tions; an even mix of specialists and PCPs is usually involved. The level of com-
plexity and risk of such ties is as high as it gets, as is the strategic value of the ties.

<table>
<thead>
<tr>
<th>Accountable Care and Clinical Integration</th>
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<tr>
<td>Where do accountable care organizations (ACOs) fall on the integration scale? CIOs and ACOs both have high levels of complexity and risk and require an aligned physician group. The predominant difference is that an ACO is defined by the Centers for Medicare &amp; Medicaid Services (CMS) as a Medicare Shared Savings organization with specific integration waivers allowing physicians and hospitals certain relationships that would not normally be afforded non-ACO participants. CIOs are ACOs that can accept value-based payment from multiple payers and do not have the CMS ACO waiver protection. The strategic value for ACOs and CIOs is their ability to function in a value-based reimbursement structure. They are organizations with a payment and care delivery model that links reimbursements to quality and reduced cost of care. A CIO or ACO may use capitation, fee-for-service, or some type of shared savings model of payment for the services, depending on the payer.</td>
</tr>
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</table>

Physician Leadership and Engagement at Multiple Levels

A CIO requires physician leadership in multiple areas:

- **Governance.** Physician leadership is required at the board of managers or board of directors level. Physicians should chair and play lead roles in sub-committees, such as the quality committee.

- **Management.** A strong CEO or president (physician or nonphysician) is key to accelerating and managing physician engagement at all levels. Although some would disagree, the authors believe that physicians must be at the head.

- **Operations.** The clinical and financial performance of medical groups, independent practice associations, and provider networks must be driven by physi-
Physicians who clearly understand clinical and financial endpoint expectations. Performance evaluations of practicing clinicians should be done by physicians.

- **Patient population.** CIOs and ACOs have specific physician leadership needs related to developing sophisticated care models for complex senior and special-needs populations.
- **Value-based purchasing requirements.** Physician leadership is required to assess the ability to implement value-based purchasing exchange products.

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**One Example of a CIO**

One southwestern health network CIO with four owners (a seven-hospital system, a hospital-sponsored medical group, a dedicated physician network, and an independent practice association) operates as a taxable not-for-profit entity that integrates hospital services and the multiple types of physician practices. (A taxable not-for-profit engages in some business activities that are unrelated to its nonprofit status, thus it pays taxes on that income.) A hospital-sponsored medical group represents employed physicians working together and includes about 100 PCPs and about 900 specialists. Alongside the employed physician group, the CIO physician network consisting of independent physicians and the IPA make up the overall CIO physician network. As the organization moves toward meaningful clinical integration, its evolving interface with payers, including the mix of fee-for-service and value-based reimbursement, reinforces increasing clinical integration.

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**PHASE TWO**

In the second phase of CIO development, health systems transforming into value-based CIOs must focus on essential components. The project will require multiple workgroups, task forces, and a great deal of structured interface with physician leadership. The project should address the following issues:

- **Organizational or governance structure.** Create a “one enterprise” culture for shared accountability, risks, and rewards.
- **Organizational infrastructure.** Focus on administrative services, budgeting and financial modeling, a clinical model, an operational model, and information technology needs.
Network development. Develop and mature the CIO network to align across the health plan and CMS product continuum to enable maximum health system flexibility and options.

Care delivery transformation. The clinical models will change, with an increased emphasis on implementation of evidence-based practices, patient engagement, seamless care transitions, and capacity optimization.

Payer contract restructuring. In the short term, restructuring means adding sufficient size and scope to the delivery system to enhance its attractiveness to payers. In the intermediate term, it means collaborating with government, private payers, and employers to reward value and build accountability for managing healthcare quality and costs. In the long term, it means being accountable for the entire health of a defined population (a stage few organizations will have the size to accomplish).

Another example of a CIO joint venture structure could merge the physician members, organized under a physician limited liability company (LLC) with up to 50 percent ownership, and the hospital or health system, likely a 501(c)(3) or LLC with 50 to 100 percent ownership, into an integrated entity, either a CIO or an ACO, that is wholly owned by the health system or a joint venture with the physicians. This entity provides management services, and it contracts with payers and CMS for care management fees, physician value-based performance, and, ultimately, for “single signature” agreements (agreements that bind both hospitals and providers to a common contract with a payer).

Such CIOs share the savings they achieve through clinical integration and better-focused care management. A percentage goes to specialist groups, and a percentage goes to primary care groups in the form of per-member-per-month fees. The rest of the savings goes to the hospital. The amount that is split, the CIO’s value-based reimbursement, is based on mutual shared savings and meeting quality metrics. Some CIOs have dozens of value-based purchasing metrics; some commercial-based products are pushing toward more than 100 quality metrics. Already, the Medicaid program is moving to value-based purchasing metrics.

Costs of Developing a CIO

The costs of developing a CIO occur in multiple categories:

- Physician alignment strategies may entail hospital-sponsored medical group (also called an employed physician network) development (Exhibit 10.2),
comanagement specialty entities, service line bundled payments, medical home development, or a combination of all four. The total costs vary according to the number and type of alignment methods but will include legal, consulting, and administrative costs as well as ongoing operational costs.

- Organizational development includes planning, legal and other related services, and its regulatory compliance. Costs go to legal and consulting support.
- Payer contracting and network development requires staffing support. Costs go to salaries and management fees.
- Care management includes development of protocols, benchmarks, and standards. Costs go to licensing, software, and personnel.
- Informatics include information technology and health insurance exchange–necessitated infrastructure. Costs go to hardware, software, and licensing.
- Health plan services and third-party administration (TPA) includes core health plan and administration services, such as claims management and financial tracking. Costs are paid by the payer or other TPA partner.

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### Exhibit 10.2: Hospital-Sponsored Medical Group Structural Options

<table>
<thead>
<tr>
<th>Three Basic Structures</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model A: Embedded Medical Group</strong></td>
<td>A hospital-sponsored medical group is a virtual stand-alone medical group with an advisory board, physician executive, and chief administrative officer, but embedded in a health system structure.</td>
</tr>
<tr>
<td><strong>Model B: Separate Medical Group</strong></td>
<td>Not a virtual stand-alone medical group, it is structured as a separate 501(c)(3) or LLC legal entity sponsored by a stand-alone health system.</td>
</tr>
<tr>
<td><strong>Model C: Medical Foundation Model</strong>&lt;br&gt;(Most commonly found in states subject to the corporate practice of medicine laws)</td>
<td>The medical group is structured as a separate for-profit entity, with a contract to provide clinical services for a discrete period. The foundation established by the health system houses all the assets and personnel of previously autonomous medical groups.</td>
</tr>
</tbody>
</table>

*Note: Many other variations exist (including legacy models, foundation-owned medical groups, for-profit medical groups, exclusive professional services models, and more), but these three models are the most common.*
Physician education and training (e.g., for managing the medical staff interface) includes development and transformation of a clinical model and performance metrics. Costs go to compensation for modeling, development, and other support.

**PHASE THREE**

The final phase of CIO development includes the physician collaboration project and establishing the clinical model. The fact that three of the four discrete projects embedded in the three phases are physician-centric explains why physician leadership is so essential to meaningful clinical integration—and why physician organization-centric decisions are necessary.

In gaining physician engagement, remember the following:

- Physician organization-centric decisions are key. Use a “boots on the ground” approach that involves physicians at every level of the organization. This is not the time for top-down mandates; physicians need to be meaningfully involved in all meetings and moments of decision.
- Physician-centric decisions are vital. The decisions that will be made will have significant impact on how physicians practice and take care of their patients. The decisions can cause administrative and time burdens, and physicians must be at the strategy and decision-making table.
- Moving to a CIO clinical model is a transformative and evolutionary process. The model involves the right care at the right place at the right time, and emphasizes care mobility and patient satisfaction. Organizations will not reach this endpoint in a few months; it likely will take two to three years of concerted efforts.

Keep in mind one central facet of physicians: They generally do not want someone to advocate for them, even when that other person is a physician; physicians want to advocate for themselves.

CIOs start with a physician organization focus and often with physician organization functions. In some cases, a physician umbrella organization (PUO) serves as the best organizing vehicle to facilitate and coordinate physician equity and governance participation in the CIO. The PUO sits between the physician organization’s board and the independent, contracted, and employed physicians who serve the CIO’s patients.
Functions of the PUO include

- serving as a vehicle for physician capital contributions and investment in the CIO;
- selecting physician representatives for the CIO board;
- determining physicians’ positions on key policy issues and communicating those positions to the CIO physician board members;
- expediting two-way communication between the CIO board and physicians;
- educating physicians regarding the advantages of participating in the PUO and the CIO; and
- recruiting physicians to participate in the PUO and the CIO.

In many cases, the other role of the PUO is to support the organization’s clinical governance council to hold membership accountable for clinical performance, ensuring membership standards are upheld (particularly in credentialing) and that quality targets are met.

Limitations of the Traditional Medical Staff Model

Many readers have experienced the types of medical staff meetings during which it is difficult to keep order, stay focused on an agenda, and avoid discussions turning into gripe sessions. Some of those meetings no doubt erupted into shouting matches and at times ended with great divisions. As health systems move toward tighter clinical integration, they need to fine-tune and expand the existing physician governance and decision-making structure to minimize the effects of these types of meetings. The agenda must be more focused on how to solidify a tightly integrated delivery system across the care continuum emphasizing quality and efficiency. Moreover, most medical staff structures today are not designed to handle the issues of physician employment and CIOs. Current structures generally include a hospital board delegating responsibility for the medical staff to a medical executive committee, which then interacts with medical staff departments, while the hospital CEO is left somewhere outside that chain of authority. Further compounding the problem is the existence of increasing numbers of employed physicians who may or may not fall under the oversight of the medical staff. The core problem is that hospital boards and management have limited authority to drive change to enable greater clinical quality, operational efficiency, and effectiveness.

While many options exist, we feel that a better CIO–medical staff governance collaboration model starts with the end in mind and features a system board with authority over the quality committee and the clinical integration committee (CIC).
CIC subcommittees include system credentialing, system quality, and system peer review. The quality committee and CIC interface with executive leadership and the CEO, and both work well with the system board. Feeding into the various quality and clinical integration committees are a physicians council (representing the medical executive committees and the system hospitals) and various advisory boards (representing the other elements of the system, including health plans, other physicians, and specialty products and services).

**The Importance of Care Coordination**

A patient-centered medical home (PCMH) is likely to be one of the key component parts of a CIO. It functions as the care coordination model for the CIO. Although several definitions exist, the best defines a PCMH as a system rooted in primary care that uses a primary care physician to manage patient care and services. It requires a care team that may involve the use of physician extenders such as nurse practitioners, mechanisms to get patients actively involved in their care, enhanced patient access, use of a disease registry, and coordination of care across the continuum (see Exhibit 10.3). The American Academy of Family Physicians (2012) defines a PCMH as “an ongoing, active partnership with a personal primary care physician who leads a team of professionals dedicated to providing proactive, preventive and chronic care management through all stages of life.” The term originated in 1967 when the American Academy of Pediatrics suggested the concept to refer to pediatric patients’ medical records being archived in a central location.

How does the CIO PCMH work in practice?

Care coordination is central to any clinical integration effort. Patients are stratified according to a variety of data sources, including claims, prescriptions, labs, referrals, medical records, emergency room admissions, and health reimbursement accounts. Health status is divided into low-risk patients who require acute episodic care but mostly routine health maintenance; medium-risk patients, for whom a diagnosis may be unknown but whose chronic disease is stable; and high-risk patients, whose chronic disease is unstable or changing and who have been recently hospitalized.

Care coordination and the success of clinical integration is ultimately determined and sustained by several components (see Exhibit 10.4). The exhibit shows how the various components work together to enhance quality.

Care coordination varies by health status. In all cases, it involves personal physicians, care coordinators, and allied health professionals. For low-risk patients, episodic outreach is adequate. For medium-risk patients, mostly episodic outreach suffices, supplemented with occasional monthly interventions. High-risk patients...
often require weekly or monthly interventions. Care coordination must provide both clinical management (including a sharp focus on patient outcomes and the clinical pathways that get them there) and resource management (including predictive modeling-based provider cost analyses and pay-for-performance benchmarks).

**Legal Considerations**

Many of the concepts introduced here and in Chapter 9 have multifaceted legal complexities. Readers should always consult competent legal counsel that has expertise in antitrust law and other laws.

We also present the material here and in Chapter 9 with the major focus of a hospital or health system creating the CIO. We do so because the majority of CIOs
Chronic Disease Management
- Disease management for patients with common health conditions
- Case management for patients with multiple diagnoses compounded by social and behavioral issues
- Catastrophic or complex case management

Pharmacy Management
- Ensure appropriate use of drugs
- Prevent inefficient drug utilization
- Prevent fraud, abuse, and misuse
- Reconcile medications between care settings

Care Transitions
- Manage patients' care post-discharge
- Coordinate care between providers and community resources
- Prevent avoidable readmissions

Outreach and Engagement
- Manage health
- Promote wellness

Outcome Measurement
- Benchmark and identify best practices
- Report accurate, actionable, and timely information
- Measure patient and provider satisfaction

Process Improvement and Innovation
- Define new approaches to improve outcomes

Inpatient Care
- Identify patients admitted to IP and observation status
- Use standard criteria for appropriate level of care and length of stay
- Intensify focus on discharge planning

Exhibit 10.4: Key Components of Care Management Model
CONCLUSION

The steps to clinical integration really just make sense. Organizations can start by educating all levels of physicians about what the future holds and forming closer ties to physicians, whatever the contractual means. Then an administrative level is built on top, and efforts are made to be certain that clinical products and services complement, rather than compete with, each other. Although the execution may be difficult, the structure is simple, and physician leaders must be heavily involved in every activity.

Thoughts for Consideration

Which level of integration is your organization ready for? Are you still tying physicians in contractually? Have you moved to a physician–hospital organization for payer negotiations?

How would a PUO assist in your integration efforts?

Is a specialized CIO an option for your organization? For which clinical area or areas?

Should your organization form or participate in an ACO?

Do you have specific, discrete leadership opportunities for physicians at the governance, management, and operations levels? What are they?

SUGGESTED READING


