Clinical Integration Self-Assessment Tool v.2.1 (Network/IPA version)

By

Alice G. Gosfield, JD

Alice G. Gosfield, J.D.
Alice G. Gosfield and Associates, P.C.
2309 Delancey Place
Philadelphia, PA 19103
(P) 215-735-2384
(F) 215-735-4778
agosfield@gosfield.com
www.gosfield.com

Clinical Integration Self-Assessment Tool v.2.1

Context and Use

> *"Physicians working together, systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities."* -Gosfield and Reinertsen (2011)

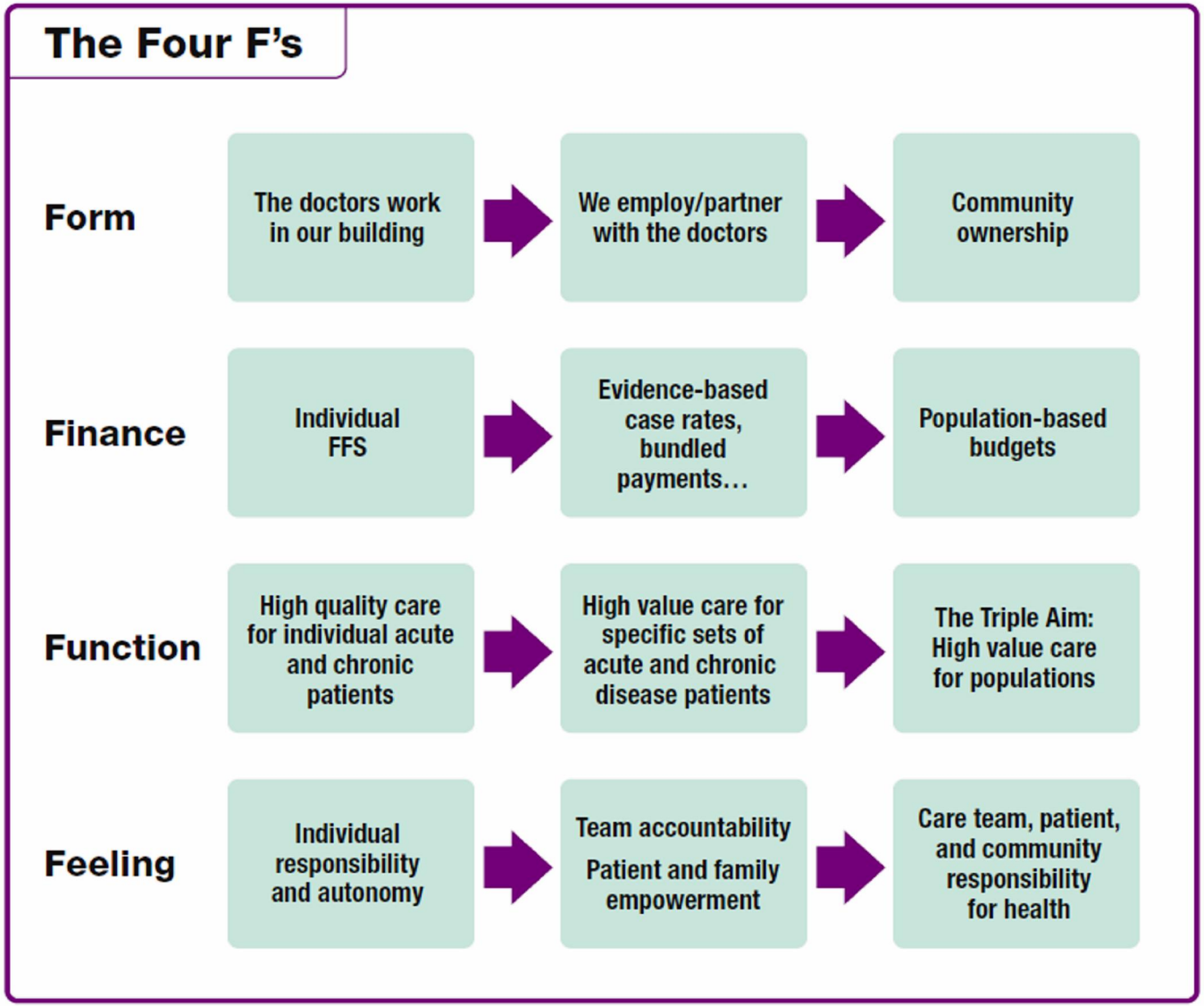
The original Clinical Integration Self-Assessment Tool v.2.0 (CISAT) (http://uft-a.com/CISAT.pdf) was oriented around employed physicians on one hand, whether employed by hospitals or in medical groups, and hospital-centric entities, whether the organized medical staff or a newly forming accountable care organization (ACO) type of entity, on the other hand. In my recent travels around the country, though, I am finding that there are significant numbers of otherwise still independent physicians who would like to consider coming together in a clinically integrated network or affiliation without merging into a single practice entity. In order to help those physicians begin to envision what a truly clinically integrated network that will succeed in the new value-driven environment might look like, I have taken the 17 attributes that Jim Reinertsen and I set forth in v.2.0 and have postulated three scenarios for each focused around a network of otherwise independent physicians.

Even at the ñcommitted and capableò phase, the scenarios acknowledge that there are very few networks or IPAs anywhere in the country that actually have sustained themselves with innovative contracts and so, there are few whose infrastructure manifests the characteristics set forth here. Therefore, even at the ñcommitted and capableò level, the scenarios anticipate yet further work to be done by these organizations as new opportunities for innovative payment and recognition unfold.

As with v.2.0, the attributes cluster around the ñFour Fôsò which we first set forth in ñAchieving Clinical Integration With Highly Engaged Physiciansò (http://uft-a.com/PDF/ACI-fnl-11-29.pdf).

Also as with v.2.0, we would welcome refinements to this document. I am sure that we have not hit on all of the issues and challenges that physician networks will confront to position themselves for a new future. We would welcome comments from the field. Finally, I would like to thank Jim for his comments on my initial drafting of this v.2.1.

Alice G. Gosfield, JD
January, 2012



		Not Really in the Game	Making an Effort	Committed and Capable
FUNCTION Structure and Purpose	***We are an already existing IPA or a newly forming network of otherwise independent physicians.***	We are coming together to bargain around fees. We think the hospitals and health plans have too much power and we are going to go our own way. We formed an entity to do that, but we don't really know what we are supposed to do.	We formed an IPA in 1996 but never got a real contract. We have been repricing under a messenger model. We are starting to agree to use clinical practice guidelines to measure a few things; and we have begun to share data with each other.	Our purpose is the collective improvement of the value of our care for our customers. We know if we do that we can achieve long term financial viability for ourselves. We collaborate with each other for measurement, analysis of data, and changed processes of care. We are prepared to accept new forms of payment to further our ability to make more change. We have invested with our time and infrastructure for the foundation of a real program.
FUNCTION Governance and Leadership	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	We held elections and have officers. We don't really know what they are supposed to do that's different from what we did in 1995. Some of our participants seem far further along on new approaches to care than others.	We have formed a number of working groups around clinical conditions and we are confronting the challenges of gathering data from disparate EHR systems. The low hanging fruit is becoming apparent.	We have well defined working groups and committees. We communicate efficiently with each other electronically. Our leaders keep us informed and we give them our opinions. We trust that we can rely on them. Everyone contributes something to our efforts.

		Not Really in the Game	Making an Effort	Committed and Capable
FUNCTION Leadership and Followership	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Three guys called us together and while we think the idea of doing something is good, few of us have any time to do anything. Besides we just want to do as little as possible in order to be able to bargain for better fees, or to get the health system to pay attention to us.	We've decided that if this is really going to be meaningful we are going to have to get a commitment of time from everyone but not everyone has to perform the same roles. We are developing clearer expectations with respect to what those roles are. We have developed better communication techniques. We understand we will only succeed with shared values. We have articulated what those are in a document and we are assigning tasks to everyone.	Our network consists of dedicated, enthusiastic physicians who want to make change and are willing to work for it. We share information electronically and we vote on important decisions, but our leaders keep us informed and we trust their decisions because we all know what we are trying to do. We have clearly shared values which we all support.

		Not Really in the Game	Making an Effort	Committed and Capable
FINANCE Business Model : Volume, Throughput, Efficiency, Value	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	100% of our business is FFS. We've adopted the workings of a messenger model, but it doesn't get us better rates and no one seems to take us seriously.	We have educated ourselves about new forms of payment including case rates, bundled payments and global payments. We are analyzing which approaches would work best for our constellation of clinical specialties. We have some P4P payments. We are considering a transaction with the hospital because we are much stronger now than we were.	We have negotiated some case rates contracts. We have used PROMETHEUS Payment principles to guide many of our changes. We could apply for one of the CMMI Bundled Payment projects, particularly for post-acute care. We are exploring taking broader types of risk for larger populations.
FINANCE Compensation: Salary, Productivity, Value	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	We are driven by two things: higher fee schedules and use of the ancillary services our members own. We don't think compensation models in groups are anyone else's business.	While much of our payment is still FFS, we use our P4P money to fund infrastructure and to support the efforts of our primary physicians to further the medical home model. We have begun to measure utilization of ancillary services – who orders them and who provides them. We are looking at how compensation within our member groups might support our overall goals.	We focus intensely on improving our value. We measure as much as we can and analyze where we can improve. We eliminate "time and touch stealers" on an ongoing basis as one of our core values. We openly share our compensation models and are tracking the quality and efficiency they generate.

		Not Really in the Game	Making an Effort	Committed and Capable
FINANCE Financial Relationships with Others	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	We openly compete with the hospital. We actively seek new investment opportunities in ancillaries to leverage our patient referrals. We only pay attention to other providers, such as home health, if they have payment relationships with our members as medical directors and advisors. We have no real idea of how to approach any health plan.	We are exploring how we can relate to other types of providers, including home health to prevent readmissions, and hospice to manage end of life issues. Some of our specialists think they can begin to work better with the hospital on co-management initiatives and centers of excellence now that we have some data about ourselves and we know better what we have to do to help them.	We are actively engaged in contracts which require us to clinically collaborate with other providers, which, when successful, increases our payments.

		Not Really in the Game	Making an Effort	Committed and Capable
OPERATIONS Standardization: Guidelines and Protocols	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Each member does his own thing. Some groups talk about guidelines, but we don't really intrude in each others' business.	We formally adopted some guidelines but only a few enthusiasts actually use them. We can't figure out how to measure anyone's performance, so we hope for the best.	We expect all of our participants use our approved guidelines and we measure our compliance with them. We share data and analyze what works. We intervene with those who need improvement.
OPERATIONS Standardization: Referrals and Care Coordination	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Our members refer wherever they wish. We have no knowledge of how well this is working, from either a quality or cost standpoint. Why should we? This is the health plans' problem.	It's understood that most referrals go to certain specialists, hospitals and agencies, but this is based on longstanding relationships, habits, and subjective impressions—not on any data on the performance of those referral providers. We have no formal agreements with anyone.	We actively manage a preferred list of doctors, hospitals, SNFs, home health and other agencies to which we refer, based on measured performance on both quality and cost. We actively share performance data with these referral providers, and they have a stake in our bundled payments and other value-based performance contracts.
OPERATIONS Standardization: Relationships with Referral Sources	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Our members accept referrals from whomever they want. We don't get involved in that.	We are beginning to have conversations about actively managing referrals—both to whom and from whom. We are beginning to ask how our referral sources are scoring in the quality initiatives in town.	We are actively engaged with our referral sources, meeting with them, using common practice guidelines, clinically collaborating in the treatment of patients in the community, and sharing quality and performance data.

		Not Really in the Game	Making an Effort	Committed and Capable
OPERATIONS Standardization: EMR and Documentation	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Our members are all over the ballpark. Some have no EMR at all. Several have different systems. Some took donations from the hospital. No one seems to like what they have.	We are realizing that maximizing the ability to gather standardized data will be key. We have begun to develop documentation templates. We are actively exploring the most efficient way of doing this. Sometimes registries seem to be more efficient than EMR data.	All our members are on the same EMR. It is a requirement for membership. We standardize our documentation as much as possible.
OPERATIONS Standardization: Medical Home Implementation	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Our primary care physicians manage their chronic disease patients using their best efforts. Our specialist members conduct business as usual.	We are looking more at how we can keep our chronic patients out of the hospital through chronic care guidelines. We are thinking about sharing mid-levels among our member practices to focus on chronic care. Our specialists are starting to talk more with the primaries about active collaboration.	We use patient registries. Our practices focus intensely on keeping patients out of the ER and the hospital. All our primaries have achieved Level III NCQA certification as a Patient-Centered Medical Home and our specialists collaborate with them as part of a Patient-Centered Neighborhood.

		Not Really in the Game	Making an Effort	Committed and Capable
OPERATIONS Standardization: Capacity Control (See also Feelings: Value as Value,	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Our members like to be on the cutting edge with new technologies. Wherever possible, they buy and use the latest imaging and other technologies, because they increase their revenues. We wonder if some of our doctors are over-utilizers, but we don't have any data on this.	We would like to track utilization patterns of our members, but it is difficult because we don't submit most of their claims. We think our use of guidelines will help but we aren't sure.	We have agreed to be parsimonious about new technology based on "best value for patients" rather than "highest revenue opportunity for our members." This includes our recruitment decisions as well; we don't bring in new members who appear to be major drivers of overuse of technical procedures that are lucrative for them, but of little added value to our patients.
OPERATIONS Measurement and Transparency	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Our members don't have common medical records—paper or electronic. No one shares information about performance with anyone else. Our members are in private practice in every sense.	We have started to measure quality, service, and efficiency on a few issues, as a pilot. If it goes well, we will expand it. There is a lot of concern about whether the data are accurate, and relevant. But we believe we'll need to do this at some point, so we'd better get started.	We share data across all providers who are part of any patient's care team and throughout the network. We have a common data exchange that allows real-time access to clinical information. We actively learn from each other. Performance data for the network (productivity, quality scores, customer satisfaction) is shared with patients and the public, and is a major driver of improvement.

		Not Really in the Game	Making an Effort	Committed, and Capable
FEELING Culture and Values: Teamwork	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	We have no stated expectations for professional team behavior. There are a number of jerks in the network, but we don't interact with each other enough that it's a problem.	Teamwork is a stated value because it will help all our professionals operate at their highest and best use, but it really isn't translated into action or systems. We are beginning to realize that we are really going to have to work closely together and the chronic complainers and the doctors who act out with nurses and others will impede our ability to get things done.	Teamwork is a stated value. We specifically recruit for teamwork and respectful professional behavior. Jerks are not tolerated, regardless of how technically proficient or productive they are.
FEELING Culture and Values: Non-physicians	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	We don't use mid-level providers because the doctors don't want to "give up" the 15% more Medicare pays them for the same work and commercial payors don't recognize what the mid-levels do anyway.	We are beginning to deploy mid-level personnel in an organized way, with common expectations regarding the tasks they can perform in our members' practices. We contract with nurse practitioners to help our members. The members pay for their time and bill for their services.	Our mid-level practitioners are fully engaged as part of the "team" with sufficient standardization that all practitioners, including the physicians, are engaged at their highest and best use. We actively use mid-level practitioners to enhance the value of the network's services.

		Not Really in the Game	Making an Effort	Committed, and Capable
FEELING Culture and Values: Patient-Centeredness	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	We are as independent as we can be and stay out of legal trouble. We care about better fees; but that's it. The patients aren't a factor.	Our network thinks patients can be helpful with design and improvement of care, mainly for market share. We've begun some satisfaction surveys and the creation of a "patient advisory council" but we haven't done anything to formalize this idea.	We have an active patient council that has a lot of influence on the design of our care, particularly for coordination of chronic disease care. Patients and families participate in our substantive committees and are members of our board. Physicians are expected to share informed decision-making with patients and families. Our guiding question is "What would be the right thing to do for our patients?"
FEELING Culture and Values: Value as a Value	***We are an already existing IPA or a newly forming network of otherwise independent physicians***	Our job is high quality care, as we define it. Period. Higher quality always costs more. Lowering health care costs is someone else's problem.	We have a utilization committee that talks to high utilizers who order lots of tests and have longer LOS, but that's about it.	We actively manage overuse in our network. We help our members lower their expenses through group purchasing. Our job is to deliver the same or higher quality at ever-decreasing overall cost, by decreasing overuse and being more resourceful and efficient.