Clinical Integration Self-Assessment Tool

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Context and Use

This document is a Clinical Integration Self-Assessment Tool designed to help the leaders of organizations understand their current level of clinical integration, and to chart a course toward higher levels of integration ï whether the organization(s) involved are medical groups, hospital-employed physician entities, the organized medical staff, or even accountable care organizations (ACOs) of one type or another.

This self-assessment follows on many of the ideas we set forth both in ñInformed Consent to The Ties that Bindò [*http://uft-a.com/PDF/InformedConsent.pdf*] and in our white paper ñAchieving Clinical Integration with Highly Engaged Physiciansò [*http://uft-a.com/PDF/ACI-fnl-11-29.pdf*]. Following the ñFour Fôs Frameworkò, which we expounded there, the self-assessment allows organizations to assess specific attributes of clinical integration, grouped around the Four Fôs.

The **green** sections of the tool present issues relevant to integration within a single medical group or hospital-employed physician model. The **purple** language is oriented around the organized (independent) medical staff and/or a newly developing ACO of any type, where physicians are typically members of multiple different entities. Please note: by ñACOò we do not mean exclusively a Medicare Shared Savings Program Accountable Care Organizations in the Health Reform legislation. Although we have expressed some skepticism about how that particular story will unfold, we do believe that all healthcare providers must become more accountable, transparent, patient-centric, and safe, and must simultaneously improve both quality and cost. In order to make this move from a volume-driven to a value-driven business model, clinical integration will be essential for everyone.

The scenarios in the tool are merely descriptive of potential manifestations of increasing clinical integration from left to right. Other descriptions may well be more accurate for your setting. We encourage you to develop your own descriptions both of where your organization is as well as your desired state of transformation. We hope to develop a ñlibraryò of such work, and have posted one example already at *www.uft-a.com/CISAT/library*.

As we have begun using this tool in the field, we have come to understand that while all of the attributes are in some way relevant to coalescing and integrating physician environments, they will, of necessity, have to be modified for certain settings. For example, we have found that academic medical centers have very different problems with respect to internal compensation models. Public hospitals and public health clinics are constrained by direct government budgetary contexts and defined resources. Nonetheless, even these types of programs have found the document useful.

The best use of this tool appears to be its ability to generate conversations among doctors in various settings about important, practical issues in clinical integration. In particular, it can help you to establish a common view of what your current level of integration really is, and about what the idealized version of what a truly clinically integrated entity would encompass.

We hope to refine the tool over time and would welcome comments with respect to its application, potential additions or deletions, or comments on how it has worked in defined settings.

To reset the context for its use, we are including here, first, the ñFour Fôsò framework and then the Clinical Integration Self-Assessment Tool.

We look forward to your comments to us at *info@uft-a.com*.

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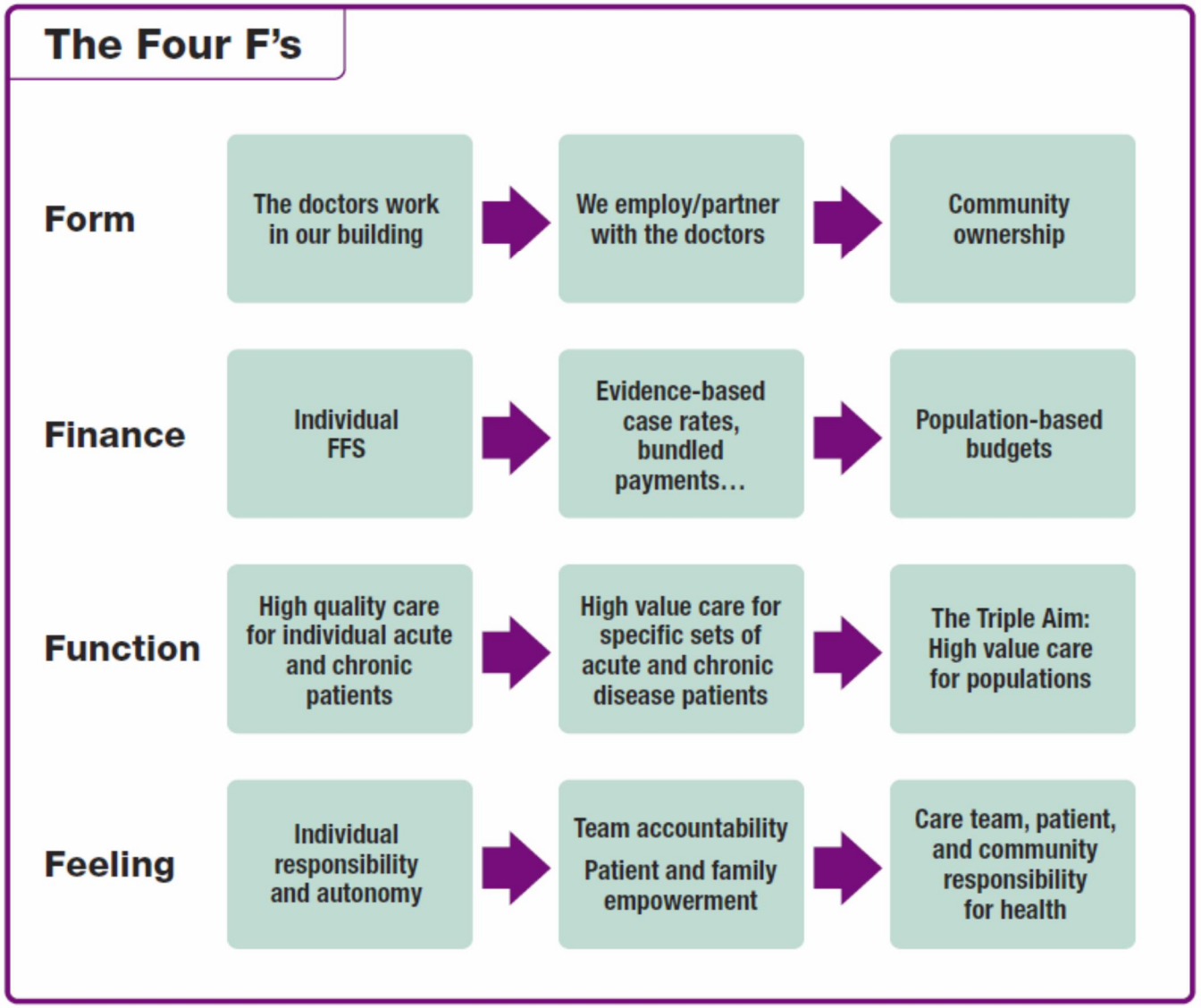

		Not Really in the Game	Getting Started	Fully Integrated
FUNCTION Structure and Purpose	***We are hospital-employed physicians who are now trying to function as a medical group***	We're a group in name only. We're really 25 otherwise independent practices. No apparent shared purpose other than limiting overhead and hospital financial support. Individual physician autonomy is paramount.	Many of us feel we're ready to be a real group practice, but others aren't willing to give up their autonomy.	Stable organization with clearly stated, shared purpose. It's understood by everyone who joins that they're expected to practice as a group, not just as an individual. "A real group practice"
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	Medical staff in general has no idea what the hospital/ACO's vision for quality and value is, and what it requires of them. The doctors simply signed up for the ACO because everyone else did, and no investment was required. This is about "Me."	The doctors understand the need to work collaboratively to improve quality in the ACO, but are skeptical about reducing costs. And there is no history of working well across in/outpatient practices on anything.	The medical staff knows and embraces the vision of the hospital/ACO for quality and value, is engaged in making it happen, and has a track record of some successes working across diverse practices and settings. There is a strong sense that this is about "Us," not about "Me."
N Governance and	***We are hospital-employed physicians who are now trying to function as a medical group***	It's not clear how decisions are made. Hospital execs? A few powerful docs?. Leadership is suspect, and not valued.	The group's leaders discuss a lot, but decide very little. If we do decide, we often revisit decisions. Implementation is patchy. Leadership is tolerated, but not valued.	Big decisions, including major strategic and cultural changes, are openly processed. Once made, decisions are implemented effectively. Leadership is trusted and valued.

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	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	There have been ñno confidenceò in management votes in the medical staff, terminations of senior leadership in the organization and upheavals in management.	The medical staff is split between those who value independence and those who want hospital employment for security. The ACO/hospital management is trying to stay neutral and neither side trusts them. There is some question about the strategic direction of the organization.	There is a high degree of confidence in management and leadership. There is active communication among the medical staff, management and the board, and clear sense of direction.
FUNCTION Leadership and Followership	***We are hospital-employed physicians who are now trying to function as a medical group***	Hospital execs and a few ñfoundersò control everything and keep the financial transactions of the group secret. The younger physicians really have no idea about what decisions are made and how. They think there are secret deals somewhere.	We have sent some of our physicians to some outside educational programs about the business of medicine. Someone mentioned succession planning once. We are beginning to share some of the details of the groupôs finances.	We expect all of our staff to be aware of the challenges to the practice and participate actively in learning about how to meet the challenges. We have a clear plan for leadership development. Everyone knows about all the financial transactions of the practice.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	Individual rights have historically been paramount in credentialing, privileging and all other decisions, and that appears to continue in the ACO. Eight physicians on the staff get called on to do everything. The rest of us just keep our heads down and ignore them.	The MEC functions well for the inpatient stuff but there isnôt much engagement among the broad membership of the medical staff. The MEC doesnôt appear to have any way to govern what we do in our office practices. We no longer have more than one staff meeting a year.	Our medical staff leaders actively engage with the membership on issues important to traditional inpatient care, as well as new ACO issues such as readmissions and chronic disease coordination. Interest and participation in meetings to manage all of this has been rekindled, and attendance is high.

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FINANCE Business Model : Volume, Throughput, Efficiency, Value	***We are hospital-employed physicians who are now trying to function as a medical group***	100% of our business is FFS. The group makes money by generating RVUs and reducing overhead.	70% of our business is FFS and the rest is a mix of value-based contracts. We are schizophrenic. Our CFO doesnôt know whether to laugh or cry when we have a busy month in the OR, or imaging. We pay a lot of attention to quality if there are bonuses involved, but otherwise not so much.	More than 60% of our payments are ñvalueò driven (bundled payment, case rates, episode of care, capitation, and other shared incentives for quality and cost).
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	Both the hospital and the doctors make money from generating volume, particularly in lucrative services. Each entity keeps its prices secret from the others. Our main joint purpose is to negotiate higher rates from payors.	We have a Center of Excellence with some quality incentives with our biggest payor. Otherwise, we have had a little pay for performance, but not much else. Essentially, we still make money on volume, but with some experiments on value-based payment.	We are primarily focused on value-based payments and have multiple programs where the ACOôs/hospitalôs success and the physiciansô success are bound together financially and clinically.
FINANCE Compensation: Salary, Productivity, Value	***We are hospital-employed physicians who are now trying to function as a medical group***	Pure FFS productivity. No relationship to practice costs or quality. Special deals for some physicians. Each is his own cost center. All arrangements are secret.	FFS productivity, with bonus for group and individual quality scores. The metrics for the bonus are known and get a lot of attention. We argue a lot about ñattributionò and what is fair.	Market-based salary, with more than 10% bonus for living the values of the group, and achievement of group goals. Everyone knows what everyone gets paid, and most think itôs fair.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	Physician comp is each practiceôs business; there is no connection to our larger joint organizational work.	We have had conversations at the ñsteering committeeô for the hospital/physician organization about aligning compensation methods across all the independent practices, but there is a lot of tension about this.	Even though we are all independent practices and entities, we have reached agreement in principle that we will align compensation methods across all practices with the external payment model for our hospital/physician organization.

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FINANCE Financial Relationships with Others	***We are hospital-employed physicians who are now trying to function as a medical group***	We really focus on the ñdealò that we made with the hospital when they purchased our practice. We are suspicious of any financial contracts and partnerships, even within the group itself e.g. between primary care and specialists.	We have entered one contract in which our group, some independent specialists, and the hospital will share risk/reward for our overall quality and cost performance for a population. We have no results yet, and some of us are very skeptical about whether we will be able to work effectively together. There is very little trust..	We are actively engaged in contracts which require us to clinically collaborate with the hospital and with independent physicians in order to be able to get better payments from the plans Our experience is mixed, but we are steadily learning and improving in our ability to work together.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	There is a strong residue of distrust from previous failed joint ventures between various doctors and the hospital. Our history of managed care contracting in the PHO was a nightmare. Now, it appears that our primary purpose in contracting together is to get higher rates for physician services, without any change in what physicians actually do.	We are working with cardiology, oncology and orthopedics to develop co-management arrangements that will facilitate more bonuses for better performance from our two largest payors. We have purchased the diagnostics of some of the practices in the community.	The physicians and the hospital are ñsignificant-othersò business-wise. We donôt do anything without open consultation with each other, and we have a good track record of collaborating from a business perspective on joint ventures, co-management agreements, and other strategies.

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OPERATIONS Standardization: Guidelines and Protocols	***We are hospital-employed physicians who are now trying to function as a medical group***	Each doctor or practice does his/its own thing. Any standing order sets etc. are for each individual doctor.	We formally adopted some group-wide protocols but only a few enthusiasts actually use them.	We have standardized whatever is standardizable. We are all measured on and expected to follow the protocols that weôve adopted.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We donôt evaluate physicians for their economic performance, nor do we require standardization for privileging or participation.	A few clinics and practices have adopted guidelines and some standing order sets, but they are not an expectation of all physicians on the medical staff.	Standardization is an expectation of all physicians, is taken into account in credentialing and privileging and those who cannot conform or actively resist have their privileges and/or ACO contracts terminated.
OPERATIONS Standardization: Referrals and Care Coordination	***We are hospital-employed physicians who are now trying to function as a medical group***	Our doctors 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 plansô problem.	Itôs understood that most referrals go to certain specialists and agencies, but this is based on longstanding relationships, habits, and subjective impressionsð 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, 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.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	The physicians in the ACO are free-range chickens and refer wherever they want. We canôt really control that.	We have a list of preferred physicians to whom our ACO physicians are supposed to refer, but itôs not mandatory. (The ñpreferredò doctors take call here and thatôs why theyôre ñpreferred.ò We have no actual data on their quality or cost.)	As an integrated organization we require that our employed physicians and those with services agreements with us (e.g., co-management) refer to our specified list of providers, which is developed based on specific performance criteria for quality and cost.

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OPERATIONS Standardization: Medical Home Implementation	***We are either a multi-specialty group practice, or we are hospital-employed physicians***	Our primary care physicians manage their chronic disease patients using their best efforts. We have no registries or staff specifically to support these PCPs in improving coordination of care. Why would we add this overhead? The hospital is already losing over $100,000 on each doctor.	We are looking more at how we can keep our chronic patients out of the hospital through chronic care guidelines and training of our office assistants e.g. we call the patients to follow up on weight control and drug regimens. We are trying to track the effectiveness of this but donôt have any evidence that it helps.	We use patient registries and patient navigators. We focus intensely on keeping patients out of the ER and the hospital, using high-risk clinics and other evidence-based methods. We have achieved Level III NCQA certification as a Patient-centered Medical Home.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	Medical home (PCMH) is something primary care physicians do in their offices to get more reimbursement. We donôt see what this has to do with specialty care, or with the hospital.	We are beginning to understand that if medical homes succeed, we will see far fewer admissions, but patients will be healthier. We think it is better if we get involved with our primary care physicians to help them with this. For example, we are training NPs and PAs in the Wagner chronic care model and will lease them to the primaries in the community.	We are actively supporting PCMH models throughout our network. We help our primary care physicians, even those whom we do not employ, to become accredited. We are beginning to deploy the PCMH principles to interactions among primary physicians and specialties which address complex chronic patients including hematology-oncology, endocrinology, rheumatology and infectious disease.

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OPERATIONS Standardization: Capacity Control (See also Feelings: Value as Value, p.15)	***We are either a multi-specialty group practice, or we are hospital-employed physicians***	Our physicians like to be on the cutting edge with new technologies. Wherever possible, we buy and use the latest imaging and other technologies, because they increase our groupôs revenues. We wonder if some of our doctors are over-utilizers, but we donôt have any data on this.	Because of RAC audits on medical necessity, we document very carefully. We are beginning to track utilization patterns of our doctors, but take no action. We rarely say ñnoò to a new technology, especially if we or our physicians can bill for it.	We make our decisions on new technology based on ñbest value for patientsò rather than ñhighest revenue opportunity for us.ò This includes our recruitment decisions as well; we donôt bring in doctors who appear to be major drivers of overuse of technical procedures that are lucrative for them, but of little added value to our patients.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We acquire technologies to keep our physicians happy and increase our revenues. We will buy the expensive diagnostics the cardiologists canôt bill for anymore, even though the higher co-pays are bankrupting our patients. We havenôt found a titanium implant or other new technology we donôt like. If we build it, they will come.	Weôve started to be concerned about the technology use of some of our medical staff, especially in their offices. Our concern is partly about our cost profile to purchasers, but itôs also about internal competition. With whatôs in the hospital plus our physiciansô offices, we have more MRI capacity than most small nations. We know thatôs a problem, but are struggling to do anything about it.	Weôve revised our recruitment and capital planning processes with the explicit aim of controlling the capacity of overused services in our community. For example have actually said ñNoò to the acquisition of a urology practice that wished to continue office radiation therapy. We have sent a clear signal that members of the ACO must clear it with the ACO board before acquiring expensive new technologies.

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OPERATIONS Standardization: Relationships with Referral Sources	***We are hospital-employed physicians who are now trying to function as a medical group***	We accept referrals from people and agencies we donôt know and send form reports to them with no further follow-up or communication	We are beginning to talk more with our referral sources, including primary care physicians, visiting nurses, and social service agencies, and are thinking it might be useful to know how they 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.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We take referrals from anyone. We donôt actively engage with primary care physicians who donôt come to the hospital anymore since they use the hospitalists to manage their patients when they are here.	We have begun to engage around clinical issues (e.g., readmissions) with physicians in the region, but this is primarily focused around the negative financial impact weõll suffer if we donôt get this under control.	We are actively engaged with community physicians who participate in our care design/coordination committees. Some of these physicians have begun to participate in our ACO payment relationships as well.
OPERATIONS Standardization: EMR and Documentation	***We are hospital-employed physicians who are now trying to function as a medical group***	We have 2 or 3 warring camps of doctors. Some want one EMR system, some want another, and a third group doesnôt want anything. So we have a hodge podge of EMRs that donôt work together.	We have implemented a group-wide EMR in primary care, mainly to achieve ñmeaningful useò bonuses and to improve billing and coding. The EMR doesnôt work so well for specialists, and isnôt really enhancing quality.	It is a requirement of participation that all clinicians (including referral providers) use our EMR and templates for documentation and measurement. The EMR is widely thought to enhance quality and safety of care, as well as improved documentation for billing/quality measurement purposes.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	Our first attempt at CPOE was a nightmare. As a result, the physicians are not very receptive to this and the EMR we have doesnôt lend itself easily to physician documentation.	We have found a new EMR vendor and have a modified CPOE program which we are rolling out carefully over some time, but we think it will be at least a year before everyone is using it effectively.	We have had EMR and CPOE in place for a couple of years now and everyone is on board. We are now moving to expand the capacity of these programs to provide more meaningful data that will permit us to manage more effectively to produce better value.

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OPERATIONS Measurement and Transparency	***We are hospital-employed physicians who are now trying to function as a medical group***	We measure individual doctorsô productivity, but nothing else. We donôt have a common medical recordð paper or electronic. Each specialty keeps its own record, which no one else sees. So each specialty has a ñprivate,ò unmeasured, unmonitored, practice.	We measure individual doctorôs productivity, and we also measure patient satisfaction and quality but only when there is a financial incentive to do so. We argue a lot about whether the data are accurate.	We have a common clinical, financial, and quality measurement system, shared across all providers who are part of any patientôs care team, whether theyôre in our group or not. Performance data for the whole group (productivity, quality scores, efficiency, customer satisfaction) is shared with all members of the group, as well as with patients and the public, and is a major driver of improvement.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We do traditional credentialing and privileging and take incident reports in the physicianôs file into account in reappointment, but we are really only focused on egregious quality outliers.	We have begun to engage in more systematic measurement of known problems to take into account in privileging and quality initiatives. The physicians have been a little skeptical but there hasnôt been any outright mutiny and some think it is actually improving care.	We use explicit measures that are known and publicized and that all the physicians understand are a predicate for their continued participation with us. We not only measure quality in terms of patient satisfaction and conformity with the evidence-base and our programs, we also measure value, efficiency and overuse.

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FEELING Culture and Values: Teamwork	***We are hospital-employed physicians who are now trying to function as a medical group***	We have no stated expectations for professional team behavior. There are a number of jerks in the group but theyôre technically OK and productive, so we tolerate them, as long as there are no actual physical assaults.	Teamwork is a stated value, and clearly described as an expectation in employment agreements, but it really isnôt translated into action or systems e.g. recruiting criteria, regular performance feedback, or compensation.	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.
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We have a disruptive physician policy, but only physicians who actively throw things in the OR have ever been disciplined. We talk about teamwork, but the nurses arenôt very happy about the physician-centric culture here.	Some departments have run team-building projects, and in those instances there was higher employee satisfaction and better quality results overall, but we donôt require this on an enterprise-wide basis.	We have formally organized teams with shared accountability and organizational responsibility across the enterprise. We evaluate physicians for their continued participation with us based on how well they work in teams.
FEELING Culture and Values: Non-physicians	***We are hospital-employed physicians who are now trying to function as a medical group***	We donôt use mid-level providers because the doctors donôt want to ñgive upò the 15% more Medicare pays them for the same work and commercial payors donôt recognize what the mid-levels anyway.	We are beginning to deploy mid-level personnel in an organized way, with common expectations regarding the tasks they can perform and that they will be used. They are a shared expense to the whole group.	Our mid-level practitioners are fully engaged as part of the ñteamò with sufficient standardization that all practitioners, including the physicians, are engaged at their highest and best use. We actively use the mid-level practitioners to enhance the value of the practiceôs services.

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	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We donôt recognize non-physician practitioners (NPPs), no matter how independent under state law, as staff participants.	We permit those physicians who want to, to utilize non-physician practitioners. We do lease some NPs to primary care physicians in the community to help them deliver better chronic care.	With the influx of insured patients and more Medicaid patients, we expect to utilize NPPs more and more; and our medical staff bylaws and agreements expect physicians to engage with them effectively as members of the clinical care team.
FEELING Culture and Values: Patient-Centeredness	***We are hospital-employed physicians who are now trying to function as a medical group***	This is a medical group. Itôs designed for the convenience of the doctors, and to reinforce their professional authority. Doctor knows best.	Our group thinks patients can be helpful with design and improvement of care, mainly for marketing purposes. Weôve discussed the creation of a ñpatient advisory councilò but we havenôt 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 sit on the search committees for leadership positions. Physicians are expected to share informed decision-making with patients and families. Our guiding question is ñWhat would be the right thing to do for our patients?ò
	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We measure patient satisfaction because it looks good to do so, but we are mostly concerned about risk management and avoiding lawsuits.	We have patient focus groups to help us orient our services from a satisfaction perspective and have had some patients come to a board meeting once or twice to describe their experiences.	Patients are deeply involved in our organization. They sit on the MEC and other committees. They are among our board members.
FEELING Culture and Values: Value	***We are hospital-employed physicians who are now trying to function as a medical group***	Our job is high quality care, as we define it. Period. Higher quality always costs more. Lowering health care costs is someone elseôs problem.	òCostò to us means ñoverheadò and we work hard to reduce it.. We think some doctors in the group might be profiting from ñoveruseò but we havenôt done anything about it, yet.	We actively manage overuse, both in our group and in our larger referral community. Our job is to deliver the same or higher quality at ever-decreasing overall cost, whether by decreasing overuse, or overhead.

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	We are the hospital medical staff, trying to be more clinically integrated with each other, and with the hospital, e.g. becoming an ACO	We are all about ñNo margin no mission.ò We are intensely focused on revenues. We like physicians who order our services a lot and the physicians who do the professional components of those services like them, too.	We understand that we are at risk for better value and readmissions and have implemented some new programs with physicians to focus on how to begin to change this, but this is not really a driving force for us. Weôve heard about ólean ô organizations, but we donôt really know what that means or how it could help.	We are intensely focused on how we can work with our physicians to create better value in terms of improved quality at the same or lowered costs. We provide actionable data to the physicians on a contemporaneous basis, and then support them in helping us effect meaningful change. This is our mission.