

What's New in Clinical Integration?

John Harris, Director, Veralon



Today's provider efforts to form clinically integrated networks (CINs) suggest clinical integration is gaining traction. Providers are starting to address the array of opportunities to improve care, lower cost, and receive the associated rewards. We have seen significant movement in five pillars of clinical integration.

PAYER ENGAGEMENT

Payers are focusing additional funds on value-based arrangements rather than traditional fee-for-service payments. The clinical integration pioneers of the past brought together employed and independent physicians, seeking better fee-for-service rates from payers. Payers often resisted, leaving many of these pioneers with good systems, but little payer uptake. Now, CINs are finding real opportunity in the financial upside of payers' value-based incentive arrangements.

PHYSICIAN LEADERSHIP

Three years ago, physician leaders were skeptical that there was real change occurring. Today, we rarely have to spend time convincing them. They have decided they need to take action, and what they want to discuss is how. They recognize that improving quality and managing costs are part of their responsibility, and they are much more accepting of standardized care protocols and clinical pathways.

CARE MANAGEMENT

Physicians recognize that they may not be best suited to every task, particularly when caring for chronically ill patients. With almost 80 percent of Medicare spending going to care for patients with five or more chronic conditions, this is a major issue. Achieving better results for chronically ill patients often requires getting patients to change their behavior. Most physicians lack the training and time to drive behavior change.

The most common alternatives to having physicians handle all aspects of care for the chronically ill seem to be the Patient-Centered Medical Home model and the use of care managers—nurses, social workers, or even medical assistants—to work closely with chronically ill patients. CINs sometimes provide these services from a central organization to help primary care practices overcome a “small numbers” problem.

A few more intensive care management programs, like Health Quality Partners (HQP) in Doylestown, Pa., stand out for their success in managing the care of complex and vulnerable patients with chronic conditions with better outcomes and lower cost. Using continuous, in person nurse-to-patient contact, HQP has cut Medicare costs for the most complex patients by 22 percent.

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QUALITY MONITORING

Quality measures are still not perfect. But they are at least coalescing, so efforts to improve quality are likely to satisfy multiple payers. With some effort, a CIN may be able to align its payers around consistent measures so its physicians can focus on the same issues for all patients.

PATIENT INFORMATION AND DATA SHARING

IT vendors have built quality measurement systems into their tools, simplifying data collection. This improvement is essential to supporting physicians and other clinical integration leaders as they identify opportunities to improve results. Some CINs, like Hunterdon HealthCare Partners in Flemington, N.J., are starting to integrate data across a standard electronic health record, smoothing the flow of clinical information at the point of care, and improving care delivery.

Now that's starting to sound like some real value. ●

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877.676.3600

www.veralon.com

info@veralon.com