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Physician Integration – Whether It be Clinical or Otherwise: Perhaps It Is Time to Focus on the Physicians

By Richard Klass, Tom Curtis, and Paul DeMuro, PhD

One may wonder why some stress that for customers to come first, one must make their employees a priority; i.e., if you want happy customers, you need satisfied employees. All too often, physicians become employees of hospitals, companies backed by private equity sponsors or health plans, or part of large medical groups and/or Accountable Care Organizations

(ACOs), and they are not truly integrated into the practice, and are not happy. Some even tell their physicians that everything will be the same in the new model.

Many organizations strive for true clinical integration, an active and ongoing program to evaluate and modify the practices of physicians in networks to facilitate a high degree of interdependence and cooperation of its physician members with the goals of improving care, reducing costs, and improving access to care. Conversely, others focus mainly on ensuring their physicians are engaged productive members of their organizations.

Healthcare is complicated. The time clinicians spend on non-patient care activities has significantly increased. Unfortunately, organizational growth often comes with less transparency, less time for physician input, and discussion of what works for the clinicians and what does not. All too often, the prevailing system smothers physicians because they are antithetical to building a cohesive medical group. These systems often include not only their compensation, but their workflow, and ways to treat their patients. Incentive payment systems may even be put in place without input of the physicians, and the appropriate recalibration over time to account for a physician's specific patient population.

WRVU requirements to keep physician compensation levels often take priority over the factors that drive clinical integration. WRVUs measure productivity, not the status of clinical integration. Key performance indicator (KPI) data collection and measuring systems monitoring clinical integration effectiveness should vary according to a health systems' unique characteristics. In general, the KPIs should measure the extent there is:

• Coordinated care across the continuum of healthcare services required including supporting education and social services.

• Patient and/or family involvement in care planning for all patients.

• Primary care availability demonstrated by the mix of inpatient to ambulatory visit volume.

• Team effectiveness and cross referral within the healthcare system.

• Common use of proven individualization of care pathways for patients with co-morbidities.

• Performance measurement tools that measure clinical outcomes and those outcomes are tracked and shared across stakeholders.

Most healthcare systems have shared patient electronic charts across the care continuum. Physicians have the patient information at hand and historical data is there for subsequent analysis. What is often missing is management ensuring organizational goals and aims are agreed upon by the providers and care teams and dedicated resources are in alignment with desired outcomes.

When physicians become employees of large organizations, their quality of care and behavior become the subject of system-wide policies and the opportunity to resolve quality or behavioral issues informally is often lost. Rather than receiving collegial intervention, the employee of a hospital, health plan or large medical group may be subjected to a formal disciplinary process in which the decision-makers are system level administrators with no knowledge of the physician as an individual. Harsh outcomes may result from such reviews and the physician’s employment may be jeopardized by events that were formerly resolved by a conversation.

We need to revive the recognition that an encounter involves a patient and a physician and for the former to be satisfied, it is important to be responsive to the needs and desires of the

treating physician. We need to ensure that physicians understand the data and data analytics. Systems should be designed for the particular patient population served and the treating physician.

Clinicians must have the tools to improve care in a cost-effective manner, and incentives designed accordingly. It is not sufficient to merely have a fair market value consultant declare that the compensation of the physicians is at the 50th or 75th percentile. Physicians need to be involved in these processes, including when health plan contracts are negotiated.

Designer solutions need to be employed, and starting tomorrow is too late.

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