Defining the New Paradigm of Healthcare Delivery

Healthcare in the United States is in need of systemic change. This reality is not only recognized by hospital systems, providers, and insurers, but by policy makers too. In fact, one of the principal mandates of the Affordable Care Act is to encourage or promote innovative methodologies for reducing costs, increasing efficiency, and enhancing the quality of care.

The notion is not new. As far back as the early nineties, both the government and groups of providers have attempted to create alternatives to the prevailing fee-based models of delivering care. Most all of these approaches involve systemic integration. This is to say, wisdom has shown that movement away from pay-for-service and towards pay-for-performance models must involve specific ways for providers and hospitals to collaborate—to disseminate accurate information about patients’ medical histories across disparate silos of care, to create and put into practice certain standardized medical protocol that improve patient outcomes, and to create mechanisms for capturing these clinical innovations in order to demonstrate—to both commercial and government payors as well as patients—that they facilitate a higher quality of care.

In essence, this is what is meant by “value-based healthcare”: not only developing ways for large groups of providers and hospitals to provide a higher quality of care, but also creating the means to demonstrate this improvement to the world at large.

“Clinical integration” is thus a sort of catch-all term that references the generalized trend to reduce inefficiencies and redundancies in treatment and diagnostic procedures, to standardize patient information sets so that all providers have access to reliable and comprehensive patient data, and to encourage enhanced communication and collaboration among providers regarding what kinds of care modalities work—then putting this knowledge into practice.

In attempting to understand how to take these notions from the abstract to the real, it may prove instructive to examine how Clinical integration has been defined. The American Medical Association defines CI as “the means to facilitate the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused.” And Don Berwick, former acting administrator for the Centers for Medicare and Medicaid Services posited a “Triple Aim” objective at the core of CI: “to transform healthcare to produce better care for individuals, better health for populations, and lower per capita healthcare costs.”

Certainly, we can all accept the broad mandate to make healthcare better, more accessible, more efficient, and less expensive. However, there is no like consensus regarding the means to accomplish these goals.

Clinical integration is a dynamic concept—there are a multitude of ways for groups of physicians to incorporate the bedrock principles. As a recent article in Truven Health Analytics points out, “In practice, clinical integration takes many forms. It can range from simple care coordination efforts for a clinical condition, such as developing care teams for diabetes patients, to the formation of large-scale health systems that employ physicians.”

Many recent initiatives in CI have demonstrated its various incarnations. Jacksonville’s Mayo Clinic, for instance, has created a clinically integrated department of transplantation, in which liver, renal, and pancreas transplant surgeons, transplant nephrologists, hepatologists, lung failure pulmonologists, heart failure cardiologists, and critical care medicine specialists all coordinate care for each transplant patient. Since instituting this enhanced coordination, the program has shown significant growth and is now one of the largest liver transplant programs in the nation.

At the other end of the spectrum, in 2004 Advocate Health Care in Illinois launched an ambitious program of system-wide clinical integration. Advocate’s clinically integrated network is a collaborative effort by more than 4,000 physician members and ten hospitals covering 356,000 lives. Advocate’s mandate for its participating physicians includes both “physicians’ commitment to a common and broad set of clinical initiatives,” as well as “financial and other mechanisms for changing physician performance (‘pay for performance’).” In practice, this mandate encompasses a broad set of performance benchmarks that span the clinical spectrum. Examples include increasing usage rates of generic medications, performing depression screening for cardiovascular patients, and increasing rates of HgbA1C screening, LDLs, and eye exams for diabetes patients.

Advocate’s clinical integration program has shown tremendous promise. In 2012, for instance, the program’s Asthma Control Rate initiative achieved a control rate of 66 percent (compared to a national control rate of 50 percent) and saved $6.2 million in direct and indirect medical costs. The Cholesterol Control initiative achieved a reduction of 25 to 55 percent in coronary heart disease events and a 43 percent reduction in mortality. And the Annual Eye Examinations program recorded a reduction of 60 to 70 percent in serious vision loss.

These are but two examples of the variety of ways in which groups of physicians may incorporate the principles of clinical integration. As many other CI programs across the nation have shown, a crucial ingredient for success is to formulate strategies that are appropriate to a specific time and place—that are in step with the objectives of the group of caregivers involved as well as cognizant of the resources of a given hospital system. As we move further into this new age of value-based healthcare, both the Jacksonville Mayo Clinic and Advocate Health Care Partners provide illustrative examples of ways to coordinate treatment in order to improve the quality of care as well as lower costs.

In the very near future, rates of reimbursement will begin to correlate directly with good patient outcomes. Likewise, physicians will be tasked with demonstrating that the care they provide is of high quality. The best way to achieve this objective is through incorporating appropriate degrees of clinical integration, for only groups of physicians, unified in the objective of providing the highest quality of care with greater efficiency at less cost, can create the measurable standards—and accompanying medical protocol—necessary to demonstrate the value of the services they offer.