'The time is now for clinically integrated networks'

By Lia Novotny | August 20, 2018

As healthcare organizations turn their focus to value-based and accountable care, many look to clinical integration as a way to make sure that all providers are working toward the triple aim of healthcare: to improve the patient experience, improve population health, and reduce costs.

But clinical integration depends heavily on collaboration and collegiality among providers, a lofty goal – and one that's not always easily achieved.

AthenaInsight sat down with Lloyd Darlow, M.D., vice president of clinical integration at Cayuga Medical Center (CMC) in Ithaca, New York, to discuss how his organization maintains its clinically integrated network, Cayuga Area Plan, and provides the resources to deliver better care for patients and populations at lower cost. CMC has more than 200 physicians serving 150,000 residents of Tompkins, Cortland, Seneca, and Tioga counties.

Lloyd Darlow, M.D.

Q: Why is clinical integration important for patients and their community?

A: More and more physicians, employed and independent, are realizing they need clinical integration to survive in the era of accountable care and value-based contracting. A clinically integrated network (CIN) – that is, primary care physicians, specialists and Advance Practice Providers (APPs) working collaboratively with hospitals – gives them the tools they need to succeed and the practice support and technology support to meet their quality metrics for value-based care.

Q: What does collaboration look like in a network like yours?

A: We have clinical practice specialists and care management nurses assigned to each practice. If

you have a patient with multiple medical conditions who's been hospitalized or visited the ED multiple times a quarter, that automatically triggers a consult with a care management nurse. The nurse will contact the provider saying, "Hey, I saw your patient in the ED for the third time this month. Let's talk about what kind of care management services the network can provide to decrease these high-cost ED visits."

And if I have a patient who needs help with alcohol management, as a primary care provider, do I even know what resources exist for that patient? What their coverage will pay for? I don't know the answers. But my clinical practice support person does and will connect the patient to the right resources.

If you don't have the support staff in place and the infrastructure in place, you're really kidding yourself if you think this kind of collaborative support is going to happen organically, because it isn't.

Q: How do you foster and build this culture of collaboration?

A: We don't leave anything to chance. We do an extensive orientation with every provider on what it means to work in a community like this. And we train the physicians right up front on the tools at their disposal to provide better outcomes and not drive healthcare costs through the roof – tools grounded in a collaborative approach, such as care management nurses and integrated quality data analysis. Then we give them a quality report card every quarter to make sure they are taking advantage of these tools.

We train our APPs and licensed social workers in the same way. We talk about utilization management, we talk about our resources, we talk about collaborative care. We've figured out ways of integrating multiple kinds of providers who all see things the same way.

With specialists, we sort of force them to play in the sandbox with the PCPs. For example, in order for a PCP to get quality credit for a patient with diabetes, they need an eye exam from an ophthalmologist documented in the record. So we make sure the ophthalmologist knows they have to send that report for the PCP to get the credit.

What you want to come out of this is an understanding by the specialists that, "I am part of something greater than myself. And really in the end, if we all succeed, then I succeed."

Q: Why should physicians want to work in a clinically integrated network like yours?

A: First of all, we've been able to work with our payer partners to make sure that we have the funds available to attract good physicians and to offer the value-based incentives that you need to drive these quality programs.

And I think clinical integration lets physicians choose the employment model that fits them best. If you want to be employed, contracted, independent – we have models for all of those.

In fact, this is how practices can stay independent. If you're an independent physician working in a community that isn't clinically integrated, it's really hard for you to do your job well; but with the tools, practice support and quality data of a CIN, it isn't.

Honestly, I can't understand why physicians in this day and age would voluntarily go to a community where there was no CIN in place for them to join.

Finally, the outcomes are better with clinical integration – you just can't ignore that. We all want to feel like we've done good work at the end of the day. And I think we've given physicians in this network a lot of reasons to feel good about what they've chosen to do.

Q: Can this model be reproduced elsewhere? Is it scalable?

A: Yes, you can bring this to any community. We have seen this work in a city much larger than ours. It could work in one much smaller and more rural.

What you need is to start with an understanding by the physicians that their attitudes are going to drive this. If they believe in this, it can be done no matter where you are. You look at a system like Advocate in Chicago doing this with thousands of physicians spread across multiple hospitals. So it is scalable.

If physicians are willing to work collaboratively with colleagues, and if every provider on the team is willing to be equally accountable to the care of the patient, then this absolutely can succeed anywhere.

Lia Novotny is a frequent contributor to athenaInsight.