Another large health system is betting on clinical integration with independent and employed physicians, and the trend is likely to continue.

WellStar Health System made big news this week with the announcement that it was in merger discussions with Emory Healthcare. WellStar is the largest nonprofit health system in Georgia; merging with Emory Healthcare, which includes the flagship Emory University, would give the system academic support that CEO Reynold Jennings says is needed to help improve and inform physicians on evidence-based guidelines.

“One of the reasons you’re going to see a trend of strong community health systems joining with academic medical centers is that they have researchers,” says Jennings. “It’s a good partnership to give physicians confidence that there are no top-down driven standards.”

Another trend that will continue is the development of clinical integration networks. Dignity Health, Baylor Scott & White Health, Memorial Hermann Healthcare System, and now, WellStar Health, are all developing clinically integrated networks as part of their strategy to improve care along the continuum as well as engage and align with physicians.

WellStar Health’s clinical integration effort was 14 months in the making, and it will go before the board for final approval next month. Out of 1,200 affiliated and employed physicians, Jennings says WellStar has received a “statement of interest” from 800 to be part of the network, which is called WellStar Clinical Partners.

Engaging Independent and Employed Physicians

Clinical integration networks have the power to fade the bright dividing line between the needs of employed and independent physicians—when the networks are governed right. For example, WellStar Clinical Partners is governed by a 15-member physician board. Ten of the doctors on the board are private; only five are employed by WellStar.

“I've worked with over 30,000 doctors in my career,” says Jennings. “Their issue is being connected together, and clinical integration brings information technology and physician leadership structure together to have that connection.”

Clinical integration is more than giving a physician practice a new IT platform that aims to connect the dots on patient care, cost, and quality. It can also give them a voice, and a window into how to prepare for major healthcare changes coming down the pike.

Dallas-based Baylor Scott & White Health has developed a robust clinical integration network called the Baylor Scott & White Quality Alliance, and it, like WellStar, includes independent physicians. One such doctor told me that one of the benefits of joining the Quality Alliance was just being able to have a resource available to answer questions about value-based care models.

“Before the Quality Alliance, it was just a big black hole,” says Andrew Chung, MD, FACP, who has an independent internal medical practice in Dallas where he sees 30–40 patients per day. “What it (the Quality Alliance) has done is given us more information on how important it is to have a changing healthcare view rather than fee for service.”

What hospital and health systems are finding out, sometimes the hard way, is that once-independent-now-employed doctors don’t necessarily want to lose all their independence when it comes to patient care and practice. Developing a clinical integration network can give independent doctors the umbrella of
support they need to improve cost and patient outcomes.

It’s hard to judge these types of networks now because they are so new. But it’s becoming clear they are on the rise. In HealthLeaders Media’s latest intelligence report, The M&A and Partnership Mega-Trend: Deals for Growth and Survival, improving clinical integration was consistently among the main reasons that organizations entered into new partnerships.

There are other benefits that clinical integration can bring to an organization, says Rob Schreiner, MD, FACP, FCCP, managing director for Huron Healthcare, a healthcare consulting firm. Aside from better clinical outcomes, the potential for savings exist, too because of the efficiencies created by standardizing work among fragmented systems.

Schreiner says he believes there are three basic steps to getting physicians on board with a clinically integrated network:

1. Create a belief that cost reduction and outcome improvement on a global scale is noble work.
2. Convince physicians they have they can do this without making their work life worse.
3. Empower doctors to reorganize themselves to standardize effective care.

Schreiner says many physicians are wary that clinical integration is HMO 2.0. Having lived through that era of patient gatekeeping, he says clinical integration is different.

“The trick is organizing care in such a way that groups of patients experience improvement over time,” says Schreiner.

Improving groups of patients’ health is the core of population health, which, with major efforts focused on reimbursing for care based on outcomes instead of outputs, may mean clinical integration eventually becomes a new normal instead of another initiative.

“There are a few locations out there who have all or most employed doctors,” says Jennings. “That’s a small subset of all healthcare systems. Most of us have a changing percentage of employed and private [doctors]. The way the market is settling out, it will be very difficult for most community-based systems to have 100% employment.”

Jacqueline Fellows is an editor for HealthLeaders Media.