Clinically Integrated Networks

Right For Your Practice?

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Disclosures

- Consultant: Accelerando Advisors
- Consultant and Advisory Board Member: Cognoa
- Advisory Board Member: DotCom Therapy

Learning Objectives

- Recognize the structure and purpose of Clinically Integrated Networks
- Consider the benefits and risks of joining a CIN to your independent practice

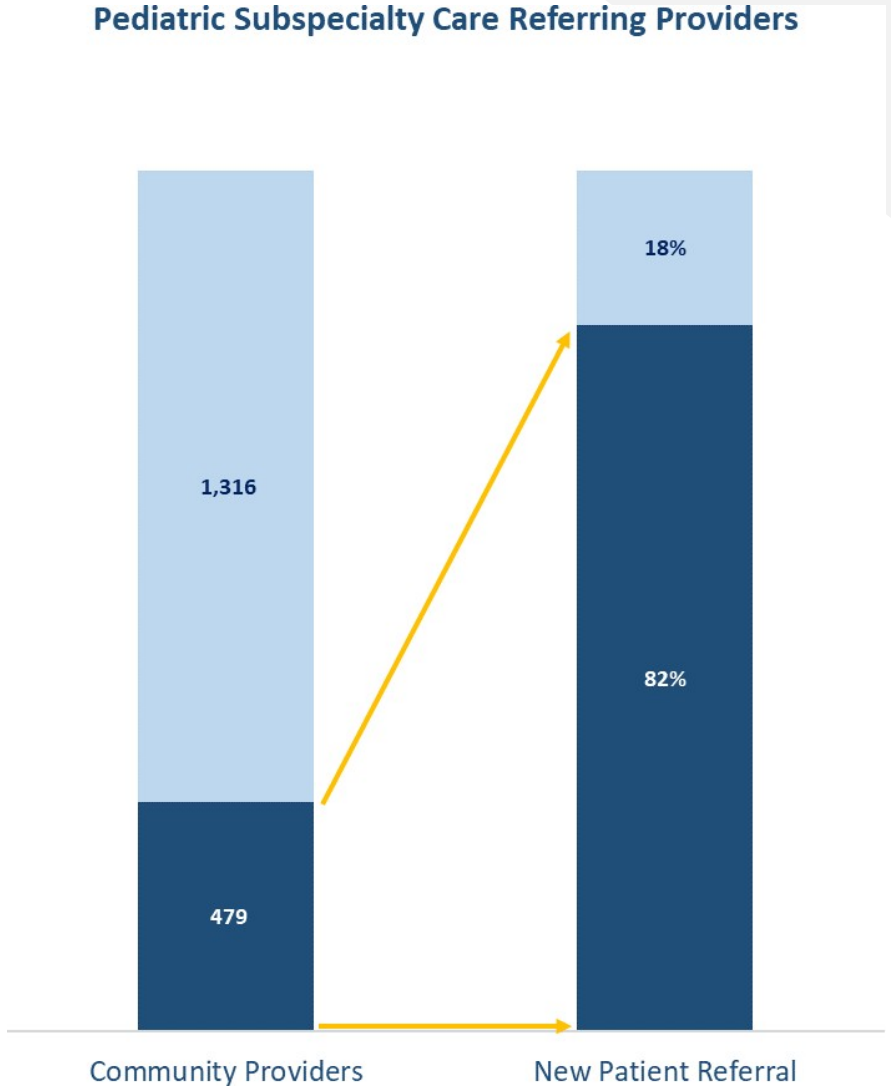
Clinical Integration

A brief history….

Integration Journey…

Primary care guides a patients path to specialty care

- Community providers refer most new patients
- Numerous clinicians in the community referral network
- Which community providers refer >10 patients annually?
  - 82% of new patient referrals
- Many community pediatrician groups in the area are small



Hospitalization and Health Equity

- Measure: census tract-level inpatient bed-day (IPBD) rate

$$\textbf{IPBD rate} = \frac{\text{\# days children from given census tract spend hospitalized}}{\text{\# children within census tract}}$$

  - Normalized by 1,000 children and annualized
  - Allowing calculation of IPBD rates across all causes, conditions, sub-specialties
- Assessed in association with census tract child poverty rate (US Census)
  - Categorized tracts into quintiles according to child poverty rates

Countywide bed-day disparities

Child poverty quintile	IPBD rate per 1,000 children per year
Low	88
Low-medium	113
Medium	131
High-medium	144
High	171

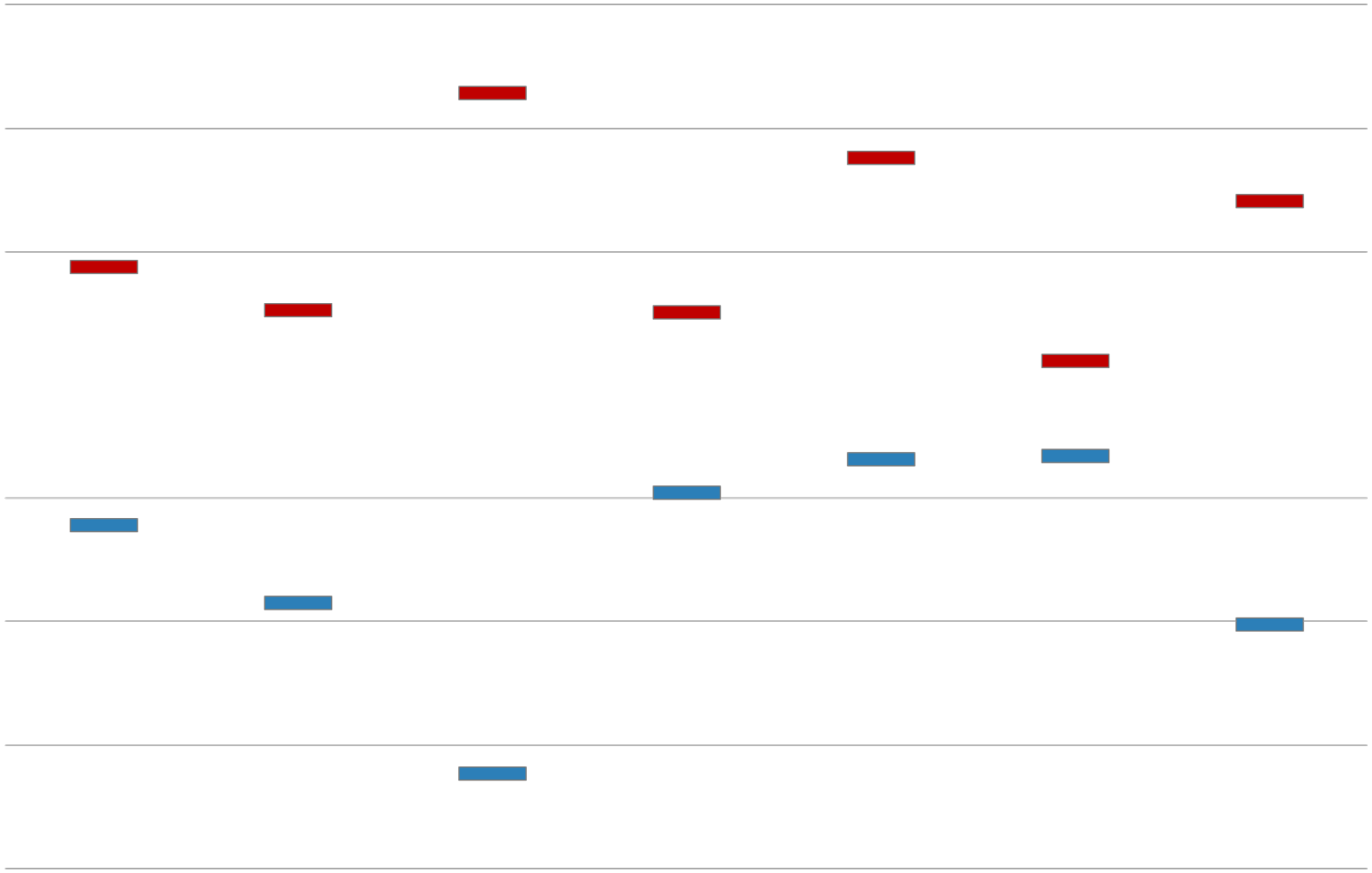
- Median IPBD rate 118 per 1,000 children per year (IQR 87-165)
- IPBD rate and poverty rate correlated
  - r=0.36; p<0.001
- **If each tract had the same IPBD rate as the low poverty tracts:**
  - **33% fewer bed-days**
  - **~8,000 fewer days per year (~22 years)**

Condition-specific disparities (relative differences)

Relatively more IPBDs

County mean

Relatively fewer IPBDs

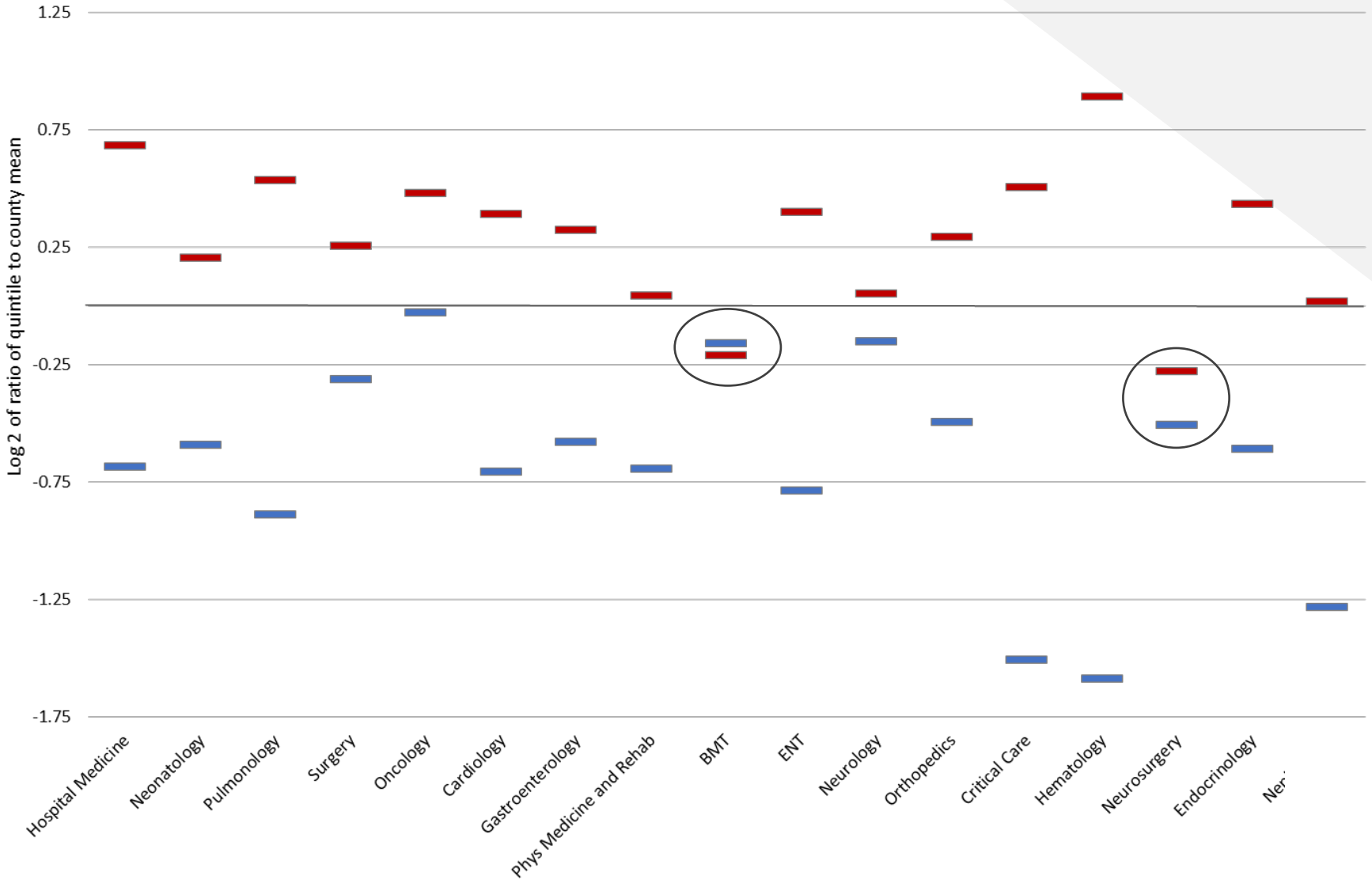


Specialty-specific disparities (relative differences)

Relatively more IPBDs

County mean

Relatively fewer IPBDs



Pediatric Care for a Population of Children Requires…

Implementing and funding prevention strategies for building health

Working collaboratively with communities and schools

Population Risk Stratification and implementing strategies for each level of risk

Family engagement and involvement, two-way communication with specialists

What defines Clinical Integration?

- Established mechanisms to improve quality of care
- Selective choice of network physicians who are likely to further efficiency
- Investment in the necessary infrastructure and capability to be successful

Clinically Integrated Network Objectives

Establish Provider Network, Contract Negotiation

New partnership model with employed and independent physicians

Define performance improvement initiatives

Provide a platform for interoperable communication, joint contracting, care redesign

Clinical Integration

- Legal Options
- Physician Leadership
- Participation Criteria
- Performance Improvement
- Interoperable Technology
- Contracting Options
- Flow of Funds

Legal Options

- A CIN can be created as:
  - Physician-Hospital Organization
    - JV between Health System and Medical Staff
  - Independent Practice Association
    - Owned and operated by physician partners
  - Subsidiary of a Health System
    - The Health System is the sole corporate member
    - Member physicians sign separate legal agreements to participate

Physician Leadership

- Governance Structure
  - Board Members
  - Board Meetings
  - Communication to at-large participation
- Committee Leadership
  - Physician Leadership with paid participation for independent physicians
- Interaction with Existing Committees in the Health System
  - Executive Committee
  - Contracting Committee/Revenue Cycle
  - Quality Committee
  - IT Committee

Participation Criteria

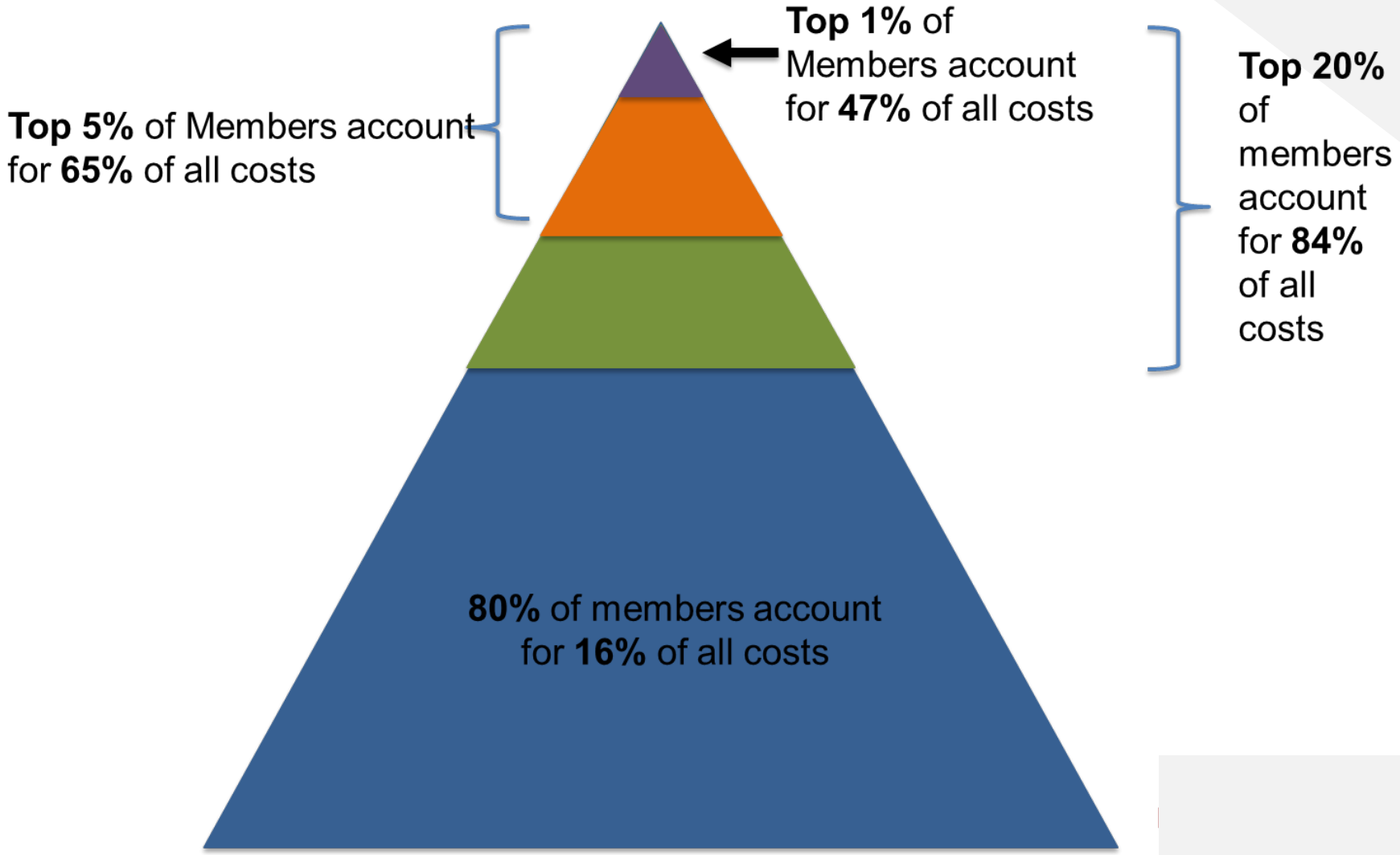
- Adherence to Goals and Program Guidelines
  - IT infrastructure for interoperability
  - Access and use of CIN website to view individual, practice, network performance
  - Compliance with clinical protocols and care pathways
  - Participation in all network contracts
  - Improve accuracy of attribution

Performance Improvement

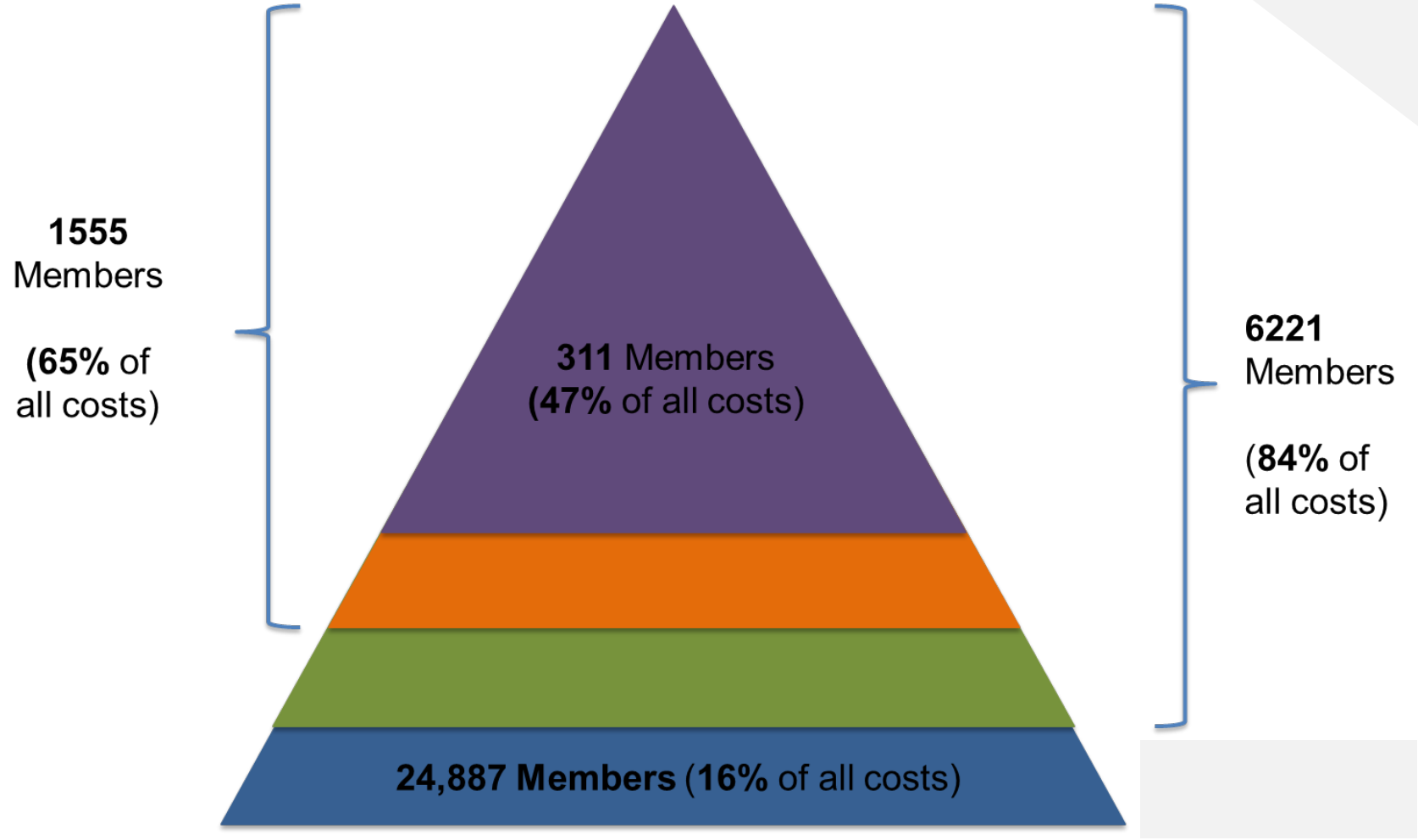
Understanding Our Population

- High level of resource use (e.g., visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care
- Frequent hospitalizations (i.e., two or more in last year)
- Multiple co-morbidities, including mental health
- Poor compliance with prescribed treatment/medication
- Psychosocial status, lack of social or financial support
- Multiple risk factors

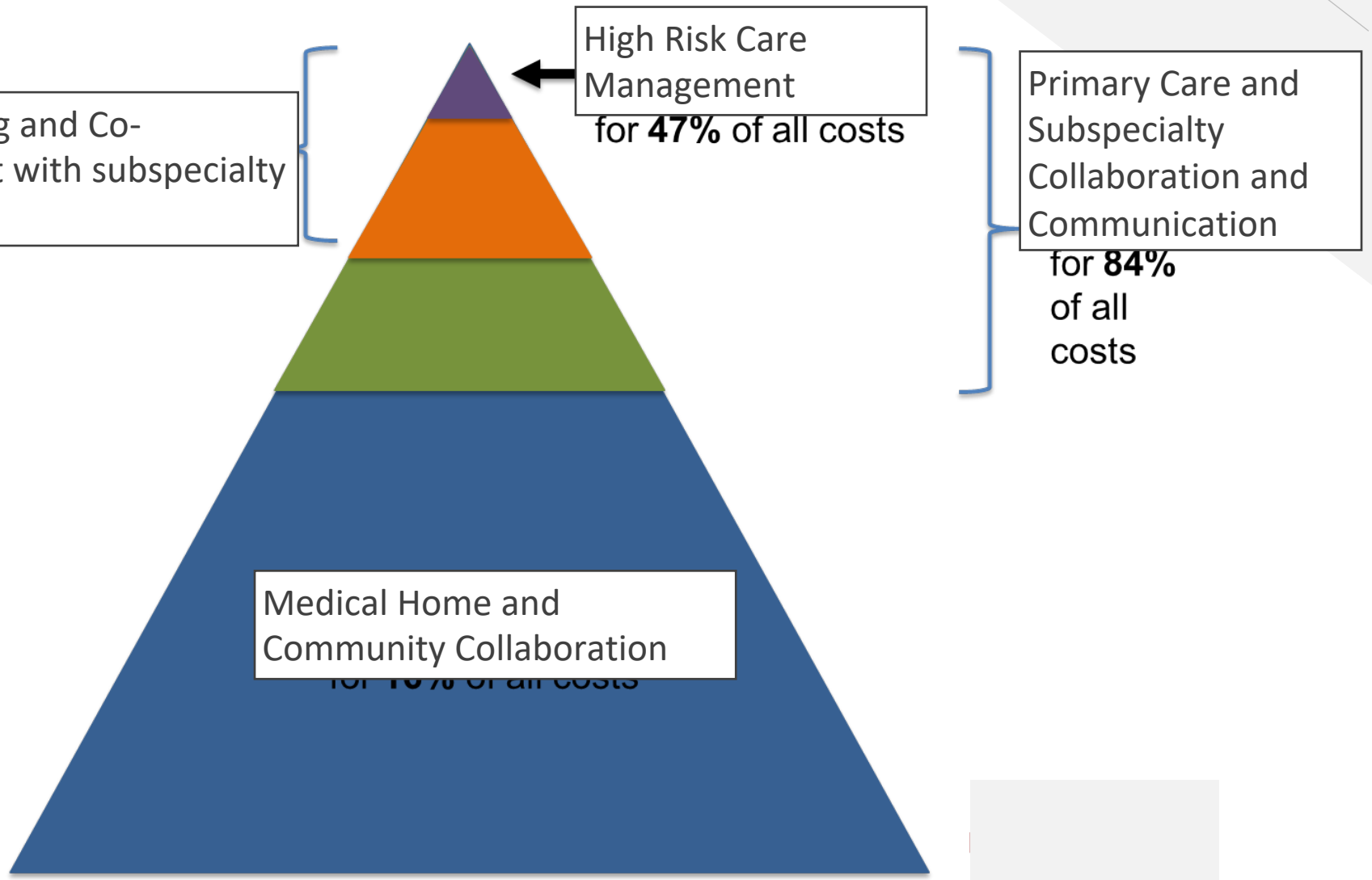
Top 1% Cost


Top 1% of Members account for 47% of all costs
Top 5% of Members account for 65% of all costs
Top 20% of members account for 84% of all costs
80% of members account for 16% of all costs

Triangle Weighted By Cost



Interventions



High Risk Care Management

- Identify the “highest risk” children
- Provide intensive, high-contact, care management, care coordination, and help with social needs
- Hypothesis: providing this type of care management will be associated with:
  - Improved medical and family outcomes,
  - Decreased high-cost utilization,
  - Decreased cost


RN Case Manager
Social Worker
Community Health Worker
Shared Team Members

Pediatric Subspecialty and Primary Care Collaboration

- Pediatric Primary Care and Subspecialty Care practices operate independently of each other
- Disconnect
  - Low acuity referrals
  - Inefficiency during the subspecialty care visit
  - Follow up prevents access to new patient visits
  - Unnecessary Emergency Department visits and admissions
  - Poor communication between primary care and subspecialty
  - Lack of follow through on discharge plans

Role of the CIN

- Improve operational efficiency
- Improve ease of communication
- Reduce avoidable, duplicative services
- Care Redesign
  - Right setting and right provider for care
- Focus from inpatient to preventive care and population health
- Patient experience—not only provider but the system

Pediatric Subspecialty and Primary Care Collaboration

Standardization
- 1. Referral Process

Communication
- 1. Portal or established

Education and Co-management
- 1. Care

Pediatric Subspecialty and Primary Care Collaboration: Referral

Portal or Website for referral criteria

Secure transfer of information from the referring doctor

Labs or studies exported to appropriate request forms

Mechanism for urgent referral, follow up to referring clinician

Process to review records and studies with goal of X days between referral and visit

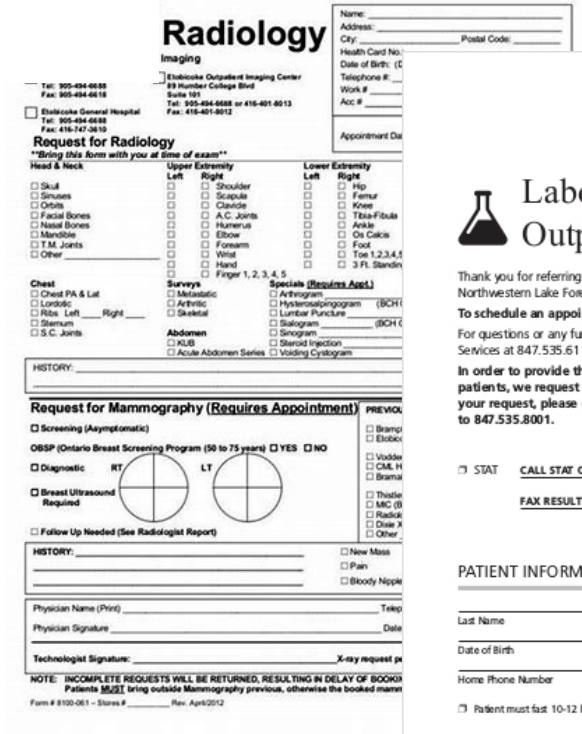
From Guidelines to Referral

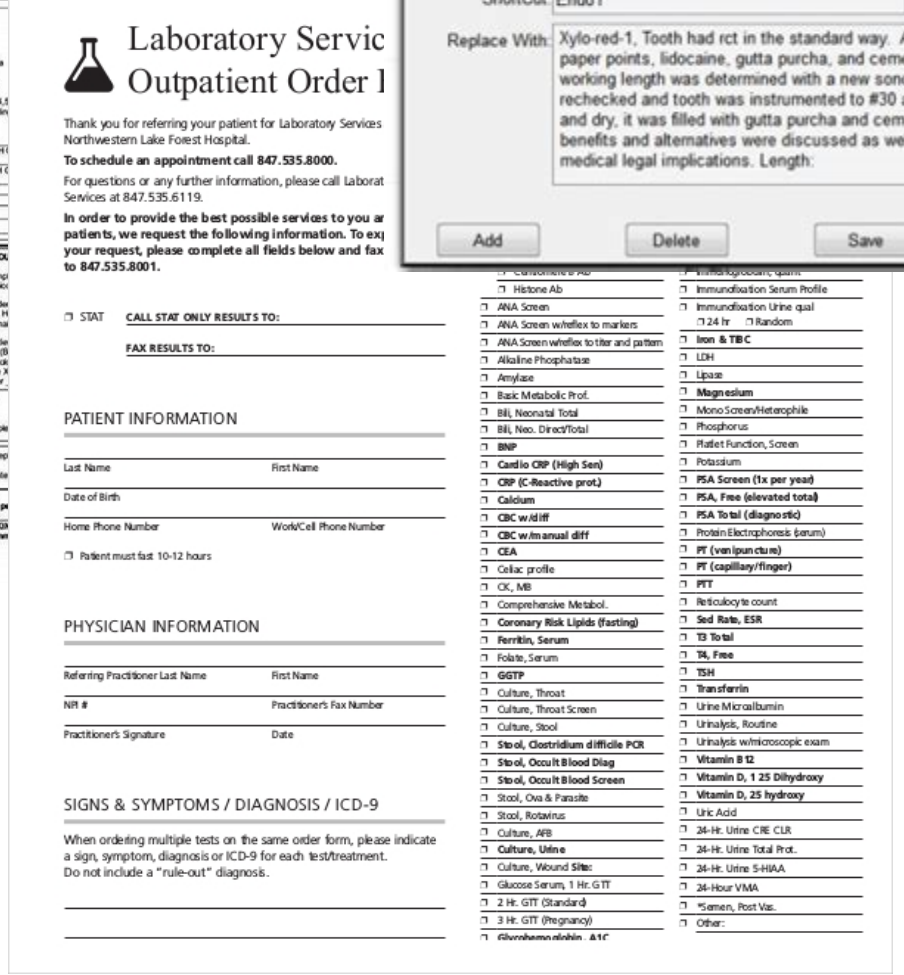
Guidelines:

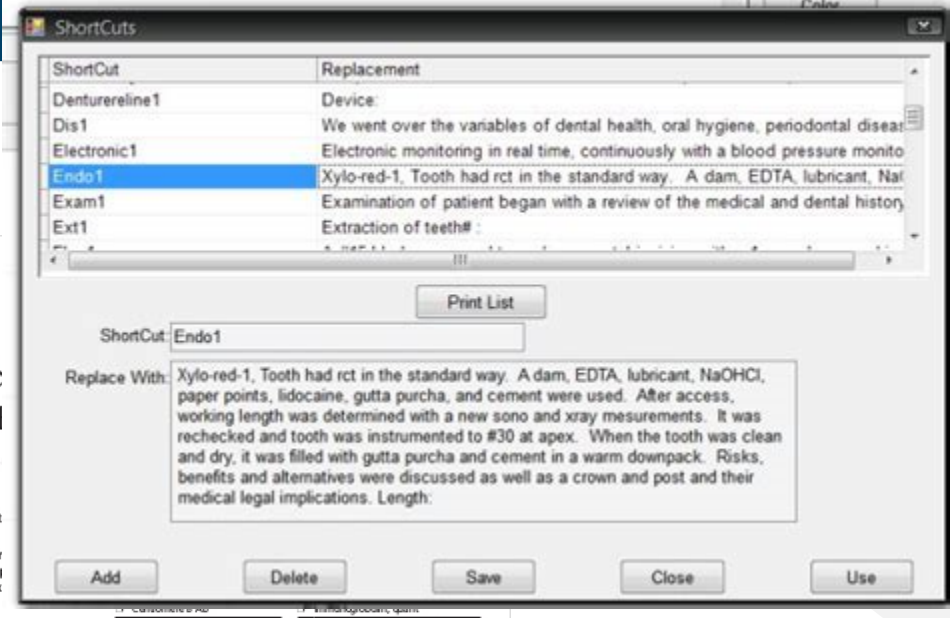
Lab orders:

Xray orders:

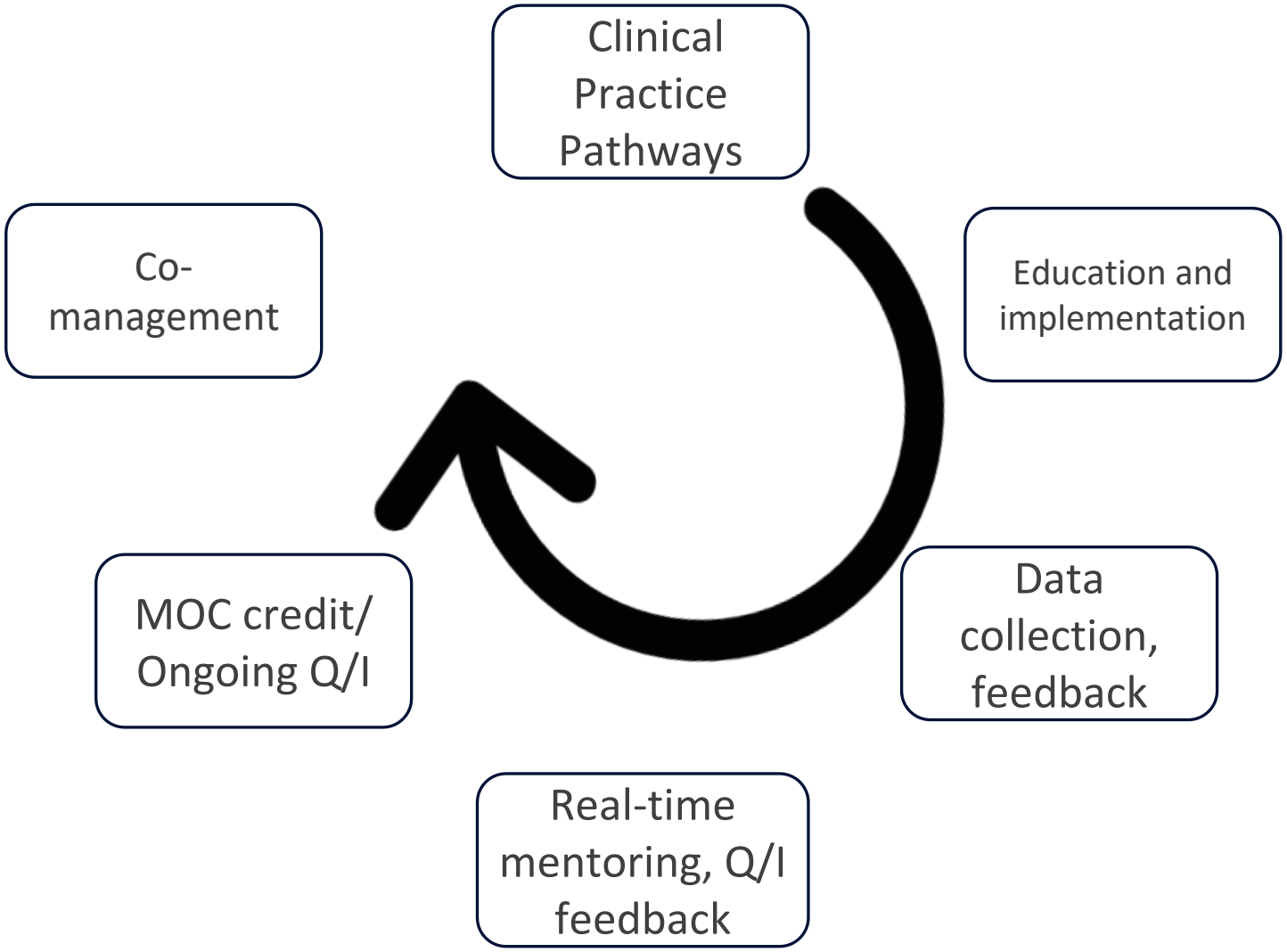
Clinical Notes:


Radiology
Imaging
Request for Radiology
Request for Mammography (Requires Appointment)


Laboratory Servic
Outpatient Order l
PATIENT INFORMATION
PHYSICIAN INFORMATION
SIGNS & SYMPTOMS / DIAGNOSIS / ICD-9



Education/Mentorship Lifecycle



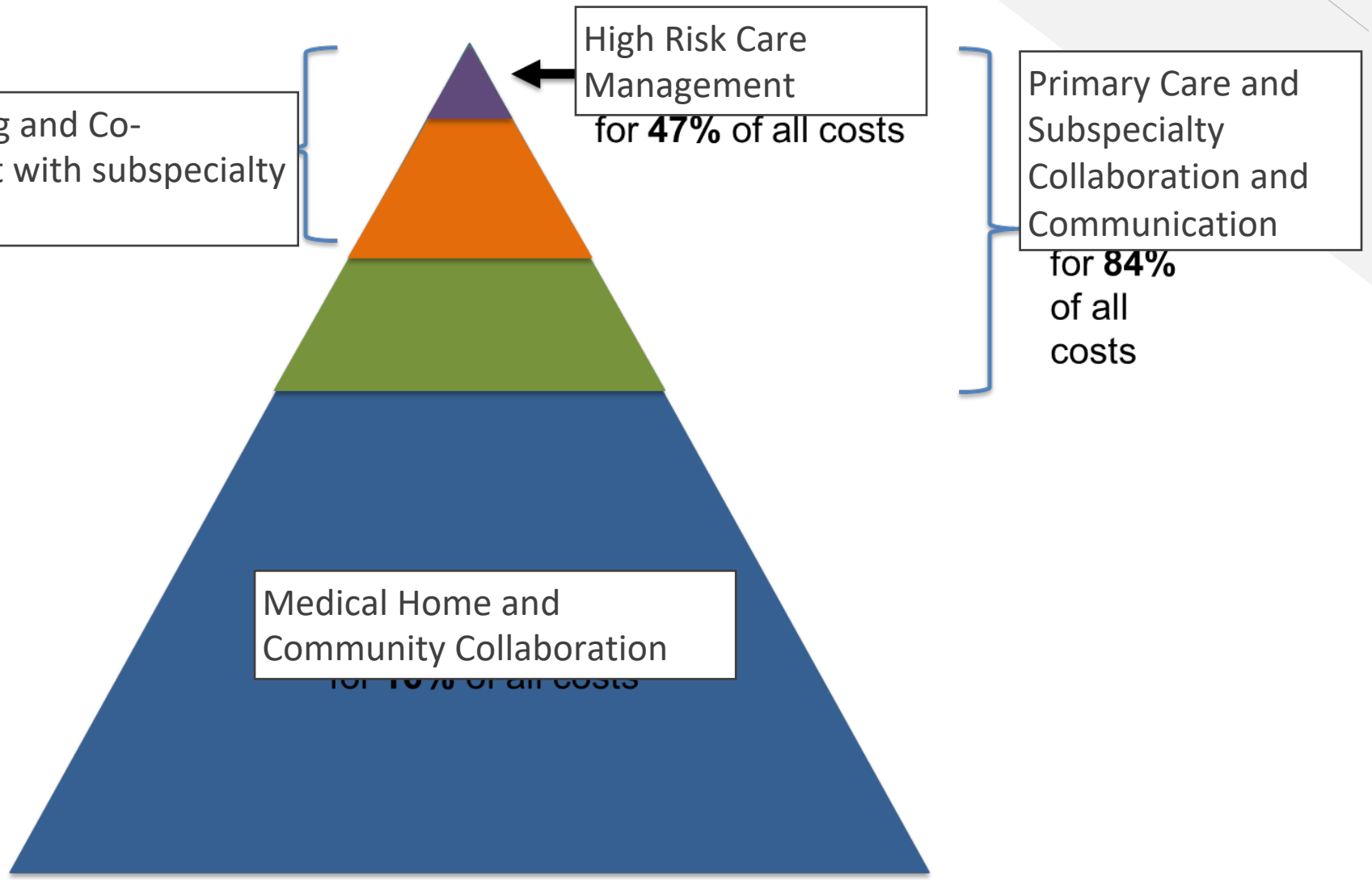
TEAM-BASED CARE

Project ECHO

- **E**xtension for **C**ommunity **H**ealthcare **O**utcomes
  - Pediatric rural settings
  - Pediatric Development and Autism Management
  - Pediatric Behavioral Health
  - Epilepsy
  - Pediatric Environmental Health conditions
  - Zika

Service Outreach and Integration

Interventions



Alignment with Primary Care

- Accurate Attribution
- Data sharing and contracting
- Electronic Health Record communication and data sharing
- Resources for Practices
  - Access to Care Management
  - Language line
  - Quality Improvement/Maintenance of Certification
  - Learning Collaboratives for new challenges
  - Discounted conference fees

Information Technology

Information technology

Interoperability; Direct Messaging

Data management, exporting from practices

Ongoing accurate attribution

Mechanism for communication between primary care and subspecialty

Patient registry and data system for quality metrics

Contracting Options

Contracting Options

- Premium base rates
  - Increased FFS rates based on expected performance
  - Payment for services which may not otherwise be covered (telehealth)
- Performance Incentives
  - Incentive payments made for performance improvement initatives
- Shared Savings
  - Reduction in the total cost of care

Flow of Funds

- Key Considerations:
  - Funds should be distributed based on measurable performance
  - Distribution methodology should be straightforward
  - Goal to increase transparency of funding