



# 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....



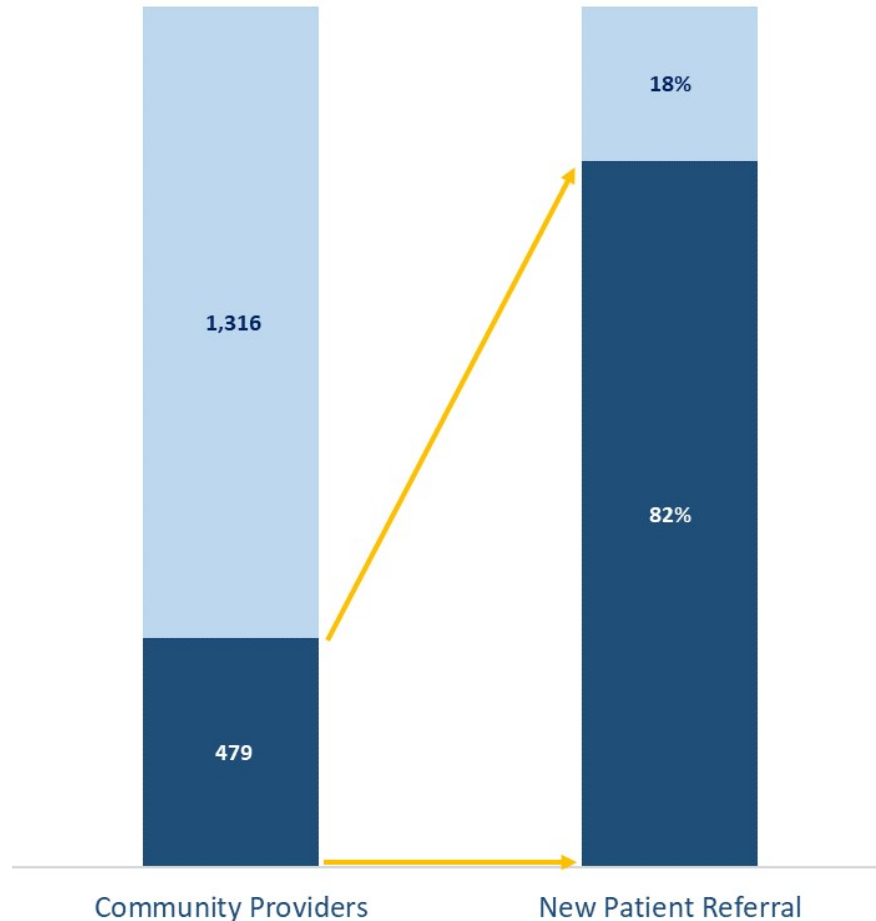
# Integration Journey...



# 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

Pediatric Subspecialty Care Referring Providers



# Hospitalization and Health Equity

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

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

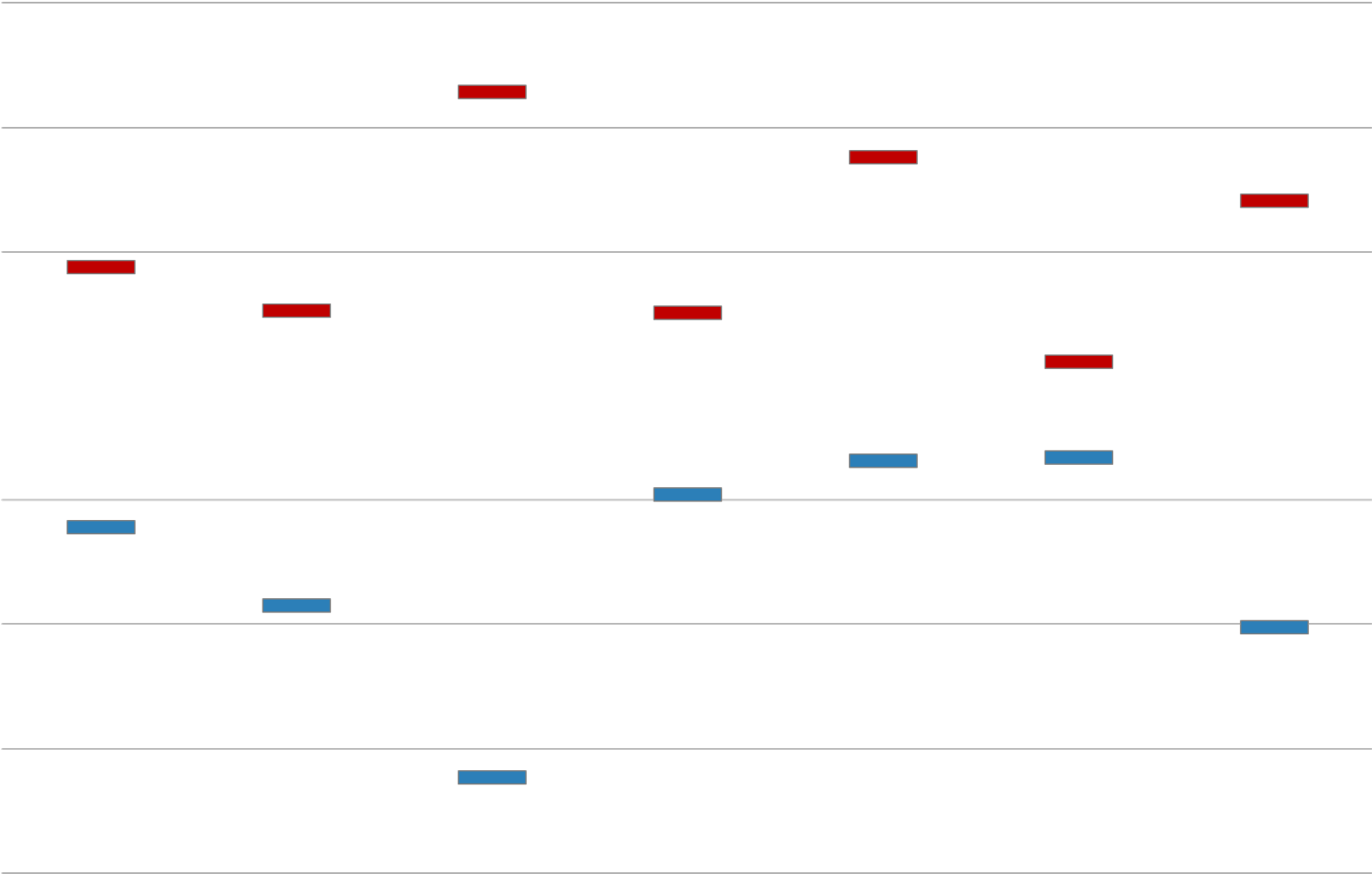
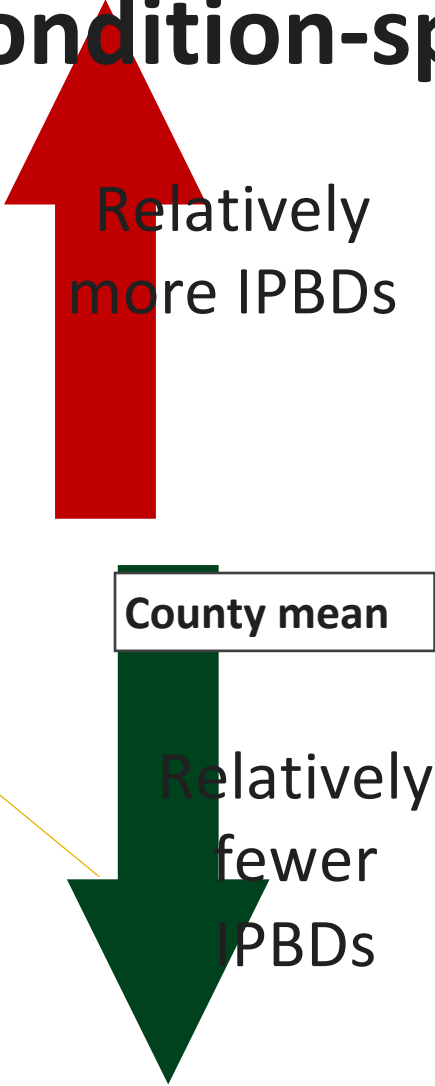
- Normalized by 1,000 children and annualized
- Allowing calculation of IPBD rates across all causes, conditions, sub-specialties
- Assessed in association with census tract child poverty rate (US Census)
  - Categorized tracts into quintiles according to child poverty rates

# 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	

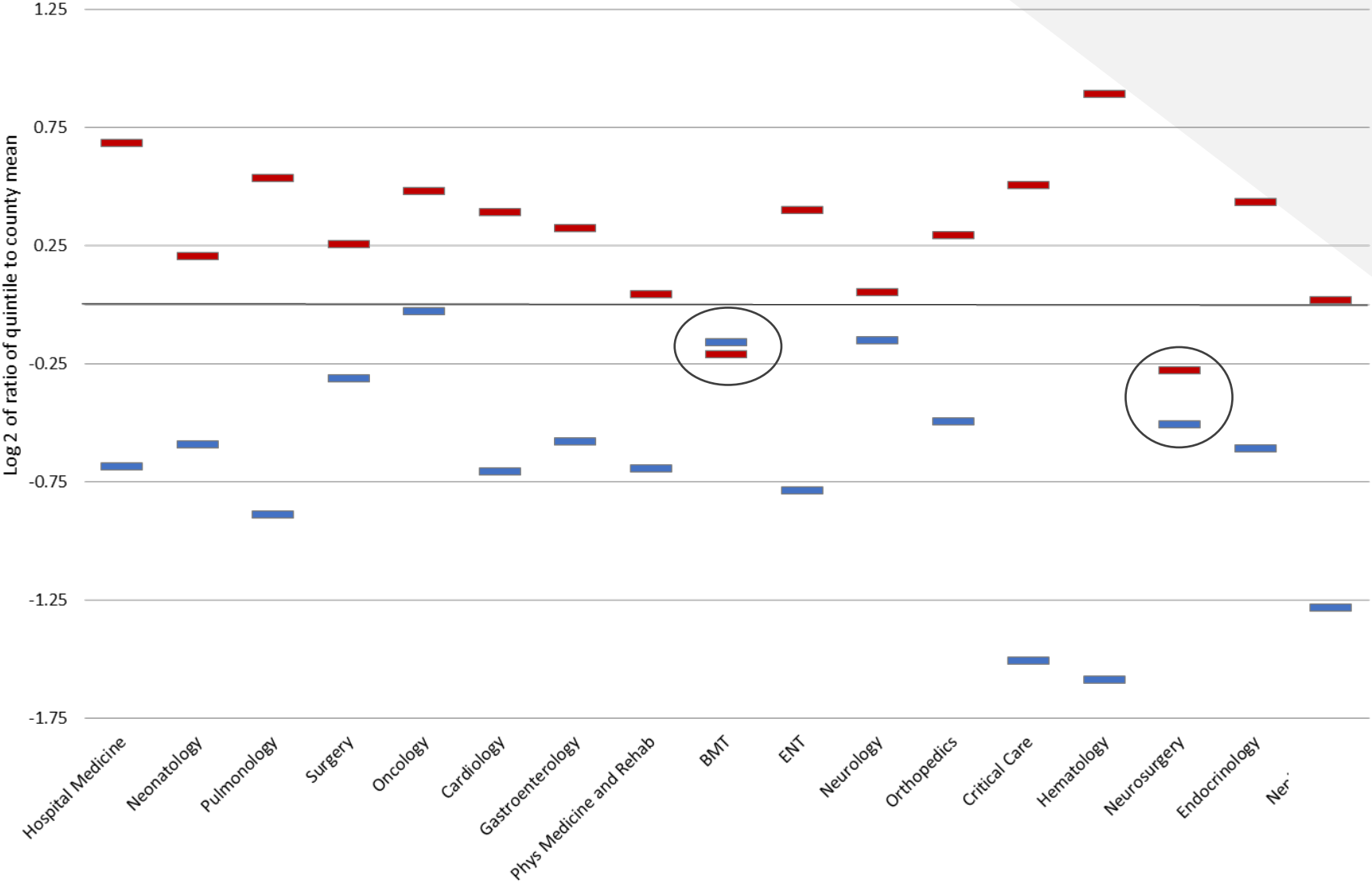
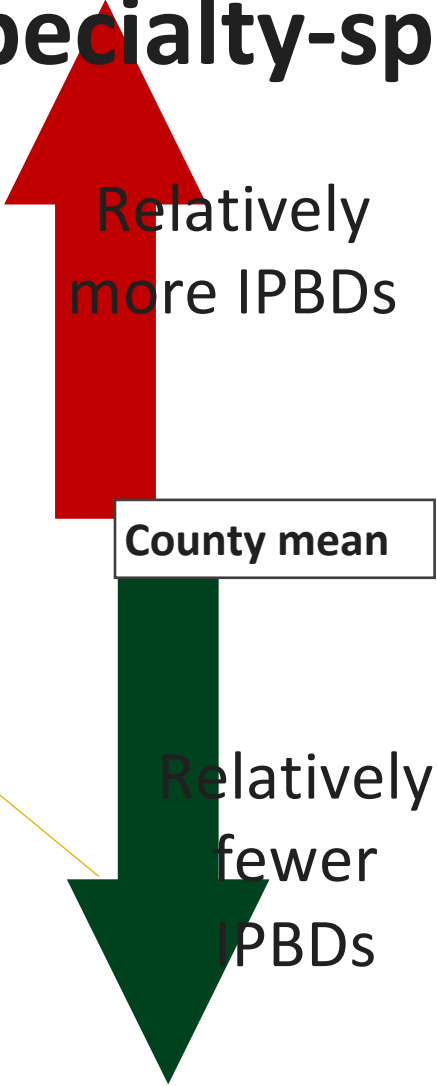
- Median IPBD rate 118 per 1,000 children per year (IQR 87-165)
- IPBD rate and poverty rate correlated
  - $r=0.36$ ;  $p<0.001$
- **If each tract had the same IPBD rate as the low poverty tracts:**
  - 33% fewer bed-days
  - ~8,000 fewer days per year (~22 years)

# Condition-specific disparities (relative differences)





# Specialty-specific disparities (relative differences)



# 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



The background features a series of diagonal lines and geometric shapes. A prominent light gray diagonal band runs from the top left towards the bottom right. To the left of this band is a solid yellow parallelogram. Above the gray band, in the top right corner, is a dark blue parallelogram. Several thin lines in gray, blue, and yellow are scattered across the white background, creating a modern, architectural feel.

# **Performance Improvement**



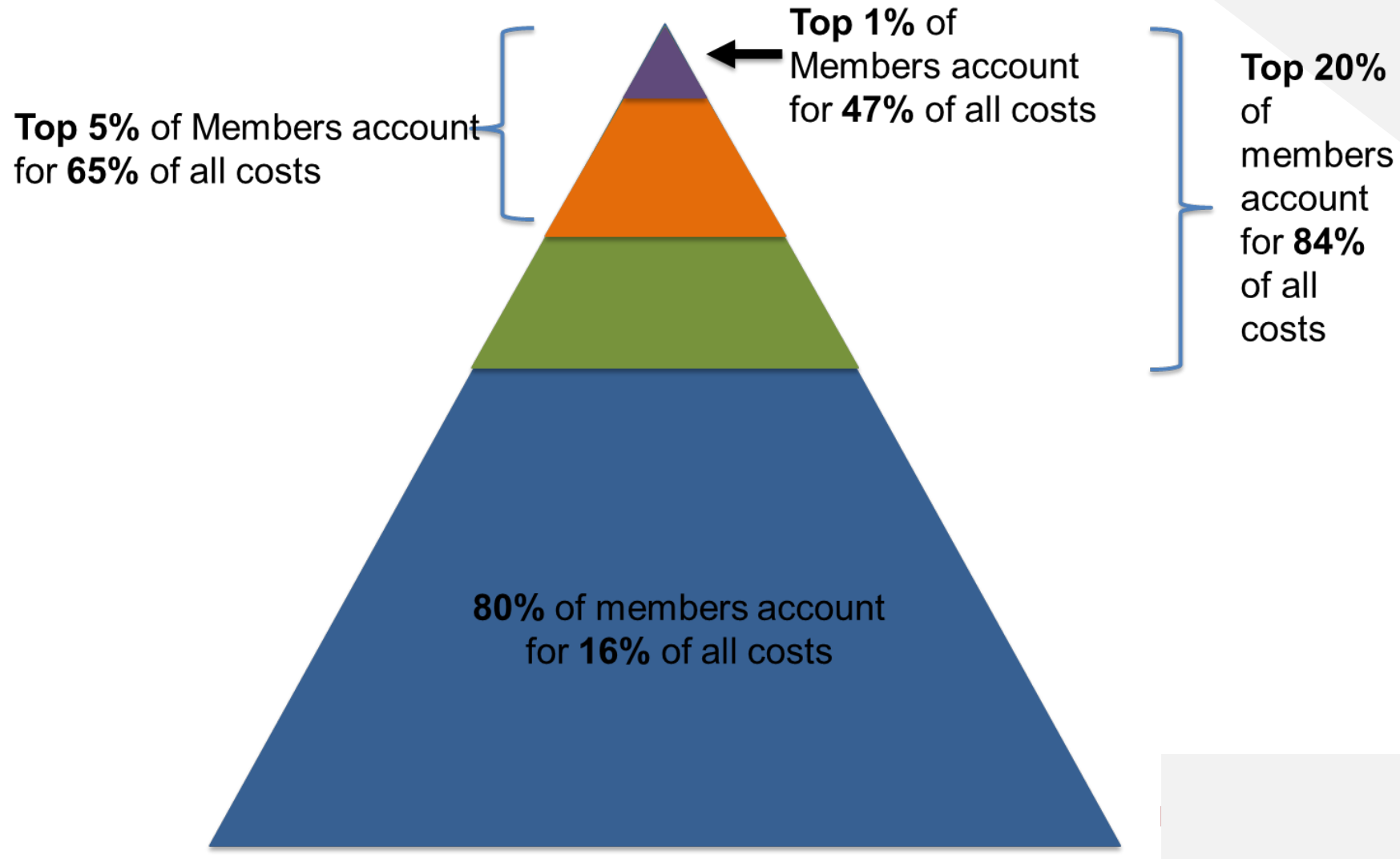
## Understanding Our Population



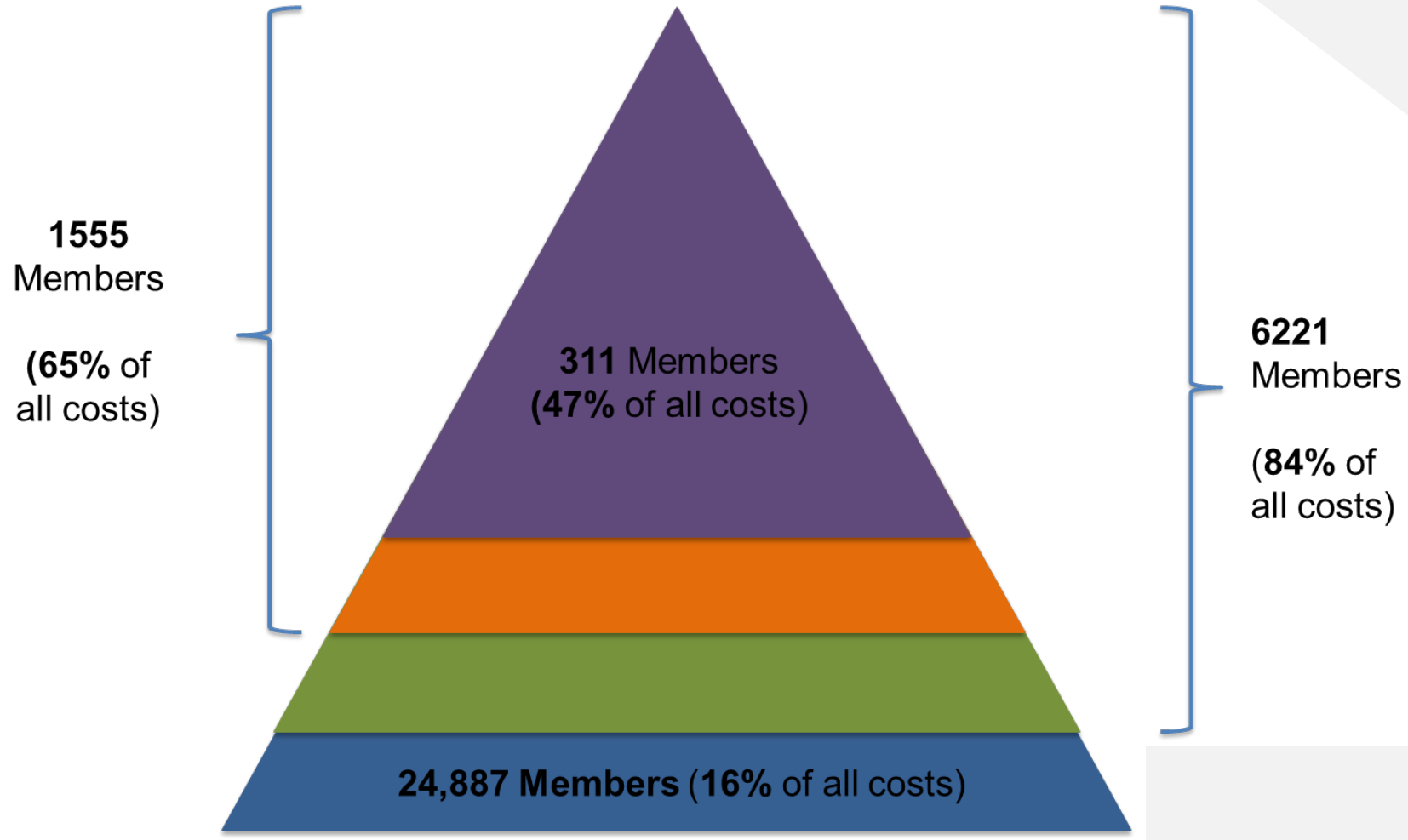


- High level of resource use (e.g., visits, medication, treatment or other measures of cost)
- Frequent visits for urgent or emergent care
- Frequent hospitalizations (i.e., two or more in last year)
- Multiple co-morbidities, including mental health
- Poor compliance with prescribed treatment/medication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

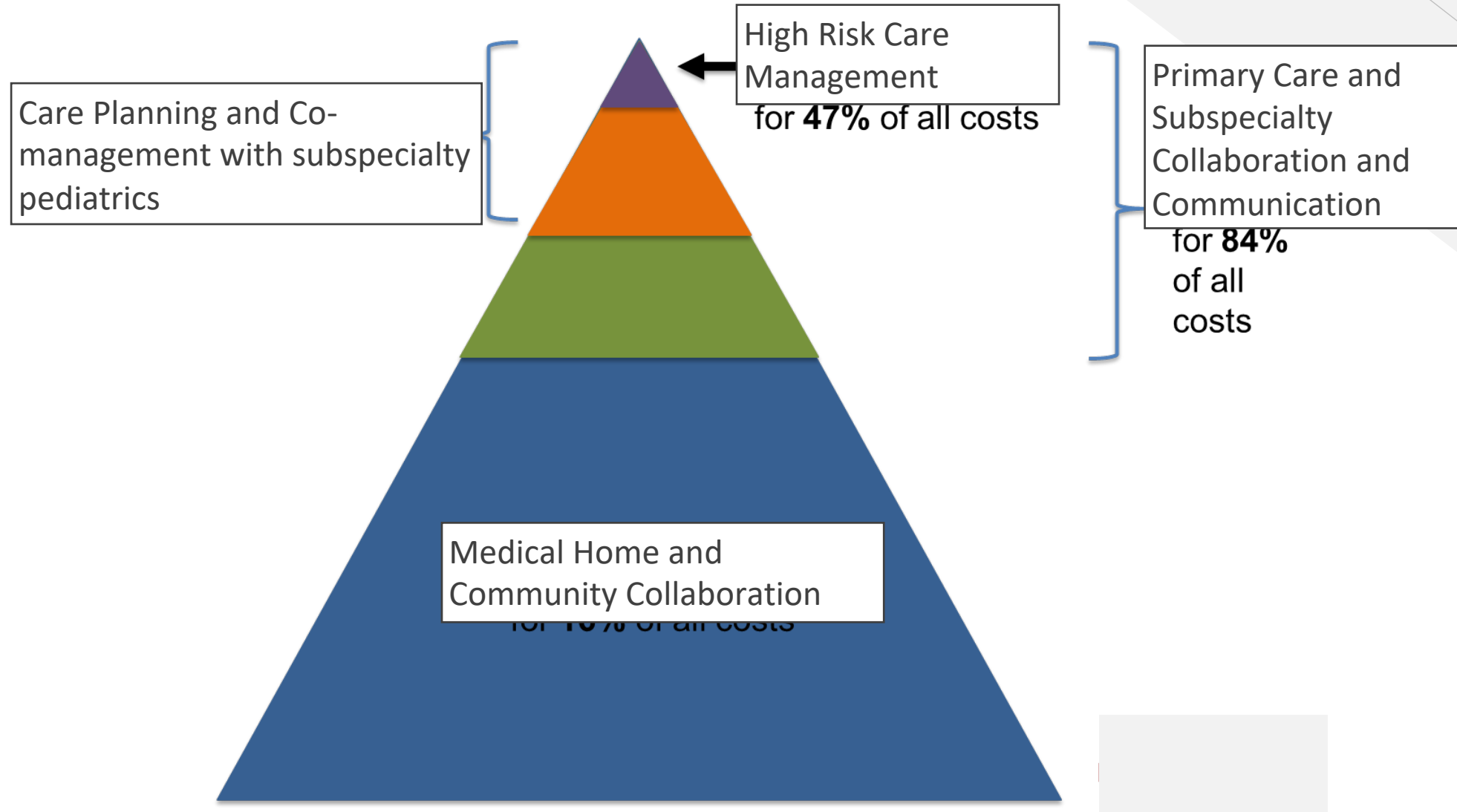
# Top 1% Cost



# 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





# 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**

Tel: 905-494-6688  
Fax: 905-494-6610

☐ Stollmoe General Hospital  
Tel: 905-494-6688  
Fax: 905-494-6610

☐ Stollmoe Outpatient Imaging Center  
89 Number College Blvd  
Suite 101  
Tel: 905-494-6688 or 416-401-8013  
Fax: 416-401-8012

**Request for Radiology**  
\*\*Bring this form with you at time of exam\*\*

**Head & Neck**

☐ Skull  
☐ Sinuses  
☐ Orbits  
☐ Facial Bones  
☐ Mandible  
☐ TM Joints  
☐ Other

**Chest**

☐ Chest PA & Lat  
☐ Lateral  
☐ Ribs Left Right  
☐ S.C. Joints

**Upper Extremity**

**Left**

☐ Shoulder  
☐ Scapula  
☐ Clavicle  
☐ A.C. Joints  
☐ Humerus  
☐ Elbow  
☐ Forearm  
☐ Wrist  
☐ Hand  
☐ Finger 1, 2, 3, 4, 5

**Right**

☐ Shoulder  
☐ Scapula  
☐ Clavicle  
☐ A.C. Joints  
☐ Humerus  
☐ Elbow  
☐ Forearm  
☐ Wrist  
☐ Hand  
☐ Finger 1, 2, 3, 4, 5

**Lower Extremity**

**Left**

☐ Hip  
☐ Femur  
☐ Knee  
☐ Tibia-Fibula  
☐ Ankle  
☐ Calcus  
☐ Foot  
☐ Toe 1,2,3,4,5

**Right**

☐ Hip  
☐ Femur  
☐ Knee  
☐ Tibia-Fibula  
☐ Ankle  
☐ Calcus  
☐ Foot  
☐ Toe 1,2,3,4,5

**Specials (Requires Appt.)**

☐ Arthrogram  
☐ Hysterosalpingogram (BCH)  
☐ Lumbar Puncture  
☐ Sialogram (BCH)  
☐ Sinogram  
☐ Steroid Injection  
☐ Voiding Cystogram

**Abdomen**

☐ KUB  
☐ Acute Abdomen Series

**HISTORY:**

**Request for Mammography (Requires Appointment)**

☐ Screening (Asymptomatic)

☐ Diagnostic

☐ Breast Ultrasound Required

☐ Follow Up Needed (See Radiologist Report)

**HISTORY:**

☐ New Mass  
☐ Pain  
☐ Bloody Nipple

Physician Name (Print) \_\_\_\_\_ Tel: \_\_\_\_\_  
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Technologist Signature: \_\_\_\_\_ X-ray request by \_\_\_\_\_

NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING  
Patients MUST bring outside Mammography previous, otherwise the booked mammogram will be cancelled.

Form # 8100-061 - Stores # \_\_\_\_\_ Rev. April 2012



## Laboratory Services Outpatient Order 1

Thank you for referring your patient for Laboratory Services  
Northwestern Lake Forest Hospital.

To schedule an appointment call 847.535.8000.

For questions or any further information, please call Laboratory Services at 847.535.6119.

In order to provide the best possible services to our patients, we request the following information. To expedite your request, please complete all fields below and fax to 847.535.8001.

☐ STAT CALL STAT ONLY RESULTS TO:

FAX RESULTS TO:

### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work/Cel Phone Number \_\_\_\_\_

☐ Patient must fast 10-12 hours

### PHYSICIAN INFORMATION

Referring Practitioner Last Name \_\_\_\_\_ First Name \_\_\_\_\_

NPI # \_\_\_\_\_

Practitioner's Fax Number \_\_\_\_\_

Practitioner's Signature \_\_\_\_\_

Date \_\_\_\_\_

### SIGNS & SYMPTOMS / DIAGNOSIS / ICD-9

When ordering multiple tests on the same order form, please indicate a sign, symptom, diagnosis or ICD-9 for each test/treatment. Do not include a "rule-out" diagnosis.

**ShortCuts**

ShortCut	Replacement
Denturereline1	Device:
Dis1	We went over the variables of dental health, oral hygiene, periodontal disease
Electronic1	Electronic monitoring in real time, continuously with a blood pressure monitor
Endo1	Xylo-red-1, Tooth had rct in the standard way. A dam, EDTA, lubricant, NaOHCl, paper points, lidocaine, gutta purcha, and cement were used. After access, working length was determined with a new sono and xray measurements. It was rechecked and tooth was instrumented to #30 at apex. When the tooth was clean and dry, it was filled with gutta purcha and cement in a warm downpack. Risks, benefits and alternatives were discussed as well as a crown and post and their medical legal implications. Length:
Exam1	Examination of patient began with a review of the medical and dental history
Ext1	Extraction of teeth# :

**Print List**

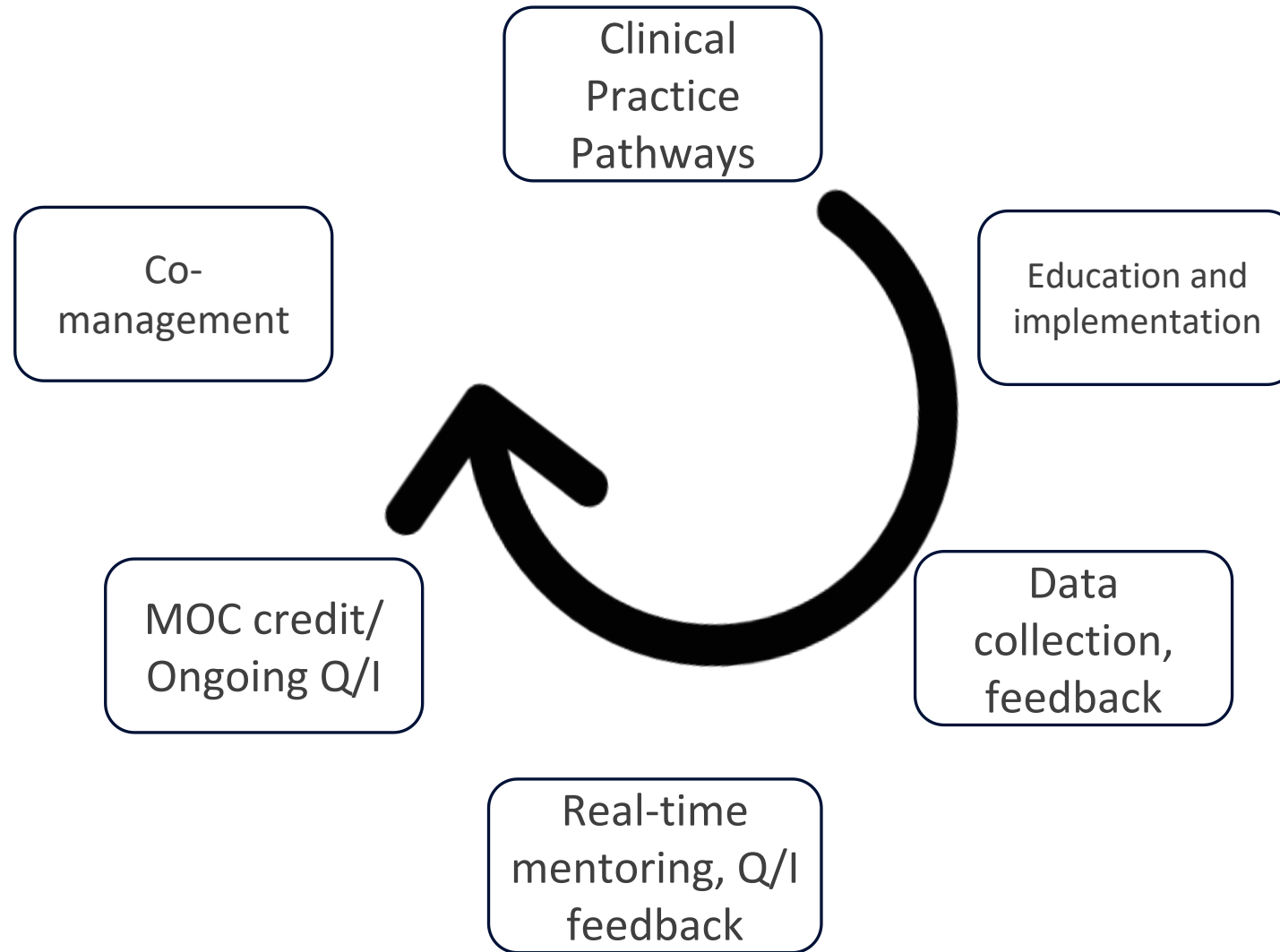
ShortCut: Endo1

Replace With: Xylo-red-1, Tooth had rct in the standard way. A dam, EDTA, lubricant, NaOHCl, paper points, lidocaine, gutta purcha, and cement were used. After access, working length was determined with a new sono and xray measurements. It was rechecked and tooth was instrumented to #30 at apex. When the tooth was clean and dry, it was filled with gutta purcha and cement in a warm downpack. Risks, benefits and alternatives were discussed as well as a crown and post and their medical legal implications. Length:

**Add Delete Save Close Use**

<input type="checkbox"/> Comprehensive Panel	<input type="checkbox"/> Immunoglobulin G (IgG)
<input type="checkbox"/> Histone Ab	<input type="checkbox"/> Immunofixation Serum Profile
<input type="checkbox"/> ANA Screen	<input type="checkbox"/> Immunofixation Urine qual
<input type="checkbox"/> ANA Screen reflex to markers	<input type="checkbox"/> 24 Hr <input type="checkbox"/> Random
<input type="checkbox"/> ANA Screen reflex to titer and pattern	<input type="checkbox"/> Iron & TIBC
<input type="checkbox"/> Alkaline Phosphatase	<input type="checkbox"/> LDH
<input type="checkbox"/> Amylase	<input type="checkbox"/> Lipase
<input type="checkbox"/> Basic Metabolic Prof.	<input type="checkbox"/> Magnesium
<input type="checkbox"/> Bili, Neonatal Total	<input type="checkbox"/> Mono Screen/Heterophile
<input type="checkbox"/> Bili, Neo. Direct/Total	<input type="checkbox"/> Phosphorus
<input type="checkbox"/> BNP	<input type="checkbox"/> Platelet Function, Screen
<input type="checkbox"/> Cardio CRP (High Sen)	<input type="checkbox"/> Potassium
<input type="checkbox"/> CRP (C-Reactive prot.)	<input type="checkbox"/> PSA Screen (1x per year)
<input type="checkbox"/> Calcium	<input type="checkbox"/> PSA, Free (elevated total)
<input type="checkbox"/> CBC w/diff	<input type="checkbox"/> PSA Total (diagnostic)
<input type="checkbox"/> CBC w/manual diff	<input type="checkbox"/> Protein Electrophoresis (serum)
<input type="checkbox"/> CEA	<input type="checkbox"/> PT (van Willebrand)
<input type="checkbox"/> Coeliac profile	<input type="checkbox"/> PT (capillary/finger)
<input type="checkbox"/> CK, MB	<input type="checkbox"/> PTT
<input type="checkbox"/> Comprehensive Metabol.	<input type="checkbox"/> Reticulocyte count
<input type="checkbox"/> Coronary Risk Lipids (fasting)	<input type="checkbox"/> Sed Rate, ESR
<input type="checkbox"/> Ferritin, Serum	<input type="checkbox"/> T3 Total
<input type="checkbox"/> Folate, Serum	<input type="checkbox"/> T4, Free
<input type="checkbox"/> GGTP	<input type="checkbox"/> TSH
<input type="checkbox"/> Culture, Throat	<input type="checkbox"/> Transferrin
<input type="checkbox"/> Culture, Throat Screen	<input type="checkbox"/> Urine Microalbumin
<input type="checkbox"/> Culture, Stool	<input type="checkbox"/> Urinalysis, Routine
<input type="checkbox"/> Stool, Clostridium difficile PCR	<input type="checkbox"/> Urinalysis w/microscopic exam
<input type="checkbox"/> Stool, Occult Blood Diag	<input type="checkbox"/> Vitamin B 12
<input type="checkbox"/> Stool, Occult Blood Screen	<input type="checkbox"/> Vitamin D, 1,25 Dihydroxy
<input type="checkbox"/> Stool, Ova & Parasite	<input type="checkbox"/> Vitamin D, 25 hydroxy
<input type="checkbox"/> Stool, Rotavirus	<input type="checkbox"/> Uric Acid
<input type="checkbox"/> Culture, AFB	<input type="checkbox"/> 24-Hr. Urine CRE CLR
<input type="checkbox"/> Culture, Urine	<input type="checkbox"/> 24-Hr. Urine Total Prot.
<input type="checkbox"/> Culture, Wound Site	<input type="checkbox"/> 24-Hr. Urine 5-HIAA
<input type="checkbox"/> Glucose Serum, 1 Hr. GTT	<input type="checkbox"/> 24-Hour VMA
<input type="checkbox"/> 2 Hr. GTT (Standard)	<input type="checkbox"/> Semen, Post Vas.
<input type="checkbox"/> 3 Hr. GTT (Pregnancy)	<input type="checkbox"/> Other:
<input type="checkbox"/> Fluorescent albumin - ALC	

# Education/Mentorship Lifecycle





# TEAM-BASED CARE





# Project ECHO

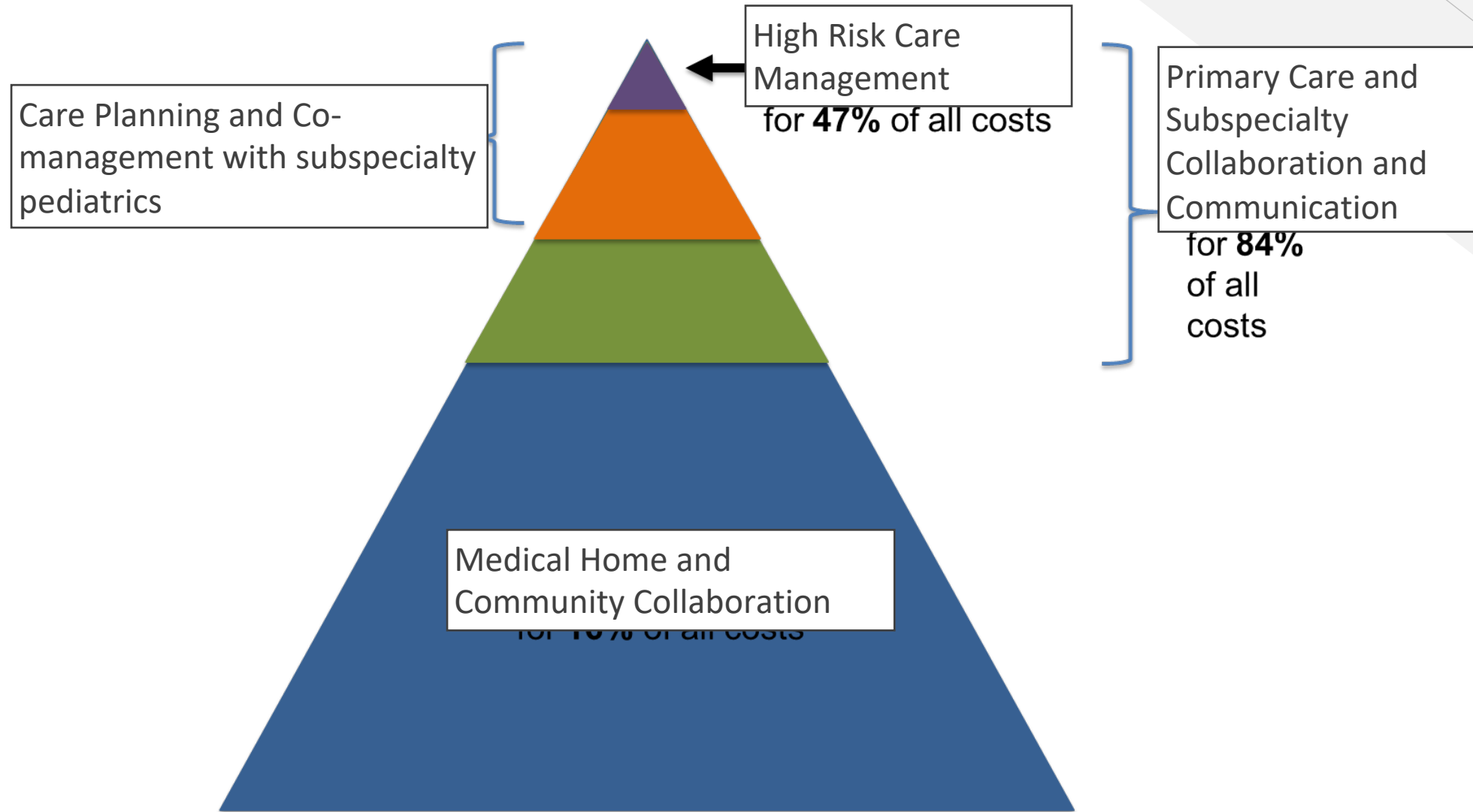


- **E**xtension for **C**ommunity **H**ealthcare **O**utcomes
  - Pediatric rural settings
  - Pediatric Development and Autism Management
  - Pediatric Behavioral Health
  - Epilepsy
  - Pediatric Environmental Health conditions
  - Zika

# 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



CONTRACT

shall

# 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 initiatives
- 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