Clinically Integrated Networks

Right For Your Practice?

Colleen Kraft MD, MBA, FAAP
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...

From Independence to Employment: Hospital Systems 

Organizations Partnerships with physician 

Independent practice partnerships,
Primary care guides a patient's 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

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

- 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

<table>
<thead>
<tr>
<th>Child poverty quintile</th>
<th>IPBD rate per 1,000 children per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>88</td>
</tr>
<tr>
<td>Low-medium</td>
<td>113</td>
</tr>
<tr>
<td>Medium</td>
<td>131</td>
</tr>
<tr>
<td>High-medium</td>
<td>144</td>
</tr>
<tr>
<td>High</td>
<td>171</td>
</tr>
</tbody>
</table>

- 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
- Relatively fewer IPBDs
- County mean
Specialty-specific disparities (relative differences)

- Relatively more IPBDs
- Relatively fewer IPBDs

County mean
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 5% of Members account for 65% of all costs

Top 1% of Members account for 47% 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

1555 Members
(65% of all costs)

311 Members
(47% of all costs)

24,887 Members
(16% of all costs)

6221 Members
(84% of all costs)
Interventions

Care Planning and Co-management with subspecialty pediatrics

High Risk Care Management
for 47% of all costs

Primary Care and Subspecialty Collaboration and Communication
for 84% of all costs

Medical Home and Community Collaboration
for 19% of all costs
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:
Education/Mentorship Lifecycle

- Clinical Practice Pathways
- Education and implementation
- Data collection, feedback
- Real-time mentoring, Q/I feedback
- MOC credit/Ongoing Q/I
- Co-management
TEAM-BASED CARE
Project ECHO

- **Extension for Community Healthcare Outcomes**
  - Pediatric rural settings
  - Pediatric Development and Autism Management
  - Pediatric Behavioral Health
  - Epilepsy
  - Pediatric Environmental Health conditions
  - Zika
Service Outreach and Integration
Interventions

High Risk Care Management for 47% of all costs

Care Planning and Co-management with subspecialty pediatrics

Primary Care and Subspecialty Collaboration and Communication for 84% of all costs

Medical Home and Community Collaboration for 10% of all costs
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 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