Tales From the Front:
How an IPA and Hospital System Are Currently Working to Implement a Clinically Integrated Network

July 1, 2014
Meeting Objectives

- Define the foundational elements of a Clinically Integrated Network (CIN)
- Recognize community barriers to CIN implementation
- Illustrate mitigation strategies for eliminating community barriers to CIN implementation
- Understand effective communication best practices of CIN for the providers, hospital and patients
- Identify real-time learnings for individual CIN design and operations
Market Trends are Creating Vulnerabilities for Hospitals and Physicians

**Environmental trends**

**Hospitals**
- Increasing Medicaid enrollment
- Mandated Managed Care penetration
- Pressure to demonstrate quality
- Pressure to manage populations
- Health systems focusing on population health

**Physicians**
- Real income has not increased in 30 years, particularly in Primary Care
- Unfair negotiations with Payors
- Pressures to report quality and cost of care
- Difficult to remain independent
- Physicians organizing to manage populations

**Areas of Vulnerability**

**Medicaid expansion**
- New populations in 2013 and further expansion in 2014 may create downward pressure on rates and utilization

**Managed Care Plans attempting to reduce costs by:**
- Reducing inpatient utilization
- Reducing ER utilization
- Care provided at lowest cost option

**Health Insurance Exchanges**
- Shift commercial enrollment into new products with potentially different/lower reimbursement

**Increased Provider competition**
- Consolidation
- Local/regional/national competitors

**Pricing structure**
- Greater price sensitivity for patients/families
- Physician incentives to direct care to lower-price alternatives
Systems Nationally are Re-positioning to Respond to Healthcare Payment Reform

Increasing financial opportunity and alignment

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<thead>
<tr>
<th>Provider-sponsored Plans</th>
<th>Capitation Full Risk</th>
<th>Shared Risk</th>
<th>Bundled Payments</th>
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<th>Clinical Integration</th>
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What is a Clinically Integrated Network?

A clinically integrated network is an effort among physicians in collaboration with a hospital or health system to develop active and ongoing clinical initiatives designed to improve the quality of health care services and control costs.

- Fosters collaboration between physicians and hospitals to **increase quality and efficiency of patient care**.
- Allows provider networks that include independent physicians and hospitals to **participate in collective negotiations with health plans without antitrust risk**.
- Presents a powerful business model and clinical strategy to **thrive in the advent of consumerism, pay-for-performance, accountable care and quality report cards**.
- May allow hospitals through CIN to legally provide additional office practice support to physicians members beyond just managed care contracting, such as **information technology system infrastructure**.
Clinical Integration is a Contracting Strategy in Itself but Also Builds Foundational Capability for Risk

- Formal program between health system and defined private physicians
- Designed to improve quality and cost
- Allows some benefit distribution back to the physicians
- No downside financial risk
- First step in shifting from a volume-based focus to a value-based focus
- Still subject to FTC/OIG scrutiny on market share

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Clinical Integration is a Defined Program by the FTC to Allow Joint Contracting Without Financial Risk

The Building Blocks of Clinical Integration

- Enhanced Accountability
- Quality Data Aggregation and Reporting
- Performance Measurement and Incentives
- Evidence-Based Best Practice Utilization
- Legal Entity and Governance Structure

Clinical Integration is “an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”

-Federal Trade Commission (FTC) Definition
Clinical Integration is the Foundation for Building Critical Risk Capabilities

Network Development
- Stakeholder Engagement
- Value Proposition
- Participation Criteria
- Physician Leadership
- Incentive Design

Organizational Structure & Planning
- Payor Contracting Strategy
- Physician Governance
- Committees and Decision-Making
- Financial Structure
- Organizational Incentive Alignment

IT Infrastructure and Capability
- EMR & EHR
- Clinical and Financial
- Patient Engagement Tools
- Integration with existing systems

Analytics
- Clinical Metrics & Results
- Cost Analytics
- Standard vs. Ad-hoc Reporting
- Risk Identification
- Regulatory vs. Operational

Cross-continuum Coordination
- Strong Primary Care
- Communication
- Referral Management
- Population-Based Programs
- Shift to Ambulatory Management
- Transitions of Care

Collaboration Platform
- Common Protocols
- Physician-Guided Quality Best Practice Dissemination
- Clinical Metric Selection
- Peer Review; Transparency
- Build Network Culture
Identifying Community Barriers is Essential to a Successful Implementation

The CIN* must address these concerns in the beginning of the design process:

- Trust in the CIN and the Hospital Member
- Willingness and ability to share data
- Ability and resources to comply with CIN initiatives
- Willingness to allow CIN to do contracting

* CIN = Clinically Integrated Network
A Perceived Need for a CIN by All Involved Stakeholders is Crucial to Ensuring the Design Continues on its Path

The community and hospital must identify champions of the CIN to maintain alignment of the design and implementation.
The Relationship Between the Physicians and the Hospital Member Will Ultimately Lead to the Success of the CIN

Relationship Factors

1. Previous History
   - Hospital initiatives that went poorly
   - Former leadership
   - Misalignment of values
   - Political concerns

2. Current Relationship
   - Ongoing initiatives
   - Current leadership
   - Communication
   - Level of collaboration
   - Future potential

3. Community Primary Care
   - Inpatient vs. outpatient needs
   - Technology support
   - ED, admit and discharge processes
   - Medical staff requirements

4. Community Specialists
   - Inpatient vs. outpatient needs
   - Medical staff requirements
   - Operating Room access

In order to mitigate potential barriers, the CIN must incorporate fundamental elements:

- Value Propositions
- Transparency
- Voice in the design
- Value Added Services

Collaborative CIN Design
Community Physicians Must Submit Data to the CIN to Be Officially Clinically Integrated

- Willingness to share data is one barrier, but the ability to share data can be even more complicated

**Requirements**
- Patient specific data will be submitted via claims, HIE and EMR
- Secure submission and reception of data is legally critical
- Physicians will have individual performance metrics
- Performance will be viewed by the Quality Committee
- Possibility of remediation, probation and termination
- Data aggregated for submission to payors
- CIN must justify quality programs, patient care and cost

**Mitigation of Barriers**
- Population Management
- Potentially reduce costs
- Potentially improve patient care
- Enhance care coordination

**Derived Clinical Metrics at Physician Level**

**Aggregate Clinical Data**

**PHI**

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The CIN Will Have Certain Requirements and the Physicians Must Be Able to Meet Those Demands

Mitigation of Barriers
- Physician designed criteria
- Physician designed policies and best practices
- CIN Quality support
- CIN IT support

Participation Agreement
- Quality and citizenship measures
- Qualifications
- Technology requirements

Policies
- Performance
- Data sharing
- Governance
- Credentialing

Care Delivery
- Best practices
- Quality initiatives
- Care mgmt.

Practice Performance
- IT solution
- Training and onboarding
- Physician change management
- Staff change management

Collaborative CIN Design
Payor Contracting Can Be a Sensitive Component and a Difficult Barrier for Some Autonomous Physicians

### Challenges
- The CIN will be a joint contracting vehicle
- Participants must participate in the CIN contracts
- Participation Agreement criteria and foundation of a CIN

### Mitigation of Barriers
- CIN will be a collection of multiple physicians as opposed to individuals, which may be attractive to payors
- Standardization of quality, best practices and processes

### Parameters
- Exclusive vs. non-exclusive
- Single signature
- Opt in vs. opt out
- Large IPAs and PHOs vs. small or solo practices

### Strategy and Process
- Who is “In and Out” of the Contracts
- Carve Outs
- Pay for performance vs. shared risk vs. full risk
- Lead contractor
- Relationship with hospital member
- Specialty vs. primary care

### Collaborative CIN Design

- CIN selected Executive Director and Director of Payor Contracting
- Incentives potential
The First Step to Engaging the Community is Establishing Strong Value Propositions

Value propositions will vary by segment and market

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<thead>
<tr>
<th>Segment</th>
<th>Market</th>
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<tbody>
<tr>
<td>Physicians</td>
<td>Current FFS reimbursement</td>
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<td>Payors</td>
<td>Size of practice</td>
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<td>Employers</td>
<td>Epidemiology</td>
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<tr>
<td>Hospital / Health System</td>
<td>Population demographics</td>
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Sample Physician Value Proposition

<table>
<thead>
<tr>
<th>ALL PHYSICIANS</th>
<th>Illustrative</th>
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<tbody>
<tr>
<td>• Increased access to continuum of care data</td>
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<td>• Performance and benchmarking data</td>
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<tr>
<td>• Promotion of a quality brand</td>
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<th>Private</th>
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<td>• Remain independent</td>
<td>• Improved communication with Specialists</td>
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<td>• Improved communication with Specialists</td>
<td>• Improved coordination of care and services for patients</td>
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<tr>
<td>• Increased patient volume</td>
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<td>• Improved relations with System and PCPs</td>
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<td>E.g.:</td>
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<tr>
<td>• Maintain / Enhance patient volume</td>
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<tr>
<td>• Improved alignment of services across system facilities</td>
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1 Clear, thoughtful value propositions will make a case for Clinical Integration and on-going value-based transformation across varying stakeholders

2 Value proposition development will identify physician leaders and solidify the vision for the CIN

3 Transparency in engaging with physicians can increase alignment and lead to successful value-based efforts
Alignment with Key Physicians Requires Balance Between Value Drivers

Qualities the CIN Needs (Recruitment Criteria)

• High-quality physician groups with strong values
• Good cultural fits and appetites for innovation
• Experience in value-based models
• Groups willing and able to share data; have effectively adopted an EHR
• Eagerness to help build and shape the CIN, including physician (especially PCP) participation in leadership
• Broad enough geography and PCP/Specialist coverage to provide care across the continuum

Benefits the CIN Offers (Value Proposition)

• Increased access to continuum of care data
• Performance & benchmarking data
• Promotion of a quality brand
• Preserve reimbursement opportunities
• More voice in market
• Improved PCP-Specialist communication
• Improved coordination of care and services for patients
• Optimize current IT capabilities
• Maintain or enhance patient volume

Engaged, collaborative, aligned physician network

Disparate physician groups with varied perspectives

*CIN = Clinically Integrated Network
A broad range of media and processes can be used for CIN communications

<table>
<thead>
<tr>
<th>Emails</th>
<th>In Person</th>
<th>Call</th>
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</table>
| • Personalized emails  
• Email blasts  
• Electronic newsletter | • One-on-One meetings  
• Town hall meetings  
• Focus Groups  
• Demonstrations  
• Practice Manager meetings | • Direct calls  
• Conference calls  
• Webcasts |

<table>
<thead>
<tr>
<th>Technology</th>
<th>Print</th>
<th>Miscellaneous</th>
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</table>
| • CIN/hospital website  
• Applications (phone, tablet)  
• Webinars  
• YouTube  
• Social media  
• Physician portal | • Newsletter  
• Brochure  
• Pre-sale packet  
• Recruitment packet | • Medical conferences  
• CME events  
• Summits |

A combination of these media will be used to reach each target audience
Examples of Different Channels of Communication

**eNewsletter**
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.

**CIN eNewsletter Title**
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.

**Mobile App**
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.

**Physician Recruitment Packet**
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.

**CI Design Updates**
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.

**Contact Us**
- Write here about detail what is included in this newsletter for your readers.
- Write here about detail what is included in this newsletter for your readers.
The Initial Communication and Most Effective in the Early Stages Will be Personal, One-on-One Conversations

The CIN must decide who delivers these messages

- Community physician champions
- Hospital leadership
- Physician liaisons

30 Seconds

- What is a CIN
- Why the CIN is being developed
- Who was involved with the design of the CIN
- Contact for further information

5 Minutes

- CIN is physician led
- Focused on quality and value
- Private representation
- Maintain pediatric delivery integrity
- Mitigate changing market dynamics

10 Minutes

- Other CIN participating practices
- How the CIN supports the private practice model
- Willingness and ability to share data
- Hospital resources and IT support
- Benefits of joining the CIN

30 Minutes

- Value added services included in the CIN
- Dues structure
- Potential incentive structure
- Contracting approach/strategy
- Evolution to new payor, hospital and physician relationships
- Overall practice (including staff) expectations
- Governance model
Best Practices and Lessons Learned Should Inform the CIN’s Communications and Design Strategy

Plan, Plan, Plan
- Have a well-defined communications timetable
- Assign ownership and identify key communicators from the beginning
- Establish the foundation for success

Varied Yet Consistent
- Use various media to get the message across
- Decide early on consistent core messages to permeate all communications
- Tailor message and media to your target audience

Collaborate Across the Team
- Share the production of communications with the rest of the project team

It’s Never Too Early!
- Engaging stakeholders early starts to build interest and trust in the CIN

Be Willing to Adjust Your Strategy
- Review effectiveness of communications regularly
- Extract learnings from target audience feedback

Hospital executive leadership and community leadership must be champions for the CIN
Real Time Learnings Can be an Effective Tool in Your Design Process

**Successful CIN Implementation**

- Perceived need by the community and the hospital
- Physician led design and implementation
- Collaboration with the Hospital
- Trust and transparency with the Hospital
- Meaningful Value Propositions
- Adequate resources for design and implementation
- Communicate, communicate, communicate

Questions for Tom on from the community perspective?

Questions for Rick from a national perspective?