Kenai Peninsula Clinically Integrated Network

Central Peninsula Hospital’s Plan for Population Health Management

June 14, 2016
The Challenge: Crossing the Shaky Bridge
The Premise

Finance

Macro-economic Payment System
• Government Payers
  • Changing from F-F-S to PBPS
• Private Payers
  • Follow Government payers
  • Steerage to lower cost providers

Function

Provider Imperatives
• F-F-S
  • Management of price, utilization, and costs
• PBPS
  • Management of care for defined population
  • Providers assume insurance risk

Form

Provider organization
• Evolution from
  • Independent organizations competing with each other for market share based on volume to
  • Aligned organizations competing with other aligned organizations for covered lives based on quality and value provided

Network Evolution
• From Independent Managed Care Plans squeezing providers in order to compete solely on cost to
• Independent Coordinated Care entities demonstrating improved population health within a fixed global budget
The CPH Response

• Form a Clinically Integrated Network to prepare to take responsibility for the care of a defined patient population, managing both quality and cost of care through clinical and financial integration among providers.

• Quality is expected to improve across the care continuum, including population health, primary care, acute care, post-acute care, long-term care, and behavioral and mental health care.
CIN’s – Definition

• **In the words of the Federal Trade Commission:**
  – “...an active and ongoing program to evaluate and modify practice patterns by the network’s provider participants and create a high degree of interdependence and cooperation among the providers to control costs and ensure quality . . .

• This program may include:
  – (1)establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care;

  – (2)selectively choosing network physicians (the “A” team) who are likely to further these efficiency objectives; and

  – (3)the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.”

• **Different motivation than the PHOs of the 90s**
CIN’s – Objectives

• Establish a network of providers that enables better coordination of care

• Create a new partnership model with employed and independent physicians that includes defined roles for physician leadership
  – Avoids the cost of acquisition and allows for independence

• Define performance improvement initiatives that provide demonstrated value to the market

• Provide a platform for joint contracting that supports care redesign and performance improvement initiatives

• Create a model for success under value-based (risk) contracts

• Satisfy FTC requirements
What is a Clinically Integrated Network?

Source: Becker’s Hospital Review
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CIN’s – Legal Options

• Utilize up-to-date FTC and DOJ guidance

• Organize in a structure that supports program objectives
  – Physician-Hospital Organization
  – Independent Practice Association
  – Subsidiary of the Health System

• Each legal option is capable of achieving clinical quality + financial objectives though they differ in ownership structure and capitalization requirements
CIN’s – Legal Contracting Advantage

• Anti-trust avoidance
  – The Department of Justice and the FTC define clinical integration as an active and ongoing program to create a high degree of interdependence and cooperation among physicians and hospitals to control costs and ensure quality.
  – Because of this requirement for higher quality and greater efficiency, the antitrust laws that often prohibit joint contract negotiations, permit properly structured clinically integrated providers to engage in collective negotiations with health plans or other payers.
  – Providers who are not economically integrated (such as independent physicians) may not engage in “single signature” third-party contracting unless they become clinically integrated.
CIN’s – Defined

• **How do CINs differ from PHOs?**
  – CINs are arrangements (usually separate legal entities) sponsored by hospitals but co-managed by physicians who assemble the resources required to manage care for defined patient populations
  – Like PHOs, CINs are “membership” organizations requiring doctors to meet strict criteria
  – Unlike PHOs, they are under-inclusive (think of the hospital’s “A” team)
  – They may evolve into ACOs, but don’t need to
What is a Clinically Integrated Network?
CIN’s – Physician Leadership

• Trust and transparency between doctors and hospitals is paramount

• Enhanced electronic communication between doctors and hospitals is required

• Strong physician representation on boards and committees

• Clear goals and objectives must lead to enhanced quality and efficiency – our purpose
CIN’s – Physician Leadership

• Role of the Hospital or Health System

– Typically the sponsor of the CIN

– Balancing hospital and physician interests is key

– Hospitals bring capital, HIT and administrative support, but at a price – they expect certain reserved powers and a place “at the table”
CIN’s – Physician Leadership

• Role of Physicians

  – Active participation in the clinical improvement and clinical protocol development process
  
  – Sharing of clinical data electronically with the CIN and their peers
  
  – Participation in CIN’s managed care contracts once the CIN achieves clinical integration
  
  – Avoidance of conflicts of interest
CIN’s – Physician Leadership

• Boards, Committees and Officers

  – Board of directors reflects the “balance of power” with physicians in leadership roles

  – Class voting, super-majority voting requirements and reserved powers are combined to forge a sustainable compact between the hospital and physicians
CIN’s – Physician Leadership

• Primary care physicians can be given an elevated status in a CIN, i.e., their role in governance and leadership
  – Patient-centered medical homes have an important role in a CIN giving patients greater accessibility through:
    • e-visits
    • group sessions
    • use of APNs
    • patient coaches/care managers
What is a Clinically Integrated Network?
CIN’s – Participation Criteria

• Participation Criteria (via participation agreements):
  – Maintaining the appropriate IT infrastructure allowing clinical data sharing in real-time
  – Standardized clinical care protocols that minimize variation
  – Consistent clinical performance measures and reporting across the CIN
  – Infrastructure that promotes care coordination and duplication reduction
  – Participation in all network contracts
What is a Clinically Integrated Network?

Source: Becker’s Hospital Review
CIN’s – Performance Improvement

• Variance and cost reduction — Improving operational efficiencies

• Clinical efficiency — Reducing avoidable, unproductive and duplicative services

• Care model redesign — Ensuring treatment in the most optimal setting and by the right provider

• System optimization — Shifting focus to preventive care and population health management

• Patient experience — Objective and meaningful comparisons between providers of care
CIN’s – Performance Improvement

• Improve Quality
  – Adverse events are costly in terms of clinical outcomes and financial results.
    • The death of one of every 10 Medicare patients is attributable to lapses in patient safety, and those incidents result in nearly $9 billion in excess healthcare costs\(^1\).
    • Nearly 100,000 people per year in the U.S. die as a result of healthcare-associated infections, more than breast cancer and prostate cancer combined.
  – Quality and operational improvements are requirements for a clinically integrated network. CINs provide the means to engage physicians in determining how quality is defined and measured, and allow them to take an active role in care redesign and protocol development to increase quality.

\(^1\) GE Healthcare Research
CIN’s – Performance Improvement

• Quality tools to help get us there

  – Clinical protocol compliance applications
    • Enable organizations to set parameters for cost, risk and outcomes

  – Patient or disease registries
    • Registries collect data related to patients with a specific diagnosis

  – Patient dashboards or scorecards
    • Alert providers to gaps in care or quality measures at the point of care

  – Clinical surveillance and infection tracking applications
    • Aggregate and display near real-time inpatient data

  – Quality analytics solutions
    • Can generate report cards on physician performance
What is a Clinically Integrated Network?

Source: Becker’s Hospital Review
CIN’s – Information Technology

• EHR’s
• Meaningful Use
• MACRA Rate Changes
  ▪ 4%+- in 2019, up to 9%+- in 2021 (plus 10% bonus for high performers)
• Disease Registries
• Outcomes Data Analysis
• Benchmarking within your CIN
• Benchmarking outside of your CIN
Health information technology (HIT)

- HIT is necessary for CINs to effectively coordinate care, communicate among the sites of care in the network, collect measurable data and address a wide variety of other needs:
  - Enable providers across a network to access patient information and refer patients to specialists using an integrated information system
  - Allow access to clinical guideline adherence at the provider, practice, and network levels
  - Develop disease registries
  - Enable patient access to clinical support through a portal, such as secure provider messaging, reminders and alerts, test results viewing and prescription refill requests
  - Report provider, practice, and network-level patient outcomes
CIN’s – Information Technology

• Health information technology (HIT) (continued)
  – Organizations need **four key capabilities** to deliver effective population health

  • **Data control** aggregates and manages data from across the community to make information accessible where and when you need it.
  • **Healthcare analytics** deliver the business and clinical intelligence to generate insights and drive better decisions.
  • **Care coordination and management solutions** enable care team collaboration and increased patient compliance that drive improved outcomes for patient populations.
  • **Wellness and patient engagement solutions** help organizations promote healthier lifestyles for the patients in their population.

  – These capabilities are **not** found in EMRs!
What is a Clinically Integrated Network?
CIN’s – Contracting Options

- Performance incentives — Incentive payments made for performance improvement initiatives
- Global Payment/Shared savings
- Provider-Based Health Plans
- Premium base rates
- Contracts both for providing care and purchasing care
That is a Clinically Integrated Network

Source: Becker’s Hospital Review
CIN’s – Benefits

• Sustain Independence
  – The United States has seen rapid consolidation over the past decade among insurers, physician practices, and pharmacies for two main reasons:
    • to achieve efficiencies through economies of scale
    • to get the upper hand in contract negotiation
  – Consolidation into larger hospitals and physician groups has also been a means to better coordinate care, enforce practice guidelines, standardize procedures, employ cost-control measures and drive quality improvement programs.
  – While a trend, it’s not the preferred choice for all providers. Clinically integrated networks offer an alternative to consolidation, achieving the same aims of scale, care coordination, evidence-based practice, cost control, and quality improvement, while allowing provider independence.
CIN’s – Benefits

• Population Health Management
  – The goals of population health management are to improve the health of patients and to reduce costs by aligning the economic incentives for care delivery and utilization among the patient, provider and payer.

  – Because of their organizational relationship, CINs are well-positioned to contract with payers and employers to manage population health.
Kenai Peninsula Clinically Integrated Network

• CPH is on a journey to develop a Clinically Integrated Network on the Kenai Peninsula
  – Why?:
    • Positions us to partner with an insurance provider to respond to RFP coming from the DHHS to develop a Medicaid CCO demo project
    • Aligns with the recommendations expected to come out of the Mayor’s Task Force
    • Creates the infrastructure to achieve a closer integration with other health care providers
    • Positions us to improve the health of our population
    • Strengthens hospital/medical staff relationships
    • Positions our provider community favorably for health care system reform beyond Medicaid that we KNOW is coming
Kenai Peninsula Clinically Integrated Network

• Goal is to model a Coordinated Care Organization based on the Eastern Oregon Coordinated Care Organization
  – EOCCO provides coverage to nearly 50,000 Medicaid patients in 12 rural and frontier counties in eastern Oregon
  – In the EOCCO model, the insurance company and owners accept the ultimate risk for operating within a global budget
  – Providers are at risk for their share of the shared savings
  – The shared saving model aligns incentives so that the goal of all parties is to produce a healthier population at a lower cost
  – Global payments entail significant administrative complexity, requiring technical infrastructure and personnel devoted to managing financial risk – hence the need for an insurance company partner