INDUSTRY INSIGHT REPORT

CLINICALLY INTEGRATED NETWORKS

A Framework for Clinical and Financial Success

urac®

For many organizations, the journey toward achieving the Triple Aim of better clinical outcomes, improved efficiencies and consistent patient satisfaction begins with clinical integration. By forming a clinically integrated network (CIN), groups of otherwise unaligned physicians, primary care practices, specialty groups, hospitals and other healthcare organizations can join forces to negotiate with managed care companies and health plans to improve the quality and efficiency of care.

But structuring these networks is complicated. While CINs enable health systems and providers to deliver value-based care, they come with many clinical and operational challenges, including those related to technology, governance, organizational alignment and care coordination. And there are very real compliance threats. The U.S. Federal Trade Commission, Department of Justice and state regulators closely scrutinize the structures of these networks to safeguard against antitrust violations.

This industry insight report explores how providers and healthcare organizations have navigated these complexities to achieve success in the new value-based healthcare economy and how accreditation helps organizations build their CIN framework.

ALIGNING PHYSICIANS TO IMPROVE OUTCOMES, QUALITY AND COSTS

True organizational alignment requires not only the ability to measure each member's performance and identify variances, but also to successfully engage providers to adopt solutions that will improve and streamline care. Success depends upon effective communication, care coordination, adherence to clinical guidelines, strong financial management and ongoing training—of physicians and patients alike.

Communication and patient engagement turned out to be major drivers of unnecessary ER utilization for patient populations within St. Vincent's Health Partners (SVHP), a CIN based in Bridgeport, Conn. Lack of a functioning health information exchange (HIE) in the state meant that physicians were often unaware that certain patients frequented an ER for preventable reasons. Through its relationships with several large health plans, SVHP could access and analyze payer data to identify these patients and share the information with physicians.

It also provided physicians with patient education materials and talking points that helped physicians remind patients to call their office before heading to the ER for non-urgent reasons. They could then decide together the most appropriate course of action. When patients did call, physicians typically directed them to urgent care, the physician's office or, if it was an actual emergency, to the ER.

This simple intervention resulted in a 70 percent drop in inappropriate ER utilization among an employer group and a 25 percent drop among a commercial patient population, says Kyle Lanning, SVHP's Integration and Information Manager.

"Patients assume their doctor won't be available, so providing this continuous messaging helped tremendously," he says.

Monument Health, which describes itself as Western Colorado's largest CIN, develops metrics by consensus to ensure physicians are aligned and engaged. Clinical leaders meet with prospective physician partners to explain the network's objectives, get their feedback on metrics and quality improvement initiatives and to give them a heads up that the network may one day ask them to adjust their workflow or clinical practices if certain measures or outcomes fall outside of the network's targets, says CEO Stephanie Motter.

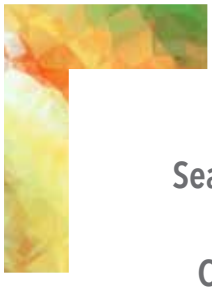
These upfront conversations help avoid pushback down the road. When conversation and data recently showed that some ER providers were likely deviating from established clinical protocols related to CT scan utilization, Motter's team met with hospital leaders to find out why. They learned that the hospital had launched an initiative to improve throughput, which may have influenced the ER providers' decisions to order the scans.

Motter's team met with hospital administrators and ER physician leaders to better understand the issues and patterns to help ER providers realign with established protocols. Radiologists also met with ER physician leaders to share utilization data and review established standards of care. The conversations went surprisingly well.

"The radiologists didn't want to tell their ER colleagues how to practice," says Motter. "But because we socialized it up front and told them that this kind of conversation might happen at some point, there wasn't any pushback or anger. It went off pretty smoothly."

Within six months, CT scan utilization dropped by about 15 percent, Motter says.

Seattle Children's Health Network involves physician leaders and payers in its quarterly meetings about outcomes, cost and utilization data. Physician leaders from each member location huddle with clinical and financial analysts from the network and their contracted health plans to collectively identify areas to improve care and to agree upon the interventions they'll need to deploy across the network, says Michael Murphy, executive director.



Seattle Children's Care Network is currently undergoing the URAC accreditation process.

The network's Quality and Care Transformation Committee also hosts a monthly conference call with physicians to share data, review their progress and develop improvement plans. Although it can be challenging to get physicians to step away from their hectic schedules for these 60- to 90-minute calls, about 98 percent of practices participate, Murphy says.

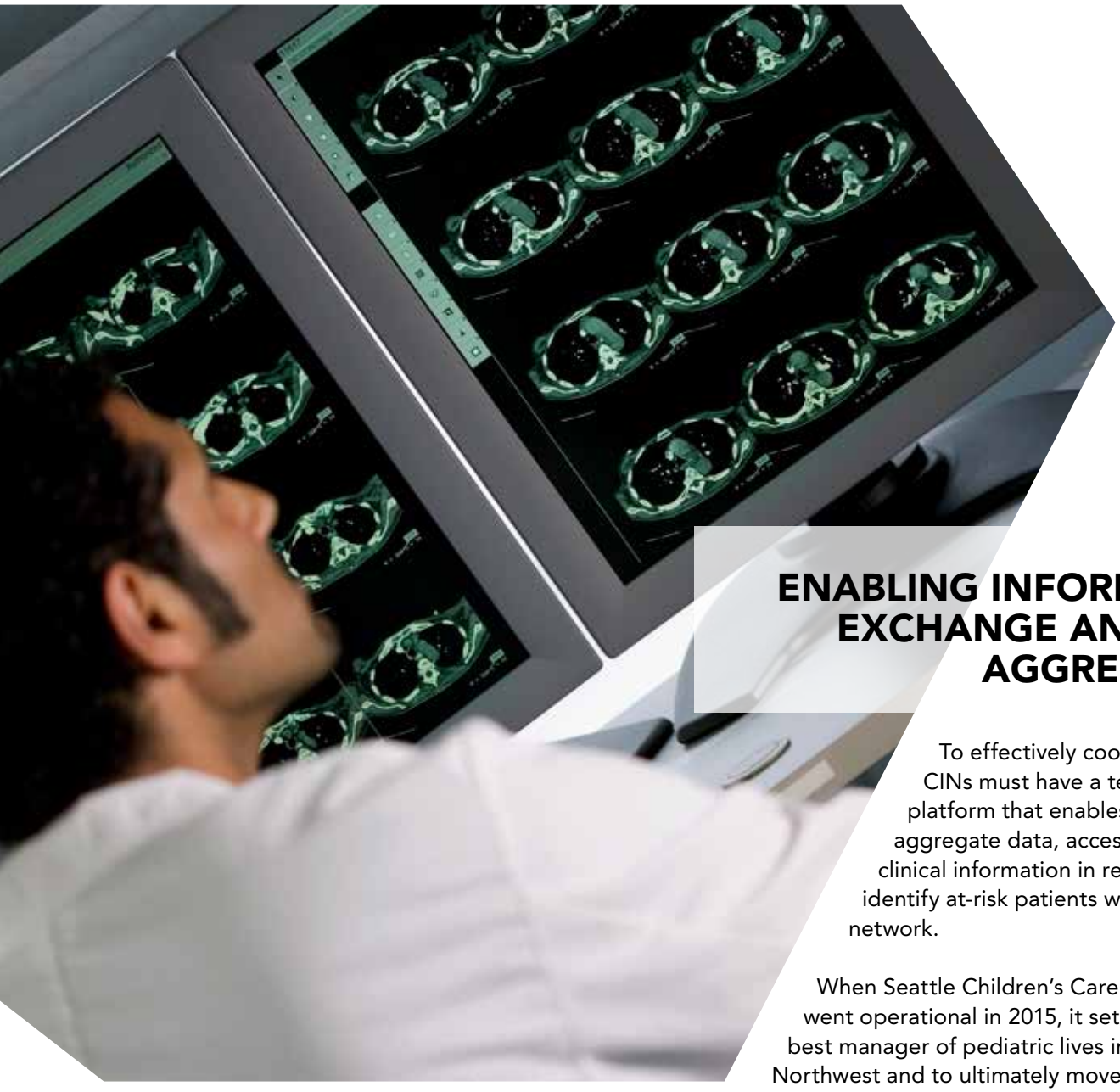
Murphy attributes this high engagement to the network's collaboration with physicians and the support it provides. Some of that support includes working with each practice to help them achieve certification as a patient-centered medical home. The CIN also plans to roll out a learning management system that will simplify and manage all provider education, including each physician's Maintenance of Certification process, he says.

Advanced Health Select is one of the largest CINs in Ohio, serving most major healthcare markets in the state. It includes three large regional healthcare systems—Cincinnati-based Mercy Health, Akron-based Summa Health and Cleveland-based MetroHealth System. Key to the network's success is its centralized approach to improving patient access. For example, Summa Health provides a clinical access center that supports all practices across its ACO.

The clinical access center provides after-hours access services such as answering services and prescription refill support; daytime support for overflow calls to physician practices; 24-7 nurse triage; appointment scheduling; outbound calls for quality initiatives and practice optimization support, according to Ellen Smith, VP of business development and access for Summa Health.

"We focus on our clinical access center to be an extension of the physician practice," Smith told attendees during an April 2017 webinar.

Customer service staff at the clinical access center have access to a comprehensive provider directory, Smith said. This gives them "more information to meet the caller's needs, to understand who our providers are, what types of specialty care they provide so they can get patients to the right point of care more quickly and more accurately," she said.



ENABLING INFORMATION EXCHANGE AND DATA AGGREGATION

To effectively coordinate care, CINs must have a technology platform that enables providers to aggregate data, access and share clinical information in real time and identify at-risk patients within the network.

When Seattle Children's Care Network first went operational in 2015, it set out to be the best manager of pediatric lives in the Pacific Northwest and to ultimately move toward single-signature contracting. But first the network had to ensure seamless information exchange between its members, which include Seattle Children's Hospital, a 650-specialist medical group and 21 primary care practices.

Combining forces into one entity required legal and regulatory expertise and sophisticated, interoperable technology. It also required months of diligent IT work, Murphy says. Because its sites use several different EMR systems, the network needed to implement a population health tool that could pull the disparate EMR data into one place. The process was arduous, requiring the network to create unique interfaces between each practice's EMR and the new platform, Murphy says.

The resulting platform is integral to the network's success. It allows data analysis across the network to identify treatment and utilization trends, barriers to access and areas that need clinical improvement and standardization, Murphy says. The network uses the data as a jumping-off point for collaborating with providers to identify how they can work together to improve.

"When you're in a clinically integrated network, no longer are you looking at whether a physician did a good job when a patient came to their primary care practice," Murphy says. "You're looking longitudinally at the patient across all sites of the organized system of care. You're looking at metrics and measures that span across the continuum of care, at how frequently patients come, the dynamics that drive utilization and how to collectively implement interventions, care coordination and care management."

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Monument Health, which includes about 400 healthcare providers and specialists, as well as a regional hospital, a critical access hospital and a behavioral health hospital, requires all providers to have full connectivity with a regional HIE. Those who don't have this capability must invest their own resources to connect or upgrade, Motter says.

"We sometimes get pushback, but in the end, we work with the physician group and the HIE network to help them get the best price," she says.

SVHP has a different challenge. It includes more than 400 independent and employed primary and specialty care providers, a flagship local hospital and several skilled nursing facilities (SNFs), home health agencies and hospice agencies. They use 12 different EMR platforms, making interoperability a challenge. With no functioning HIE network, it had to get creative about sharing information when it formed in 2012.

While some networks require members to use the same platform, SVHP wanted to give members the freedom to choose their own technology platform. Last year it secured a grant from Microsoft to create a data warehouse that will combine payer and provider data from various sources into one central location.

They'll use the data to generate reports for providers that will give them practical insights into their patient population.

"This will allow our team to identify trends in patient care that produce better outcomes," Lanning says.

THE ACCREDITATION PROCESS AS A FRAMEWORK FOR SUCCESS

A growing number of CINs are leveraging accreditation to ensure their framework positions their organization to meet the many clinical, organizational and financial challenges they will face.

URAC's Clinical Integration Accreditation Program aligns closely with FTC guidance, and can be instrumental in assessing a network's level of clinical and financial integration. Essentially, it provides the roadmap healthcare networks need to be clinically integrated and avoid antitrust issues.

"Going through the process of accreditation helped St. Vincent's Health Partners verify that what we had in place was correct," says Lanning. The network in 2014 was the first Physician Hospital Organization in the nation to earn Clinical Integration Accreditation from URAC, and recently became reaccredited.

One area where URAC's accreditation process helped SVHP improve its processes was in information sharing. URAC's CIN accreditation standards require networks to ensure information sharing across the entire network.

"That standard and the purpose behind it helped push us to look at what more we could do to exchange information with each other," Lanning says. One of the communication gaps the network identified was related to transitions of patients who were at high risk of readmission. With no functioning HIE in place, SVHP established a rather low-tech solution to ensure timely care coordination.

The network now downloads and analyzes patient data every day from its member hospital to track all patients, particularly those with a higher risk of readmission. The network shares this information with all relevant providers, and flags the at-risk patients who were recently admitted to their organization or services.

"It's simple, but it works," Lanning says.

When Phoenix Children's Care Network (PCCN) began its journey toward clinical integration five years ago, it needed an organizational framework that would give it legitimacy with payers. Because PCCN would be negotiating contracts with insurers and paying quality-based incentive bonuses to its 1,000 providers, there was inherent risk of inducing referrals and perceived anti-competitive practices if the arrangements weren't structured carefully.

"We are *the* pediatric player in our region, so the fear was that if we were aggressive in negotiating contracts, an insurer could report us for colluding and trying to drive up costs. We needed to structure [PCCN] so that no one could poke holes in our internal processes," says Casey Osborne, vice president of PCCN, which is now the largest pediatric-dedicated, clinically integrated organization in Arizona and one of the few networks of its kind in the U.S.

The network looked to URAC for guidance and ultimately structured its CIN around the four essential pillars that form the basis of URAC's Clinical Integration Accreditation standards:

- A governing structure that provides compliance and oversight;
- Top-down organizational alignment that ensures business arrangements are patient-centric and structured around improving outcomes, quality and costs;
- Care coordination built around a population health mindset;
- An integrated IT infrastructure that enables information exchange and data aggregation.

"URAC has done a thorough review of federal and state regulations," Osborne says. "Their accreditation process really helps you ensure that your CIN is set up in proper fashion and has the proper structure in place."

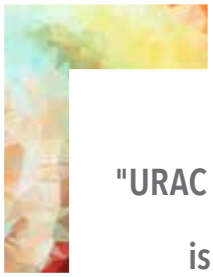
For example, URAC's standards require CINs to create an infrastructure that aligns with requirements established by the Centers for Medicare and Medicaid Services (CMS) as well as other federal and state agencies.

"Because of this, payers don't have to worry about the risk they're delegating by allowing our clinically integrated network to provide services to their patient population," Osborne says.

Other URAC standards guide CINs through establishing the infrastructure and policies necessary for transparently monitoring its accounting and financial practices.

"Achieving URAC accreditation really gave us credibility," Osborne says. "We can demonstrate that we're keeping proper documentation and audit trails and that we'd perform well if any regulator decided to come in and audit or review the services we're providing on the payer's behalf."

Accreditation recently helped PCCN land a contract with a commercial health plan to serve as its exclusive network for pediatric care. "Our URAC accreditation showed that we have all of the processes and governance in place," Osborne says. "The fact that we're accredited by URAC has allowed us and the payer to focus more on



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operationalizing the product and less on reviewing our capabilities and core competencies."

As the first pediatric CIN to achieve URAC accreditation, PCCN is a bit of a trailblazer. Other pediatric networks are lining up to follow. Their leaders have approached PCCN for guidance on pursuing accreditation.

"They see the benefits of accreditation—how it can help them achieve credibility with payers and help them build what they wouldn't even know they need or how to build it," Osborne says.

Seattle Children's Care Network is currently undergoing the URAC-accreditation process.

Says Murphy, "Other than going to the FTC and getting their sign off, which is a lengthy, costly direction to go, URAC accreditation is the best way to be recognized as a vibrant clinically integrated network."

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URAC is the independent leader in promoting healthcare quality through accreditation, certification and measurement. URAC accreditation is a symbol of excellence for organizations to showcase their validated commitment to quality and accountability.

Our Provider Integration and Coordination Programs include PCMH Certification, Clinical Integration and Accountable Care Accreditations, and Telehealth Accreditation. Our approach defines the standards of excellence without prescribing how organizations must meet those standards, to allow organizations to continue innovating while ensuring patient protection.