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Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

FIVE STEPS TO SUCCESSFUL CLINICAL PROGRAM DEVELOPMENT

- Prioritize 1-3 initiatives based on "curve shifting" (performance vs. external benchmark) and "curve narrowing" (internal variation in performance) opportunities
- Establish initial problem statements and areas of focus within each initiative
- Approve 5-10 "big rock" tactics to be implemented to drive change based on current efforts, accepted clinical literature and other leading practices
- Finalize outcomes and process measures to be used to monitor implementation, including operational definitions and targets
- Define the infrastructure required to execute both tactics and reporting

PROVIDER STRATEGIES FOR DEVELOPING A SUCCESSFUL CLINICALLY INTEGRATED NETWORK

LESSONS LEARNED FROM HEALTHCARE LEADERS ABOUT THE ROLE OF CLINICAL INTEGRATION IN DRIVING VALUE

Now more than ever, the competitive priority for hospital and health system leadership is focused on value – improving quality while controlling costs. As the Affordable Care Act continues to bring tighter federal regulations and uncertain reimbursement changes, and the industry rapidly transitions to value-based care models, the approach an organization selects will determine its fate.

To address today's demands, some organizations have reorganized into clinically integrated networks (CINs) – physicians, hospitals and post-acute care (PAC) providers collaborating to improve value.

CIN development has been proven to enhance an organization's value, but as Einstein said, "The definition of insanity is doing the same thing over and over and expecting different results." In other words, providers must understand and accept that developing a CIN requires transformative changes in how they deliver care.

In multiple sessions, 50 healthcare executives from across the country convened to discuss the role of clinical integration in helping providers excel in today's value-based environment. While all markets are different, this paper documents the strategies, recommendations and insights the group found to be consistent to CIN development and success.

AREAS OF FOCUS

Executives identified the following four areas as having the most significant potential impact on CIN development:

- Physician Engagement
- In-Network Care Coordination
- Post-Acute Care Utilization
- Pharmacy Spend Management

It's not enough to simply set up a CIN as an organizational structure. Instead, successfully developing a CIN requires effective tactics designed around an organization's unique clinical capabilities and strategic goals, as well as the needs of its patient population.

"Clinically integrated networks create differentiation by clearly defining the clinical activities that drive the program," said Navigant Director Dennis Butts, Jr. "Successful CINs also actively pursue a contracting strategy that monetizes clinical work so it balances the financial realities of the transition from fee-for-service to a value-based environment."



BUNDLING AS A PHYSICIAN ENGAGEMENT STRATEGY

Bundled payments – single, fixed payments for services by two or more providers during an episode of care or specific time period, to include acute and post-acute care – represent a key opportunity to engage physicians in a CIN strategy and better connect care across the continuum.

The goal of bundled payment programs, such as Medicare’s Comprehensive Care for Joint Replacement (CJR) and Episode Payment Models, is to create an aligned model that improves the value of care, addresses a significant portion of the total cost of care and provides physicians with better visibility into their performance. Organizations engaging primary care and specialist physicians are using bundling as a successful strategy through commercial contracts, Medicare programs or virtual bundles within shared savings contracts by creating episodes of care within their attributed populations.

Virtua Health’s Senior VP of Clinical Integration Stephen J. Kolesk, M.D., suggests the following approach for developing a bundled program: “A successful bundling initiative starts with physician engagement and buy-in. As such, management will need to identify physician leaders and influencers that can effect change while ensuring physicians – particularly specialists – are engaged in the development of bundled programs from the onset. Use of data to show physicians who the key players are and the variations in care that exist is also essential, as is having regular meetings and education sessions to communicate metrics and ongoing opportunities.”

Physician Engagement

Since a CIN approach represents a cultural shift for many physicians and managers, engaging medical staff is one of the major challenges executives will face in building a CIN.

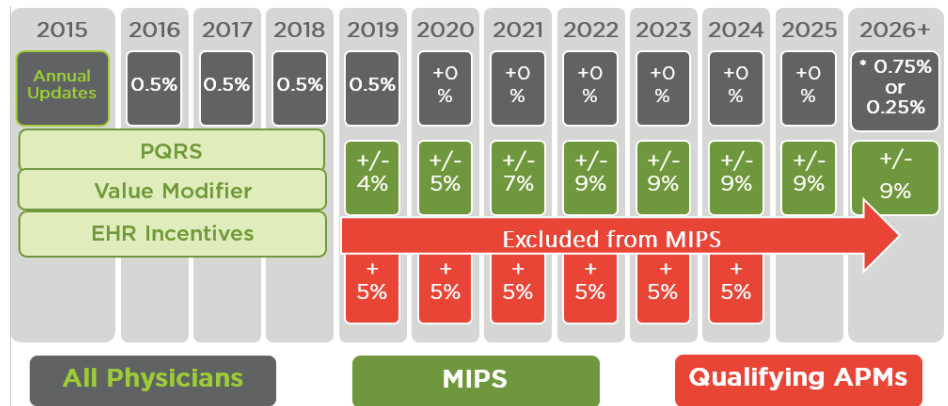
A successful CIN needs to be physician-led and professionally-managed, with physicians understanding the need to rely on others for such aspects as data analytics and project management, suggests Mark Shields, M.D., retired senior medical director for Advocate Physician Partners – one of the nation’s first and largest CINs. “Excellence in the operating room doesn’t mean you can develop clinical protocols,” said Dr. Shields.

Participation and collaboration among all physicians across the care continuum is an essential ingredient of any high-performing CIN, according to Dr. Shields. As such, physician expectations should be detailed in an upfront provider agreement, to include measures based on performance and an understanding that collaboration among physicians across specialties is required. Physicians that do not maintain the standard should not be able to remain in the CIN.

Developing appropriate incentives is a necessary initial step to get physicians on board. “You’ll be asking doctors to work in new ways, and they’ll need to be rewarded for their time,” said Dr. Shields. While there’s no perfect incentive approach, he believes the draw of improving patient outcomes is meaningful for engaging physicians. “Better care is why physicians went into medicine in the first place,” Dr. Shields said.

The Medicare Access and CHIP Reauthorization Act (MACRA) also presents an impetus for physician CIN participation. MACRA aims to curb physician spending by rewarding better care, not more care. The carrot-or-stick approach has physicians facing payment increases or decreases of up to 9 percent, with enhanced care coordination a central theme to MACRA success (see Figure 1).

FIGURE 1: MACRA IMPLEMENTATION TIMELINE



Finally, transparency in data analytics – allowing doctors to see the difference that the practice is making – is another important element to getting buy-in. “Each physician needs to know how they can be accountable to the needs of payers, providers and patients,” according to Dr. Shields. “Getting transparency even in limited data amounts of data is important to give your physicians something to act on.”

According to Butts, organizations taking physician engagement to the next level are engaging a multidisciplinary clinical team of mid-level practitioners, care managers, performance improvement personnel, data analysts and other office staff. “This type of collaboration helps to drive performance by embedding the CIN program within the office workflow, supporting key initiatives with the proper personnel and providing insights on where physicians should focus based on robust analytics,” Butts said.

In-Network Care Coordination Enhancement

Network-wide enhancements in care coordination – including improvements in care transitions and reductions in variation, overuse of services and medical errors – have been proven to improve quality, efficiency and patient satisfaction.

Linking healthcare data into one clinical data repository, implementing automated workflows and simplifying communication are tactics that improve in-network care coordination. Physicians engaged in CINs have also seen success with the addition of care coordinators as part of a care team.

Executives recommend hardwiring mechanisms into the CIN’s processes and technology that increase data transparency (Who is going where? What is it costing? What are the outcomes?), educate the community on the benefits of the network and promote a referral system. Moreover, in-network care coordination is distinct from market share in a fee-for-service environment and should be differentiated as such, executives suggest.

“When it comes to costs, there are some procedures that hospitals are going to have to let go of,” said Jill Watson, CEO of the [Kansas City Metropolitan Physician Association \(KCMPA\)](#), part of the Kansas City Performance Group. “For example, we can’t perform a GI procedure in an academic medical center for the same cost as in an outpatient clinic. When you can’t compete, it is better to make those facilities ‘in-network.’”



Post-Acute Care Network Development

True clinical integration between a CIN and selected partners across the entire care continuum is vital to improving value. An integrated PAC network comprised of skilled nursing, rehabilitation, home health services and palliative care is as essential to a successful CIN as the coordination of care across preventive, outpatient and inpatient acute hospital care.

PAC strategies encompassing multiple care sites also require a collaborative network of preferred providers committed to mutual quality, access, experience and cost goals. Executives recommend the following strategies for setting and achieving these goals:

- Apply comprehensive quantitative and qualitative criteria to tease out top performing post-acute partners;
- Engage care management, physicians and other stakeholders in selecting PAC network participants;
- Complete a capabilities assessment for effective management of PAC network; and
- Establish post-acute metrics and an associated scorecard to measure and monitor ongoing performance.

In-network care coordination – the proportion of all care for a given managed population that is retained within a CIN – helps to ensure that the CIN:

- Has total visibility into all care for its patients; 
- Maximizes the impact of the CIN’s clinical transformation initiative;
- Responds to the expectations of healthcare purchasers; and 
- Creates a sustainable path to risk and value-based payment models.

“By providing training about what to do when a patient has, for example, a urinary tract infection, we can help control readmission rates.”

MAYANK SHAH, M.D.
CHIEF MEDICAL OFFICER
PRESENCE HEALTH PARTNERS

Mayank Shah, M.D., chief medical officer at Chicago-based [Presence Health Partners](#), shared his health system’s advantage in the market.

“We own a number of nursing facilities and we’ve focused on two initiatives: using nurse navigators to review acute care hospital charts before transferring patients to skilled nursing facilities, and providing education through our case management-developed sessions to nurses at the nursing home,” said Dr. Shah.

While quality and cost savings are the key drivers, many healthcare leaders will find that expanding the network to include PAC also increases engagement in the accountable care strategy. That level of involvement is fundamental to developing a team approach to patient care.

“We like to review care transitions of every sort,” said KCMHA’s Watson. “We want to get to a point where we analyze every discharge, gather the data and provide it to our physicians.”

Managing Pharmacy Spend

As the fastest growing portion of total cost of care in the U.S. – particularly within commercial populations – the pharmacy is currently under intense scrutiny, both publicly and within health systems.

According to the [Department of Health and Human Services](#), **prescription drugs** accounted for about 16.7 percent of all U.S. healthcare spending in 2015 – or **\$457 billion** – up from 7 percent in the 1990s. Escalating prices for specialty drugs were a major contributor to this inflation, with specialty drug spend estimated at **\$27.1 billion** in 2015, almost twice as high as 2009.

Optimizing pharmacy utilization and adherence through improved collaboration with physicians, pharmacies and health plan partners is vital to the success of any CIN. Overseeing these expenditures responds to major pressure points for payers, employers and consumers, and engages both primary care physicians and specialists in clinical transformation efforts.

“Appropriate management of pharmacy spend can materially impact total cost of care without significant cannibalization risk, all-the-while enhancing quality,” said Dr. Shields. “It’s vital that CINs focus on clinical standardization, management processes and collaboration with pharmacies.”

Use of generic prescriptions, associated with both lower costs and improvements in quality due to increased patient compliance, presents an opportunity for seamless utilization and adherence improvements. Executives also recommend addressing overuse of antibiotics through antimicrobial stewardship programs that reduce resistance and associated costs while improving patient outcomes.

THREE MAJOR OBSTACLES PREVENTING PROVIDERS FROM CIN OPTIMIZATION:

- **Payer Receptivity** – Payers are often unwilling to structure mutually beneficial contracts with networks that offer sufficient upside potential to offset losses in fee-for-service revenue. This is due to the fact that most networks have unproven track records or lack sufficient geographic reach to meet access requirements.
- **Contract Sustainability** – Shared savings models are a transition step to partial or full capitation, which requires organizations to maintain risk-based capital reserves and balance sheets. The financial benefits of shared savings programs are directed at primary care physicians and are inherently short-term, unless they incorporate bundled payments as a means to engage specialists and focus on reducing spend in high-cost procedures.
- **Infrastructure Costs** – Building a network-wide infrastructure that is effective and scalable requires significant capital investment that must be made initially and on an ongoing basis to drive performance. The investment of time and resources is an additional consideration.

ADDITIONAL CIN DEVELOPMENT CONSIDERATIONS

Super CINs

Executives discussed development of CINs spanning multiple organizations, also known as “super CINs,” as a viable alternative to a merger. Focused on long-term value instead of short-term savings, super CINs allow organizations to retain their independence, yet not go it alone in creating the infrastructure and capabilities to more successfully participate in shared savings contracting.

Super CINs are emerging to provide geographic coverage, accumulate a sufficient amount of coverage lives, leverage investments across a broader base, and accelerate clinical transformation efforts through best practice sharing and joint evidence-based medicine guideline development. While super CINs do not mandate a particular approach to care delivery at each organization, increasingly they will seek to improve and standardize results in order to assume greater degrees of risk over time.

Participation in a super CIN should be considered for providers experiencing the following:

- Network is unable to meet the geo-access requirements of payers and employers
- Network is unlikely to secure contracts covering 300K-400K lives given market size and composition
- Payers are refusing to offer sustainable contracts or support infrastructure build
- Health system is reluctant to invest more capital into network’s infrastructure
- Network has struggled to drive performance due to insufficient expert support and best practices

Experienced executives have learned that if super CIN partners improve the value equation to patients and payers, they can also be a desirable partner for employers and payers under mutually beneficial contract terms, such as shared savings and total cost-of-care contracts that include infrastructure payments and administrative funding.

[Integrated Health Network \(IHN\) of Wisconsin](#) – eight health systems with a combined 53 hospitals that care for 85 percent of Wisconsin residents, or more than 2.5 million lives – is one of the first multi-system, clinically integrated accountable care networks in the country. Core work in that super CIN occurs among a clinical integration committee, according to IHN CEO Kurt Janavitz.

“We have been primarily focused on quality initiatives and development of a common suite of metrics, and we’re beginning to focus more intently on total cost of care,” said Janavitz. “It’s essential that all of our members demonstrate benchmark levels of performance on these metrics, as well as improvement over time.”

IHN’s chief information officer (CIO) handles the integrity of the data and all issues around the suitability of the platform, Janavitz added. In addition, a governance committee was formed that includes the CIO and chief medical officer, both of whom are fully-supportive and invested in joint decision making.

“Super CINs have the ability to serve as the accelerators of local member clinical integration programs and enablers of their own global programs, both narrowing and shifting the performance readiness curves of super and local CINs.”

WILLIAM MAYER, M.D., MPH
PRESIDENT & CEO
FEDERATION CARE NETWORK (MICHIGAN)

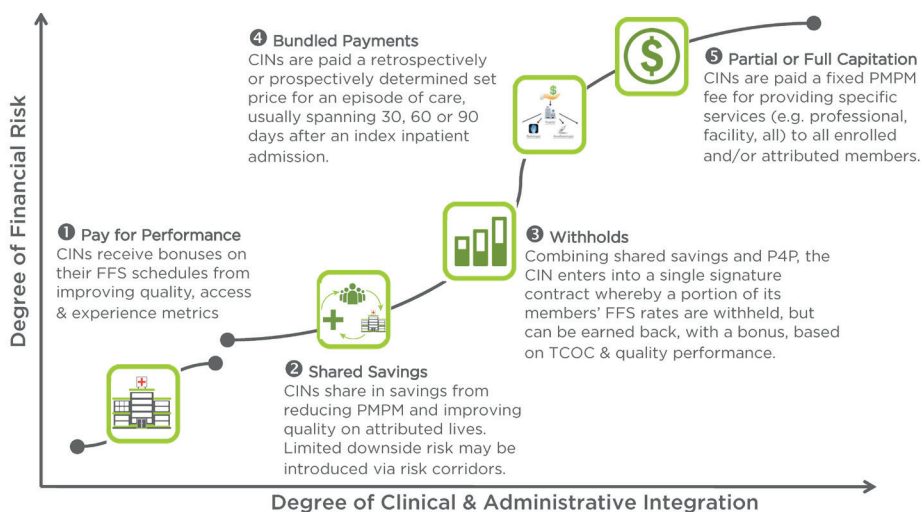
Provider-Sponsored Risk

Taking on provider-sponsored risk – one of the most challenging aspects of value-based care for many providers – is a key element for retaining and enhancing network value. If adopted carefully with the safeguards of risk corridors that expand over time, the assumption of risk can enable CINs to retain the value they create (see Figure 2).

“Assuming risk is crucial in gaining payer interest,” suggests Navigant’s Butts. “It’s also needed to avoid the shared savings trap that can give payers half of the savings, requiring providers to have to beat their own performance year over year.”

FIGURE 2

TO RETAIN THE VALUE THEY CREATE, CINS MUST MOVE UP THE VALUE CHAIN BY ASSUMING INCREASING FINANCIAL RISK



CONCLUSION

As health systems continue to manage the transition from volume to value, many are exploring reorganization into clinically integrated networks (CINs) to enhance the efficiency and effectiveness of the care they deliver.

Provider executives attending a pair of Navigant summits discussed strategies, recommendations and insights they've found to be consistent to developing a successful CIN, including:

- Areas providers should focus on to best manage CIN impact (Physician Engagement, In-Network Care Coordination, Post-Acute Care Network, Pharmacy Spend Management)
- Additional CIN development considerations (Super CINs, Provider-Sponsored Risk)

Summit attendees overwhelmingly agreed that CINs offer a way to organize and deliver care that leads to results, especially as pressure from employers to reduce premiums and the government's expansion of value-based programs continue. Executives were encouraged to continue in their quest to build and expand their clinical network strategies to support continuous development of services that meet the needs of the populations they serve.