Overcoming the Challenges of Launching a Clinical Integration Network (CIN)

A large integrated health care system sought to create a clinical integration network (CIN) to further develop value-based care programs and more specifically align with independent practitioners seeking a closer, value-oriented relationship.

Problem to Solve

A clinical integration network (CIN), sometimes called a clinically integrated network, is a vehicle for physicians to align more closely with health systems and adapt to new reimbursement trends that emphasize value-based payments.

Under the guidance of physician-led governance committees and review boards, a CIN is a specific type of legal arrangement enabling physicians and hospitals to collaborate on improving the quality and efficiency of care, while continuing to operate independently. In today's era of value-based payment models, a CIN typically provides an efficient organizational structure for providers to reduce costs, maintain margins and more effectively manage utilization and population health. A CIN also allows participating physicians who are not ready for hospital employment a means of maintaining their independence.

Starting a CIN can be daunting due to countless legal and regulatory challenges unique to CINs, and the complications of adhering to a CIN's myriad of quality-related requirements. That was the challenge faced by a large integrated health care system that sought to create a CIN to further develop value-based care programs and more specifically align with independent practitioners seeking a closer, value-oriented relationship. To develop

and manage the CIN's quality infrastructure, the health care system turned to Freed Associates (Freed) for assistance.

Strategy and Tactics

The CIN's initial focus was on ambulatory care. Freed consultants worked closely with the organization's director of ambulatory quality and patient safety, and primary care and specialty physician stakeholders, to identify and analyze evidence-based clinical guidelines and implement related quality measures. The project team's work included:

1. **Identifying evidence-based guidelines and associated quality measures** – To support physicians' adherence to evidence-based clinical protocols, reduce care variations and demonstrate clinical integration – per CIN regulatory requirements – the health care system adopted standard, evidence-based guidelines and associated quality measures. Conditions with both high prevalence and cost were identified, and dozens of condition-specific clinical guidelines were analyzed. The team then identified or developed more than 130 quality measures for 10 different specialties covering primary and specialty care. A key selection criterion for a quality measure was its ability to "move the needle" on improving care quality or affordability.
2. **Presenting measures for internal review and approval** – Before the CIN quality measures could be implemented, they were reviewed and approved by the health care system's physician-led governance mechanisms, including a clinical initiatives committee (CIC) and accountable care organization (ACO) board. The team developed tools to support the physicians' presentation of guideline-related information and the recommended quality measures. Feedback from the CIC and ACO board was incorporated into the final quality measures.
3. **Developing quality measure requirements** – After committee review, input and approval, the team developed requirements documentation for each approved quality measure. All components of the measures were noted, based on industry-standard quality measure aggregators such as NCQA (HEDIS, P4P), CMS (PQRS, MIPS, Medicare ACO), specialty societies, and component input from individual physician specialists. The resulting requirements documents contained detailed quality measure criteria and specifications to guide developing new and modified EHR workflows and required reporting. The project team was responsible for ensuring that other enterprise teams had a thorough understanding of the measure specifications.
4. **Reporting measure results** – Once the requirements documents were completed, the team developed a plan to prioritize and manage the training and workflow changes needed leading up to reporting the quality measure results. This centered on creating Epic-based work plans and schedules, including assessing the work needed to design, build and test discrete data capture for quality measure components and developing training materials for physicians and clinical staff.

5. **Preparing for CIN annual review process** – The team created a prioritization/scoring tool. This included specific benefit and feasibility criteria to support the CIN physicians' annual quality measure review and determine if a measure should be maintained, changed or retired for the next measurement year.
6. **Creating an internal communications plan** – Given the importance of keeping participating physicians and other employees informed throughout the CIN implementation process, the team created an internal communications plan. This plan, which kept all pertinent audiences informed along the way, included FAQs, weekly articles, monthly newsletters, and quarterly webinars and CME offerings.

Additionally, the team developed infrastructure tools for quality improvement and activities to support quality assessments. For example, developing a quality improvement (QI) resource compendium consisting of more than 130 QI and condition-specific on-line resources, as well as provider quick reference guides summarizing EMR documentation requirements for key quality measures.

Results

The client implemented its CIN quality program as planned and on-schedule. The team's work translated into analyzing more than three dozen prevalent population conditions, approving and adopting over 130 CIN quality measures across 10 specialties, driving CIN quality measure requirements documentation for Epic IT design and development, developing a scoring tool for annual measure review, and creating and implementing an internal CIN communications plan.

Conclusion

Providers increasingly must be accountable for delivering higher-quality care more efficiently and at a lower cost. By developing and implementing a top-tier CIN infrastructure, the health care system positioned itself to more readily achieve its quality, efficiency and cost-reduction goals and enhance its utilization and population health capabilities. Physicians participating in the new CIN can maintain their independence while also enjoying these same clinical and financial benefits.

