

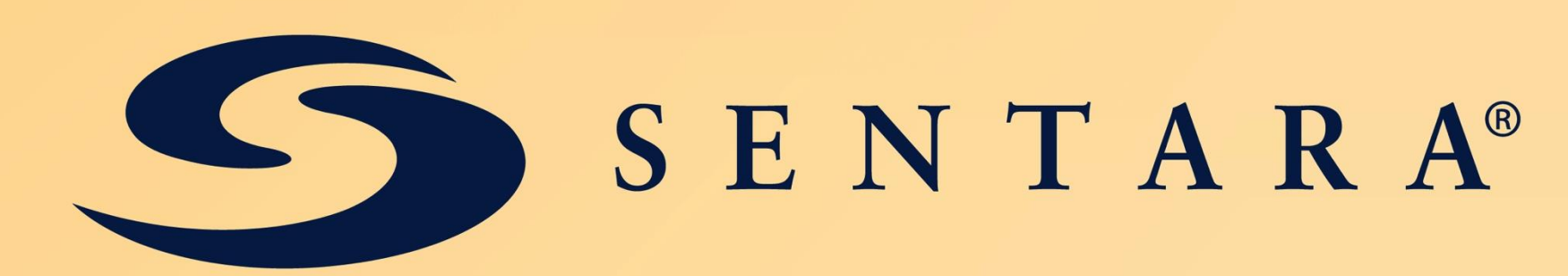


Merging the Players in Population Health:

A story of a CIN (Clinically Integrated Network)

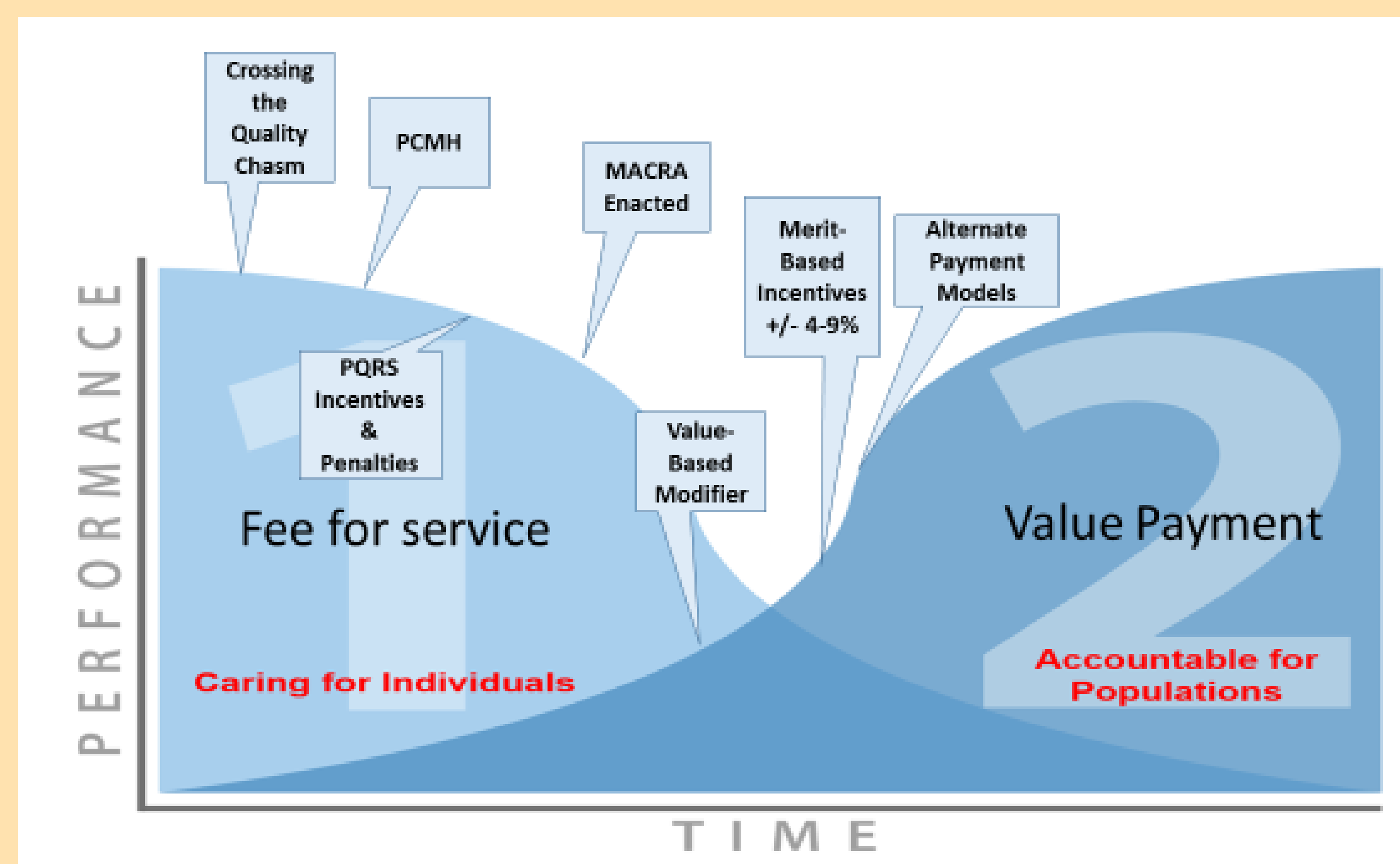
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sentara nurse



Evolution of Healthcare

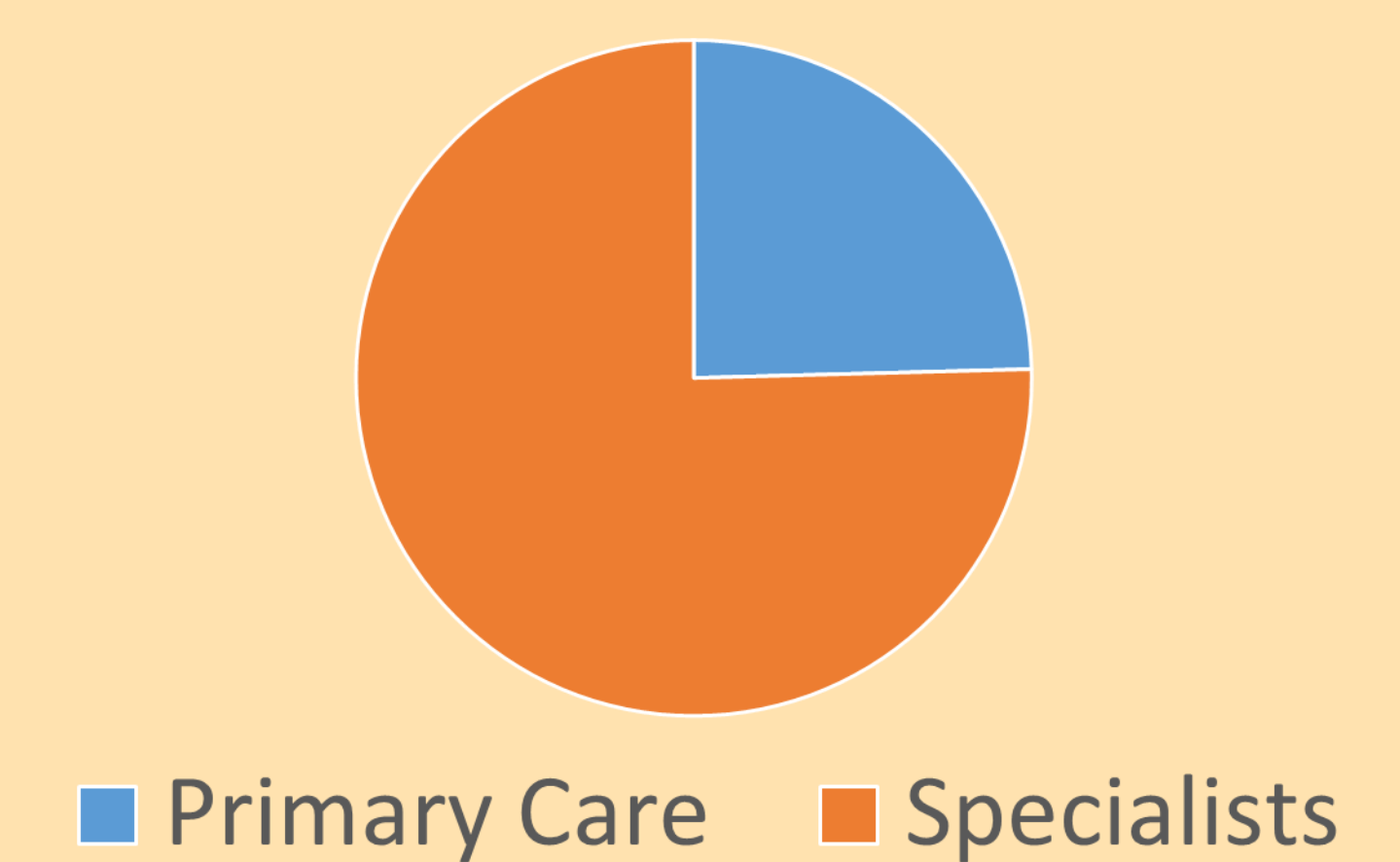
With the introduction of the **Medicare Access & CHIP Reauthorization Act** of 2015 (MACRA), healthcare is moving away from fee for service and toward value-based payment. We are beginning to cross the “chasm” between the diminishing curve of caring for individuals on a volume basis and climbing up the predicted second curve of caring for populations & being reimbursed on a value basis.



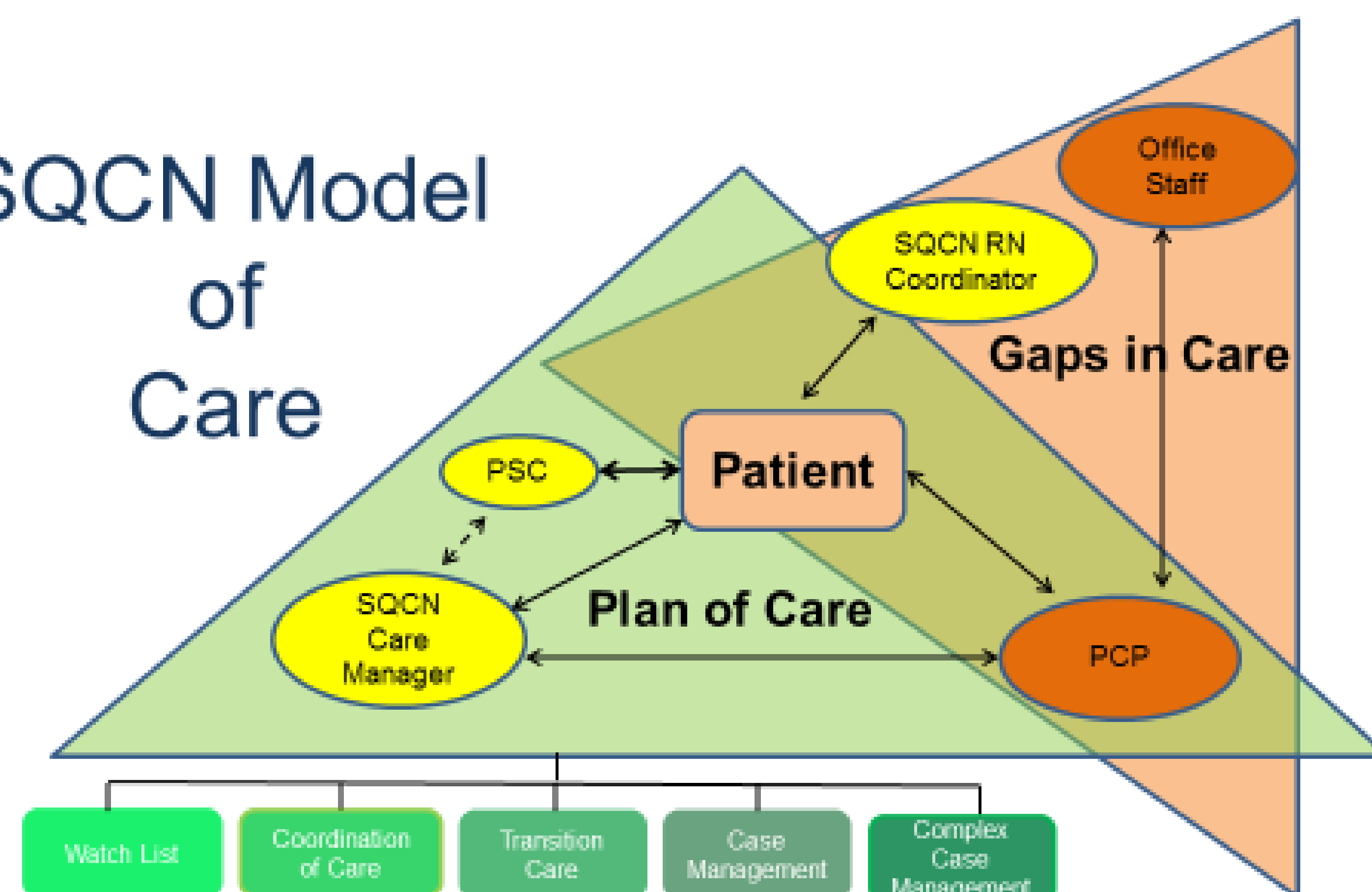
The Story of our Clinically Integrated Network

A Clinically Integrated Network (CIN) is collaboration among a hospital or health system, independent/private practices and employed physicians which fosters interdependence and cooperation among providers and enables them to achieve higher quality and greater cost-effectiveness than they likely could accomplish on their own.

Our CIN is located in four regions of the commonwealth of Virginia.



SQCN Model of Care



CCTM Role Competencies

Competency	RN Quality Coordinator	RN Care Manager
Patient/Population Centered Care	Population	Patient & Family
Teamwork & Collaboration	Providers & staff throughout network, insurer, IT & administration	Providers & staff in assigned practices, Care Managers from insurer and medical group(s)
Evidence-Based Practice	Locating evidence for best practices; Evaluating organizational environment; Protocol development & dissemination	Knowledge of best evidence incorporated into Nursing Care Plans, Patient Interventions & Teaching
Quality Improvement	NCQA, HEDIS, & other quality measures; Network performance on quality dashboard; Practice workflow	Patient adherence & possession ratios; A1C levels in diabetic patients
Safety	Protecting patient PHI	Strategies to reduce risk of harm to self & clients.
Informatics	Assist members in adoption & use of registries & IT platform; collaborate with IT for reports & data maintenance	Effectively communicate across multiple platforms to inform all care team; Utilize decision-support tools to identify & prioritize patients

2014

3 Contracts
30,800 lives
Quality RN (1):
Practice Key Roles,
Onboarding &
Training
Care Managers (2):
Shared, High-
Cost/High Utilizing
Patients

2015

4 Contracts
31,000 lives
Quality RNs (3):
Quality Scorecard
Reports, PI, PQRS
reporting, Access
Survey
Care Managers (4);
Independent,
Predicted risk,
Hospital & ED f/u

2016

6 Contracts
66,500 lives
Quality RNs (3.5):
Quality Scorecard,
Clinical
Workgroups,
Generic Rx, Access
education
Care Managers (7):
Added ULP/Health
Coach, redesigned
outreach,
Documentation
Audits
Member Services
added

2017

8 Contracts
69,000 lives
Quality RNs (3.5):
Quality Scorecard &
transparency of
data, Access survey
& coaching, Total
Cost of Care
Workgroups &
Protocol
development
**Care Managers (6 +
1 ULP):** Targeted
TCOC & high
frequency of
diagnosis in
population, ED & In-
pt coordinated with
other resources