St Johns Care Collaborative

Strategy Summit
February 8-9 2013
St Johns County Physicians and Flagler Hospital

Friday Evening

Welcome
Facilitators
Summarized Agenda and Objectives
Ground Rules

Collaborative Functions
Collaborative Form
Welcome and Introductions: Your Facilitators

Kent Bottles, MD  Allan Field, FACHE

Martie Ross  Jeffrey Ellis

David McMillan  Ellen Brown

Survey Responses
Would you consider participating in a newly formed Clinically Integrated Network?

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73.10%</td>
<td>19</td>
</tr>
<tr>
<td>No</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Need more information to make decision</td>
<td>26.90%</td>
<td>7</td>
</tr>
</tbody>
</table>

Survey results as of 9:00am February 7, 2012

Do you agree the rapidly changing health care system requires greater collaboration between our community's hospital and its physicians?

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>90.00%</td>
<td>27</td>
</tr>
<tr>
<td>Disagree</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td>Uncertain</td>
<td>10.00%</td>
<td>3</td>
</tr>
</tbody>
</table>

Survey results as of 9:00am February 7, 2012
Do you feel that scores on payer imposed quality metrics, such as the Medicare value-based purchasing modifier, will impact your access to patients and reimbursement in the future?

Survey results as of 9:00am February 7, 2012

How would you rate your personal understanding of new Value Based Reimbursement models?

Survey results as of 9:00am February 7, 2012
How would you rate your personal understanding with clinically integrated networks?

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Understanding</td>
<td>10.00%</td>
<td>3</td>
</tr>
<tr>
<td>Average Understanding</td>
<td>46.70%</td>
<td>14</td>
</tr>
<tr>
<td>Very Limited Understanding</td>
<td>43.30%</td>
<td>13</td>
</tr>
<tr>
<td>Not Interested</td>
<td>0.00%</td>
<td>0</td>
</tr>
</tbody>
</table>

Florida ACOs

- **PIONEER ACOS**
  - One (1) system

- **MSSP ACOS: JULY, 2012**
  - Ten (10) Systems

- **MSSP ACOS: JANUARY, 2013 START DATE**
  - Fourteen (14) Systems

- **Commercial ACO’s**
  - Two (2) Clinically Integrated Networks
  - Two (2) Commercial ACO’s
  - One (1) Newly Announced ACO
Collaborative Function

Martie Ross
Allan Field
February 8, 2013

Clinical Integration

• Providers accountable to each other and to community to deliver high-quality care in efficient manner
  • Collectively define and enforce standards of care
  • Coordinate patient care
• Crucial strategy for population health management
Clinically Integrated Network

- Lean infrastructure to support provider accountability
- Vehicle for independent providers to jointly negotiate with payers
  - Access to patients
  - Access to payment
  - Access to actionable information
- Inevitable, not optional (probably)

Participation Agreement

- Individual providers join a CIN by signing a participation agreement
- Terms of agreement established by CIN governing body
  - Parties’ respective rights and responsibilities
  - Demonstrates CIN legitimacy to payers
- Compliance with agreement terms
CIN Functions

• Core functions
  • Promote evidence-based medicine
  • Facilitate care coordination
  • Negotiate and manage payer contracts
  • Additional support services

Promote Evidence-Based Medicine

• EBM = integrating individual clinical expertise with the best available external clinical evidence from systematic research

• Clinical protocols
  • Identify (prioritize)
  • Implement (education, technology solutions)
  • Monitor (reporting on quality measures)
  • Remediation
  • Corrective action
Facilitate Care Coordination

- Identify high-risk, high-cost patients
  - Disease registries
  - Data analytics
- Aggressive interventions
  - Patient navigator
  - Remote monitoring
  - Transitional care management
  - Health information exchange

Manage Payer Contracting

- Standard fee schedule
- Narrow networks and Tiered benefit plans
- Pay for performance
  - Shared savings programs
- Bundled payments
- Centers of Excellence
- Global budgets
Shared Savings Programs

Key Contract Terms

- Identify parties to contract
- Define population/patient attribution
- Calculate total-cost-of-care benchmark
- List quality metrics
- Set out minimum performance standards
- Specify savings percentage

Shared Savings Program Performance

- Providers continue to bill fee-for-service
- Track performance on quality metrics
- Calculate payer’s actual total cost of care
- Actual – benchmark = savings
- Payer pays CIN percentage of savings
- Adjust benchmark, start over
Shared Risk Programs

• Variation on shared savings
  • One Sided - If actual costs exceed benchmark, CIN not liable for difference
  • Two Sided - If actual costs exceed benchmark, CIN is liable for difference
    • Eligible for greater share of savings
  • Window of opportunity on One Sided shared savings is closing

Allocation of Rewards

• Participant buy-in
• Easy to understand, implement
• Recognize all patients not created equal
• Incentives for evidence-based medicine, care coordination
Pool Allocation

- Three pools: PCP, specialists, and hospital
- Example: Allocation by financial performance
  - Allocate total claims target by type of service category
  - Compare allocated target amounts to actual claims by type of service

Example Pool Allocations

- Savings by type of service can be allocated to various pools using percentages such as those presented below

<table>
<thead>
<tr>
<th>Pool</th>
<th>IP</th>
<th>OP</th>
<th>PCP</th>
<th>Specialist</th>
<th>RX</th>
<th>Ancillary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>30-60%</td>
<td>30-60%</td>
<td>0%</td>
<td>0-10%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>PCP</td>
<td>15-30%</td>
<td>15-30%</td>
<td>100%</td>
<td>20-50%</td>
<td>50-75%</td>
<td>25-75%</td>
</tr>
<tr>
<td>SCP</td>
<td>10-25%</td>
<td>10-25%</td>
<td>0%</td>
<td>30-60%</td>
<td>25-50%</td>
<td>25-60%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Milliman Healthcare Reform briefing paper; Published January 2012.
Minimum Thresholds

- Quality measures
- “Good citizenship” requirements (examples)
  - Specialty-specific CMEs
  - Use of Category II codes
  - Use of registry
  - Engagement with med management staff
  - Committee participation/attendance
  - Generic Rx utilization

Primary Care Physicians

- Incentives to effectively manage patient care
- Example: Allocation based on individual PCP patient population’s actual total cost of care vs. risk-adjusted target
Specialists

- Incentives to provide high-quality care in cost-effective manner
- Examples
  - Value-based purchasing modifier
  - Risk-adjusted patient volumes
  - Cost per episode of care

Specialists

- Financial rewards for services to CIN
  - Defining appropriate use criteria for referral to specialists
  - Specifying appropriate indications for diagnostic and therapeutic interventions
  - Establishing performance measures related to specialty care
  - Developing innovative solutions to enhance communication between PCPs and specialists
- Future benefits through bundled payments, Centers of Excellence
Hospital

• Incentives to improve operations in manner that generates savings
  • Readmission rates, never events, infection rates
  • ER visits, admissions through ER
  • Appropriate use of diagnostic tests
  • Return on CIN investment

Other CIN Functions
Physician Practice Support Services

• Back-office functions
• Group purchasing
• HR/staffing
• Physician value-based purchasing
• ICD-10 transition and compliance
• HIPAA Privacy and Security Rule compliance
• Patient-centered medical home accreditation
Other CIN Functions

- Patient engagement strategies and tools (e.g., shared decision-making)
- Clinical co-management and gainsharing opportunities
- Bundled payments for specific episodes of care (e.g., surgical procedures, maternity)
- Centers of Excellence (by service line)
- Develop and market health plan (e.g., hospital employee health plan, Medicare Advantage)

Collaborative Form

Jeff Ellis
Allan Field
February 8, 2013
What is the greatest barrier to better cooperation between the hospital and community physicians?

Survey results as of 9:00am February 7, 2012

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of trust of hospital</td>
<td>20.00%</td>
<td>6</td>
</tr>
<tr>
<td>Lack of trust among physicians</td>
<td>20.00%</td>
<td>6</td>
</tr>
<tr>
<td>Time and effort to create solutions</td>
<td>43.30%</td>
<td>13</td>
</tr>
<tr>
<td>Expense of creating solutions</td>
<td>10.00%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>6.70%</td>
<td>2</td>
</tr>
</tbody>
</table>

What is the greatest barrier to better cooperation among physicians in the community?

Survey results as of 9:00am February 7, 2012

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of trust of hospital</td>
<td>20.00%</td>
<td>6</td>
</tr>
<tr>
<td>Lack of trust among physicians</td>
<td>20.00%</td>
<td>6</td>
</tr>
<tr>
<td>Time and effort to create solutions</td>
<td>43.50%</td>
<td>13</td>
</tr>
<tr>
<td>Expense of creating solutions</td>
<td>10.00%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>6.70%</td>
<td>2</td>
</tr>
</tbody>
</table>
How Structure Facilitates the Organization’s Function

• Provides structured environment for discussion and decision
• Promotes trust and transparency
• Balances power among diverse participants
• Protects individual rights and concerns
• Facilitates joint decision-making in a safe environment

Key Elements of an Effective Structure

• Balanced time/energy/economic investments by participants
• Balanced voting rights/ reserved powers for participants
• Shared vision and goals while recognizing “sacred cows” to be protected
• Formal, but flexible and adaptable, rules of operation
• Provides fair opportunity for participants to engage and be heard
• Allows for organizational change/growth to address evolution of function
Straw Man Organizational Structure

- What is the best way for physicians to enter a business relationship with the hospital?
  - As individuals
  - As practice groups
  - By specialty

In your opinion, how important is it for the physician community to establish a separate organization in order for the physicians to effectively deal with the hospital in a Clinically Integrated Network?

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly Important</td>
<td>46.70%</td>
<td>14</td>
</tr>
<tr>
<td>Somewhat Important</td>
<td>43.30%</td>
<td>13</td>
</tr>
<tr>
<td>Not Important at all</td>
<td>6.70%</td>
<td>2</td>
</tr>
<tr>
<td>I am Indifferent</td>
<td>3.30%</td>
<td>1</td>
</tr>
</tbody>
</table>

Survey results as of 9:00am February 7, 2012
If such a physician organization is important for physicians, are you willing to invest time, energy, and money in that organization to make it functional and effective?

<table>
<thead>
<tr>
<th>Value</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>96.70%</td>
<td>29</td>
</tr>
<tr>
<td>No</td>
<td>3.30%</td>
<td>1</td>
</tr>
</tbody>
</table>

Surveys results as of 9:00am February 7, 2012

Straw Man Organizational Structure

- Is a separate physician organization useful, desirable, necessary?
- If so, how should it be structured and governed?
- How will it facilitate the establishment of a trusting relationship among physicians and between physician and the hospital?
- How can the physicians relate to the hospital if no PO is formed?
• What is the purpose of the PHO?
• How should it be structure and governed?
• How will it facilitate the establishment of a trusting business relationship between the hospital and participating physicians?

• How can a committee structure help the entire organization to perform its functions?
## Questions for Consideration

<table>
<thead>
<tr>
<th>Critical Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Should physicians participate in the CIN directly or through a separate physician organization (&quot;PO&quot;)?</td>
</tr>
<tr>
<td>2. If a PO is preferred, how should the PO's Governing Board members be chosen?</td>
</tr>
<tr>
<td>3. How should the CIN Governing Board be chosen?</td>
</tr>
<tr>
<td>4. With what authority should the CIN be vested? Should the authority be at the PO or PHO?</td>
</tr>
<tr>
<td>5. What rights should be reserved by physicians?</td>
</tr>
<tr>
<td>6. What rights should be reserved by the Hospital?</td>
</tr>
<tr>
<td>7. What matters should require supermajority vote?</td>
</tr>
<tr>
<td>8. How should supermajority votes be accomplished?</td>
</tr>
<tr>
<td>9. What tasks should be assigned to committees, study groups, and/or task forces?</td>
</tr>
</tbody>
</table>