



From Zero to CIN

How a Community Hospital and Local Physicians Built a Clinically Integrated Network in Less than Nine Months

December 2013



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Flagler Hospital is a non-affiliated 335-bed acute care hospital in St. Augustine, Florida. Most of the physicians on the hospital's 250-member medical staff are in small, independent practices.

In the time BC (before CIN), the doctors related to the hospital and to each other in the traditional medical staff fashion. Except for the formal medical staff structure, there was no forum to share ideas or consider common strategy among hospital and physician leaders. There was little trust on which to build broader clinical or economic relationships.

Like most hospital governing bodies, Flagler's Board of Directors faced the challenges of foretold revenue reductions, threatened competition from nearby metropolitan health systems, and uncertainty about healthcare reform.

At the same time, payers and local employers were offering new opportunities. Payers proposed new contracts with innovative incentives: pay-for-performance rewards; network access fees; and shared savings payments. Leading employers were looking to the hospital for leadership on strategies to reduce their costs, including comprehensive employee wellness programs.

Board Leadership

Through facilitated strategic planning, Board members came to understand that closer alignment between the hospital and community physicians was essential to meeting these challenges. Board members observed:

- Declining revenue highlighted the need for cost controls requiring medical staff participation and changes in physician behaviors. The hospital and the physicians shared a common interest in protecting the market from outside control.
- The challenges of healthcare reform, as well as payers' and employers' push for new payment models, demanded coordination and collaboration among all community providers.

Hospital leaders refused to bury their heads in the sand. With PYA's assistance, Board members and hospital administration became educated and began envisioning a new future for the hospital.

At the dawn of that new future, the Board made the brave decision to invite and empower the physicians to lead the process of developing a clinical integration strategy. The hospital assumed the costs associated with this process (including stipends paid to physicians to compensate for their time and effort) and directed Administration to provide facilitation.

Clinical Integration Committee

The Board enlisted several recognized physician leaders (not necessarily the then-existing medical staff leadership) to serve as the Board's Clinical Integration Committee (CIC). The Board charged the CIC with presenting detailed recommendations on how the hospital and community physicians could form and operate a successful clinically integrated network ready to contract with payers by August 2013.

The initial CIC members, supported by a PYA physician executive, educated themselves about the key characteristics and functions of a clinically integrated network. Next, the CIC sponsored education sessions for all community physicians on changing market conditions that demanded hospital-physician integration. Again, PYA facilitated, providing presenters and collateral materials.

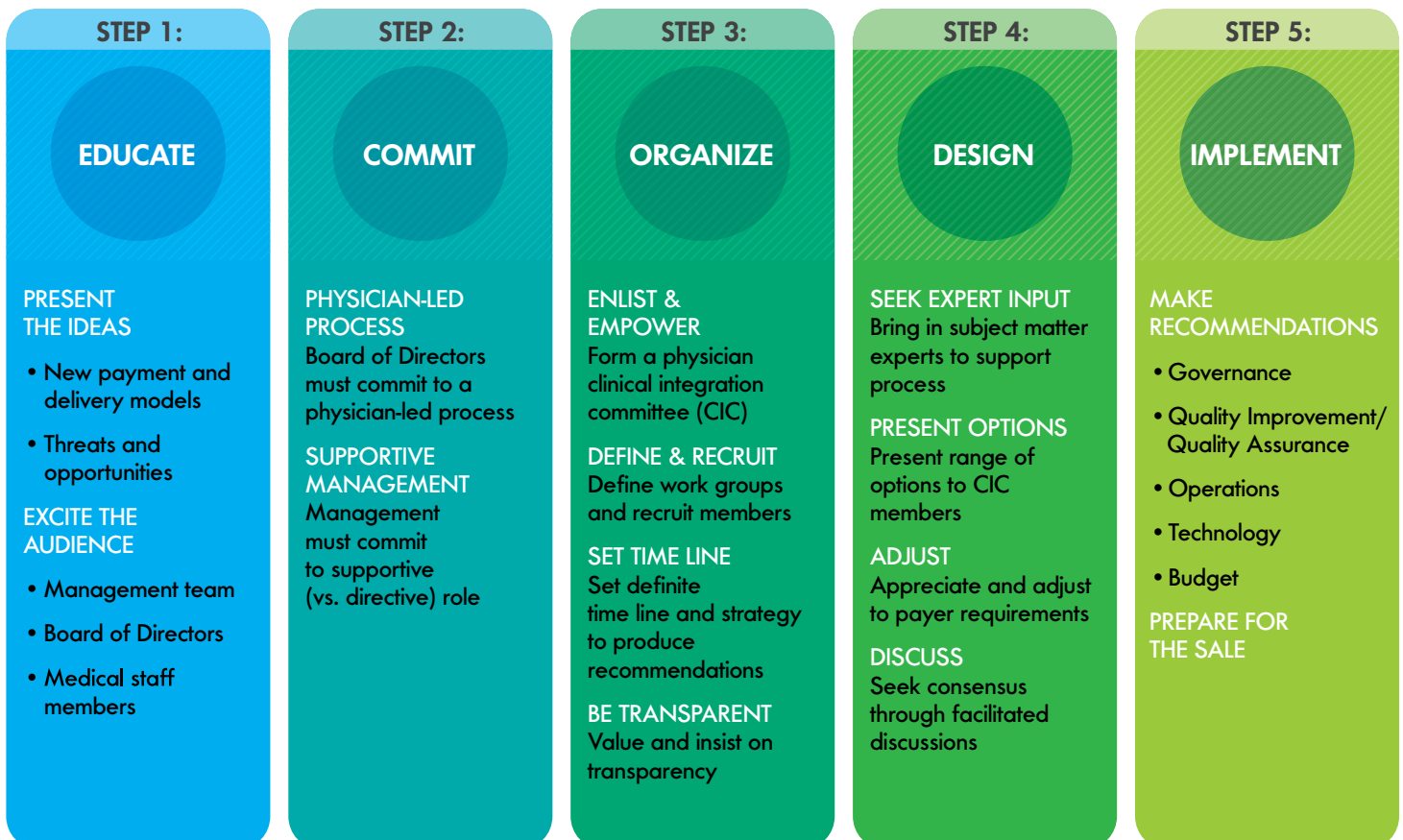
The organize-to-operate timeline began with these education sessions in November 2012. It allowed nine months to achieve success. This tight timeline, driven by payers' insistence on new payment models (and a

desire for the CIN to participate in the Medicare Shared Savings Program in 2014) turned into a blessing rather than the anticipated curse because it kept all parties intensely focused on the process.

The CIC saw the need for broader physician participation, and thus created five workgroups, comprised of physicians and supported by hospital administration, to support its efforts: Governance; Quality/Operations; Technology; Communications/Network Development; and Finance. PYA assisted in drafting detailed workgroup charters and facilitating each of the initial workgroup meetings in January 2013.

Early on, CIC members recognized that the strength of a CIN depends on whether physicians trust the organization to address their common concerns while respecting their individual interests. Building this trust requires a carefully crafted balance of power reflected in the CIN's governance structure.

FIVE STEPS TO A CLINICALLY INTEGRATED NETWORK



The Summit

Embracing this challenge, CIC and workgroup members - nearly 50 physicians - committed to a two-day, off-site summit to discuss, debate, and reach consensus on the CIN's governance structure. In advance of the summit, PYA developed, disseminated, and analyzed the results of an electronic survey which assessed the opinions of all medical staff members on CIN participation and structure.

Armed with this data, PYA consultants organized the summit, prepared background materials, and facilitated (and, on occasion, refereed) the physicians' discussions during the two-day event.

PYA consultants did not present a "fill-in-the-blank" organizational model. Instead, they helped the physicians develop several options, highlighting the pros and cons of each. They listened carefully to physicians' comments and concerns, and suggested modifications designed to address those concerns.

By the end of day two, the physicians in attendance reached consensus on a CIN governance structure. That consensus created a sense of ownership and commitment to the continuing process. The physicians left the summit believing in the possible, overcoming their doubts and reservations about working with one another and with the hospital.

Work Groups

For the next six weeks, each CIC workgroup discussed and developed its specific recommendations regarding the CIN's form and functions, with guidance and support from the PYA consultant assigned to that workgroup.

- **Governance** - crafted a detailed organizational chart for the jointly owned Physician-Hospital Organization (PHO) that would operate the CIN; reviewed, revised, and approved the PHO's draft operating agreement, subscription agreement, and participation agreement; and developed an election process to select the PHO's initial Board of Directors.
- **Quality/Operations** - defined a process to establish and enforce demanding standards of care and to support robust care coordination activities among CIN participants; explored opportunities for hospital efficiencies and physician management services; detailed PHO strategic planning needs; and specified PHO's staffing needs.
- **Technology** - identified the CIN's technology needs and related budget; developed a request for proposal (RFP) and a schedule for IT solution implementation.
- **Communications/Network Development** - devised a medical staff education and recruitment strategy.
- **Finance** - prepared financial projections for the first three years of the CIN's operations with anticipated expenses and income derived from PHO participation fees, shared savings, and network access fees (including participation in the Medicare Shared Savings Program, private payer initiatives, and direct contracting with employers).

FIVE KEY LESSONS LEARNED:

- 1 Get to the starting line through education. A common understanding of the need for clinical integration is the CIN building permit.
- 2 Be brave and empower the physicians to lead the process.
- 3 Focus first on building trust. The rest will follow.
- 4 Get everyone in the same room. Set the expectation that they own the process.
- 5 Push through the details. A grand scheme is important, but a step-by-step implementation plan turns that scheme into reality.

Once finalized by the workgroups, PYA collated these recommendations into a report for review and approval by the full CIC. Following a lengthy meeting with spirited but respectful discussion (again facilitated by PYA), the CIC voted unanimously to recommend the report to the Flagler Board of Directors.

Back To The Board

At the hospital Board's next meeting, CIC members presented the final report and answered questions from Board members. The Board voted unanimously to accept the physicians' recommendations and to commit the financial resources necessary to operationalize them.

In four short months, physicians who previously had shared little economic or clinical interests built consensus around a detailed plan to form a PHO and

operate a CIN in partnership with each other and the local hospital, with which they had little to no pre-existing business relationships.

The hospital and community physicians became educated about coming changes to the healthcare payment and delivery system, and then accepted the challenge to improve quality and enhance efficiency through collaboration.

Getting Off the Ground

Following Board approval in April 2013, a flurry of activity ensued. Nominations were opened for the seven physician seats on the PHO's governing body, and more than 20 physicians threw their hats in the ring.

All active medical staff members were invited to sign a letter of intent to participate in the CIN. More than half of them did so, each receiving the right to vote for the PHO's initial physician board members. The hospital elected its CIN Board representatives, including a community representative.

In conjunction with those elections, final arrangements were made to formally incorporate the PHO and commence its operations. At this point, the hospital and the physicians were advised by separate legal counsel regarding finalization of the corporate documents developed through the collaborative process; i.e., the PHO's operating agreement, the subscription agreement, and the hospital and physician participation agreements.

Upon completion of that process, both the physicians and the hospital were confident they could embark on this new endeavor knowing their respective individual interests were legally protected.

In early June 2013 - just seven months after the first education session was conducted for medical staff members - First Coast Health Alliance (FCHA) (the name the parties selected for their PHO), conducted its organizational meeting.

With PYA facilitation, the FCHA board approved the organizational documents, elected officers, appointed committee chairs, adopted a conflicts-of-interest policy and compliance plan, approved a CIN physician recruitment plan, received an update on the technology RFP, and reviewed several payer opportunities.

By early July, FCHA had hired a full-time executive director, responded to an RFP from the local school district to provide a comprehensive wellness program, and commenced conversations with other private payers. FCHA also was aggressively recruiting additional physicians to join the CIN.

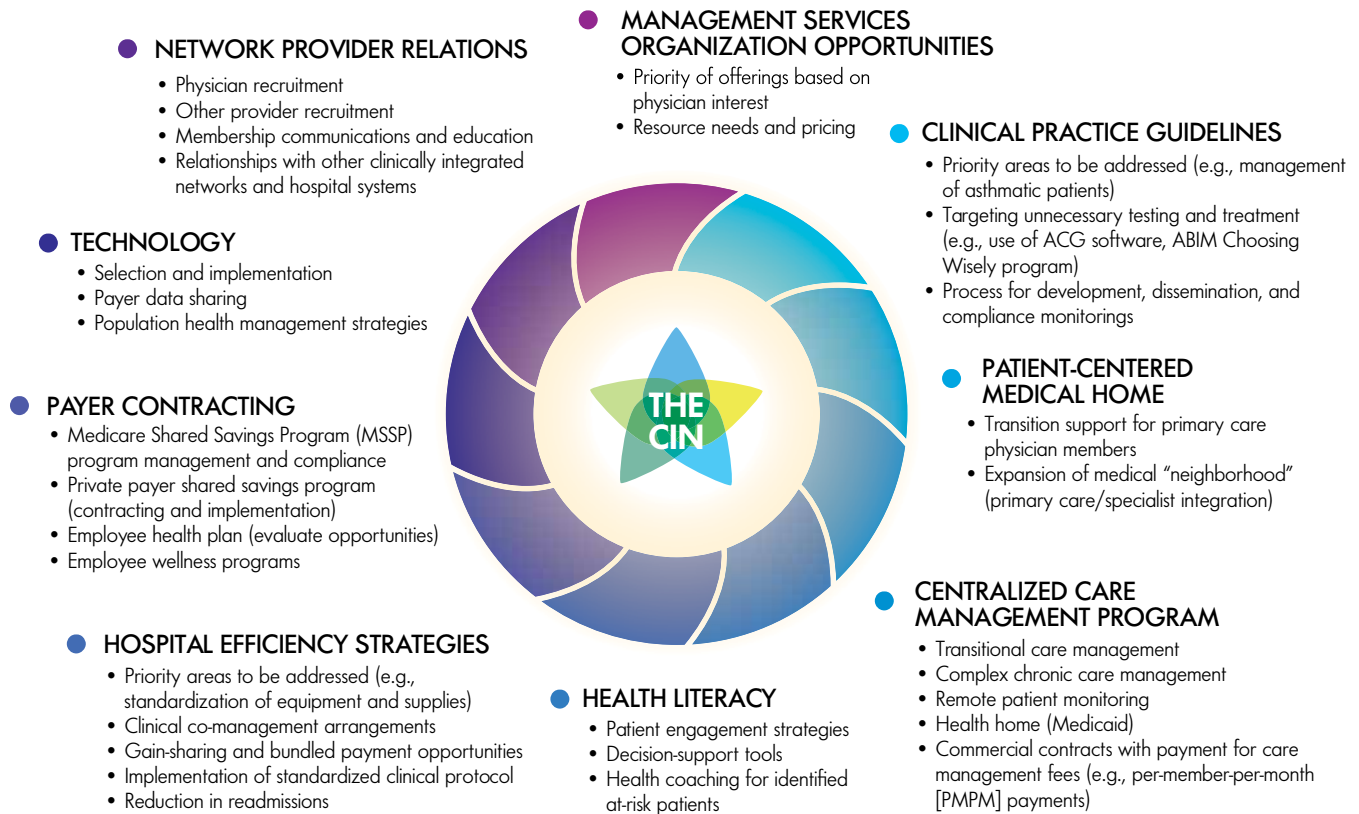
By the end of July, FCHA, with PYA's technical support, had submitted its application to participate in the Medicare Shared Savings Program as an Accountable Care Organization. By then, its membership ranks had swelled to nearly 200 physicians. Full committees had been appointed and had set themselves to work implementing the recommendations in the Board-approved CIC report.

“PYA's expertise in organizational formation and operations, and their knowledge of healthcare reform has allowed us to accomplish an amazing amount of progress in a short period of time.

”
-John Franks
Executive Director
First Coast Health Alliance

What's Next

Building the CIN is only the first step in a long process. FCHA participants now must operationalize the network by pursuing the following opportunities:



Final Thoughts

Despite all of the buzz around hospital-physician alignment and clinical integration these days, finding a starting point for network development can be a real challenge. One should not underestimate the effort involved in fostering a culture of trust. Enlisting the assistance of an honest broker - someone who can help build and maintain lines of communication between and among physicians and hospital executives - can help meet this challenge.

That same honest broker can present a straw man to which the parties can react, rather than starting from scratch in building their network. And, finally, that broker can develop and implement work plans for network development and deployment. These services are essential, given everyone involved already has a full-time job and little time to manage such a significant undertaking.

PYA consultants have the skills, creativity, and experience to get you beyond preliminary discussions and into real collaborative planning and implementation.

Questions about CINs?

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