AGENDA

Drivers
Why is the Market Moving Toward Clinical Integration Networks?

Definition
What is a Clinically Integrated Network and How Does It Work?

Pacers
How Fast Do We Need to Move Toward Clinical Integration Networks?

Model Options
Given the Drivers and Pacers, What Are Our Options?

Action Plan
How Do We Assess the Need for Clinical Integration Networks?
Key Trends in Healthcare

- **Fee-for-Service**
  Providers paid a specified amount for each service provided.

- **Pay-for-Performance**
  Incentives for higher quality measured by evidence-based standards.

- **Value-based Purchasing**
  Percentage reimbursement at risk, earned back by high quality outcomes.

- **Bundled Payments**
  Single payment for episodes of treatment, shared by hospital and physicians.

- **Shared Savings**
  Percentage of savings from reduced cost of care shared with hospitals and physicians.

- **Global Payments**
  All services compensated in one payment that manages the patient across the delivery system.

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**Risk Shift**

- Consumers
- Employers
- Health Plans
- Government Payers

- Physicians
- Medical Groups
- Hospitals
- Other Providers

Source: HFMA 2010 The Advisory Board 2010
Moving from Volume to Value

- **Volume-Driven Health Care**
  - High quality, low cost
  - Encourages care coordination
  - Right care, right place, right time
  - Patient centered
  - Rewards health and prevention

- **Value-Driven Health Care**

Source: Sg2
• Preserve / Improve Market Position
• Enhance Care Coordination
• Eliminate Waste and Inefficiencies
• Standardize Protocols and Care Pathways
• Reduce Variance
• Define, Measure and Report Quality
• Manage Utilization
The Price for Failing to Take Advantage of an Opportunity

We will miss a key element in moving from leader to market dominance.
We will miss a key element in moving from first class to leader.
We will miss a key element in moving from midstream to first class.
We will miss a powerful paradigm shift in the way we operate.
We will miss receiving a key element in the future success of the entire operation.
We will miss a cornerstone to the overall business strategy.
We will miss a major competitive distinction.
We will miss a powerful strategic advantage.
We will miss a significant strategic advantage.
We will miss a slight strategic asset.
We will miss a powerful tactical advantage.
We will miss a significant tactical advantage.
We will miss a slight tactical asset.
We will miss something pleasant and rewarding.
We will miss something interesting and enjoyable.
The Price for Failing to Solve a Problem

Recovery will be impossible.
We will lose everything we consider important.
Recovery will be possible but unlikely.
We will lose most of what we consider important.
Recovery will be a long, expensive process.
We will lose something very valuable to us.
We will have to shift our entire way of operating.
We will have to rearrange many of our plans for the future.
The price will be terribly expensive.
The price will be extremely difficult to pay.
The price will be difficult to pay.
The price will not be easy to pay.
The price will be more than we want to pay.
It will prevent us from pursuing something else that’s important to us.
The price will be a long-term hassle.
The price will be mild irritation.
The price will be brief discomfort.
The Process of Change

1. Establishing a sense of urgency
2. Creating the guiding coalition
3. Developing a vision and strategy
4. Communicating the change vision
5. Empowering broad-based action
6. Generating short term wins
7. Consolidating gains and producing more change
8. Anchoring new approaches in the culture
9. *Celebrating successes
Change Readiness Curve

Strategic Readiness

- Low Urgency: Been Here Before
- High Urgency: Major Change is Essential
- Medium Urgency: Focused Change is Necessary

Urgency (Opportunity or Burning Platform)
Leading Change – Right of Passage

Major Change is Essential

Focused Change is Necessary

Been Here Before

Urgency (Opportunity or Burning Platform)
Components of a Clinically Integrated Network

- Structure & Governance
- Infrastructure & Funding
- Physician Leadership
- Participation Criteria
- Performance Objectives
- Information Technology
- Distribution of Funds
- Contracting

Clinically Integrated Network
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“Why is the Market Moving Toward Provider Networks?”

DRIVERS
Employers and Payors searching for strategies to address top 10%

Concentration of Health Care Spending in the US Population, 2009

Percent of Total Health Care Spending

- Top 1%: 21.8%
- Top 5%: 49.5%
- Top 10%: 65.2%

Percent of Population, Ranked by Health Care Spending

- Top 1%: $51,591/yr
- Top 5%: $17,402/yr
- Top 10%: $9,570/yr

Payor mix and lack of rate parity will drive new strategies

Payor mix:
- BCBS: 48%
- Aetna: 12%
- Cigna: 13%
- UnitedHealthcare: 27%
- Kaiser: 100,045
- Other: 92,215
- Commercial: 60,496
- Medicaid Beneficiaries: 58,612
- Uninsured: 49,862
- Medicare Eligible: 100,045

Source: Kaiser Family Foundation
Driving Forces for Alignment

Hospital Objectives
- Gain Market Advantage for Growth Strategy
- Stabilize Market / Secure Access
- Transform Care Delivery
- Strengthen Financial Position

Physician Objectives
- Stabilize Income from Declining Reimbursement
- Secure Patient Capture / Referral Network
- Improve Work-Life Balance
- Private Practice Exit Strategy
Alignment Models & Reform Era Imperatives

All hospital-physician alignment models achieve some of the key objectives of alignment. However, Clinical Integration is the only model that allows organizations to accomplish all of the objectives.

<table>
<thead>
<tr>
<th>Alignment Model</th>
<th>Leverage Stakeholder Strengths</th>
<th>Manage the Care Continuum</th>
<th>Embrace Reimbursement Risk</th>
<th>Reshape the Value Curve</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO</td>
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<tr>
<td>IPA</td>
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<td>PCMH</td>
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<td>Co-Management</td>
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<td>Employment/Enterprise</td>
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<tr>
<td>Clinical Integration/HEP</td>
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</table>

☐ No Achievement  ☐ Partial Achievement  ☐ Full Achievement
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What is a Clinically Integrated Network and how does it work?
A Clinically Integrated Network (CIN) is a selective partnership of physicians collaborating with hospitals to deliver evidence-based care, improve quality, efficiency, and coordination of care, and demonstrate value to the market.

### Clinically Integrated Network

<table>
<thead>
<tr>
<th>Payors and Employers</th>
<th>Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>CI Entity</td>
<td>$</td>
</tr>
<tr>
<td>Participation Agreement</td>
<td>$ Distribution of Funds</td>
</tr>
</tbody>
</table>

**Benefit to Stakeholders**

**Physicians**
- Preserving private practice model through alignment
- Enhanced reimbursement through contracting for demonstrated network quality

**Markets and Hospitals**
- Align independent, employed, and specialist physicians in one organization
- Enhanced reimbursement under FTC guidelines for demonstrated quality

**What It’s Not**
- Physician employment
- Hospital-led initiative
- Mechanism to gain negotiating leverage over payors
## FTC Perspective on Clinically Integrated Networks

<table>
<thead>
<tr>
<th>FTC Regulation</th>
<th>Definition of Clinical Integration</th>
<th>Indicia <em>(Probability)</em> of Clinical Integration</th>
</tr>
</thead>
</table>
| **Price Fixing:** unreasonable constraint of competition | - An *active and ongoing program* to *evaluate and modify practice patterns* by providers  
- A high degree of interdependence and cooperation among *select providers* to control costs and ensure quality?  
- Network providers *demonstrate cooperation and interdependence* in providing care?  
- A commitment *to reduce costs, improve quality and increase efficiency*? | 1. Use of common information technology to ensure exchange of all relevant patient data  
2. Development and adoption of clinical protocols  
3. Care review based on the implementation of protocols  
4. Mechanisms to ensure adherence to protocols. |

**Market Power:** monopolization of a market
Components of a Clinically Integrated Network

- Structure & Governance
- Infrastructure & Funding
- Participation Criteria
- Performance Objectives
- Physician Leadership
- Information Technology
- Contracting
- Distribution of Funds

Clinically Integrated Network
Clinical Integration Network Objectives

1. Develop a network that includes independent physicians in the market
2. Provide a mechanism to align the clinical practices of physicians across service lines
3. Identify areas of opportunity within the system for quality and efficiency improvements
4. Provide compensation for achieved results
5. Improve the value equation (cost and quality) for healthcare delivered within the network
CIN REVENUE & FUNDING SOURCES

Reporting Incentives and Membership Fees
- Initial Investment
- Membership Fees
- PQRS Reporting

Hospital Efficiency Program (HEP)
- Serious Complications
- Throughput
- Reduction in Variation
- Pharmacy Management

Payer Contracts
- Increase FFS
- Quality Metrics
- Shared Savings

Self Funded Health Plan
- Administrative Fee
- Quality Metrics
- Shared Savings

Pay-for-Performance
- Quality Metrics
- Efficiency
- Health Risk Assessments

Employer Contracts
- Narrow Network
- Shared Savings

1-2 Years 2-3 Years 3+ Years
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“How Fast do we need to move toward Provider Networks?”
Market Pacing

Static Market A: Slow Pace of Change

Dynamic Market B: Fast Pace of Change
Network Drivers

Risk-based Payment

Declining FFS market will require network model to meet Reform Era Imperatives

Local Market Conditions will Impact Timing of Network Development

FFS

Financial Performance

Time
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOSPITAL PROFILE</strong></td>
<td>Location, access, inpatient volume and market share, EBITDA, profit margin, quality scores, asset distribution, IT infrastructure, etc.</td>
</tr>
<tr>
<td><strong>MARKET CHARACTERISTICS</strong></td>
<td>Supply and demand of beds &amp; access, demographics, population growth, CON requirements, uninsured, HIX</td>
</tr>
<tr>
<td><strong>COMPETITIVE LANDSCAPE</strong></td>
<td>Competitive intensity, history of irrationality, pursuit of new strategies and/or payment models</td>
</tr>
<tr>
<td><strong>PHYSICIAN PROFILE</strong></td>
<td>Mix of independent, employed, multispecialty or super groups, historical hospital-physician and physician-physician relationships</td>
</tr>
<tr>
<td><strong>PAYOR PROFILE</strong></td>
<td>Payor mix, rate parity and willingness to offer P4P or risk-based contracts</td>
</tr>
<tr>
<td><strong>EMPLOYER PROFILE</strong></td>
<td>Large employers (&gt;1,000 employees) pursuing contracts with providers; small employers likely to abandon plans for Exchanges</td>
</tr>
</tbody>
</table>
What have we learned from Physicians?

- Desire to **preserve** private practice
- Succeed amid **future** changes in reimbursement
- Active involvement in **governance** of network

**Barriers** to network development include:
- Trust with Hospitals
- Defining Quality
- Physician Engagement

*Physician Economic Satisfaction*

(1 = LOW, 5 = HIGH)
What have we learned from Health Systems?

• Our ability to influence how we get paid will diminish

• Quality, will be dictated by a payer not a physician-led network

• Savings, resulting from improved performance will only benefit the payer

• Volume, tied to narrow or preferred networks will be directed away from us
Stakeholders Are In One of the Four Quadrants

- **PLAN**
  - Ready to support alternative reimbursement models
  - Capable of implementing clinical and financial models to support population management.

- **ACT**
  - Ready to support alternative reimbursement models
  - Capable of implementing clinical and financial models to support population management.

- **MONITOR**
  - Limited change is anticipated
  - Specific capabilities exist to implement network strategy
  - Urgency could change based on education regarding future performance and clinical requirements

- **EDUCATE**
  - Ready to accept change and capture market opportunities or respond to unsustainable conditions
  - Not supportive of provider networks to meet market or economic stability requirements

- Plan:
  - Low Readiness
  - Low Urgency

- Act:
  - High Readiness
  - High Urgency

- Monitor:
  - Low Readiness
  - High Urgency

- Educate:
  - High Readiness
  - Low Urgency
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MODEL OPTIONS
Six Critical Questions to Gain Clarity

1. Why do we exist?
2. How do we behave?
3. What do we do?
4. How will we succeed?
5. What is most important, right now?
6. Who must do what?

These Six Critical Questions are from Patrick Lencioni’s *The Advantage: Why Organizational Health Trumps Everything Else in Business*

What leaders must do to give employees the clarity they need is to agree on the answers to six simple but critical questions:
Alignment Model Spectrum

TACTICAL

- Pay for Call
- Directorship
- IT Deployment
- Co-Marketing

STRATEGIC

- Independent Practice Association
- Joint Venture
- Management Services Organization
- Physician Advisory Council

TRANSFORMATIONAL

- Accountable Care Organization
- Clinically Integrated Network
- Physician Enterprise
- Hospital Efficiency Program
- PCMH
- Foundation
- Institute
- Co-Management
- Professional Services Arrangement
- Gainsharing
- Employment

Degree of Alignment

Resources Required

HIGH

LOW

LOW

HIGH
Network Alignment Options

TACTICAL
- Pay for Call
- Directorship
- Joint Venture
- IT Deployment
- Co-Marketing

LOW HIGH Degree of Alignment

STRATEGIC
- Gainsharing
- Management Services Organization
- Physician Advisory Council
- Physician Enterprise

LOW HIGH Resources Required

TRANSFORMATIONAL
- Clinically Integrated Network
- Hospital Efficiency Program
- Accountable Care Organization
- Foundation
- Institute

DHG HEALTHCARE
A **Hospital Efficiency Program** is an agreement between the hospital and the CIN to improve quality and reduce costs within the hospital. Payments and targets are defined in advance and if achieved are allocated back to the CIN for distribution to network physicians. Areas of focus are defined via a set of initiatives and metrics, each with its own predefined baseline and performance targets.

## Benefit to Stakeholders

### Physicians
- Increased quality and efficiency through standardization
- Receive payment for demonstrated efficiencies and care coordination in various initiatives

### Markets and Hospitals
- Reduce expenses in the “system” and gain efficiencies
- Establish a sense of urgency to reduce waste

## What It’s Not
- Gainsharing
Evolution of Clinically Integrated Network

Scope of Contracting / Competencies

Value to Network Participants

NETWORK

Pay for Performance
Messenger Model Contracting
Medicare Advantage Contracts
Associate Health Plan

CIN

Single Signature Negotiated Contracts
Hospital Efficiency Agreement

Ability to demonstrate selectivity, cooperation, modified behavior and results; can negotiate agreements with payors, employers or hospital

FTC Criteria
“WHAT ARE THE MAJOR COMPONENTS OF A CLINICALLY INTEGRATED NETWORK?”
Components of a Clinically Integrated Network

- Structure & Governance
- Infrastructure & Funding
- Participation Criteria
- Performance Objectives
- Physician Leadership
- Clinically Integrated Network
- Information Technology
- Distribution of Funds
- Contracting
Overview: Other than an employment-only model, a CIN usually is structured as a joint venture or subsidiary Physician Hospital Organization, or an Independent Practice Association (IPA).
Key Characteristics:

- Participation Fees **will** be different for Owners than for Participants
- All physicians will sign the same Membership Agreement
- Active participation is required to achieve performance goals
- Profit distribution to owners only, based on company’s profits
- Performance rewards will be available to Owners and Participants based on performance
Overview: The CIN is a separate business entity with a distinct identity, mission, and vision, dedicated leadership and staff, sustainable sources of revenue, and participating provider agreements with physicians that create potential value for both physicians and payors.

Sources of Revenue

The CIN will need to offset costs of building the network (Infrastructure) and eventually provide returns through various revenue sources depending on the maturity of the network.
Overview: Member physicians or groups that satisfy certain guidelines and criteria must sign an agreement outlining the expectations and requirements for participation in the CI program.

Sample Participation Criteria

- **Physician Leadership**
  - Active member of “Hospital” Medical Staff
  - Participate in educational programs
  - Complete orientation program
  - Provide leadership and oversight over defined operations

- **Information Technology Adoption**
  - Utilize professional and office email
  - Access to high-speed internet
  - Implement the preferred health information technology
  - Share clinical information / data

- **Quality Improvement**
  - Develop, implement, and monitor clinical protocols
  - Review member physician performance
  - Develop / implement corrective action plans and process improvement initiatives

- **Contracting Requirements**
  - Participate in jointly negotiated contracts
**Overview:** CINs identify metrics and targets designed to meaningfully impact the clinical practice of all network physicians, and to align their conduct with hospital initiatives, so as to improve quality and demonstrate value across the entire continuum of care.

### Examples of Performance Improvement

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Variance & Cost Reduction** | Minimize variable physician performance not related to patient characteristics | • Minimize orthopedics supply chain cost  
• Staffing and productivity opportunities |
| **Unnecessary Care Reduction** | Reduce avoidable, unproductive and duplicative services                  | • Prostate cancer screenings for elderly patients  
• Reduce Readmissions                   |
| **Clinical Restructuring**  | Ensure treatment in most optimal setting with most appropriate level of provider | • Early step down from an IP to SNF bed  
• Partnerships with a local retail clinic to offer non-urgent care |
| **System Optimization**     | Shift focus to upstream, preventative care with emphasis on CI and population health | • Disease-based medical homes  
• Patient engagement strategies using telehealth |

Source: Sg2 Analysis
Overview: Health systems must empower physicians to have an influence on the future direction of the network. This will help integrate physicians’ clinical expertise into hospital operations and increase cooperation and credibility of the CI network.

Lead and participate on sub-committees supported by CIN or Health System personnel.
**Overview:** CINs use an IT-dependent performance improvement architecture with data-based mechanisms and processes to monitor and track utilization, quality, and efficiency of resource use to demonstrate value.

- **Digitize** critical information on an individual within each care site
- **View** health-related data via a customizable user interface within an enterprise
- **Exchange** health-related data within and between enterprises
- **Derive** value and intelligence to improve care quality and outcomes and to curb costs
- **Deliver** clinical and patient information to enhance patient care experiences and practitioner effectiveness

**CLINICAL CARE VALUE**

- **Advanced Clinical Decision Support**
- **Health Analytics**
- **Health Information Exchange (Private)**
- **Healthcare Portals or Registries (Clinicians and Patients)**
- **Intermediate Electronic Medical Records**
- **IT Optimization**

**Source:** IBM Center for Applied Insights
Overview: The CIN establishes an organized plan to link performance on defined gradients to eligibility for incentive payments.
FINANCIALS
## Economic Considerations

<table>
<thead>
<tr>
<th>Estimated Start-up Costs for Clinically Integrated PHOs</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Leader</td>
<td>$200,000</td>
<td>$300,000</td>
<td>$400,000</td>
</tr>
<tr>
<td>Administrative Leaders</td>
<td>$150,000</td>
<td>$200,000</td>
<td>$250,000</td>
</tr>
<tr>
<td>Staff</td>
<td>$200,000</td>
<td>$300,000</td>
<td>$400,000</td>
</tr>
<tr>
<td><strong>Physician Participation</strong></td>
<td>$30,000</td>
<td>$40,000</td>
<td>$50,000</td>
</tr>
<tr>
<td><strong>Information Technology</strong></td>
<td>$1,000,000</td>
<td>$1,750,000</td>
<td>$2,500,000</td>
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<tr>
<td><strong>Marketing and Communication</strong></td>
<td>$75,000</td>
<td>$100,000</td>
<td>$125,000</td>
</tr>
<tr>
<td><strong>Overhead</strong></td>
<td>$20,000</td>
<td>$35,000</td>
<td>$50,000</td>
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<tr>
<td><strong>Care Management Infrastructure</strong></td>
<td>$100,000</td>
<td>$150,000</td>
<td>$200,000</td>
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<tr>
<td><strong>Legal and Consulting</strong></td>
<td>$250,000</td>
<td>$500,000</td>
<td>$750,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$2,025,000</td>
<td>$3,375,000</td>
<td>$4,725,000</td>
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</tbody>
</table>

Staff Costs include: Administrative Director, Nurse, Analytics / IT, Provider Relations
## Sample Client Pro Forma

<table>
<thead>
<tr>
<th></th>
<th>Start-Up</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
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<tbody>
<tr>
<td><strong>REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Physician Membership Fee</td>
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<td>$62,500</td>
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<td>Physician Membership Dues</td>
<td>-</td>
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<td>$250,000</td>
<td>$275,000</td>
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<td>Health Plan Shared Savings</td>
<td>-</td>
<td>-</td>
<td>$1,525,000</td>
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<td>$250,000</td>
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<td>6-Months Working Capital</td>
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<td>Salaries and Benefits</td>
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<td>$714,563</td>
<td>$735,999</td>
<td>$985,417</td>
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<td>Total Hospital Staff</td>
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<td>$100,786</td>
<td>$103,809</td>
<td>$106,923</td>
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<td>Legal/Consulting/FMV</td>
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<td>$51,500</td>
<td>$53,045</td>
<td>$100,000</td>
<td>$103,000</td>
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<td>$15,914</td>
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<td>Overhead</td>
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<tr>
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<td>$500,000</td>
<td>$925,000</td>
<td>$1,450,000</td>
<td>$1,300,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$986,875</td>
<td>$2,292,754</td>
<td>$3,251,685</td>
<td>$3,902,546</td>
<td>$6,008,415</td>
<td>$6,775,544</td>
</tr>
<tr>
<td><strong>EBITA (Operating Income)</strong></td>
<td>$(486,875)</td>
<td>$(1,294,361)</td>
<td>$(27,536)</td>
<td>$(314,579)</td>
<td>$1,358,717</td>
<td>$3,045,677</td>
</tr>
<tr>
<td>(less withhold)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Depreciation</td>
<td>$196,429</td>
<td>$196,429</td>
<td>$196,429</td>
<td>$400,000</td>
<td>$3,004,677</td>
<td></td>
</tr>
<tr>
<td><strong>EBIT</strong></td>
<td>$(486,875)</td>
<td>$(1,490,789)</td>
<td>$(233,965)</td>
<td>$(511,007)</td>
<td>$958,717</td>
<td>$2,645,677</td>
</tr>
<tr>
<td>Interest Expense</td>
<td>$64,928</td>
<td>$56,319</td>
<td>$47,269</td>
<td>$105,045</td>
<td>$86,122</td>
<td></td>
</tr>
<tr>
<td><strong>EBT</strong></td>
<td>$(486,875)</td>
<td>$(1,555,717)</td>
<td>$(280,283)</td>
<td>$(558,276)</td>
<td>$853,672</td>
<td>$2,559,555</td>
</tr>
<tr>
<td>Taxes (Assuming 0%)</td>
<td>$- -</td>
<td>- $ - $ -</td>
<td>- $ - $ -</td>
<td>- $ - $ -</td>
<td>- $ - $ -</td>
<td>- $ - $ -</td>
</tr>
<tr>
<td><strong>Net Income</strong></td>
<td>$(486,875)</td>
<td>$(1,555,717)</td>
<td>$(280,283)</td>
<td>$(558,276)</td>
<td>$853,672</td>
<td>$2,559,555</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td>-156%</td>
<td>-9%</td>
<td>-16%</td>
<td>12%</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>Probable Case - Cumulative Net Income</td>
<td>$(486,875)</td>
<td>$(2,042,592)</td>
<td>$(2,322,876)</td>
<td>$(2,881,152)</td>
<td>$(2,027,479)</td>
<td>$532,075</td>
</tr>
</tbody>
</table>
### Hospital and per Physician 3-Year Net Impact

#### Physician Impact

<table>
<thead>
<tr>
<th>Category</th>
<th>Start-up</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Buy-in</td>
<td>$ (1,000)</td>
<td>$ -</td>
<td>$ -</td>
<td>$ -</td>
</tr>
<tr>
<td>Annual Membership Dues</td>
<td>$ -</td>
<td>$ -</td>
<td>$ (500)</td>
<td>$ (500)</td>
</tr>
<tr>
<td>Quality / Shared Savings Distribution</td>
<td>$ -</td>
<td>$ 3,028</td>
<td>$ 3,093</td>
<td>$ 3,166</td>
</tr>
<tr>
<td>Physician Impact per Year</td>
<td>$ (1,000)</td>
<td>$ 3,028</td>
<td>$ 2,593</td>
<td>$ 2,666</td>
</tr>
<tr>
<td><strong>Cumulative Net Impact per physician</strong></td>
<td>$ (1,000)</td>
<td>$ 2,028</td>
<td>$ 4,621</td>
<td>$ 7,287</td>
</tr>
<tr>
<td><strong>Total Cumulative Physician Net Impact</strong></td>
<td>$ (500,000)</td>
<td>$ 1,014,036</td>
<td>$ 2,440,275</td>
<td>$ 4,039,593</td>
</tr>
</tbody>
</table>

#### Hospital Impact

<table>
<thead>
<tr>
<th>Category</th>
<th>Start-up</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ending Balance of CIN Operations</td>
<td>$ (2,361,875)</td>
<td>$ (664,393)</td>
<td>$ (129,803)</td>
<td>$ (38,794)</td>
</tr>
<tr>
<td>Hospital Employee Health Plan Savings</td>
<td>$ -</td>
<td>$ 1,525,000</td>
<td>$ 1,448,750</td>
<td>$ 1,376,313</td>
</tr>
<tr>
<td>Impact of Inpatient Initiatives Savings</td>
<td>$ -</td>
<td>$ 998,393</td>
<td>$ 1,136,649</td>
<td>$ 1,289,217</td>
</tr>
<tr>
<td>Financial Impact of CIN per year</td>
<td>$ (2,361,875)</td>
<td>$ 1,859,001</td>
<td>$ 2,455,596</td>
<td>$ 2,626,736</td>
</tr>
<tr>
<td><strong>Total Cumulative Net Impact</strong></td>
<td>$ (2,361,875)</td>
<td>$ (502,874)</td>
<td>$ 1,952,721</td>
<td>$ 4,579,457</td>
</tr>
</tbody>
</table>
### CI Contract Estimates

<table>
<thead>
<tr>
<th>CI Contract Estimates</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mkt Population (‘17, ‘18)</td>
<td>1,445,055</td>
<td>1,456,483</td>
</tr>
<tr>
<td>Market Share</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Estimated Covered Lives</td>
<td>462,418</td>
<td>466,075</td>
</tr>
<tr>
<td>Estimated % of Risk Contracts</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Estimated Covered Lives (% Risk)</td>
<td>46,242</td>
<td>69,911</td>
</tr>
<tr>
<td>Estimated PMPY Health Costs</td>
<td>$4,500</td>
<td>$4,500</td>
</tr>
<tr>
<td>Estimated Health Costs for Risk Contracts</td>
<td>$208,087,920</td>
<td>$314,600,328</td>
</tr>
<tr>
<td>% Reduction</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Total Estimated Reduction</td>
<td>$10,404,396</td>
<td>$15,730,016</td>
</tr>
<tr>
<td>% Shared Savings with CIN</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>CI Shared Savings Amount</td>
<td>$5,202,198</td>
<td>$7,865,008</td>
</tr>
<tr>
<td>Key Elements</td>
<td>Definition</td>
<td>MWHC Components</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| Costs and Capital | The hospital's operating costs attributed to the implementation of the network. This assumes a joint-venture model. | • Hospital and Employed Physician Membership Dues  
• Health Plan Rate Increase and Network Premium  
• Overhead Allocation to CIN |
| Hospital Health Plan Cost Saving | An initiative that formally aligns quality improvement, cost containment and operational efficiency efforts across each hospital and the network. | • Net Impact of Shared Savings within the Associate Health Plan |
| Market Share Impact | Shifts in market share due to the introduction, performance and sustainment of Clinical Integration contracts with payers in the Hospital market. | • Payer Contracts that include; Associate Health Plan, Cigna, Aetna, Medicare, United Healthcare, BCBS / Anthem |
| Operating Cost Reduction | Shifts in operating costs that can be attributed to specific performance initiatives led by CIN providers. | • Variable Cost Assumptions |
| Service Line Impact | Shifts in volume attributed to improved coordination of care, reduced outmigration and leakage to non-Hospital provider facilities. | • IP Contribution Impact  
• OP Contribution Impact  
• Readmission Penalty Impact |
## Estimated Impact Analysis—Conservative Scenario

**Clinically Integrated Network**

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>3 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPN costs and capital</td>
<td>(1,470,200)</td>
<td>(2,133,392)</td>
<td>(416,625)</td>
<td>83,196</td>
<td>(3,937,020)</td>
</tr>
<tr>
<td>Health plan cost savings</td>
<td>287,694</td>
<td>359,618</td>
<td>407,567</td>
<td>1,054,878</td>
<td></td>
</tr>
<tr>
<td>Market share increases</td>
<td>97,918</td>
<td>480,592</td>
<td>1,529,532</td>
<td>2,108,042</td>
<td></td>
</tr>
<tr>
<td>Operating cost reduction</td>
<td>199,839</td>
<td>1,050,835</td>
<td>1,741,684</td>
<td>2,992,359</td>
<td></td>
</tr>
<tr>
<td>Service line growth</td>
<td>(47,298)</td>
<td>34,426</td>
<td>47,470</td>
<td>34,598</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>(1,470,200)</td>
<td>(1,595,239)</td>
<td>1,508,846</td>
<td>3,809,450</td>
<td>2,252,857</td>
</tr>
</tbody>
</table>
INFRASTRUCTURE / GOVERNANCE
CI PHO – Future State Organizational

Board of Directors

CIN

Administrative Leader

Director of Operations

Director Physician Services

Director of Quality

Physician Leader

Director of Managed Care

Subcommittees

Director of Managed Care

Provider Network Specialist

Administrative Assistant

Year 1

Year 2-3

Year 4-5

Director of Operations

Physician Office Support

IT specialist(s)

Director Physician Services

Physician Liaison(s)

Credentialing Coordinator

Director of Quality

Data Analyst(s)

Care Manager(s)

Nurse(s)
Board & Committee Structure

**BOARD COMPOSITION**

**PHYSICIAN CHAIR**

**COMMITTEES**

**CHAIRMED BY PHYSICIANS**

- MANAGING BOARD
- Finance and Contracting
- Clinical Quality
- Membership and Operations
- Communication and Education
- Information Technology
INFORMATION TECHNOLOGY
Mount Carmel Health Partners Network

**PHYSICIAN PRACTICE**

**LABORATORY**

**PHARMACY**

**HEALTH SYSTEM**

---

**PATIENT REGISTRY**

- Point-of-Care Module
- Mailing List (Chronic Patients)
- Compliance with Metrics
- Performance Dashboards

---

**CLAIMS DATA**

- **✓** Billing Data (CPT/ICD9)
- **✓** Patient Demographics
- **✗** Practice Financials
- **✗** Cost Data
Example: Mount Carmel Health Partners

### Registry(ies)
- All
- PQRS Only
- Custom Only

### Compliance Status Type
- Overall Status

### Compliance Status
- All
- Guideline Met
- Guideline Not Met

### Care Measure Criteria
- Well Child Visit 3-6 Year
- Well Visit 0-15 Months (# Visits of 6 Required)
- Well Visit Adolescent

### Health Plan
- All
- MEDICARE
- UNKNOWN

### Patients with Ages Between:
- 0
- 120

### Table Data

| System ID | Last Name | First Name | MI | Suffix | Gender | DOB       | Health Plan | Phone Number | Overall Status |
|-----------|-----------|------------|----|--------|---------|-----------|-------------|--------------|----------------|----------------|
# PHYSICIAN DASHBOARD

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Potential Score</th>
<th>Physician Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Quality</td>
<td><strong>Sample Measures</strong>&lt;br&gt;&lt;br&gt;<strong>CAD Mgt:</strong> An LDL-C test performed for CAD patients during the measurement year.&lt;br&gt;<strong>COPD Mgt:</strong> % of COPD patients that had an annual physician visit.&lt;br&gt;<strong>Diabetes HbA1C testing:</strong> % diabetic members 18-75 who had at least one HbA1C testing within 12 months.&lt;br&gt;<strong>Preventative Care:</strong> Breast Cancer Screening (40-69 years old).&lt;br&gt;<strong>Preventative Care:</strong> Colorectal Cancer (50-75 years old)</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>IT Adoption</td>
<td>Internet Access&lt;br&gt;Email Address&lt;br&gt;Install Patient Registry (MedVentive)</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Credentialing</td>
<td>Meets NCQA standards for credentialing</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>CMS metrics</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Completion of required educational programs</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>Committee involvement</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total Score</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>
Clinical Integration (CI) Case Studies
The value proposition for physicians to join a network typically includes one or more of the following:

1. Access to preferred rates or contracts/pop. (Economics)
2. Opportunities for Physician Leadership (Control)
3. Lower cost EMR solutions (Practice Costs)
4. Quality and HIE solutions (Technology)

Networks that meet 3 of these benefits can usually overcome typical barriers associated with trust and skepticism towards the health system and the concept of clinical integration.

While typical PHO or MSO services like credentialing, provider relations, coding education and CME sessions are valued by physician practices, physicians rarely acknowledge these as reasons to join a network.
Mount Carmel Health Partners

Location: Columbus, OH
Hospital: 4-hospital system
Ownership: 50/50 Joint Venture
CI Physicians: / Medical Staff: 850 / 1,500

<table>
<thead>
<tr>
<th>Categories</th>
<th>MCHP Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Membership Fee</td>
<td>Annual Withhold on CI Contracts</td>
</tr>
<tr>
<td>Information Technology</td>
<td>MedVentive</td>
</tr>
<tr>
<td>Phase I Initiatives</td>
<td>MCHP Engagement Criteria (over 850 participating physicians), MedVentive (patient registry adopted), Pay for Quality Programs, PHO Board</td>
</tr>
<tr>
<td>Phase II Initiatives</td>
<td>MediGold HEDIS (MCHS- Medicare Advantage Plan), Associate Health Plan OB Project, Molina Medicaid OB Project. “Gaps In Care”</td>
</tr>
<tr>
<td>Phase III Initiatives</td>
<td>In process of negotiating first ACO contract (30,000 Lives) Components include P4P and shared savings</td>
</tr>
<tr>
<td>Hospital Contracts</td>
<td>Hospital contracts independently with completely different negotiating teams</td>
</tr>
<tr>
<td>Biggest Wins</td>
<td>Pharmacy Costs, Shared Savings, Physician Quality and IT Leadership</td>
</tr>
</tbody>
</table>

Best Practices:
1. Economics
2. Physician Leadership
**Memorial Hermann Physician Network**

**Location:** Houston, Texas  
**Hospital:** 11-hospital system  
**Ownership:** Hospital Subsidiary  
**CI Physicians / Medical Staff:** 2,000 / 3,500

<table>
<thead>
<tr>
<th>Categories</th>
<th>MHMD Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Member Fee</td>
<td>$200</td>
</tr>
<tr>
<td>Information Technology</td>
<td>Crimson</td>
</tr>
</tbody>
</table>
| Phase I Initiatives    | Hospital Efficiency Program (Shared Savings)  
                         | Employee Health Plan (Shared Savings with 26,000 lives)  
                         | IT Deployment                                                     |
| Phase II Initiatives   | BCBS Medicare Advantage (50,000 Lives), Aetna ACO (150,000 Lives) and Humana PCMH  
                         | IT Deployment and Registry / Care Management Resources |
| Phase III Initiatives  | Insurance Product – MHealth Insurance product to accept fully-insured business and direct contracting with small and mid-size employers |
| Hospital Contracts     | Hospital contracts independently with completely different negotiating teams |
| Biggest Wins           | Pharmacy Costs, Inpatient Complications, Admissions to the Hospitals |

**Best Practices:**  
1. Economics  
2. EMR Subsidies  
3. HIE / IT Solutions
Regional Contracts: Bundled Payments

Total Medical Spend = $700 million
Number of Employees: 225,000

Type of Patients: Cardiac surgery

Description: Lowe’s waives employees’ usual $500 deductible and other out-of-pocket costs and pays for travel expenses to Cleveland

Win for Clinic: Expanding service area reach that has led to increased volume and has allowed the Cleveland Clinic to leverage size and scale

Win for Lowe’s: Better quality care, lower return to work times and lower costs

Additional Bundled Payments Underway: Boeing (Cardiovascular Services) and Wal-Mart Stores (Cardiovascular and Spine Services)

Best Practices:
1. Economics
### Piedmont Clinic Network

- **Location**: Atlanta, GA  
- **Hospital**: 5 Hospital System  
- **Ownership**: Hospital Subsidiary  
- **CI Physicians / Medical Staff**: 898 / 2,500

#### Categories Criteria

<table>
<thead>
<tr>
<th>Categories</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Member Fee</td>
<td>$1000 in first year, $850 each year after</td>
</tr>
<tr>
<td>Information Technology</td>
<td>Health Trust HIE and Analytics platform built by Recombinant</td>
</tr>
<tr>
<td>Phase I Initiatives</td>
<td>Left Super PHO in 90s, provided messenger model contracting and participated in Full-risk capitation / physician capitation</td>
</tr>
<tr>
<td>Phase II Initiatives</td>
<td>Established CI program in January 2010, growing physician network 15% a year with over 544 physicians in independent practice. Offered contracting and group health insurance,</td>
</tr>
<tr>
<td>Phase III Initiatives</td>
<td>Established Accountable Care Platform, affiliation agreements for regional coverage, and pursuing MSO, call center and practice support/education services for physicians</td>
</tr>
<tr>
<td>Network Contracts</td>
<td>6 CI contracts, 10+ messenger model contracts</td>
</tr>
<tr>
<td>Biggest Wins</td>
<td>Affiliation with Cigna, Wellstar health plan joint-venture and community physician participation</td>
</tr>
</tbody>
</table>

#### Best Practices:
1. Economics  
2. HIE / IT Solutions
Lessons Learned from Piedmont Clinic

**Governance**
- Board comprised of 15 Members (10 physicians, 5 administrators)
  - Executive Committee
  - Subcommittees: Quality, Contracting, Membership

**Contracts**
- Fee schedules different for hospital-based and general physicians
- 10,000 covered lives through employee health plan
  - Shared savings, based on quality standards
- Developing joint-venture health plan with WellStar

**Affiliation Strategy**
- Health system affiliation agreement
  - Network “Pool” established for affiliate hospital and attributed physicians based on performance in core measures and physician metrics
  - Aligns physicians with affiliate hospital, avoids alignment with competitor
- Physicians are full members of Piedmont Clinic
  - Same participation agreement
Best Practice: Revenue Sources for New Networks
Typical CIN Revenue Sources

**Reporting Incentives**
- PQRS Reporting
- Practitioner Assessment Forms
- Meaningful Use
- Medical Records Access

**Hospital Efficiency Program**
- Serious Complications
- Throughput
- Reduction in Variation
- Pharmacy Management

**Payer Contracts**
- Increase FFS
- Quality Metrics
- Shared Savings

**Self Funded Health Plan**
- Administrative Fee
- Quality Metrics
- Shared Savings

**Pay-for-Performance**
- Quality Metrics
- Efficiency
- Patient Centered Medical Homes

**Employer Contracts**
- Narrow Network
- Shared Savings
As one of the first contracts signed, the CIN will be the “in-network” provider to manage the Employee Health Plan. The fee-for-service payments will remain constant, but will include a shared savings and quality improvement component.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Start-Up</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated Health Plan Spend</td>
<td>$</td>
<td>$ 61,000,000</td>
<td>$ 57,950,000</td>
<td>$ 55,052,500</td>
</tr>
<tr>
<td>% Reduction</td>
<td>0%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Total Estimated Savings</td>
<td>$</td>
<td>$ 3,050,000</td>
<td>$ 2,897,500</td>
<td>$ 2,752,625</td>
</tr>
<tr>
<td>% Shared</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Total Shared Savings</td>
<td>$</td>
<td>$ 1,525,000</td>
<td>$ 1,448,750</td>
<td>$ 1,376,313</td>
</tr>
<tr>
<td>Per Physician Distribution (60%)</td>
<td>$</td>
<td>$ 1,830</td>
<td>$ 1,580</td>
<td>$ 1,376</td>
</tr>
</tbody>
</table>
## Sample HEP Dashboard

### IP Supply Expense Initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Unity of Service (UOS) Budget 2013</th>
<th>Supply Expense per UOS Hospital 2012 Actual</th>
<th>Supply Expense per UOS CIN 2013 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 1,311,824</td>
<td>$ 2,498,712</td>
<td>$ 3,935,471</td>
</tr>
<tr>
<td></td>
<td>$ 1,330</td>
<td>$ 1,281</td>
<td>$ 1,242.37</td>
</tr>
<tr>
<td></td>
<td>$ 681,348</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Measurements

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Target 1</th>
<th>Target 2</th>
<th>Target 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 414,494.31</td>
<td>$ 690,823.85</td>
<td>$ 967,153.39</td>
</tr>
<tr>
<td></td>
<td>$ 949,522.11</td>
<td>$ 1,582,536.85</td>
<td>$ 2,215,551.59</td>
</tr>
<tr>
<td></td>
<td>$ 2,384,051.43</td>
<td>$ 3,973,419.05</td>
<td>$ 5,562,786.67</td>
</tr>
<tr>
<td></td>
<td>$ 3,748,067.85</td>
<td>$ 6,246,779.75</td>
<td>$ 8,745,491.65</td>
</tr>
</tbody>
</table>

### CIN Payout as a % of Savings

<table>
<thead>
<tr>
<th>%</th>
<th>35%</th>
<th>40%</th>
<th>45%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cardiology**

- $110
- $100
- $97.37
- $95.36
- $93.35

**Pharmacy**

- $70
- $66
- $63.74
- $62.43
- $61.11

**Surgery**

- $1,330
- $1,281
- $1,242.37
- $1,216.76
- $1,191.14
CASE STUDY: DISTRIBUTION METHODOLOGY
Distribution Methodology

- Category
  - Supply
  - Pharmacy
  - Employee Medical
  - Patient Through Put

- Future Payer Contracts

- Hospital Efficiency Program → $ → $ → Clinical Integration

- Distribution Methodology
  - 40% for Local Network Performance
  - 20% for Global Network Performance
  - 40% for Individual Activity / Outcomes
40% LOCAL NETWORK PERFORMANCE*

20% GLOBAL NETWORK PERFORMANCE

40% INDIVIDUAL ACTIVITY / OUTCOME

**Employee Health Costs**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Distribution Per Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Health Cost</td>
<td>$743</td>
</tr>
</tbody>
</table>

**Global Network Performance**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Distribution Per Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Network Performance</td>
<td>$537</td>
</tr>
</tbody>
</table>

**Tier Distribution Per Physician**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Distribution Per Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>1</td>
<td>$916</td>
</tr>
<tr>
<td>2</td>
<td>$1,373</td>
</tr>
<tr>
<td>3</td>
<td>$1,831</td>
</tr>
</tbody>
</table>

**Patient Through Put**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Distribution per Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$393</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$249</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$249</td>
</tr>
<tr>
<td>Hospital D</td>
<td>$393</td>
</tr>
</tbody>
</table>

**Physicians will receive between:**

*$2,444 - $3,503

*No Performance for Supply Costs and Pharmacy Costs Initiatives

*All numbers are rounded for illustrative purposes

*This is an approximate amount and not a final range
### ADVANTAGES FOR PHYSICIANS

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Benefit Range (Per Physician)</th>
<th>2005 Total</th>
<th>2006 Total</th>
<th>2007 Total</th>
<th>2008 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement / P4P Incentives</td>
<td>$300 - $4,000</td>
<td>$12.4 M</td>
<td>$16.7 M</td>
<td>$25.0 M</td>
<td>$30.0 M</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>$1,500 - $8,000</td>
<td>$3.9 K</td>
<td>$5.2 K</td>
<td>$8.6 K</td>
<td>$9.4 K</td>
</tr>
<tr>
<td>Leadership Participation Incentives</td>
<td>$50 - $1,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitalize on Payer Relationships</td>
<td>2% - 10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narrow Network Participation</td>
<td>Exclusive access to patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Management Resources (IT, Staff, Case Management)</td>
<td>Shared network resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Purchasing</td>
<td>Reduction in expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANNUAL CI INCENTIVES FOR ADVOCATE PHYSICIAN PARTNERS**
COMMUNICATION STRATEGIES

Visible Leader(s): Admin. and Physician

Yr. 1
- Created CME educational events
- Hosted open forum discussions at each hospital
- Coordinated meetings with physician offices
- Posted webinar on website (restricted access)
- Distributed “Commitment to Quality” report
- Distributed FAQ materials
- Hosted patient registry kickoff session

Yr. 2 +
- Train-the-trainer strategy to implement IT
- Attend meetings and educate health system board members
- Provider relations constantly communicate with physician offices
- Distribute performance improvement updates
- Assist with the installation with Patient Registry
- Communicate with payers on strength of network
- Newsletter distribution

NETWORK RESULTS

- 850 participating physicians (57% of medical staff)
- 500+ physicians utilizing Patient Registry
- Engaged Board of physicians (6) and Health System (6)
- 10+ pay-for-quality programs with payers (including Employee Health Plan)
- Signed an ACO-like Contract with United Healthcare
Growth of CI Network

<table>
<thead>
<tr>
<th>Month</th>
<th>Count (net)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-11</td>
<td>513</td>
</tr>
<tr>
<td>Aug-11</td>
<td>618</td>
</tr>
<tr>
<td>Sep-11</td>
<td>682</td>
</tr>
<tr>
<td>Oct-11</td>
<td>704</td>
</tr>
<tr>
<td>Nov-11</td>
<td>711</td>
</tr>
<tr>
<td>Dec-11</td>
<td>741</td>
</tr>
<tr>
<td>Jan-12</td>
<td>766</td>
</tr>
<tr>
<td>Feb-12</td>
<td>774</td>
</tr>
<tr>
<td>Mar-12</td>
<td>783</td>
</tr>
<tr>
<td>Apr-12</td>
<td>800</td>
</tr>
<tr>
<td>May-12</td>
<td>820</td>
</tr>
<tr>
<td>Jun-12</td>
<td>819</td>
</tr>
<tr>
<td>Jul-12</td>
<td>816</td>
</tr>
<tr>
<td>Aug-12</td>
<td>814</td>
</tr>
<tr>
<td>Sep-12</td>
<td>820</td>
</tr>
<tr>
<td>Oct-12</td>
<td>818</td>
</tr>
<tr>
<td>Nov-12</td>
<td>827</td>
</tr>
<tr>
<td>Dec-12</td>
<td>830</td>
</tr>
</tbody>
</table>
Mission Statement: We provide superior healthcare and value through an integrated partnership among patients, providers and community resources.
CIN DEVELOPMENT PROCESS
Provider Network Strategy Process

Clinical Integration Development Overview

**Discover**
- Project Planning & Management
- Project Communication, Education & Kickoff
- Market Readiness
  - Data Analysis
  - Interviews
  - Market Gap Analysis
- Organizational Readiness
  - Data Analysis
  - Interviews
  - Market Gap Analysis
- Strategic & Economic Impact Analysis
- Vision Creation
- Findings & Recommendations

**Develop**
- Project Planning & Management
- Committee Formation
- Network Design
  - Structure & Governance
  - Infrastructure & Funding
  - Physician Leadership
  - Participation Criteria
  - Performance Objectives
  - Information Technology Design
  - Distribution of Funds
- Legal Document Creation
- Fair Market Valuation
- M, V, V & Identity Formation
- IT Screening & Selection
- Proforma & Business Planning
- Communication & Recruitment

**Deploy**
- Project Planning & Management
- Committee [Re]formation
- PPM Development
- Membership Education & Enrollment
- Employer & Payor Contracting
- IT System Implementation
- Dashboard Creation
- Policies & Procedure Development
- Staffing Model Selection

**Market Assessment**

**Network Formation**

**Go/No Go**

**Network Launch**
Discover Phase – Key Outputs

**MARKET GAP ANALYSIS**

**ORGANIZATIONAL GAP ANALYSIS**

**MARKET Readiness**

**Organizational Readiness**
Develop Phase – Key Activities

- Clinically Integrated Network
- Structure & Governance
- Infrastructure & Funding
- Participation Criteria
- Performance Objectives
- Physician Leadership
- Information Technology
- Distribution of Funds
- Contracting
READINESS ACTION PLAN
1. Clearly define your vision and strategy for physician and provider alignment in the post-reform era

2. Assess market urgency and organizational readiness to pursue true clinical integration

3. Educate hospital and physician leadership regarding objectives, benefits, costs and risks of clinical integration

4. Identify and commission a physician-led ‘steering committee’ to guide the organization’s clinical integration initiative
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