7 Steps Playbook

Setting the Foundation for a Clinically Integrated Network

CONIFER HEALTH SOLUTIONS®

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Think about all the healthcare services that consumers experience, from primary and specialty physician encounters to acute care hospitalization and outpatient care. Now think of all those services virtually connected. That is the basis for a clinically integrated network.

As a cornerstone for value-based care, clinically integrated networks are helping health communities across America better manage the migration from fee-for-service models. In addition, the strategic alignment of partners in the care community means the potential is powerful for improving access to quality care, sharing data to gain health insights across a defined population, managing individual health across a complete care continuum, and decreasing costs. Clinically integrated networks also enable providers to deliver care consistently across the network, resulting in minimized variance among providers and standardized protocols.

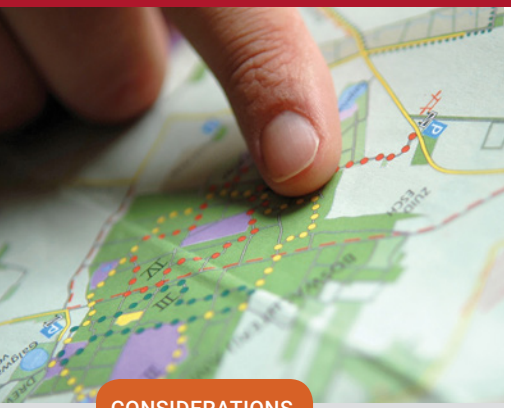
This playbook follows seven steps to map the framework of a clinically integrated network and the basic mechanics of getting started.

If your journey is already underway, use this playbook to continue to strengthen the mechanisms you have already put in place to realize sustained value within your care community. If you are just embarking on your journey to value, establishing a clinically integrated network now will provide the solid foundation required to move along the spectrum of risk. If the vision for your organization includes managing risk-based contracts and eventually becoming a provider-sponsored health plan, strengthening the alignment with potential partners delivers experience with population health management and performance-based programs to improve the value of care while reducing total cost.

We have listed the seven steps in numerical order. However, the chronology of building a clinically integrated network will vary by organization and market. Some steps may occur concurrently or in alternate order. Yet each step outlined on the subsequent pages reflects the vital components needed to build a new roadmap for local and regional healthcare communities to thrive in a value-based healthcare environment.

7 STEPS TO A CLINICALLY INTEGRATED NETWORK

1. Uniting Interested Stakeholders
2. Value Propositions
3. Governance & Participation Agreements
4. Quality Measures
5. Recruiting Physicians
6. Measurement & Improvement
7. Payer Negotiations



CONSIDERATIONS

- **Decide if the network will be regional, statewide or only encompass a few counties.**
- **Leverage admissions data to know your top referrers and talk with them first.**
- **Itemize capital and resource commitments and determine the technology you will use early in the process.**

Determine Network Territory

Exploratory conversations between a few healthcare executives have typically reflected the genesis of a clinically integrated network. Oftentimes, these one-on-one talks among leaders occur without independent facilitation. These early meetings help leaders gauge mutual interest in organizational collaborations and partnerships.

Common elements that health leaders consider before developing a clinically integrated network include:

Market Drivers

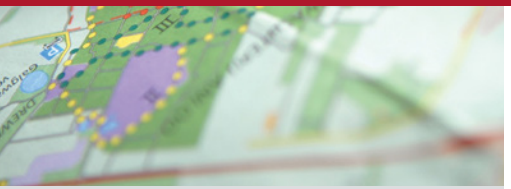
Where do opportunities exist for partnerships? Is your vision to create a network that spans multiple counties, the state or an entire region? Do you know which local organizations complement your strategy? For example, a hospital system without employed physicians will look to align with an established physician organization partner. First decide what you want to build. Then assess your local market and healthcare landscape to thoroughly identify all your opportunities and potential partnerships.

Admissions Data

Your own admissions data will provide a strong indication for potential partners. Which physicians care for most of the patients in your hospital or organization? Talk to them first. Recognize that you will not easily access data from physicians who are affiliated with other hospitals in your market. Work with the data you can access and recognize where you may not have a clear picture of providers in your market.

Data discovery with potential network members breaks down barriers and offers an accurate picture of each organization interested in collaborative patient care.

Uniting Interested Stakeholders, *Continued*



FACTS

The transformation of healthcare toward more integrated and accountable delivery systems has brought physician practices and other physician enterprises into health systems, as partners and collaborators, in unprecedented numbers.

Source: AHA Environmental Scan 2016

States across the country are promoting integrated care delivery as part of their efforts to deliver high-quality, cost-effective care to Medicaid beneficiaries with comorbid physical and behavioral health conditions.

Source: AHA Environmental Scan 2016

Stakeholder Discovery

Getting to the point of discovery is key with every potential partner. Early in the process, expect extensive discussions and sharing of organizational perspectives and information. While discovery may not include rates and methodology, discovery does itemize the number of specialists, number of sites, and other practice characteristics that provide a true and accurate picture of each organization and what that organization can contribute as a network stakeholder.

Even when stakeholder interests align, organizations may find themselves at different levels of commitment. When forming a network, each organization needs to be in the same stage of readiness and able to contribute capital and resources as a potential network owner/partner. Stakeholders also invest in technologies that seamlessly integrate and aggregate all provider data. Make time to hear from healthcare technology partners during this early stage of development. Understanding the capabilities and requirements of technology tools that support clinically integrated networks help foreshadow the future potential of your network.

Value Propositions

CONSIDERATIONS

- **Value propositions serve as building blocks and lead to strong governance.**
- **Every stakeholder will help define the network's value; physicians must lead patient care processes.**
- **Articulate how the network will better care for patients together.**

Be Clear About What You Are

What defines your network? Vision, mission and value propositions are a great place to start the conversation. Have each stakeholder think about what, in their view, the network must achieve as a collective entity and have them put those thoughts on paper. When you begin to explore each commitment statement, it is likely that a recurrent theme will emerge. Even as a common theme begins to form, avoid settling on too narrow a vision for the network. Keep the network's purpose broad enough to support innovation and commit to revisit the collective vision as you grow.

Your value proposition may seem minor in the scope of network development, but it is a key building block that leads you to the best governance structures and guides your network's evolution into the future. Engaging stakeholders in value proposition development helps to demystify the process and fosters cohesiveness around the common good. Ultimately, the spirit behind the creation of any clinically integrated network is to provide better care for patients, together. Develop vision and mission statements to best tell that story.

Clinician-led

Physicians, clinicians and staff will all help define the network. However, physicians must lead the way to effectively put goals into practice. Whether or not they hold formal roles in governing or managing the network, physicians are at the heart of care delivery. Without a strong physician voice to emphasize the priority on patient care, your network may struggle to gain traction.

Patient Care and Patient Satisfaction

Put the core principles that will govern patient satisfaction and care delivery in your vision and mission statements. Include those non-financial elements (better coordination, greater transparency, for instance) that represent the spectrum of patient care and are critical to your network participants.

All network steering committee members should put pen to paper about what is most important to patient care. To ultimately achieve your goals, allow physicians to lead the way.

Value Propositions, *Continued*

FACT

Nearly 52 percent of executives of hospitals and health systems said they see clinical integration as the cornerstone for both the strategic alignment of physicians in their respective care communities and to better manage the health of populations across a complete care continuum.

Source: HealthLeaders Media Intelligence Survey 2015

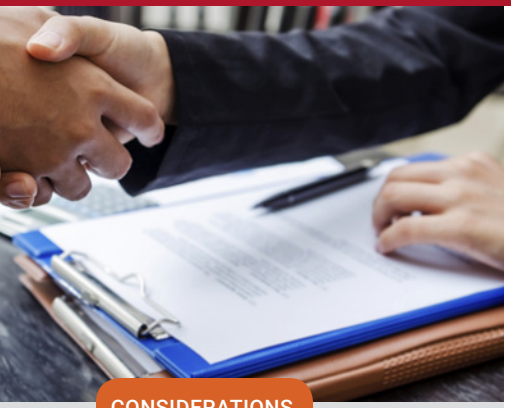
Key Audiences

Understand your audiences and what is important to them, then be prepared to discuss the value you plan to deliver. Audiences will include obvious network stakeholders such as patients, providers and payers. However, consider less obvious groups such as community-based organizations and others on the outer edges of the healthcare value chain. The network's value proposition should capture the perspective of those you will serve.

Doing the upfront work of identifying key audiences will help create a positive association with your network.

Given the number of stakeholders to consider, it may prove challenging to reach consensus around the network's value, but stay with it. Mastering this collaborative exercise will set the tone for administratively capturing the network's input, aggregating the data and calibrating the statements. Expect to host multiple strategy sessions before everyone is comfortable with the vision, mission and value propositions of your network. Talking through "what" you are and whom you will serve may seem simplistic. However, keep in mind that people bring complexity. The network should capture unique individual attributes while establishing a collective focus for the new entity.

Governance & Participation Agreements



CONSIDERATIONS

- **Determine where decision-making authority resides.**
- **Understand that an entity with single-signature contracting capabilities brings power to payer negotiations.**
- **Consider at least two layers of participation agreements: local clinically integrated groups and independent physicians.**

Build A Binding Framework

This is the point of clarity for healthcare teams to work better together and formalize arrangements for collaboration. Written agreements, a strong governance framework and organizational bylaws not only legally bind the new network, but create a new entity and underpin the spirit of clinical integration (better care). Depending on how you expect to manage your network, a variety of governance structures, policies and procedures can apply.

Here are some considerations to help you establish the best governance for the many organizations that are coming together within your clinically integrated network.

Representation

Each stakeholder must have a voice and a seat at the table during the decision-making process. Give yourself time to define the level of representation entitled to each participant and determine how to resolve conflicts between members.

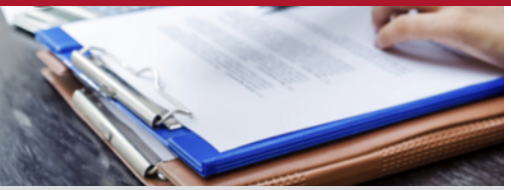
Decision-making Powers

The network must have decision-making authority to achieve the benefits of integration. Defining the data platform, outlining metrics and measurement, articulating relevant evidence-based medicine and care management best practices and contracting all need special attention. Where will the decision-making authority reside? One common structure is that of a board of directors with "single signature" authority for every type of contract, including those with payers. This structure also includes member organizations which may be part network owners or members. The oversight of the board often includes:

- Approving budgets and capital investments
- Defining ownership structure
- Facilitating transactions affecting the legal entity
- Defining acceptance and termination of member organizations
- Defining contracting strategy and negotiation parameters
- Determining how funds will be distributed

A single entity with a single signature structure packs power during conversations with commercial payers, self-funded insurers or government payers.

Governance & Participation Agreements, *Continued*



FACT

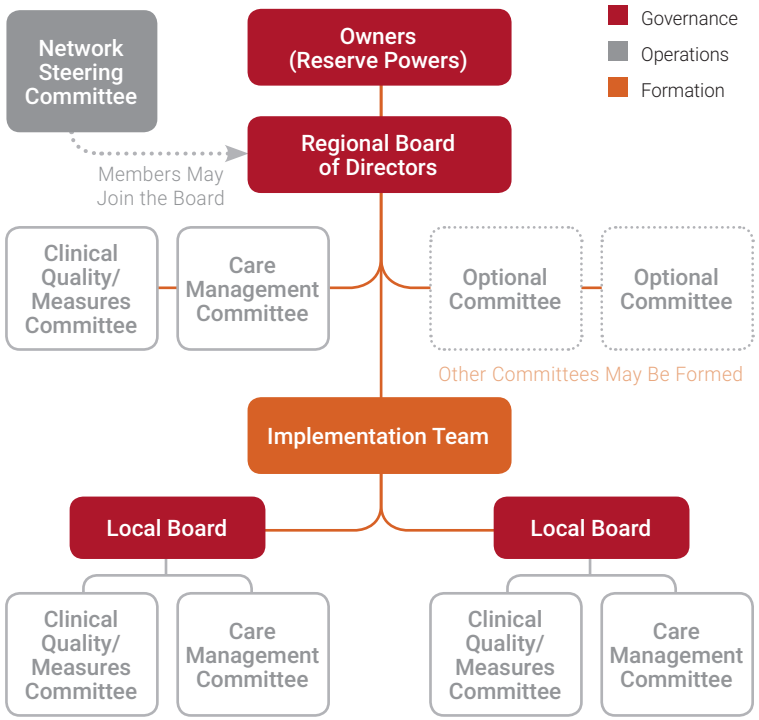
New board work may require new governance structures, such as adding a community benefit or population health committee.

Source: AHA Environmental Scan 2016

Local Clinically Integrated Networks

Often an owner or member retains its own local board of directors and governance structure. For example, a "local" clinically integrated network is typically a hospital or physician group (e.g., an independent practice association or physician-hospital organization) that is already contractually bound together. These groups practice in the local market and are choosing to partner with the network. A group of physicians—employed or not—can then recruit single physicians into the local clinically integrated network. This is an alternative to being employed by a hospital. The local clinically integrated network then contracts with the principal network entity and is required to adhere to care management protocols, but still retains independence.

GOVERNANCE AND COMMITTEE STRUCTURE EXAMPLE



Participation Agreements

Participation agreements are another part of a network's governance structure. Whatever model you decide for governance, the network will usually have a need for at least two types of participation agreements:

- **Local clinically integrated network participation agreements:** These agreements take place directly with the principal network entity and address infrastructure costs and management services that the local clinically integrated network will provide to provider participants.
- **Provider participation agreements:** These agreements are between a provider and the principal network allowing direct participation in the network. This agreement includes a power of attorney from the provider to the network to enter into risk sharing contracts on their behalf. Participation agreements also include network membership terms (e.g., addresses credentialing, clinical protocols, data access directly or indirectly via a clearinghouse, mandates like adopting an EMR/PPM and length of contractual commitment).

Drive Performance Through Measurement

Choose quality measures that are clinically relevant to measure. Are your member organizations already bound by a Medicare shared savings program? What quality measures are already included in that program? Build on existing quality measurements to adhere to programs already in place. Whatever you ultimately choose, expect a fluid process of evaluation and validation that evolves over time. The key is to start a roadmap. Once you finalize your quality measures, apply technology tools to administratively track and report provider and network quality performance *(see Step 6)*.

CONSIDERATIONS

- **Your network should start out measuring quality not clinical outcomes.**
- **Identify measures then review claims-based data to get a sense of provider performance.**
- **Quality data shines a light on patient education opportunities.**

Form a Quality Measures Committee

A quality measures committee within your network is often charged with exploring existing member obligations (strategically or contractually) to choose measures that align with the network's goals. The committee also reviews how quality measures align with financial obligations of pay for performance or shared services.

Review National Standards

Clinical integration intelligence tools exist with a built-in library of national standards of measurements (e.g., PQRS, HEDIS, CA IHA P4P, PCPI, AHRQ, NQMC, AKITA, NCQA, URAC, etc.) Leverage these tools to guide physician selection of quality measures. Start with metrics that can be measured, and as the network evolves, move on to more complex measures.

Document Quality Measures

The network's quality measures committee sets quality measures for stakeholders to review, discuss and approve. Consensus may be challenging. Work through feedback and issues with the goal of consensus. Help all stakeholders understand that unlike other areas of network development, quality measures reflect a more flexible process that evolves over time.

When choosing quality measures, it's important for everyone to recognize that it's a fluid process that evolves over time.

Quality Measures, *Continued*

FACT

The industry can realize $9B in healthcare savings by increasing shared decision making.

Source: Institute of Medicine

Access Claims-based Data

Review claims-based data from providers as this data is the most standardized across a network, and therefore the most consistent and helpful in identifying areas for improvements in care delivery and cost reduction. Networks often include data measures to gain insights into all aspects of care delivery including admission and readmission occurrences, medication reconciliation and chronic disease management. While EMR measures can be used, the network may invest significant time in attempting to collect data from multiple EMRs. Furthermore, physicians will need to be trained on how to standardize the input into the EMR to stay consistent. Standardized EMRs may be the end goal, however, it is important to start simple and move to this over time.

Track and Improve

The technology you choose for your network will help isolate areas for preventive health improvements for the defined population. For example, if patient hypertension quality measures are low, you'll have the insight into all the providers linked to that patient with low hypertension. That insight leads to patient outreach, education and provider follow-up. Continuous tracking and monitoring of quality measures also benefits payer negotiations by demonstrating active cost containment and provider performance.

CONSIDERATIONS

- Identify types of providers your network needs.
- Review existing clinical performance metrics, if available.
- Personalize a meaningful message for joining your network.
- Isolate provider gaps and overlaps in your care network, yet understand that few networks are fully formed right out of the gate.

Identify Champions

A network is only a network with provider participants. How will you communicate your vision to clinicians (and non-clinicians)? Before you begin to invite physicians and ancillary providers to your network, think about how you'll personalize participation. Refer back to the vision and value proposition statement created during Step 2 as you already determined how to make it meaningful to join the network. Networks challenge the status quo so be ready to explain how the network will coexist with a physician's already full and rigorous schedule. Participants want to understand how they'll remain independent and virtually align with your network to thrive in a new value-based healthcare landscape. Consider what's important to your community of providers (both clinical and non-clinical) as you reach out to ask them to be a part of your patient-centered, clinically integrated network.

Physician and Executive Champions

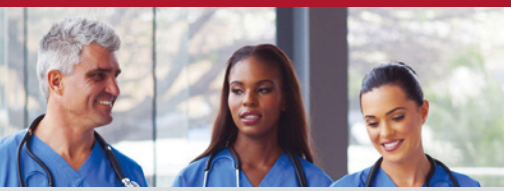
A champion is often a physician and a network executive. Champions provide a voice to communicate the mission of the network to the community. Non-clinicians and administrative resources at a hospital can also help navigate physician alliances to introduce the network. Take time to identify and empower a champion of your network. That individual(s) provides a familiar face among providers and helps lead informational meetings to explain the network's strategy to providers and answer questions.

Participation Criteria

What standards will you expect of your physician participants? Start with the basics (e.g., credentialing, a license to practice in the state). Then fold in additional requirements including admitting/in-network hospital privileges or hospitalist coverage at the network's member facilities. For the network to truly integrate, participating physicians will need a method to submit electronic data (e.g., via an EMR or practice management system). Some networks require physicians to adopt and implement an EMR or practice management system (within 12 to 18 months of signing a network participation agreement). Also include in your criteria a requirement to directly or indirectly access claims-based data after contractually signing with the network. Employed physicians typically will have a single data source. However, a different data capture/extract process will occur with independent physicians.

Participation is personal. Providers want to hear the network's position on risk, contracting and why sharing access to data is essential.

Recruiting Physicians, *Continued*



FACT

Physicians anticipate that value-based payment models will equal about 50 percent of their total compensation in the next 10 years.

Source: AHA Environmental Scan 2016

The Provider Target List

Your participation list will include both physicians and ancillary providers. Begin with a larger list and narrow it down. If available, access existing clinical performance data to assess physician performance. As you prioritize and narrow your list, you'll in essence create a database to track the number of physicians in your market, number of specialists, etc. That database then helps identify coverage gaps and overlaps. Some networks refer to NCQA credentialing standards as a baseline. For example, NCQA outlines one primary care physician for every 5,000 patients and a ratio of 3:1 for specialists to patients. These standards provide a minimum starting point. Once the network starts contracting, you'll track participation levels to ensure your network includes the right number of providers to manage the defined population.

Recruitment Strategy

The recruitment plan includes methods for reaching out to providers and outlines the value a network will offer to participating physician practices. Executive champions play a key role in documenting the strategy. Include education sessions to personally explain your position on capitated risk, clinical integration, use of technology, terms and data. Before changing the personal status quo, physicians want to understand how to retain existing reimbursement and practice models, what benefits exist for participating in the network, and their role in shared savings, bonus dollars, surplus dollars, etc.

CONSIDERATIONS

- **Primary care physicians are central to managing patient care across specialties.**
- **Train all providers on quality measurement and reporting.**
- **Improve network support of better patient outcomes via communications.**

Employ Data-Guided Quality and Performance

Every network strives for transparent, accessible health data to make informed, data-guided care decisions for a patient population. Keep in mind that most developing networks begin this effort by first focusing on preventive health measurement before evolving to population health management. Administratively, networks leverage a technology tool to aggregate disparate data sources and uniformly track and report on provider and network quality performance based on the defined set of quality measures (see Step 4). You can only improve on what you know through measurement.

Provider Education on Measurement Tools

Technology tools can automatically identify every clinician treating a single patient that may appear with a low-quality measurement score. Make time to educate and train network providers on how your selected technology tool will measure quality across patient care. Articulate how your tool will help identify care gaps, track action plans to guide improvements, and identify opportunities for cost reduction. By fostering a universal understanding and adherence to quality measures and measurement, you'll set the tone for continuous improvement for both individual and network performance.

Role of Primary Care

As part of the network, primary care physicians now gain more insight then they've had before into patient care across specialties. For example, at the point of care, primary care physicians will know who has seen his/her patient and what treatments and medicines other clinicians have prescribed. That is a new dimension of transparency. And it is this insight that actually helps evolve day-to-day practices to realize the intent behind accountable care.

A precursor to managing population health is measuring claim-based, preventive health data; it helps pinpoint care gaps and guide patient outreach efforts.

Measurement & Improvement, *Continued*

FACTS

The healthcare industry is wasting $55B in missed prevention opportunities.

Source: AHA Environmental Scan 2016

High-performing organizations are increasingly reporting to physicians how their personal performance compares with that of their colleagues and providing data in ways that intensify peer pressure.

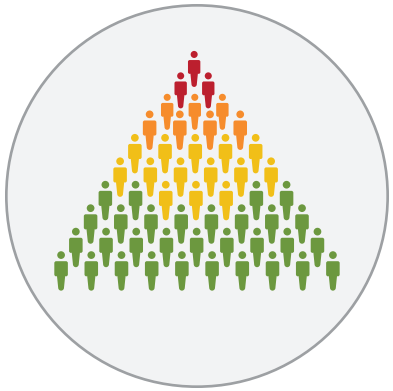
Source: AHA Environmental Scan 2016

Role of Care Coordination

What care management support will exist to reach out to patients? Hospitals or physician practices rely on external resources to support patient outreach. Partners can help fill the void by leveraging in-house utilization management and preventive health resources such as nurses, wellness and care coordinators. These resources look at the entire patient population, actively support high-risk or at-risk members, and help consistently manage patients with chronic disease(s).

Role of Data in Improving Performance

It is important to regularly meet with physicians to look at the data and how the network is performing so that you may focus on areas that need improvement.



Population	Patient Need	Health System Opportunity
Acute	Episodic Management	• Follow-up post discharge • Prevent readmissions
Healthy with Habits	Continuous Management	• Coordinate across care continuum • Keep in preferred network • Engage in health management
Chronically Ill		
Healthy	Access to Care	• Exceed consumer expectations • Grow market share • Enable capacity across the network
Total Market		

Payer Negotiations

CONSIDERATIONS

- **Understand risk and the costs for each member per month.**
- **Explore Medicaid Managed Home and government contracts.**
- **Consider adding your own employees to the network first.**

Time the Opportunity

Health leaders have a history with most all of the payers in their local markets and will understand where potential opportunities arise for the new entity. Thus, new networks often begin by focusing on existing provider agreements that come up for renewal. The contract renewal process offers a natural introduction to the network and also provides the framework to explore greater risk. Data will play a central role during this time. The quality measures captured from reporting across the care continuum can show the value of the network and then support renegotiations of terms that offer a larger geography to cover or an expanded group of providers to add to the network. There may also be data that you need from your payers so it is important to negotiate with payers early on to determine when and how data will be exchanged.

Contract Renewals

Many networks choose to mandate that each participating organization introduce the new network entity (for right of first refusal) whenever an existing contract comes up for renewal. Though this stipulation organically introduces the network into members' discussion with their respective payer(s), understand that a member's individual performance on defined quality measures may come to the forefront during this time.

Add Your Employees to the Network First

Adding employees first gives them access to the network plus all the providers in their existing health plan. When an employee sees a network provider, they save in out-of-pocket costs and the physician's existing fee-for-service arrangements remain intact. Moreover, adding employees to the risk pool also gives the network an advantage in effective population health management. The smaller population helps build the roadmap for capturing patient data and offers a solid early step to acclimate to the new process as an aligned network.

As each member's current agreement with a payer comes up for renewal, use the opportunity to introduce the network and discuss risk contracting with payers.

Payer Negotiations, *Continued*

FACT

Healthcare providers expect that the industry shift to value-based contracts will negatively impact their respective organization's bottom line.

Source: AHA Environmental Scan 2016

Risk Contract Benchmarks

Payer contracts may evolve into risk contracts. Many networks enter risk gradually by starting with shared savings, bundled payments, upside-downside or a mixture of both. Leverage access to benchmarks for risk contracts to understand cost for each member per month in a commercial market. Expertise in the nuances of payer contracts and negotiating at-risk terms brings transparency to the process and helps derive more favorable contract terms for the network.

ASSESSING THE CONTRACT VALUE OF A POPULATION

Data acquisition	Optimal price	Determine opportunity	Contract
• Historic claims data for population • Provider claims data • Cost accounting data	• PMPM price for services provided • Benchmark to historic and current population	• Estimate pricing and operational differences	• Determine pricing guardrails • Approach payers and contract

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$19+ BILLION
MEDICALLY MANAGED SPEND FOR EMPLOYERS ANNUALLY

$28+ BILLION
NET PATIENT REVENUE PROCESSED ANNUALLY

Conifer Health has partnered with more than 800 provider clients to strengthen their financial and clinical performance. The health services company helps organizations transition from volume- to value-based care, enhance the consumer and patient healthcare experience, and improve quality, cost and access to healthcare.

Annually, Conifer Health manages 25+ million patient interactions, $28+ billion in net patient revenue and $19+ billion in medically managed spend. Plus, the company's technology and health management services support care management for more than 5 million lives each year.

Questions about clinically integrated networks?

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