Hospital Affiliations and the Establishment of ‘Hospital Networks’

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Agenda

- Overview
- Models for AMC – Community Hospital Affiliations
  - Key Legal Considerations
  - Opportunities and Challenges
- Case Study of an Emerging Model – Vanderbilt
  - Grant Award for Care Coordination
  - Technology and Infrastructure
  - Involvement of Community Physicians
  - Opportunities and Challenges
Overview

- AMCs are increasingly affiliating with community hospitals in an attempt to become a larger community network and better position themselves in light of changing payment structures, declining volumes and increasing reimbursement pressure.

- There is a continuum of affiliation options with recent activity largely falling into one of the two ends of the spectrum:
  - Formal: Mergers and acquisitions
  - Informal: Contractual affiliations and care coordination

Traditional Forms of Affiliation Are Alive and Well...

- A number of AMCs and health systems continue to pursue the old fashioned, traditional method of creating hospital networks through mergers and acquisitions:
  - Number of hospital transactions increasing\(^{(1)}\):
    - 2009: 52
    - 2010: 75
    - 2011: 86
  - In 2010, approximately 20 percent of health-related M&A involved an AMC\(^{(2)}\)

...While New, Innovative Models Capture Headlines

- AMCs are seeking new, innovative ways of partnering with community hospitals, short of full ownership

- Affiliation models take a variety of forms
  - Franchise approach
  - Affiliation Agreements
    - Service Line
    - General
  - Larger Scale Collaborations

Examples: 2012 Activity re Looser Affiliations

Wave of the Future?

- “Strategic Alliance” – NJ – March 2012
  - Hackensack University Medical Center and North Shore-Long Island Jewish Health System
  - Sharing best practices and working together on co-operative programs, ACOs, management programs, IT programs, affiliated FQHCs, and referral arrangements for specialty care

- University of Iowa Health Alliance – IA – June 2012
  - Mercy Health Network, Genesis Health System, Mercy-Cedar Rapids, and UI Health Care
  - Promoting clinical integration and care coordination; improving the continuity of care that an individual patient experiences, though coordinating records and visits between the various entities

- Affiliation Agreement – NY – July 2012
  - University of Rochester Medical Center, Wyoming Cty Comm. Hospital
  - Coordination of specialty care
2012 Activity re Looser Affiliations (II)

- **“Strategic Partnership”** – Southeast – August 2012
  - Memorial Health and Novant Health
  - Shared services agreement and supply chain, clinical engineering, IT, and clinical program collaborations

- **Integration Short of Merger** – CA – August 2012
  - University of California San Francisco Medical Center and Dignity Health
  - Announced MOU to develop a partnership to integrate their healthcare systems without entering a full merger or acquisition.

- **BJC Collaborative** – Midwest – October 2012
  - BJC Healthcare (St. Louis, MO), Memorial Health System (Springfield, IL), St. Luke’s Health System (Kansas City, MO) and Cox (Springfield, MO)
  - Large scale collaboration agreement involving no financial contributions
  - Focused on sharing best practices, improving quality, and obtaining efficiencies through joint purchasing and other initiatives.

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    - Opportunities and Challenges
AMC-Community Hospital Relationship Options

Drivers of Acquisitions/Mergers

- Numerous market forces are putting pressure on AMCs to consider consolidation
  
- Threats to revenue
  - Downward pressure on reimbursement rates, especially M/M
  - Lack of primary care physician network in light of move towards rewarding coordination of care among specialists and primary care MDs
  - Projected growth in patient mix among low-revenue groups
  - Reductions to IME funding
  - Declines in NIH and philanthropic funding

Source: PriceWaterhouse Coopers report "The future of the academic medical center: Strategies to avoid a margin meltdown," Health Research Institute February 2012
Drivers of Acquisitions/Mergers (II)

- Additional costs and obligations
  - Transitions to electronic health records
  - Meeting new quality standards under PPACA
- Quality perceptions
  - The number of AMCs on top hospital lists has been declining
- Capital needs
  - Challenges in raising significant funding in this economy

Key Legal Considerations: Acquisition/Merger

- Increasingly subject to a significant level of federal and state antitrust scrutiny
- Reading Health System in Pennsylvania forced to drop acquisition of surgical hospital after FTC and state AG announced plans to file a preliminary injunction
  - FTC argued that the acquisition gave Reading too much market share over specialized surgical procedures in the local area, increasing their market share to between 49 and 71 percent for the various procedures and noted that SIR charged rates 30-40 percent less than Reading, and yet obtained similar outcomes for patients
Antitrust Challenges – Acquisition/Merger

- FTC ordered ProMedica to dissolve ownership of St. Luke’s Hospital In Ohio, after acquisition was found to be anticompetitive
  - FTC argues that ProMedica obtained a 60% market share for general in-patient acute care service in the Toledo area after the merger, and an 80% share of inpatient obstetrical services

- FTC challenge of Phoebe Putney Health System’s acquisition of Palmyra Park Hospital in Georgia under Supreme Court review
  - “By eliminating vigorous competition between Phoebe and Palmyra, this merger to monopoly will cause consumers and employers...to pay dramatically higher rates for vital health care services, and will likely reduce the quality and choice of services available”
  - State action immunity doctrine


Antitrust Challenges – Acquisition/Merger

- Attorney General inquiries re pricing
  - North Carolina AG is looking at whether there is artificially high hospital pricing following mergers
  - California AG has subpoenaed several prominent hospital chains looking into whether the hospitals raised prices post-merger in violation of antitrust laws
  - Massachusetts AG put out a 2010 report tying high healthcare costs to the market leverage of hospitals. The AG has since scrutinized several mergers:
    - Partners-South Shore
    - Northampton-Massachusetts General
  - AMCs typically have some negotiating power given size and specialty services
Additional Legal Considerations

- Compliance issues of target
  - SRDP filings as condition to close; indemnification escrow
- FMV valuation
- Corporate/transactional matters
  - Required consents
  - Form: merger, asset acquisition, substitution of corporate member

Ownership – Key Opportunities and Challenges

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>CHALLENGES</th>
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<tbody>
<tr>
<td>AMCs</td>
<td>Coordination of care</td>
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<tr>
<td>- Ability to control</td>
<td>- Combining HIT</td>
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<tr>
<td>- Brand and network expansion</td>
<td>- Clinical integration</td>
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<tr>
<td>- Economies of scale</td>
<td>- Cultural differences/building trust and integration</td>
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<tr>
<td>- Potential increased ability to participate in CMS and private payor innovation programs and ACOs</td>
<td>- Encouraging AMC physicians to commute to community hospitals</td>
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<td>Community Hospitals</td>
<td>Receptivity of community hospital clinical staff</td>
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<tr>
<td>- Financial – access to capital and bond markets</td>
<td>Historical liabilities of target</td>
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<td>Potential dilution of brand</td>
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<td>- Recruiting MDs to AMC if they can join community practice and get name</td>
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Recent examples

- April 2011 - All Children’s Hospital (St. Petersburg, FL) joined Johns Hopkins Health System
  - All Children’s retained fair amount of control
  - New medical residency program and research director

- January 2012 - Beth Israel Deaconess Medical Center acquired Milton Hospital (Milton, MA)
  - Note: CareGroup is Beth Israel parent company and also serves as the parent holding company for Beth Israel Deaconess Hospital-Milton, Beth Israel Deaconess Hospital-Needham, Mount Auburn Hospital, and New England Baptist Hospital
  - Affiliation was originally formed for purposes of care delivery, but it now describes itself as a confederated model in which they jointly borrow and purchase certain services, but largely operate in a decentralized manner

Recent examples (II)

- September 2012 - Yale-New Haven Hospital merged with Saint Raphael Hospital (New Haven, CT)
  - Reportedly allowed Yale greater access to patient beds, while providing Saint Raphael Hospital with needed capital

- December 2012 – University of Maryland Medical System acquired St. Joseph’s Medical Center in Towson, Maryland

- December 2012 – Baylor Health Care System announced plans to merge with Scott & White Healthcare
  - The merger would combine 42 hospitals to form a health system valued at around $8 billion.
  - Location of the systems means that there is no overlap between the hospitals, which leaders say will allow them to increase their scale and efficiency without worrying about internal competition between hospitals
AMC Mergers and Acquisitions since 2011

Overview: Joint Ventures

- AMCs may alternatively seek to partner with a community hospital by entering into a joint venture hospital or service line

- Joint ventures offer access to capital and shared financial risk, but less control as compared to pure ownership
Overview: Joint Ventures

- **Examples**
  - **Duke Lifepoint:** Venture aimed at partnering with community hospitals – NC, VA, and MI
    - Venture is principally owned and operated by LifePoint, which has experience operating community hospitals in 17 states
    - Duke, only a 3% owner in the venture, has stated it adds knowledge on hospital quality while using the venture to increase footprint\(^1\)
  - **Shands Healthcare in FL:** Divested full ownership of three community hospitals in favor of joint venture with Health Management Associates
    - Allows Shands to maintain affiliate networks without being principally responsible for day to day operations of the community hospitals


Key Legal Considerations of Hospital JVs

- **Antitrust**
  - If JV partners compete or is in a service line that competes with the hospital, need to ensure appropriate safeguards are in place to avoid inappropriate information-sharing

- **Fraud and Abuse: AKS**
  - Valuations of capital contributions and buy-ins

- **Tax**

- **Corporate/transactional matters**

- **Provider-based considerations**
Overview: Management Relationships

- AMC may manage a community hospital or a particular service line within the community hospital

- Key legal considerations are similar to those for JVs
  - Fraud and Abuse
    - FMV payment for management services
  - Antitrust
    - Ensure no improper information-sharing

Management: Key Opportunities and Challenges

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<tr>
<th>OPPORTUNITIES</th>
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<tr>
<td>AMC</td>
<td>Lack of ultimate control by AMC</td>
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<td>Additional revenue from selling mgmt expertise</td>
<td>Compliance-related issues and concerns (e.g., Stark, staffing models)</td>
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<td>Spreading overhead costs</td>
<td>Ability to understand different challenges and considerations given posture and location of community hospital</td>
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<td>Additional education and experience for staff</td>
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<tr>
<td>Community Hospital</td>
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<tr>
<td>Increase management expertise and resources</td>
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<tr>
<td>Potential for future additional collaborations</td>
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AMC-Community Hospital Relationship Options

Emerging Models

- Franchise/branding approach
- Service line affiliations
- Larger scale contractual collaborations
- Case study: care coordination
Franchise Approach

- AMC provides a package of goods and services to a community hospital in exchange for annual fee, such as:
  - Policies and procedures
  - Standardization of protocols
  - Clinical direction
  - Quality assurance activities (e.g., M&M reviews)
  - Credentials specialists
  - Recruitment of physicians
  - Naming rights/references on signage

Franchise Approach (Cont.)

- Value of Brand
  - In a PWC study, 59 percent of consumers indicated that they were likely to seek treatment from a community hospital if it was associated with an AMC

- Principal legal/regulatory considerations
  - Ensuring FMV fees
  - Conducting appropriate diligence on front end in light of extending name/brand
Franchises – Opportunities and Challenges

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<td>AMC</td>
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<tr>
<td>- Ability to increase geographic footprint through branding and minimal investment</td>
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<td>- Opens lines of communication for potential future collaborations</td>
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<td>- Revenue from helping develop capabilities locally</td>
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<tr>
<td>Community Hospital</td>
<td>Community Hospital</td>
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<tr>
<td>- Ability to redefine image</td>
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<td>- Access to additional resources and expertise</td>
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<td>- Potential for diffusing the name brand through use in less controlled settings</td>
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<td>- Managing expectations of community hospital in ability of this model to achieve desired results</td>
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<td>- May have less negotiating power</td>
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<td>- Desire to retain autonomy and make own decisions</td>
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Affiliation Agreements

- AMC and community hospitals are increasingly entering into affiliation agreements based on particular service lines
  - Telemedicine
  - Neonatology
  - Cancer care
  - Stroke
  - Specialized surgery
  - Trauma
- Key Legal Considerations
  - Fraud and Abuse: Anti-Kickback Statute
### Service Line Affiliations

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<tr>
<td><strong>AMCs</strong></td>
<td>Structuring arrangement in accordance with fraud and abuse laws and considerations</td>
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<tr>
<td>- Ability to expand network with minimal investment</td>
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<td>- Potential for managing care in a more efficient manner</td>
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<td>- Potential additional training sites for residents</td>
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<tr>
<td><strong>Community Hospital</strong></td>
<td>Obtaining commitment and buy-in of clinical staff of both parties</td>
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<tr>
<td>- Ability to improve access to specialty care and clinical resources</td>
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<td>- Ability to retain independence</td>
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**Recent Examples of Service Line Affiliations**

- **ED Transfer Affiliation Agreement – Steward Health Care System and Partners HealthCare System (MGH and Brigham and Women’s)**
  - Steward agrees to refer Level I trauma patients to Partners
  - Partners assists Steward in achieving Level 3 trauma designation
  - Massachusetts AG statement: “Our office has been informed of the agreement, but we will not comment further until we’ve had the chance to review the details.”

- **Cardiologist Affiliation Agreement – Christ Hospital (O.H.) and SWRMC**
  - Cardiologists within Christ Hospital’s practice would begin treating patients at SWRMC; was to expand to oncology and orthopedics
  - Christ ended the arrangement after only nine months, following the departure of Christ’s CEO, citing a difference in opinion about the role SWRMC would play.

Larger Scale Collaboration Agreements

- Recent formation of large scale, non-ownership alliances and collaborations
  - BJC Collaboration
    - Stated interest in focusing on non-labor expenses and joint purchasing, as well as improving quality and sharing best practices
  - University of Iowa, Mercy Health Network, and Genesis Health System
    - Stated purpose of developing a platform for sharing expertise, support services, and IT, while working to develop an ACO initiative

Larger Scale Collaborations

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<tr>
<td>- Expanding network</td>
<td>- Number and diversity of stakeholders</td>
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<tr>
<td>- Increasing quality of care through collaborations</td>
<td>- Organizational trust and ability to collaborate</td>
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<td>- Better positioned in light of PPACA</td>
<td>- May have antitrust limitations given remain separate entities (e.g., no joint pricing)</td>
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| - Purchasing efficiencies  
  - Potential for cost savings and efficiencies  
  - Greater volume  
  - Greater standardization of supplies |
Recent Example: BJC Collaboration

- Formed in October 2012
  - BJC Healthcare (St. Louis, Barnes-Jewish Hospital, WashU affiliation)
  - Memorial Health System (Springfield, Illinois.)
  - St. Luke’s Hospital of Kansas City
  - Cox Medical Center South (Springfield, Missouri)

- 3 states, 30 hospitals, $7B combined annual revenue

BJC Collaborative (Cont.)

- Composed of “Operating Committees” with leaders from each system
  - Seeks to reduce costs and improve outcomes

- No asset or capital contributions
  - Hospital leaders have issued statements stating that a merger was not contemplated and that none of the hospitals is in financial distress such that it was seeking a merger
BJC Collaborative (Cont.)

- Stated goal of increasing quality of care and lowering costs, including
  - Physician recruitment
  - Staff training and education
  - Population health management
  - Clinical skills training and emergency preparedness
  - Supply chain relationships
  - Capital resource analysis and other financial services
  - Sharing best practices and ideas for IT, facilities, etc.

Considerations in Selecting Affiliation Model

- What are the goals of the affiliation?
  - Financial stability/economies of scale?
  - Access to capital?
  - Physical integration?
  - Clinical integration?
  - IT integration or modernization?
  - Expansion of brand?
  - Expansion of a particular service line?
  - Recruiting medical staff?
  - Joint purchasing program?
  - Care coordination on certain service lines?
  - Sharing of best practices?
  - Maintaining autonomy?
Considerations in Selecting Affiliation Model

- Is there a clear vision articulated by both partners?
  - Governance
  - Level of integration/autonomy
  - Budgetary control

- Which legal and regulatory considerations inform the structure and terms?
  - Antitrust?
  - Fraud and abuse?
  - Tax?

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Vanderbilt Affiliate Model

Background:
• Vanderbilt established Affiliation Agreements with 3 (now 5) community hospitals in surrounding communities
• Affiliation Agreements cover:
  • Collaborative efforts to expand medical services provided by community hospital to residents of the particular service area through enhanced level of integrated care and application of scientifically informed and best evidenced based care;
  • Serves as a master agreement defining services contemplated by the parties;
  • Establishes a governance structure whereby the parties meet to discuss establishment of new ventures and services

Examples of Collaborations under Affiliation Agreements

• Maury Regional Medical Center:
  • Vanderbilt manages and provides professional services for:
    • NICU
    • Cardiac surgery and general cardiology
    • Neurosurgery
    • Radiation Oncology Joint Venture

• NorthCrest Medical Center:
  • Vanderbilt manages outpatient practice and provides professional services for:
    • Endocrinology
    • Rheumatology
    • Obstetrics and Gynecology services
Vanderbilt and its Affiliate Network

- Vanderbilt and affiliate hospitals are interconnected, but separate providers in both urban and rural settings
  - Vanderbilt University Medical Center – 1019 beds across 3 hospitals (adult, children's, psychiatric) in Davidson County, TN (pop. 635,475 (2011 US Census Data))
  - Maury Regional Medical Center System – 410 beds across 3 hospitals in Maury, Wayne, and Marshall Counties (pop. 81,509, 16,591, and 30,881, respectively) (50 miles from VU)
  - NorthCrest Medical Center – 109-bed facility in Robertson County, TN (pop. 67,106) (29 miles from VU)
  - Williamson Medical Center – 185-bed facility in Williamson County, TN (pop. 188,560) (19 miles from VU)

Affiliate Structure within Grant

- Vanderbilt is uniquely positioned to test this model because of its relationship with community hospitals with which it has only a formal affiliation, but no ownership position or control position (similar to many arrangements today)
- Hospitals represent both urban and rural settings and thus make the model scalable across other settings where urban and rural providers must work together
Affiliate Structure within Grant

- Vanderbilt and affiliates already have a cross section of patients who seek care at both institutions, but whose care today is not coordinated between providers
  - Vanderbilt Medical Group physicians constitute 40% of medical staff at Williamson Medical Center
  - Vanderbilt Medical Group physicians provide cardiology services, neurosurgery services, cardiac surgery services, neonatology services, and radiology services at Maury Regional Medical Center and its affiliates

Scale of Affiliation Agreements

- Between Vanderbilt, Williamson Medical Center, NorthCrest Medical Center, and Maury Regional Medical Center:
  - Care for portions of adult and children in 16 middle Tennessee and 2 Kentucky counties
  - Employees and beneficiaries of respective health plans comprise over 53,000 members
  - Combined medical staffs include over 160 adult primary care, 186 pediatricians, 840 other specialists
Opportunities and Challenges of Affiliate Relationship

**OPPORTUNITIES**

- **Vanderbilt**
  - Access to broader patient population, including research subjects
  - Ability to provide care in communities to help free up capacity on main campus
- **Affiliates**
  - Name brand recognition to help keep more patients in community
  - Access to protocols, expertise, and ability to provide higher level of care at hospital through service contracts

**CHALLENGES**

- **Vanderbilt**
  - Gaining trust of would-be competitors
  - Cultural challenges
    - Gaining acceptance with physicians and hospitals in community
    - Gaining acceptance with physicians internally
- **Affiliates**
  - Working with other community hospitals with which it competes for business
  - Fears of losing market share in community to Vanderbilt (patients bypass community hospital to go to Vanderbilt)

Case Study: Vanderbilt CMS Innovation Grant

- Vanderbilt awarded The Health Care Innovation Award from CMS for $18.8 million
- Funding to support the implementation and evaluation of the MyHealthTeam (MHT) model - team-based care that couples collaborative health care teams with health information technology to improve control of chronic conditions
- Goals are:
  - achieving our potential for quality of care and improved health status;
  - addressing rising prevalence of chronic disease;
  - leveraging consumer engagement;
  - addressing mismatch between supply and demand for health care services, especially primary care; and
  - addressing financial pressures mandating less-costly and more efficient care delivery systems
CMS Innovation Grant

• Initial focus will be on patients with congestive heart failure, hypertension, and diabetes, and will look to:
  • Reduce cardiovascular risks
  • Reduce 30 day hospital readmissions among patients with congestive heart failure, acute myocardial infarction, chronic obstructive pulmonary disease, and pneumonia
  • Reduce ER visits and hospital admissions for patients with hypertension and/or diabetes
  • Reduce cost of care for patients with congestive heart failure, COPD, acute myocardial infarction, or pneumonia

CMS Innovation Grant

• Seeks to accomplish such goals through the implementation of real-time informatics to coordinate care across health care delivery organizations joined by affiliation agreements designed to improve care and reduce costs

• Seeks to demonstrate effectiveness, efficiency, and scalability of the MHT model across a range of community settings supported by organizationally distinct rural and urban hospitals unified by affiliation relationships
CMS Innovation Grant

- Care coordination efforts using technologies across hospital providers include:
  - Multiple means of patient identification
  - Rapid enrollment
  - Consistent patient stratification
  - Creation of a meaningful and achievable personalized, evidenced-based care plan for enrolled patients
  - Employment of informatics tools to foster communication across providers and with patients
  - Continuous examination of composition lower costs and assure quality

Data Collection and Analysis

- MHT model is based on clinical data and not reliant on health plan data or claims:
  - Results in better care and management for ALL patients because benefits are accrued independent of health coverage or wealth (eliminating racial and ethnic disparities in quality and access)
- MHT model is patient and team-centered and encourages patients to become more involved in self-monitoring and their own treatment plans
Data Collection and Analysis

• Patient’s medical record is source for patient clinical characteristics, outcomes, utilization, and cost data
• Once enrolled, medical record from each participating site is searched and matching records are sent to a tool that creates a new “community record”
• Community record is accessible by physicians and CCs in all systems so that care can be managed across the continuum of providers
• Data to include socio-demographic, region (urban, suburban, rural), and insurance, in addition to clinical characteristics (e.g., immunization record, discharge summary, problem list, diagnostic radiology and lab results, medications list, etc.) and health care transactions (e.g., ED and hospital visits, 30-day re-hospitalization, other billable services)

Data Collection and Analysis

• All medical records are updated at the respective sites and data is automatically updated in the community record
• Data set will confirm and require consent and authorization from each patient regarding participation and sharing a data among sites
  – Update of notice of privacy practices, even if for purposes of treatment and/or hospital operations
Care Coordination Model

MHT Structure

- Participant Recruitment and Enrollment
  - Patients with congestive heart failure, diabetes, or hypertension are identified in advance by care coordinator (CC)
  - Program is introduced at scheduled office visit or visit is scheduled by CC to introduce program
  - During first visit, CC establishes plan of care, goals of treatment, and initiates appropriate home monitoring
  - Once consent from patient is obtained to enroll, patient’s medical record is sent to form the community record
MHT Structure

• Technology support includes:
  – Plan of Care Toolkit supports CC tasks by tracking and generating alerts for patients due for disease management task or non-compliant with individualized plan of care goals
  – Software provides CC and medical assistants with alerts regarding necessary patient follow up (e.g., medication change)

• Education and Outreach
  – Need to educate patients regarding health decisions is key
  – Includes education by CC, medical assistants, specialty clinics (e.g., Hypertension clinic, Heart Failure clinic, and Diabetes clinic)
  – Provides tools for self-help: blood pressure monitors, scales, and glucometers for patients who cannot purchase
  – Medical Director and CC will meet with clinical team to discuss model, process flow, roles, activities, and communication
Program Across Affiliate Network

- Utilizes platform similar to a health exchange established in Memphis, TN (MidSouth eHealth Alliance)
- Each affiliate site will have CMO and project manager for development of model at each site
- Care coordination team will be at each site: RN care coordinator, medical assistants, and RN project manager

Program Across Affiliate Network

- All CCs and MAs will have to meet certain core competencies, assessed during first 90 days
- Following metrics will be tracked for all teams to assess impact on workforce:
  - Amount and overall percentage of time RN CCs and MAs devote to patient interaction and care coordination tasks
  - Amount of time primary care providers spend in non-visit related care management
  - Number of office visits per year per primary care provider
  - Staff satisfaction with job and roles
  - Staff perception of the degree to which they are working to the top of their license
Program Across Affiliate Network
• Following metrics will be tracked for all teams to assess staffing needs:
  – Number of model patients per site (estimate 900 patients per CC and 1,200 per MA)
  – Number of model patients managed by primary care physicians, specialists, pharmacists, and social workers
  – Number of office visits per year of model patient per primary care provider and specialty provider
  – Panel of model patients for each primary care provider seen over last 18 months
  – For PCPs, ratio of time devoted to office visit vs. time devoted to care management outside of office visits
  – Ratio of primary care by the CC and MA

Assessing Outcomes
• The Community Record will provide real time analysis about the medical condition of patients to determine progress in program
• The Toolkit technology will produce up-to-date quality assurance reports on erroneous data detected by algorithms for admissible values, missing data, and missing entries, which will be sent to CCs and MAs
• Progress reports will be sent monthly to each site and Project leaders
• Data will look at hospitalizations, hospital readmissions, and emergency room visits and then evaluate intervention effects on such; along with analysis of HTN and DIAB physiologic control, adverse events, and patient satisfaction
• Will further evaluate the impact on patient preventive care and quality of life by testing changes from usual care at baseline
• Finally, cost models will evaluate reductions in PBPY while accounting for any skews in cost data, right-censoring, and imbalances between intervention and control groups. Financial models will evaluate value, return on investment, cost savings, and total costs.
Opportunities and Challenges

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<td>• Vanderbilt</td>
<td>• Fraud and Abuse Compliance because entities are not one system</td>
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<td>– Ability to manage care across a continuum without merger or consolidation</td>
<td>• HIPAA and Privacy Concerns because sharing across systems</td>
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<td>– Access to primary care physician base without employment or acquisition</td>
<td>• Quality and compliance concerns</td>
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<td>– Greater ability to manage patients to an appropriate level of care</td>
<td>• Cultural differences between standards and practices across systems</td>
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<tr>
<td>• Community Hospital</td>
<td>• Cultural challenges regarding sharing of data (by physicians for purposes of assessment)</td>
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<tr>
<td>– Access to protocols, quality metrics, disease management services perhaps not otherwise available</td>
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<tr>
<td>– Ability to manage care across a continuum without merger or consolidation</td>
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</tbody>
</table>

Key Legal Considerations

• Fraud and Abuse – careful analysis of benefits to each provider and funding mechanism for team approach
  – During CMS phase, many costs are funded by the Grant, but if this is scaled beyond grant funding, what is mechanism for employment of teams, supply of software and technology, etc.
  – Interaction of community physicians who have privileges at the hospital and the care team is provided by the hospital
Key Legal Considerations

• HIPAA and Privacy Concerns
  – Arguably, all data shared is shared either for treatment purposes or for hospital operations as a utilization management and quality assessment tool
  – But, data is very sensitive and we recommend individual consent of each patient for participation on the program, along with a detailed explanation of the use of data and revisions to Notice of Privacy Practices indicating sharing of data across the network of participating providers

Key Legal Considerations

• Quality and compliance concerns
  – Who is responsible for community record
  – If physician or other sees problems or errors in the community record or services provided, how is this handled
  – Is there a heightened responsibility or liability from faxing of EMR or paper charts
  – Are hospitals, because affiliated, liable for the errors of one another
Cultural Considerations

• May be differences between standards and practices across care settings
• Comfort level with data collection, analysis, research, etc. may vary depending on care setting
• Cost considerations may be challenging based on expenses and overhead of various systems

Questions?

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