UAMS/SVI Partnership Agreement

Proposal

Introduction

The University of Arkansas for Medical Sciences (UAMS) is the health sciences and academic medical component of the University of Arkansas. St Vincent's Medical Center (SVHS) is the Arkansas operating division of Catholic Health Initiatives, a non-profit, faith-based ministry and health care organization that operates in different regions throughout the United States. Despite differences in organizational structure, SVHS and UAMS share important values and goals. Both organizations have a charitable, non-profit purpose and both seek to provide excellent quality health care services in a cost effective manner to the entire community. Both seek to attract excellent medical, clinical and administrative staff. And both seek to increase the accessibility and responsiveness of their health care services to the public in support of the triple aims of health system reform to provide state of the art health care, a patient and family-centered care experience and lowered health care costs. Both UAMS and SVI also seek to treat employees in a just and fair manner.

SVHS and UAMS recognize that hospitals and academic medical centers will face increased financial pressures in the years ahead due to the stresses on the economy, the continued rise in health care costs, changes associated with implementation of the Affordable Care Act (ACA), changes in payment methodologies, changes in medical and communications technology and other factors. UAMS bears significant additional costs associated with medical education and research. Both organizations recognize that it is not in the community's or their organizational best interest to operate redundant, underutilized services or purchase redundant and expensive technology and equipment that add costs to health care and do not add value to the public.

It is apparent that both organizations can best accomplish their societal missions by being a part of a larger, more integrated clinical network. An appropriate model for the future involves a network in which care remains local when most appropriate for the patient and referrals are made to "hub" tertiary/quaternary facilities such as SVHS and UAMS when that is best for the patient. The ACA anticipates the development of integrated care networks that can be accountable for the quality and costs of care across the entire clinical spectrum. Such a network can only be developed on a solid operating and financial foundation.

The goals of a strategic alliance between UAMS and SVHS are to provide patient and family centered care of the highest quality in the most cost effective manner. This involves optimizing patient care quality and the patient experience while also optimizing the financial bottom line through maximizing operational efficiencies. Achieving these high level goals involves substantial change from the historical method of operation at the level of the health system. A strategic alliance between UAMS and SVHS is also envisioned to serve as the foundation for a broader, clinically integrated network throughout Arkansas, a network that can serve as a population health destination. The planning process must focus not only on short term efficiencies but also on the creation of a pathway to broader integration throughout Arkansas.

The clinically integrated network envisioned must have several components:

- Business relationships between and among the participants
- Ability to contract as an integrated entity
- Ability to have health information move with patients as they move through the system
- Ability to partner with payers to achieve goals in cost effectiveness and quality
- Ability to adopt standards of care and care pathways
- A care management infrastructure at the system level
- Ability to optimize and monitor clinical quality and cost management throughout the network
- Mechanisms for enhanced physician/ hospital alignment

Such an entity must have a core of network services that support integrated care delivery. The revenue to fund this core of new capabilities must come through efficiencies achieved through the network itself. The business case analysis of the potential value of a strategic alliance anticipates the creation of a clinically integrated network with the capabilities described above. There are both specific opportunities associated with a strategic alliance and opportunities presented by the unique circumstances currently present in Arkansas.

Three unique circumstances create a call to action for us now. The extensive telemedicine infrastructure that has been made possible by the Broadband Technologies Opportunity Program grant secured by UAMS on behalf of the state of Arkansas offers the opportunity to manage care across the entire continuum removing distance as a barrier to coordinated, patient centered care. The Arkansas Payment Improvement Initiative promises to provide incentives for care coordination at both the primary care level through enhanced support of patient centered medical homes and through bundled payments for specific defined episodes of care. Coordinated management of care episodes cannot be accomplished without formal relationships among the parties participating in an episode of care, coordination that must occur across time and locations. The passage of the private option model of Medicaid expansion by the Arkansas General Assembly this past session to expand insurance coverage enabled by the Affordable Care Act will make health insurance available to the vast majority of adult Arkansans for the first time in the state's history, five hundred thousand of whom lack coverage and access today. These three unique circumstances create an opportunity for dramatic improvement in the health system in Arkansas and in the health status of Arkansans. The improvements envisioned, however, cannot be achieved within the current fragmented, disaggregated health system that currently exists throughout the state. Hospitals and medical communities throughout Arkansas must come together to adopt methodologies for care coordination, cost and revenue sharing and accept shared responsibility of both clinical and financial outcomes. A vehicle must be created to enable innovation and coordination among health care entities that at present have no formal relationships. The model must involve partnership rather than ownership given the disparate ownership and governance models that exist throughout Arkansas at present. An alliance between SVHS and UAMS could serve to anchor such a model.

In addition to the goals of care transformation focused on the triple aim of health system reform: better care, better patient experience and lower costs, UAMS has the additional goals of educating and training the next generation of health professionals in a setting that models the

care environment of the future, and studying through research the impact of health system changes on population and individual health. In order to function effectively in a more highly integrated health system, our health professions students must be equipped with competencies that are not currently integrated into the curricula of physician, pharmacist, nurse or allied health professions student education programs. New roles will emerge as health care teams are formed and models of payment evolve. Students must be equipped with team skills, competencies with regard to system performance and system improvement, a broader understanding of the social determinants of health, techniques of population health management, how to access and optimally use health information management tools, and communication skills to partner with patients and families in an increasingly culturally diverse society. We must also expand the scope of our health professions educational programs to meet the health needs of an expanded and aging population. Our research agenda must include the study of population and individual health outcomes in a changing health system as well as develop and incorporate molecular diagnostics and therapeutics into routine care as advances in biomedical science lead to improved understanding of disease risks and disease mechanism at the molecular and genomic level. UAMS' participation in and/or leadership of a clinically integrated network must incorporate a commitment to the furtherance of this educational and research agenda as goals that are equivalent to a focus and commitment to the efficiency and quality of care delivered.

The final issue that must be considered is the constitutional authority of the Board of Trustees (BOT) of the University of Arkansas. Put simply, the BOT must retain final authority over all components of UAMS as its governing body. This legal authority cannot be transferred to another entity.

Proposal

An important initial step is the creation of a vehicle for managing the multiple new relationships needed to make such an affiliation successful. The attached organizational table depicts our vision. We envision an umbrella affiliation agreement that codifies guiding principles and the authority reserved by the governing boards of each organization as well as the processes for dispute resolution and the term of the agreement and process for terminating the agreement(s). This affiliation agreement will anticipate the formation of several sub-agreements:

An agreement for shared infrastructure services.
Academic and Research agreements.
A Clinically Integrated Network Services 501(c)3 agreement.
Agreements for service specific cooperative endeavors.

The table lists our proposal for initial shared services. The evaluation for each of the above noted services must involve a thorough evaluation of the financial savings anticipated, an agreement regarding the level of service to be provided and a methodology for tracking the actual results in service and cost compared with those projected. The principles must meet the contracting requirements of both organizations and involve appropriate compensation for services provided by one organization to the other.

Shared infrastructure support service. These infrastructure services serve the clinically integrated affiliation and provide a mechanism to minimize non-value-added infra-structure expense among participants. SVHS has access to resources in revenue cycle, electronic medical record support, and supply chain, through their parent organization, CHI. We propose that UAMS evaluate the potential value of these resources to reduce costs for UAMS through an appropriate contractual arrangement that properly reimburses SVHS/CHI for their costs. Contracts will need to be developed to collaborate in these three areas. We also propose exploration of collaborating in environmental services and food services through local contracts as additional potential areas to reduce infrastructure expenses and enhance value to the public.

Academic and Research Agreements. These agreements would include the necessary requirements for an academic affiliation. Such an agreement includessuch issues as access for students and residents, learning supervision and oversight, teaching commitments, and facilities required in support of education. The conditions for the academic affiliation must meet accreditation standards for student and residency programs. The longstanding affiliation agreement between UAMS and Arkansas Children's Hospital can serve as a template for the academic affiliation. The research component of the agreement can draw from the affiliation with ACH and ACH Research Institute. Any direct financial support of both academic and research programs would also be included in this agreement.

Clinically Integrated Network Services 501(c)3 Organization. This new entity will provide the core services needed to support a CIN, and serve as the contracting mechanism for a CIN.This should be designed and governed in a fashion that anticipates the ability to become an Accountable Care Organization (ACO) in the future. We are defining these terms as follows:

Clinically Integrated Network: Collection of physicians and hospitals working together as an integrated unit to achieve economies of scale in care delivery, enable joint contracting with insurers, and launch programs designed to increase the quality and coordination of patient care while reducing the cost of that care.

Accountable Care Organization: Collaboration between physicians, hospitals and other providers of clinical services that will be clinically and financially accountable for health care delivery for designated patient populations in a defined geographic market. The ACO is physician led with a focus on population-based care management and providing services to patients under both public and private payer programs.

Our goal is to achieve increased operational efficiency and cost savings through collaboration in infrastructure and certain clinical support areas to enable the funding of the infrastructure necessary to launch and maintain a CIN. The structure of the CIN should be such that it could eventually support the formation of an ACO if we, partner organizations and providers, and the market mature organizationally to the point that we are able collectively to be accountable for the quality and costs of care. The proposed structure of a working relationship with SVHS is envisioned to serve as the foundation around which a CIN can be developed. We envision that this new entity be structured to enable the inclusion of other participants (hospitals, health systems practicing physicians, home health agencies, etc.) as the CIN grows. This is the entity through which care management would be addressed along the care continuum, care pathways

adopted, bundled care process developed, outcomes tracked. It would be funded by the participants and governed by the participants in a shared governance model. IT support of this network would be a high priority. The entity would be the contracting vehicle for the CIN.

We propose that a vehicle for managing a clinically integrated network be developed as a 501(c) 3 shared services or management services (MSO/SSO) organization with a governance structure that includes participating health care organizations and physicians. UAMS' participation will be through delegated powers from the Board of Trustees. The primary functions of the MSO/SSO will be to provide care management support in an integrated fashion, adopt clinical care guidelines, provide telemedicine support, provide support to rural providers as needed, facilitate patient movement throughout the network, provide health information support to assure that patient information is available at the time and point of care; it will also need the capacity to coordinate the adoption, distribution and management of outcomes associated with bundled care payments and contract with payers on behalf of the participants. The adoption of payment models and levels must recognize and incorporate consideration of UAMS' expenses associated with and responsibility for health professions education and mechanisms to fund evaluation of the impact of innovations in care and payment on health outcomes.

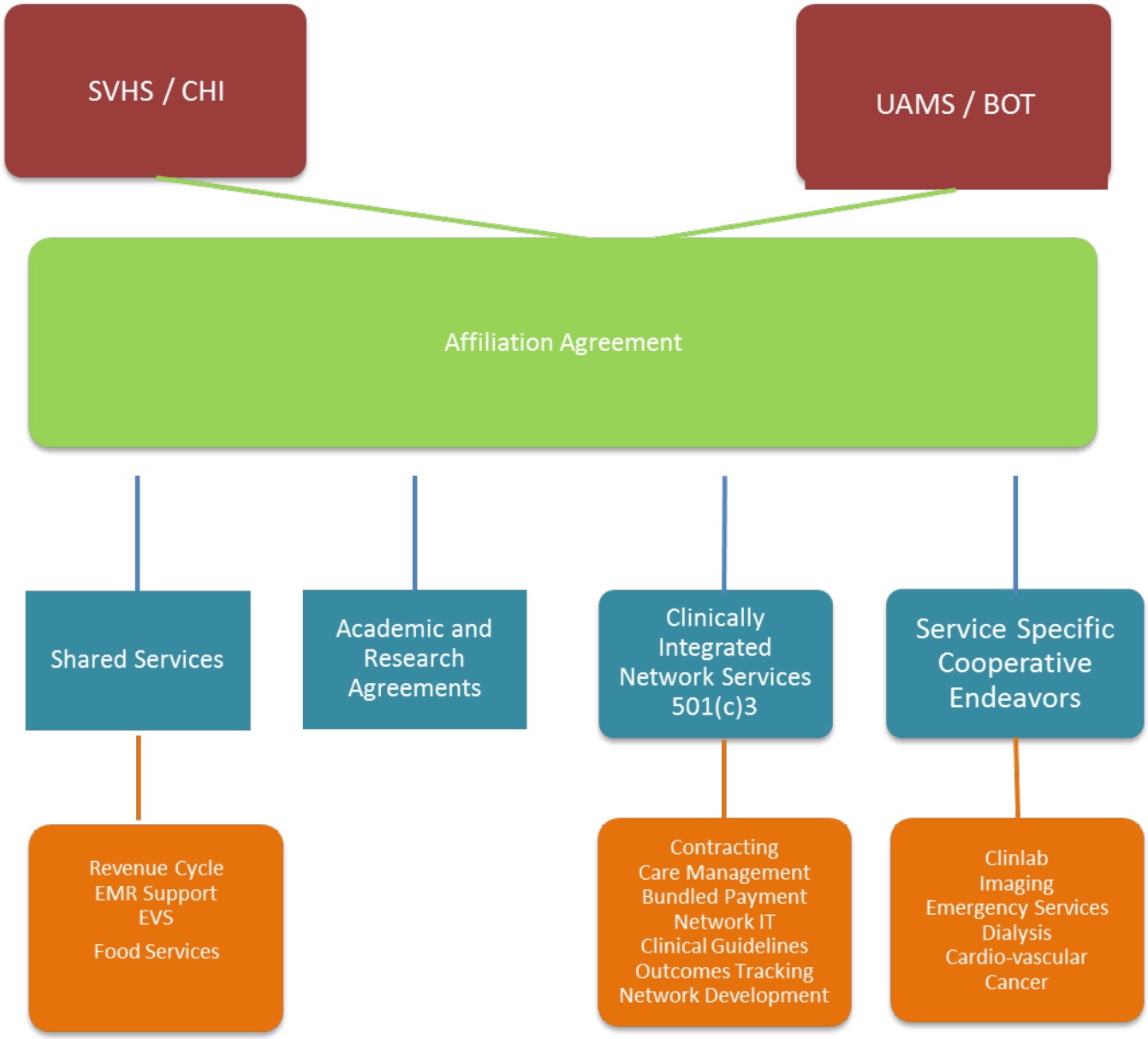
Service Specific Support Services. We propose that contractual mechanisms, under the Affiliation Agreement, be used to coordinate clinical services if these appear to be of value to both UAMS and SVHS.SVHS has the ability to provide cardiovascular services for a majority of the combined organizations while UAMS has the ability to provide oncology services, clinical laboratory services, anatomic pathology services, physician staffing for emergency services, diagnostic imaging and interventional radiology for both organizations.

We would like to explore whether cooperation in providing these clinical services can be beneficial to both organizations. These cooperative services would operate by agreements between SVHS and UAMS, but would not create a single, integrated service line under a single management structure.

Proposed Timelines.

Completed Affiliation Agreement negotiations (local leaders, local advisory boards, UA board member(s) review—August 1
Approval by CHI and UA Board during September
Clinically Integrated Network Services 501(c)3 organization—September 1 and approved by CHI Board and UA Board during September
Service Specific cooperative agreements for cardiovascular and cancer agreement by October 1, then to UA and Legislative approval during October
All other agreements approved as soon as reasonable after due diligence and appropriate board and/or legislative approval.

We believe this model offers considerable public value as well as value to both UAMS and SVHS. A focus on these areas through this mechanism would enable us to provide leadership for Arkansas toward achievement of the triple aim while strengthening the operational and financial foundation of the health care sector both in central Arkansas and statewide.


SVHS / CHI
UAMS / BOT
Affiliation Agreement
Shared Services
Academic and Research Agreements
Clinically Integrated Network Services 501(c)3
Service Specific Cooperative Endeavors
Revenue Cycle
EMR Support
EVS
Food Services
Contracting
Care Management
Bundled Payment
Network IT
Clinical Guidelines
Outcomes Tracking
Network Development
Clinlab
Imaging
Emergency Services
Dialysis
Cardio-vascular
Cancer