HSG | SUCCEEDING IN **VALUE-BASED CARE**

BUILDING A SUSTAINABLE CLINICALLY INTEGRATED NETWORK

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PREFACE

This publication identifies and outlines the necessary characteristics of a fully-functioning clinically integrated network (CIN). What it doesn't do is detail how hospitals and providers can participate in the value-based care environment during the development process.

One common misconception is that the CIN can't do anything significant until it has obtained the FTC's "clinically integrated" stamp of approval. While the network must satisfy the FTC's definition of clinical integration before single signature contracting for FFS rates and contracts can legally start, hospitals and providers can enjoy three key benefits during the development process.

Strategic Positioning
Establishing the CIN's legal and organizational structure gives participating providers and hospitals a seat at the table to begin discussing how they will transform care in their region. Once participants come together and join the collaborative enterprise, they are synergistically creating something bigger than themselves.

Economies of Scale
Hospitals and participating providers can immediately begin making joint investments in technical resources, care management infrastructure, staff and other costly population health management capabilities — capabilities that they would otherwise develop individually.

Contracting
From a contracting standpoint, during the development process, the CIN can:

- Apply to become a MSSP ACO
- Negotiate and enter into shared savings/ risk arrangements with commercial payers
- Directly contract with employers

An excellent initial option is for the sponsoring hospital/health system to contract with the CIN to manage their employee health plan. In many markets, a self-funded health system is the largest employer. And like most large employers, the cost of providing this benefit is growing at an unsustainable rate. Establishing a track record of managing costs and populations will not only reduce the sponsoring entities' healthcare costs, it will provide a marketing advantage when reaching out to other payers and employers.

Clinical integration is an active and ongoing transformation of improving clinical and business practices. Be creative. Innovate new ways to begin realizing value from closer physician alignment and enhanced relationships across a broad provider network.

Sincerely,
HSG's Clinical Integration Team





Value-based reimbursement is here. So what do we do now? We can't afford to lose millions experimenting, but we need to make sure we have a seat at the table.

INTRODUCTION

Hospitals and health systems today are on the horns of a dilemma. You must continue operating in the current fee-for-service environment while preparing for value-based reimbursement. That translates into proactively making investments in the competencies required to manage health, populations and financial risk before you are fully reimbursed for your efforts.

Clinically integrated networks (CINs) offer an effective tool for managing the transition from volume to value by:

- Creating a unified network of healthcare providers differentiated by cost and quality
- Making it easier for hospitals, employed and independent physicians and other providers to work together to reach clinical and financial goals
- Enabling effective population health management and care coordination across the full care continuum
- Providing an alternative to employment for independent community physicians
- Enhancing your ability to manage alternative payment models such as Bundled Payments, Shared Savings, and Direct Contracting
- Generating enough revenue to ensure sustainability

CLINICAL INTEGRATION AND THE LAW

Prior to pursuing clinical integration, familiarize yourself with the Federal Trade Commission's (FTC) guidance on clinical integration. The FTC defines clinical integration as:

An active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. [1]

In general, the FTC considers a network to be clinically integrated if it:

- Establishes mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality of care.
- Selectively chooses CI network physicians who are on board with efficiency objectives.
- Makes significant investments, both financial and human including shared risk, in developing the infrastructure and capabilities necessary to achieve and document collaboration and care efficiencies.

Legal and policy experts have boiled that down into six core requirements [1]:

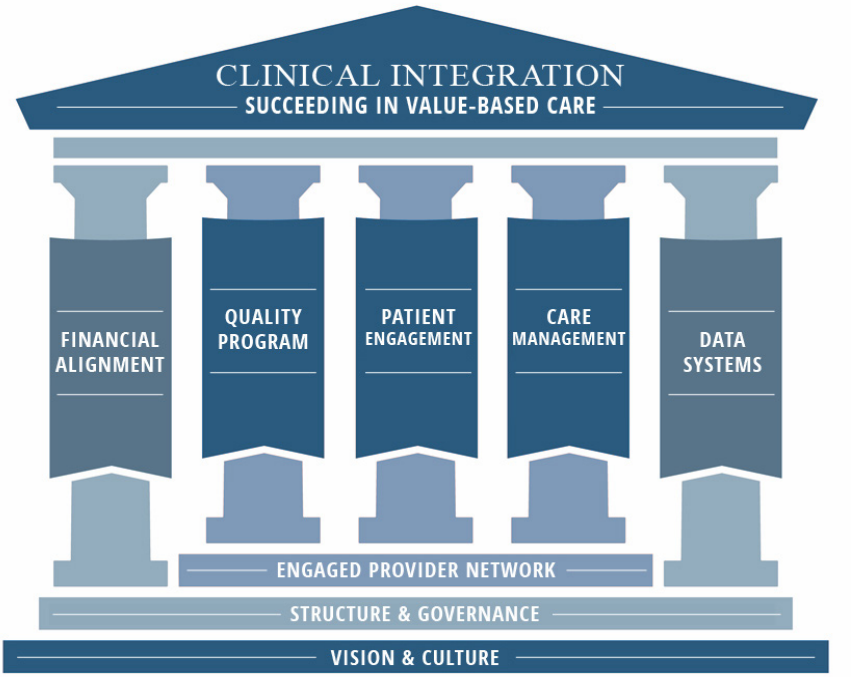
1. Implement information systems to measure and report to payers on quality, utilization, and cost effectiveness of care across the physician network
2. With significant physician involvement,develop and implement clinical protocols and guidelines to govern treatment and utilization across a wide range of disease states
3. Regularly evaluate both individual physician and the network's aggregate performance and manage that performance through financial incentives, enforcement policies and ongoing eligibility for network participation
4. Develop care management, pre-authorization and related functions to manage utilization within the network
5. Invest significant capital to purchase the information systems necessary to gather aggregate and individual data to measure performance
6. Engage physician leadership through appropriate physician governance

[1] Department of Justice, "Statements of Antitrust and Enforcement Policy in Health Care," August 1996

EIGHT KEY ELEMENTS TO BUILDING A SUSTAINABLE CIN

The illustration depicts the eight elements to success as you build your CIN:

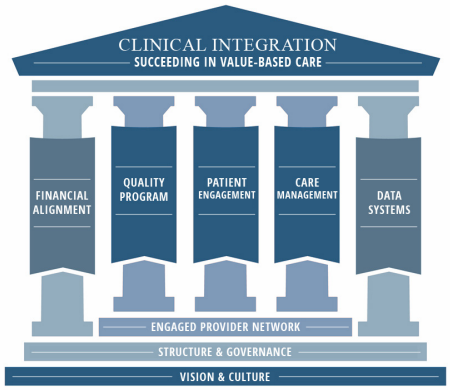
1. Vision and Culture
2. Structure and Governance
3. Financial Alignment
4. Data Systems
5. Engaged Provider Network
6. Quality Program
7. Patient Engagement
8. Care Management



VISION & CULTURE

A clear Vision and an adaptable Culture are catalysts for change and together form the foundation of Clinical Integration.

Volume and value are conflicting business models. Rarely can an organization operate successfully in both worlds.



Clinical integration is transformational. It requires a completely different business model than fee-for-service reimbursement. Success in a value-based care environment belongs to provider organizations that are able to demonstrate the greatest value in the market place by improving quality and reducing costs. This requires a complete shift from the current "heads in beds" and "patients in waiting rooms" approach to managing population health. The focus is on delivering coordinated, patient-centric care in the most cost effective setting.

Hospital and health system leadership must commit to change – or not. The good news is, this transition isn't expected to occur overnight. An organization's transformation from volume to value is an evolutionary process that takes time, resources, and, most of all, commitment.

The next step is defining the CIN's vision and strategic purpose. The vision statement must clearly and concisely outline why the CIN exists, what purpose it will serve, and its long-term destination.

Vision Development Checklist

- Understand and agree what the CIN is and what it is not
- Clarify why the creation of a CIN is necessary and what it will enable primary stakeholders to do that they can't do without it
- Define high-level goals and objectives
- Identify the individual value proposition for each stakeholder group
  - Patients
  - Physicians and other direct care practitioners
  - Hospitals and other facilities
  - Payers
- Forecast what the organization will look like 2-5 years down the road

Sample Vision Statements

1. The region's preferred network of innovative healthcare professionals providing the highest quality of care at the greatest value.

2. The (CIN) is a unique, regional health organization that brings together exceptional physicians and hospitals to better serve the community by delivering healthcare services and resources that achieve better health, better care at lower cost.

STRUCTURE & GOVERNANCE

An inclusive legal Structure and Governance model forms the base of an effective Clinically Integrated Network.

CINs usually operate as separate legal entities under the umbrella of the sponsoring organization(s). When developing the formal structure consider:

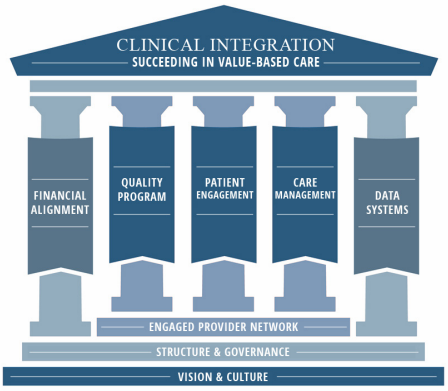
- Legal structure (i.e. LLC, Corporation, Partnership, etc.)
- Ownership structure (i.e. Sole Member, Stock Owners, Partners, etc.)
- Reserved Powers of Sponsoring Entities (i.e., owners)
- Tax status (Taxable vs. Tax Exempt)

Regardless of the legal and ownership structure, the most successful CINs operate under an inclusive governance model that involves all participating partners:

- The hospital(s)
- Employed and independent physicians
- Other care providers

The governance model must:

- Promote physician engagement and participation
- Be a consensus-driven partnership where all parties are represented



To ensure success, develop a strong committee structure, as shown in the organizational chart below.

Clinically Integrated Network - Board of Directors

Finance/Contracting Committee	Quality Committee	Data Systems Committee	Provider Advisory Committee
• Budgets • Incentives • Financial performance • Contracting strategy • Network planning to support contract execution	• Establish and monitor quality, utilization and overall clinical performance • Clinical protocols and care guidelines • Care management oversight	• Oversight of selection, implementation of data systems • Ongoing evaluation of data systems needs	• Physician participation criteria • Oversee physician quality and compliance • Peer review • Oversight of credentialing

As the network matures, consider adding a Patient Advisory Committee to gather patient/consumer perspectives

Key Governance Considerations

Board Structure	• Role/accountability/areas of oversight • Composition • Number of members • Voting rights

Board Structure Committee	• Standing Committees
	• Role/responsibilities/areas of oversight
	• Membership
	  • Number of members
	  • Composition (physicians, hospital(s), other providers)

FINANCIAL ALIGNMENT

Financial Alignment means aligning the economic incentives of participating providers and hospitals to get everyone rowing in the same direction.

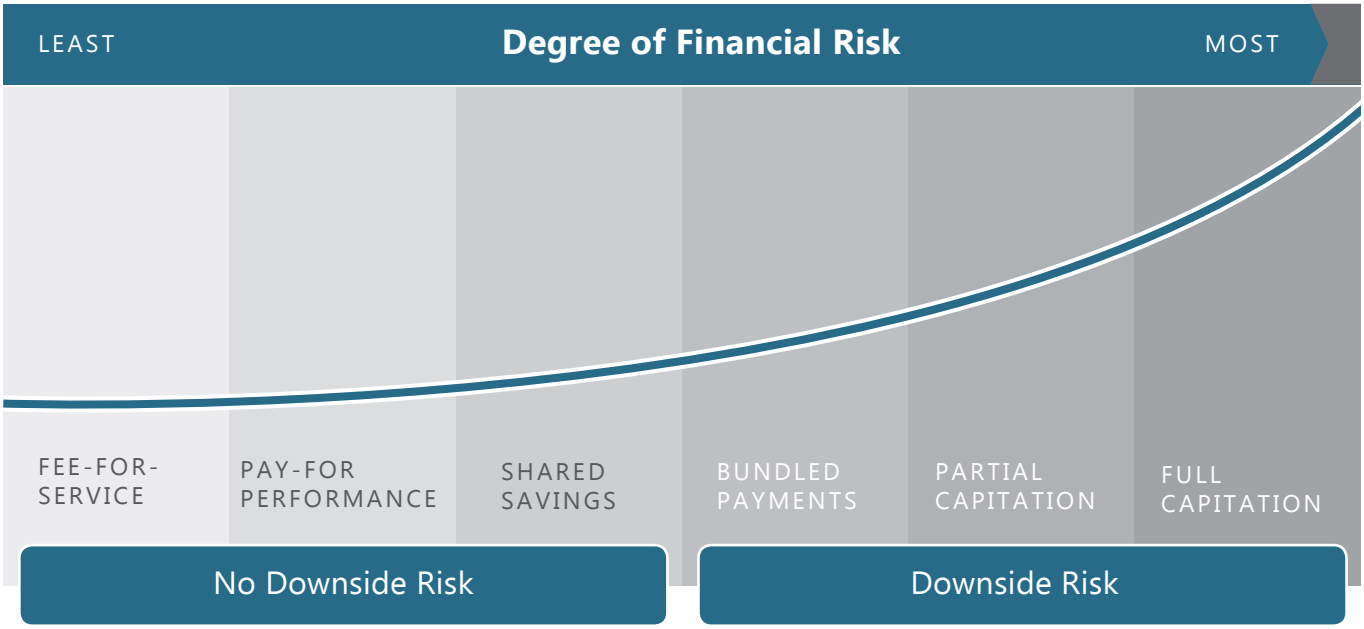
Developing a long-term contracting strategy to support the shift from volume to value is critical.

Timing is critical. Your CIN will need to strategically take on increasing levels of risk to support changing care delivery models under value-based reimbursement. Take on too much risk too soon, before your population health management capabilities are up to speed, and you could have to pay back significant sums when performance metrics aren't met. Too little too late, and you risk leaving money on the table and eroding the sponsoring organizations' operating margin – along with your ability to fund the CIN.

Many Alternative Payment Models (APMs) – pay-for-performance, bundled payments and shared savings – emphasize quality of care, better care transitions, and financial accountability. Your safest bet is to focus initially on pay-for-performance and shared savings programs with upside risk. These APMs provide the least financially-risky introduction to partial and full capitation.

Consider utilizing your own employee health plan to gain experience in a pay-for-performance environment prior to expanding to others. This approach affords an opportunity to develop and fine tune the necessary skills and to document your ability to generate savings and enhance quality.

Alternative Payment Models & Financial Risk



Downside risk and full capitation shift the financial risk from the payer to the contracting CIN. The CIN assumes responsibility for managing the total cost of care of a defined patient panel. Your goal: to generate a surplus by paying out less in medical claims than the capitated budget allowance. Ideally, you should only take on the level of risk the partner organizations can handle, based on your progress toward building the infrastructure and capabilities you need to manage that risk.

FINANCIAL ALIGNMENT

CONT.

Prior to committing to any level of downside risk, your network must have a thorough understanding of the population you will be caring for.

What You Need To Know Before Taking on Downside Risk

Current Cost Data	• Total spend to-date ($ PMPM) • PMPM Spend by type and site of service • PMPM Spend for RX
Budget	• Target Medical Loss Ratio (MLR) or Medical Expense Ratio (MER) • Projected MLR or MER
Covered Lives	• Number of lives attributed to network • Projected growth of attributed lives
Risk Sharing	• Current level of up/ downside risk • Risk sharing schedule (1, 2, 3 years out)

Incentive Distribution

Developing your incentive distribution plan in advance will establish CIN provider expectations and save time, energy, and more difficult discussions down the road. You need a methodology detailing how gains and losses from risk/ value-based contracts (and other revenue sources) will flow from the payers and employers to the network and how those funds will then be distributed among CIN owners and participating providers.

Key Considerations for Incentive Distribution Plans

- The ROI for the entity(ies) capitalizing the CIN startup costs;
- The percentage of funds (if any) that will be held within the organization to cover operating expenses, strategic investments and/ or anticipated future losses;
- The percentage of gains/ losses that will be distributed between hospital members, participating physicians, and other members;
- The percentage of gains/ losses that will be made available to primary care physicians and specialists;
- The criteria participating providers must meet in order to be eligible to participate in any shared savings/ gains – and the pro rata share thereof; and
- The baseline organizational performance measures that must be met before incentive pools will be funded.

FINANCIAL ALIGNMENT

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The "incentive distribution" conversation overlaps with the "funding the organization" conversation. Leadership should determine in advance how the organization will be funded:

- Where funds for the initial start-up and ongoing development and operation of the organization will originate.
- What the anticipated return on investment is and how long it will take.
- Whether physicians will be required to contribute money upfront to help "fund" the enterprise – and how much – or what their "in kind" contribution will be.

Physicians, hospitals, and other partners have different perspectives on how funds should be distributed. Achieving consensus on the right (i.e., mutually acceptable) formula can be a challenge!

Hospital Perspective

In the short term, we stand to lose a significant amount of revenue from traditional FFS business as the CIN impacts our utilization. Plus, we are expected to contribute a greater percentage of initial and ongoing capital and bearing a greater level of risk than the network physician and other partners as a tradeoff for a long term position of strength, successful transition to value-based payment, and reform survival.

Physician Perspective

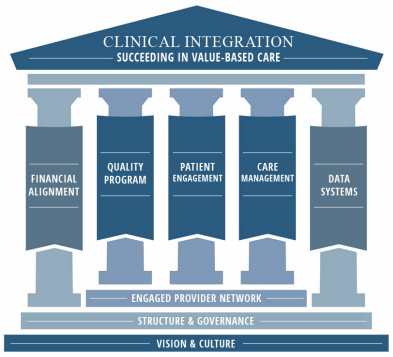
Physicians, particularly engaged PCPs, are positioned to execute implementation of the payment transformation model and manage the total cost of care requisite to achieve lower cost and higher quality. If the organization is successful it will be because of the physicians and their ability to implement the processes needed to manage care.

Remember that the initial discussions on distributing funds/incentives/profits are not cast in stone. Improvements to your analytical capabilities could make it easier to quantify individual members' contributions to profitability down the road.

DATA SYSTEMS

Robust Data Systems are a key organizational pillar, because they support the CIN's clinical and business functions and permit the flow of data required to make informed decisions.

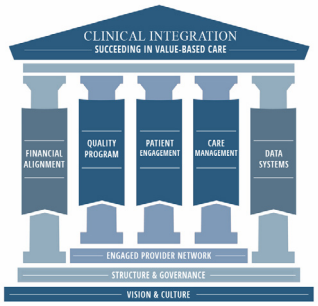
Sophisticated data systems to support the CIN's clinical and business functions are a core requirement for clinical integration. The technological infrastructure needed in a CIN primarily revolves around three capabilities: Data Collection and Integration, Data Analytics, and Data Reporting.



Capability	Functionality
Data Collection and Integration *Ability to integrate claims data with clinical data at the patient level*	• Collection, storage and access to a single point of electronic health information across the continuum. • Health Information Exchange (HIE) to collect and share data from multiple sources and providers operating on different systems across the network. • Centralized data warehouse to effectively integrate all necessary data from multiple sources (i.e. clinical, administrative, financial, claims, etc.).
Data Analytics *Ability to analyze integrated data to target cost savings, care management and performance improvement opportunities*	• Risk stratification capabilities to identify and manage high risk patient populations for the CIN's complex care management program. • Ability to track a single patient over multiple care episodes. • Ability to model the financial feasibility of prospective risk/ value-based contracts using both clinical and claims data • Physician-level patient attribution and performance measurement. • Front-end analytics for providers to assess clinical results, manage referrals, access protocols and track performance in CI program.
Data Reporting *Ability to share data with end-users and key stakeholders*	• View and update a single patient record as appropriate for the entire care team and the patient in support of care transitions. • Link disease registries directly to EMR. • Develop measurement and reporting systems that combine multiple data sources. • Offer flexibility to adjust to changing payer metrics and reporting requirement

ENGAGED PROVIDER NETWORK

Selecting an Engaged Provider Network to drive Quality, Patient Engagement, and Care Management forms the backbone of the clinical transformation that must occur to successfully shift from fee-for-service to value.



In the early development phase, CIN leadership will need to build the provider network. Look closely at three areas before inviting any providers to join your network: Cultural Fit, Continuum of Care, and Qualifications.

Cultural Fit: Will They Play Nice?

Target high-quality providers likely to further the CIN's mission and vision. Identify physicians and other partners who are excited about building a new and innovative model of care, will mold the organization's culture, and will develop and champion shared clinical practice guidelines and expectations. Identifying providers who work well with the broader healthcare community and other CIN partners -- including your hospital(s) and employed provider network(s) -- should be a chief consideration.

Continuum of Care

A robust network of primary care physicians and specialists is not enough to manage population health; you will also need a strategy for aligning provider organizations in the post-acute space – inpatient rehabilitation, subacute care, long term care, and home health capabilities. Depending on the network's contracting strategy, meeting formal payer-defined network adequacy requirements may be necessary. When assessing your CIN's physician needs, start with the gaps in your employed physician enterprise and try to fill them with physicians on your medical staff. Your best bet: independent providers who have effectively held hospital and medical community leadership roles and who actively support your pursuit of improved quality and outcomes.

Qualifications

Expand the minimum participation criteria beyond board certification, malpractice experience, and accreditations to include:

- Technical capabilities, specifically electronic data sharing connectivity capabilities (i.e. EHR utilization and willing participation in an electronic health information exchange, etc.)
- Care management resources (e.g., complex care management program, embedded care managers, PCMH recognition
- Quality/performance data (i.e., clinical outcomes, operational efficiencies)
- Cost data (to the extent to which it is publicly available)

A CIN won't survive without an engaged provider network that believes in what you are trying to accomplish. That network must be intimately involved in fulfilling traditional roles related to Quality, Care Management, Cost Containment, and Patient Engagement.

QUALITY PROGRAM

Start your CIN's quality program by defining the core measures the network will use to:

- Gauge its effectiveness
- Demonstrate its value to payers, employers, patients and other strategic partners

Include a combination of quality and utilization/ efficiency measures. Quality measures generally encapsulate aspects of the four domains that comprise the 33 ACO measures used in the Medicare Shared Savings Program (MSSP).

The 33 ACO Quality Measures Used in MSSPs	
Patient/ Care Giver	• Timely care, appointments and information • Physician communication • Patient rating of physician
Experience	• Access to specialist • Health promotion/Education • Shared decision making • Health/Functional status
Care Coordination/ Patient Safety	• All Conditions Readmissions • Chronic Obstructive Pulmonary Disease Admissions • Congestive Heart Failure Percent of PCPs who qualify for an EHR Incentive Medication Reconciliation: Post-DC IP Facility • Falls screening
Preventative Care	• Influenza Immunization • Pneumococcal Vaccination • Adult weight screening • Tobacco use assessment/Cessation Intervention • Depression screening • Colorectal cancer screening • Mammography screening • Blood pressure within 2 years
At Risk Populations	• Access to specialist • Health promotion/Education • Shared decision making • Health/Functional status

QUALITY PROGRAM

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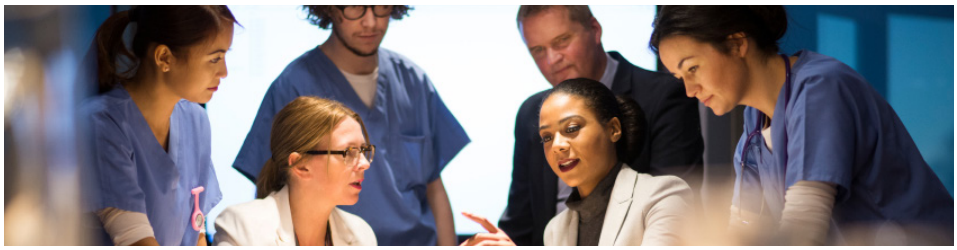

Clinical Measures

Qualifying, selecting, implementing, modifying, and eventually retiring quality measures is an ongoing, active process. Early on, CINs commonly focus on adopting CMS' 33 Quality Measures, since these measures are currently favored by payers. Some CINs adopt additional outpatient, primary care-oriented measures. Then, as the network matures, the focus shifts to a balanced mix of specialty (often hospital-centric) and primary care measures.

Qualifying Quality Measures

Develop objective baseline criteria to streamline measure selection. Measures must:

- Be pertinent to network outcomes
- Represent a true opportunity for improvement
- Demonstrate legitimate evidence supporting its effectiveness +/- endorsement by a reputable source (e.g., NQF, NCQA, payer)
- Be reportable. (Sometimes the effort required to identify a consistent data source, incorporate the measure into existing data systems, and develop standardized and automatic reporting capabilities for a single measure outweigh its benefit.)

Selecting the Final Quality Measures

Once a measure is qualified, the Quality Committee refines the meaning and impact of each individual measure by:

- Creating operational definitions
- Developing acceptable performance benchmarks
- Determining how to fairly incorporate the measure into the organization's incentive distribution process to ensure provider accountability

Implementing Quality Measures

Measure implementation refers to:

- Rolling the metric out to the network membership
- Starting the data and reporting process
- Initiating the performance improvement work

Modifying Quality Measures

Measure definitions can change mid-stream as thoughts regarding what constitutes the best care evolve. Measures may need to be adjusted accordingly.

QUALITY PROGRAM

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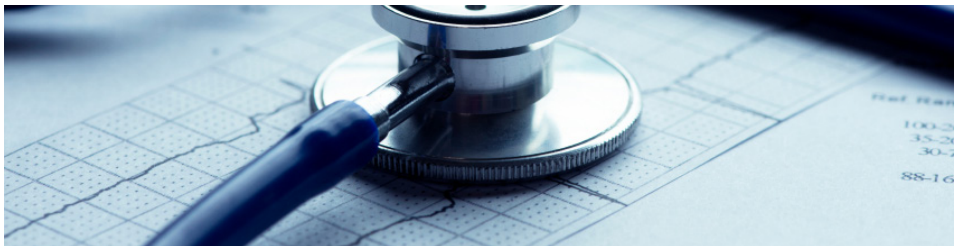


Retiring Quality Measures

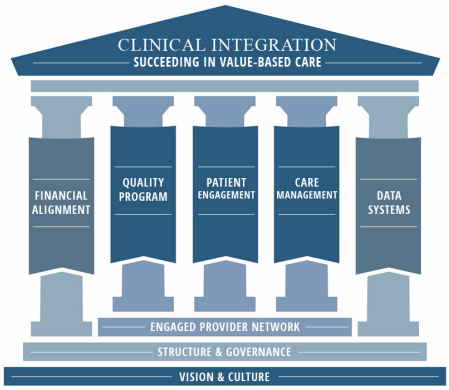
Once a measure achieves maximum improvement, becomes entrenched in the network's day-to-day operations, and has achieved a sustained level of acceptable performance, it can be retired to make room for new, evolving improvement measures.

Operational Measures

Utilization/ financial measures are another critical component of a CIN quality program. Tracking these measures allows the network to quickly identify and respond to overutilization of costly services.

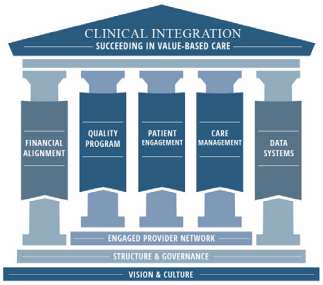
Utilization/Financial Measures to Include in Your Performance Dashboard

Measure	Measure Type
ED use rate (days per 1,000)	Utilization
Inpatient use rate (days per 1,000)	Utilization
OP surgery use rate (days per 1,000)	Utilization
Imaging use rates (days per 1,000)	Utilization
Post-acute use rates (days per 1,000)	Utilization
Percent Generic Drug Prescribing	Utilization
Total Number of 30 Day Re-admissions	Utilization
Total Cost of Care (PMPM)	Financial
Total Cost of Care by Site of Service (PMPM)	Financial



CARE MANAGEMENT

Identifying "high utilizers," managing their care, and improving their health is critical to the CIN's success under risk-based contracting. Effective care management requires designing, coordinating and executing interventions across the continuum of care.

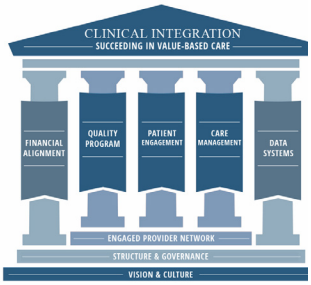


Key Components of Care Management Program Design

Risk Stratification	• What financial (i.e. average claims expense) and clinical (i.e. multiple admissions, heavy ED utilizer, comorbidities, etc.) indicators will be used to define high-risk patients? • What are appropriate thresholds for these indicators? • What percentage of the patient population that will be targeted for complex care management is cost effective?
Operating Model	• How will care coordinators work with providers to coordinate inpatient care, discharges?
Staffing Model	• Will care coordinators be concentrated centrally or deployed peripherally in the offices and hospitals or a combination of both? • Will the concentration of care managers be relatively fixed or flexible? • What is the appropriate staffing ratio of high risk care coordinators to "high-risk" patients? • What are the qualifications of the care coordinators? • How will chronic disease educators be deployed?
Patient Engagement	• What best practices and standards will be developed around patient education and engagement? • How will the effectiveness be assessed?
Transitioning Patients Between Care Settings	• What bridging programs will be developed for patients moving from inpatient to the post-acute setting or office-based care?

PATIENT ENGAGEMENT

The Institute of Medicine's 2001 report, Crossing the Quality Chasm: A New Health System for the 21st Century, revealed the need for providers to do a better job of engaging patients and their families in their care. Under value-based reimbursement and risk-based contracting, this principle increases in importance. Patients who aren't engaged do not make good partners. Risk-based contracting incentivizes CIN providers to keep patients well (or well managed) and out of the hospital and ED. Providers must explore more creative and effective ways to effectively partner with patients in their care and provide them with the information they need to make informed care decisions.



Patients who aren't engaged don't make good partners.

4 Tips for a Patient-Centered Care

Communicate and educate	A well-informed patient is paramount to patient engagement. A patient (or caregiver) cannot be an active participant in a process that is not understood on a basic level. Nodding along may or may not indicate understanding, Best practice: employ the "repeat back" technique to ascertain exactly what the patient thinks is being communicated.
Address care in the patient's environment	Previous provider initiatives focused on providing more in-depth patient education and ensuring that spoken instructions were reinforced by written materials. Under value-based reimbursement, providers must go a step beyond to understand and appreciate the patient's circumstances and daily experiences outside the physician office. The patient's care plan can then reflect this greater reality.
Incorporate patient preferences	Prior efforts at individual care plan development were very provider-centric, e.g., "Here is what you need to do to better manage your condition." These plans often failed, because patients had no intention of following them. Best practice for CIN's: Involve patients (and caregivers) in care plan development and ask them to honestly tell you what they are and aren't willing to do.
Mitigate barriers	Language, culture, emotions, pride and socioeconomic conditions are potential barriers to patient understanding and compliance. Addressing these in the practice setting is critical to customizing the care plan and predicting compliance.

HSG Can Help Your Hospital System Successfully Achieve Clinical Integration

HSG plans, designs and implements system-wide strategies for accountable care, population health management and clinical integration. We can guide your organization through the evaluation, planning and design, and implementation of a system-wide strategy to address accountable care and payment reform, including:

- ACO Planning, Design & Implementation
- Clinical Integration Program Development & Implementation
- Clinical Transformation Strategy

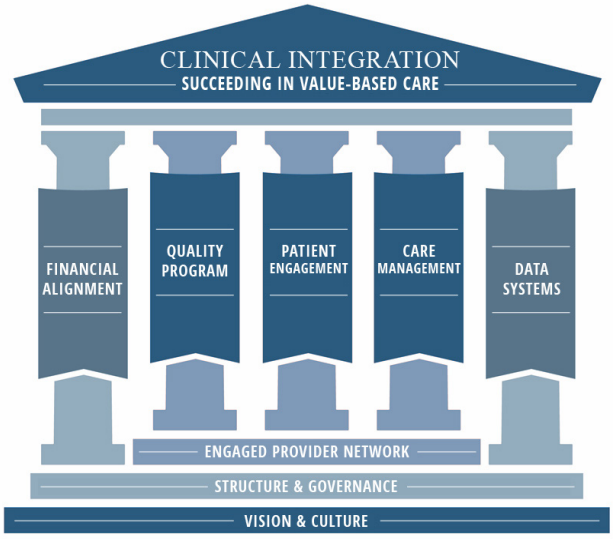
We create clinically and financially integrated provider networks capable of achieving the institute for Healthcare Improvement's (IHI's) Triple Aim:

- Improving the patient experience of care
- Improving the health of populations
- Reducing the per capita cost of healthcare

Get Started on Your Clinical Integration Strategy Today

Our team of experts has developed a robust Accountable Care Readiness Assessment to:

- Educate stakeholders on the transformation from volume to value.
- Assess key market drivers to determine the pace at which your local market is transitioning.
- Conduct a core capabilities assessment to identify gaps in the capabilities the organization needs to compete in a value-based care environment.
- Develop a detailed action plan that prioritizes immediate and long-term tasks that must occur to address and overcome the gaps.



Get the help you need today.
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MEET OUR TEAM OF EXPERTS

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HSG Partner David W. Miller primarily focuses on strategy development, including strategic plans for hospitals & health systems and employed physician groups, affiliation/merger strategies, physician alignment strategies, primary care strategies, and service line planning. He also provides board and medical staff education and retreat facilitation. Before co-founding Healthcare Strategy Group in 1999, David spent four years as a Partner with the Galvagni-Miller Strategy Group and fifteen years as an executive with Norton Healthcare in Louisville.

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Before joining HSG's consulting team in November, 2013, Dr. Terrence R. McWilliams, a Family Physician, spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital in Rhode Island. During his tenure as CMO, he supervised the Medical Staff Services Office; was responsible for quality of care/patient safety/risk management, clinical information systems, medical staff services, physician recruitment and clinical service line development. He was intimately involved in numerous system-wide initiatives, including creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

Jarom E. Bowman Senior Consultant

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Jarom Bowman came to HSG after serving as manager of operations for a large clinically integrated physician-hospital organization (PHO) in Ohio, where he was instrumental in the initial build and development of the organization and played a key role in creating a regional PHO with a partner health system. His core area of expertise revolves around clinical integration and PHO/ ACO development including the evaluation and implementation of organizational structure, governance, participation agreements, network development/ alignment, financial modeling and assessing risk/ value-based contracts.

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CONT.

Walter Hankwitz, MBA, FACHE, CMPE Senior Consultant

(423) 863-1363

Management consultant Walter Hankwitz has spent two decades of his four-decade career focusing on the IPAs, PHOs, ACOs and clinically integrated networks. He spent a decade as the Executive Director of a CIN consisting of a PHO equally owned by an IPA and a non-profit hospital system in Tennessee. His most recent accomplishments include leading four successful ACO applications, including Mercy Health Select for Catholic Health Partners in Ohio. He is well known on the speaking circuit and has shared his experiences at many regional and national conferences.

Brant P. Kelch, MPA Executive Director, Highlands Physicians

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Brant Kelch's first experience in the managed care arena dates back to the mid-1970s, when he served as Director of Health Care Financing and Program Development for UMWA Health and Retirement Fund, a national health benefits group practice with 850,000 rural beneficiaries. He brings to the table many years of experience with PPOs, MCOs, IPAs and integrated delivery systems, including national accreditation standards and financial incentive development for participating physicians. His most recent accomplishments have been in managing a clinically integrated IPA and developing/managing one of the most successful ACOs in the country.