

**BETTER TOGETHER**  
a Report to Our Members



2016 Annual Report





## Our Mission:

To achieve the best in quality and efficiency, for all patients, at every point of care

## Our Vision:

To serve as a national model for collaboration among independent physicians, healthcare providers and the communities they serve, to achieve the best possible population health at the best value





# A MESSAGE FROM LEADERSHIP



Dr. Todd Batenhorst  
*President*

On behalf of the Board of Managers, I would like to thank Flagler Hospital and the 194 member physicians who have contributed their time and leadership in the creation of First Coast Health Alliance. The alliance was formed in 2013 with the vision to serve as a national model for collaboration among independent physicians, healthcare providers and the communities they serve, to achieve the best possible population health at the best value.



Dr. Miguel Machado  
*Chief Medical Officer*

In a short period of time, FCHA has emerged as the **essential high performing provider network** demonstrating **high quality and efficient** delivery of healthcare to patients, employers, and community partners serving St. Johns, Putnam and Flagler counties. The commitment of 194 physicians spanning nearly every medical specialty, Flagler Hospital, and contributions from community providers, equip FCHA with the clinical expertise to improve both the quality and cost of healthcare.



Jason Barrett  
*EVP & Chief Administrative  
Officer, Flagler Hospital*

The clinically integrated network of FCHA presently serves over 18,000 patients in both the Medicare and commercially insured population enabling the network to provide a continuum of care spanning the pediatric and geriatric populations.



John Franks  
*Executive Director*

The reconciled results of the first contract performance periods for the Medicare Shared Savings Program, Florida Blue Shared Savings Program, and the Flagler Hospital Quality and Efficiency Program were impressive. The network generated high quality marks with a **100%** score for successfully reporting the GPRO quality measures to CMS. The Florida Blue primary care network performed at more than 2 standard deviations better than the mean for all PCP's in Florida, and FCHA met 8 of the 9 HQEP quality measures. In addition, the FCHA network generated a combined year-one contract revenue performance of \$2.9 million with Florida Blue contributing **\$1.3 million** and the HQEP effective rounding initiative contributing **\$1.5 million**.

This year's annual report highlights current programs and initiatives as well as insight into future strategies that we believe will improve the quality and total cost of care of the populations we serve. We look forward to your review and welcome your thoughts and feedback on the report.

# Our Membership

Allergy & Immunology	1	Adkison, Michael G., MD	Dhas, Vijayselwyn D., MD	Jackson, Sandra A., MD	Monzon, Raul A., MD	Signor, Robert N., MD
Anesthesiology	6	Aduen, Javier F., MD	Diaz-Granados, Paul A., MD	Jago, Kelly K., MD	Muehrcke, Derek D., MD	Sikaria, Krishna M., MD
Cardiology	21	Ahmadi, Anis A., MD	Dobies, Barry F., MD	Jayachandra, Paul D., MD	Needham, Laila B., MD	Singh, Millee, DO
CT Surgery	1	Akhiyat, Mohamed M., MD	Dolgin, Frederick C., MD	Jivcu, Benjamin, DO	Neerukonda, Suhas P., MD	Smith, Ripp A., MD
Dermatology	1	Akhter, Bushra, MD	Donald W. Monroe III, MD	Jones, James M., DO	Newell, Amber E., DO	Snyder Aaron, MD
Emergency Medicine	33	Alami, Reda, MD	Dupree, Jr., Robert E., MD	Josephkutty, Sebastian, MD	Nigro, Bruce, DPM	Snyder Kari, MD
Endocrinology	1	Aponte-Lopez, Rafael, MD	Epstein, Howard B., MD	Justice, Keith M., MD	Northrup, Tod, DO	Soroka, Stuart A., MD
Family Medicine	23	Baker, III, Howard A., MD	Ernoehazy, William S., MD	Kasraeian, Sina, MD	Oktavec, William J., MD	Soto, Jocelyn A., DO
Gastroenterology	12	Baringer, Dudley, MD	Farhat, Jawad S., MD	Kelsey, Robert C., MD	Olds, Jr., Robert W., MD	Stanescu, Elena, MD
General Medicine & Surgery	1	Barlow, William J., MD	Farraye, Marc J., MD	Kenney Heidi, MD	Pacanonska-Assefa, Irena, MD	Stanescu, Stefan L., MD
General Surgery	4	Barrier, Kate R., MD	Foody Jr., William F., MD	Kent, Jason, DO	Paley, Bruce H., DO	Stark, John B., MD
Hematology/Oncology	4	Barros, Melchor G., MD	Garcia, Jorge E., MD	Kidwai, Arif S., MD	Pantaleon, Yanet, MD	Stewart, Brian D., MD
Hospital	1	Bata, Ahmed R., MD	Gassert, Daniel J., MD	Kiekover, Brian D., MD	Patel, Jignesh, MD	Stromberg, Richard M., MD
Infectious Diseases	1	Batenhorst, Todd J., MD	George, Ferris E., MD	Kluger, Warren S., MD	Patel, Jyoti, MD	Sumith Aleti, MD
Internal Medicine	13	Benkendorf, Robert J., MD	Gerling, Gerard M., MD	Koppman, John S., MD	Pereira, Ryan J., DPM	Taliaferro, Robert B., MD
Nephrology	5	Bhargava, Hemant K., MD	Gibson, Gregory A., MD	Kudia, Ashfaq L., MD	Perumal, Amudha M., MD	Teague, Elizabeth A., DO
Neurology	3	Bishop-Rimmer, Kevin, MD	Gimmel, Patrick, MD	Lammermeier, Jeffrey S., MD	Pineau, Benoit C., MD	Tessler, Michael P., MD
Neurosurgery	2	Brenes, Ryan B., DO	Gindele, Christina, MD	LeBeau, Thomas A., DPM	Platko, William P., MD	Thompson, Matthew J., MD
Obstetrics/Gynecology	10	Brett M. Sasseen, MD	Grech, David R., MD	Lewis, Todd C., MD	Prakash, Manoj, MD	Torres-Rivera, Carlos N., MD
Ophthalmology	3	Broder, Todd, MD	Greene, Trevor O., MD	Long, Mason H., MD	Prakash, Radhika, MD	Turnage, William S., MD
Orthopedics	8	Brodeur, Mark, MD	Greenwald, David L., MD	Long, William, MD	Prisleau, John E., MD	Tutar, Ali, MD
Pain Management	3	Buendia, Jorge A., MD	Grimes, James M., MD	Look, Michael J., DO	Pubbi, Dinesh, MD	Usman, Faisal, M.D.
Pathology	3	Builteman, Cynthia M., MD	Gunn, Andrew J., MD	Lowry, Lisa P., MD	Pulsfus, Eric S., MD	Vassallo, John M., MD
Pediatrics	4	Builteman, James L., MD	Gysling Kevin, MD	Luing, Heather, MD	Purcell, John A., MD	Villanueva, Steven, MD
Plastic Surgery	1	Burleson, Michael L., MD	Haq, Iftikhar, MD	Machado, Miguel A., MD	Raghuwanshi, Raghuraj S., MD	Volk, Albert G., MD
Podiatry	5	Caracciolo, Vincent J., MD	Harper, Angel L., MD	Maetozo, Sherri L., MD	Raymaker, Brian D., MD	Vu, Anh, MD
Psychiatry	5	Cavacini, Timothy J., DO	Harris, Jean C., MD	Malik, Amir A., MD	Rill, Matthew C., MD	Vucinich, Janice L., MD
Pulmonary	1	Cline, Shelby H., MD	Harris, Patrick J., DO	Manikal, Monali	Rosado, Santiago A., MD	Ward, Timothy M., MD
Pulmonology	4	Clonch, Linda S., MD	Hassan A. Hassan, MD	Manikal, Vivek M., MD	Rosana Rodriguez, DPM	Warmuth, Marc A., MD
Radiation-Oncology	1	Collins, Cecilia A., MD	Haycook, Brian E., MD	Marema, Robert T., MD	Routhier, Christine M., MD	Weed, Jerry L., DPM
Radiology, Diagnostic	9	Connor, James F., DO	Hayes, Kevin M., DO	Mas, Jr, Miguel A., MD	Russell W. Denea, MD	Wei, Jueyang, MD
Urgent Care	1	Cordova, Francisco, J., MD	Hoogerwerf, Willemijntje A., MD	Mas, Juan C., MD	Sager, Justin M., DO	Whitlock, Warren O., MD
Urology	1	Cortes, Rafael, A., MD	Horn, Karl J., MD	Matheny II., Jack, M., MD	Saikaly, Bashar S., MD	Whitmire, Lelan F., MD
Vascular Surgery	1	Crisco, Larry V., MD	Hort, Kurtis R., MD	McCann Jr., Michael D., DO	Sanchez, Carlos M., MD	Wong, Erica E., MD
		Davani, Mandana, MD	Hossain, Tawhid S., MD	McDowall, Scott D., MD	Sanghvi, Neil K., MD	Yarian, Susan E., MD
		De Paiva, Helder, MD	Hsu, Michael C., MD	McGaw, Camille A., MD	Searle, Thomas A., MD	Young, Amanada. MD
		DeLamerens, Goar, MD	Huang, Qixia, MD	Mendenhall, Milton T., MD	Seawell, Michael R., MD	Zeljko, Tomislav, MD
		Dent, J. Gregory, MD	Husain, Kishwar, MD	Mohnani, Dena L., MD	Shah, Neenad M., MD	Zub, Christopher J., DO
		Dew, Douglas K., MD, MBA	Imraan Ansaarie, MD	Montgomery, Daniele J., MD	Shrestha, Anil P., MD	
<b>Total</b>	<b>194</b>					

# A YEAR IN REVIEW

Four years ago, Flagler Hospital and our community physicians began a journey to form a clinically integrated network, and in 2013 First Coast Health Alliance was born. The speed at which this new organization was established and has been able to realize measurable results is unprecedented. This is a testament to the commitment our physician partners have made to our mission of achieving the best in quality and efficiency for all patients at every point of care.

We have seen tremendous success in reducing length of stay, readmissions and clinical variance, which resulted in improved outcomes for patients and a distribution to our members. Looking ahead, through the hospital quality and efficiency program, we will invigorate our focus on clinical variation, inpatient resource utilization, throughput and patient experience in the coming year.

The hospital and our physician partners will also work even more closely with the FCHA care coordination team to build on our success. Currently, ninety-five percent of followed patients are seeing a primary care physician within 7 days of leaving the hospital and readmission rates for mental health have declined significantly.

Finally, the creation of our preferred provider network was a tremendous accomplishment. Our focus on acting as a complete “health system” is key to achieving our goals and remaining relevant in the market. We would like to thank you for having the vision to be part of this healthcare transformation. We are truly setting the pace in our region and our state, and we have no doubt that the rest of the nation will be looking to us as a roadmap to achieving the best population health in the coming years.





# EFFECTIVELY MANAGING POPULATIONS

# Reducing Hospital Readmissions by Improving the Continuum of Care

Research data shows that as many as 50% of patients re-hospitalized within 30 days of a hospital admission or emergency room visit never saw a healthcare professional after their initial discharge. This represents a significant cost and resource utilization in potentially avoidable readmissions.

Since formation, First Coast Health Alliance has recognized that establishing and managing a robust care coordination program is key to our success. FCHA's Care Coordination priority in year one focused on high-risk patients with frequent admissions. Recognizing our need to enhance the results of our efforts, we engaged with Dr. Rick Miller, a national expert in the areas of care coordination and population health. With his help, we have designed a plan that includes expanding our care coordination program to optimize and focus on the rising-risk population.

In October of 2015, the team was expanded to include 7 care coordinators; 4 embedded in primary care practices and 3 in the hospital setting. This expansion will target patients with poorly controlled diabetes who are likely to progress to high risk and suffer poor outcomes.

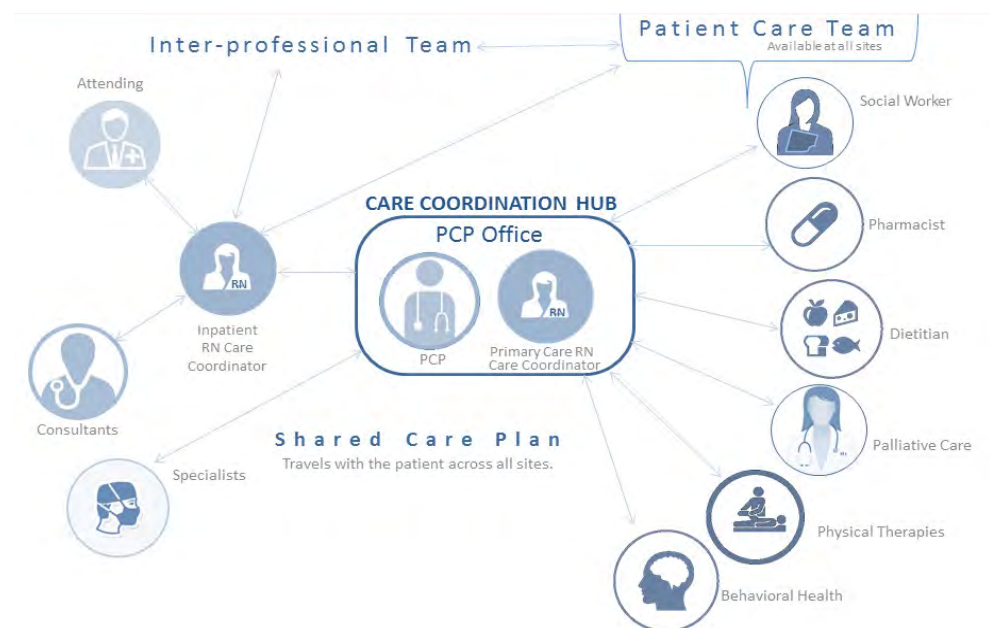
Collaboration across disciplines and throughout the continuum of care is key to our success. Our new inter-professional care team, which includes the patient's physician, RN, social worker, pharmacist and others, develops a shared care plan and seamlessly coordinates care transitions.

This is just one example of the many ways we are working together to ensure the best outcomes for our patients.

The graphic below demonstrates the collaboration that takes place between all members across the continuum of care. FCHA's Care Coordination flow utilizes a team-based approach, ensuring that the primary care office serves as the care coordination hub.



Nangela Pulsfus  
*Director, Care Coordination*





# Care Coordination Program

We realize that the healthcare landscape is changing and that we must change our care model to remain successful. In October 2015 our care coordinators moved outside the hospital walls and are now embedded in four primary care physician practices. FCHA's Care Coordination flow utilizes a team-based approach, ensuring that the primary care office serves as the care coordination hub.

Since November 2015, the Care Coordination Team has managed approximately 1,082 patients, representing **5.8%** of the total covered lives. During this time, the Inpatient Care Coordinators managed 636 hospital transitions and the Primary Care Coordinators managed 518 patients.



Of the patients that are being followed by a Care Coordinator, **95%** attend their follow-up appointments within 7 days of leaving the hospital. Since November 2015, the readmission rates for patients being followed by a care coordinator is down to **14%**.

**The Care Coordination team consists of:**

3

**RN Inpatient Care Coordinators** who follow MSSP and Florida Blue patients during the acute-care admission

4

**RN Primary Care Coordinators** who are embedded in 4 primary care physician practices covering 13 primary care physicians

1

**Ambulatory Social Services Coordinator** whose primary focus is to follow patients identified with having psycho-social needs once they leave the acute care setting

1

**PharmD** who provides medication therapy management and ensures accurate medication reconciliation prior to the patient leaving the acute care setting



# Care Coordination: Moving Outside Hospital Walls

Mrs. Yolanda Geary was admitted to Flagler Hospital for shortness of breath and pneumonia in November 2015. Mrs. Geary also suffered from COPD, congestive heart failure and Type II Diabetes with an A1C level of 10.7. She admitted to not being adherent to her diabetes plan of care and had poor follow-up with her primary care physician.

During her hospital stay, Mrs. Geary was identified and met the criteria to work with the care coordination team. Her inpatient care coordinator and pharmacist worked with her to adjust her medications to eliminate some GI side effects from her previous medication and adjusted her dosages to appropriately address her needs. She was given the appropriate orders for her specific diet and consults with nutrition and the Diabetes Nurse Educator. She also received education on heart failure management as well as the new insulin regimen. Before she was transitioned home, Mrs. Geary's plan of care was discussed among the entire interprofessional team who collaborated together to ensure all of her outpatient needs were addressed.



Upon her transition home, Mrs. Geary worked closely with the Ambulatory Care Social Worker who helped her successfully utilize several community resources for further assistance. She was able to obtain mortgage assistance from ElderSource, tax assistance, home-care assistance from the Council on Aging and financial assistance to help reduce the stress caused by some large medical bills.

Today Mrs. Geary is very thankful for the care coordination team who consistently encouraged her and helped her meet her goals. She successfully follows up with her primary care physician and receives continued support from her RN primary care coordinator. She is able to adhere to her plan of care by receiving the appropriate tools and education for her chronic illnesses. She was put on the proper medications and dosages which prevented unwanted side effects and allowed Mrs. Geary to adhere to her plan of care. Mrs. Geary also underwent bariatric surgery after exploring this option with her primary care physician, has lost over 40 pounds since March 2016 and is no longer on insulin.

# Embedding Care Coordinators Moving Outside Hospital Walls

In October 2015, FCHA embedded 4 RN Care Coordinators inside 3 primary care practices, covering the patients of 13 physicians. Positive results have already been seen after just a few short months.

“Having an embedded Care Coordinator in the office has been very good so far,” said Dr. Suhas Neerukonda. “When a patient

comes to the office and meets the care coordinator, they establish a personal relationship that improves patient adherence with the care plans. The Care Coordinator acts as an additional set of eyes to ensure the appropriate plan of care is being established while also paying close attention to any social needs that the patient may have.”

The embedded RN Care Coordinators work closely with the team’s social worker to further support patients with any psychosocial issues. The social worker also serves as a liaison between the inpatient social worker and primary care coordinator to successfully carry out discharge plans of care. Patients and their family can more cohesively be connected to community resources that they may have otherwise not known about without the help of the social worker.



*Dr. Suhas Neerukonda*

## Diabetes Management Programs

Evidence shows that when diabetic patients control their diabetes, they experience fewer complications of care, inpatient hospitalizations and better overall health and wellbeing. FCHA and Flagler Hospital offer a variety of diabetes management programs.

In November 2015, FCHA began offering free one-on-one counseling with a certified diabetes educator to further help educate those patients who did not have their diabetes under control. Patients are referred to the program by their Care Coordinators

Significant results have been seen in managing diabetic patient’s A1C levels. Prior to having embedded coordinators in their offices, 17.5% of patients tested had an A1C higher than 8. After the coordinators were embedded, the percentage significantly decreased to **12.8%**. The data also showed that practices without an embedded RN Care Coordinator had much higher percentages of patients with high A1C levels.





## Palliative Care Program

First Coast Health Alliance partnered with Community Hospice of Northeast Florida to establish a Community Palliative Consultants program at Flagler Hospital. In June 2015, Dr. Beth Teague joined the medical staff to help our patients find a better quality of life while dealing with serious illnesses. The palliative care program focuses not just on relieving physical pain and symptoms. The team also helps patients with important decision-making and establishing goals of care, emotional and spiritual issues, family dynamics and other challenges.

FCHA recognized that use of palliative care services can yield cost savings while also maximizing patient comfort and safety – and significant opportunities for utilizing palliative care services exist at Flagler.

Since the program began, over **500** patients have been served by the Palliative Care program at Flagler Hospital.



## Behavioral Health

FCHA and Stewart Marchman-Act Behavioral Health Care have partnered and developed a Care Coordination Program to treat patients with chronic mental illness. The program includes a social worker, nurse and psychiatrist to provide and coordinate treatment for individuals with chronic mental disorders that are associated with more severe symptoms, greater risk of suicide, more frequent psychotic relapses and more frequent emergency care visits. During the spring of 2016, the readmission rate dropped to **2.04%** which was down from 10.64% the previous quarter.

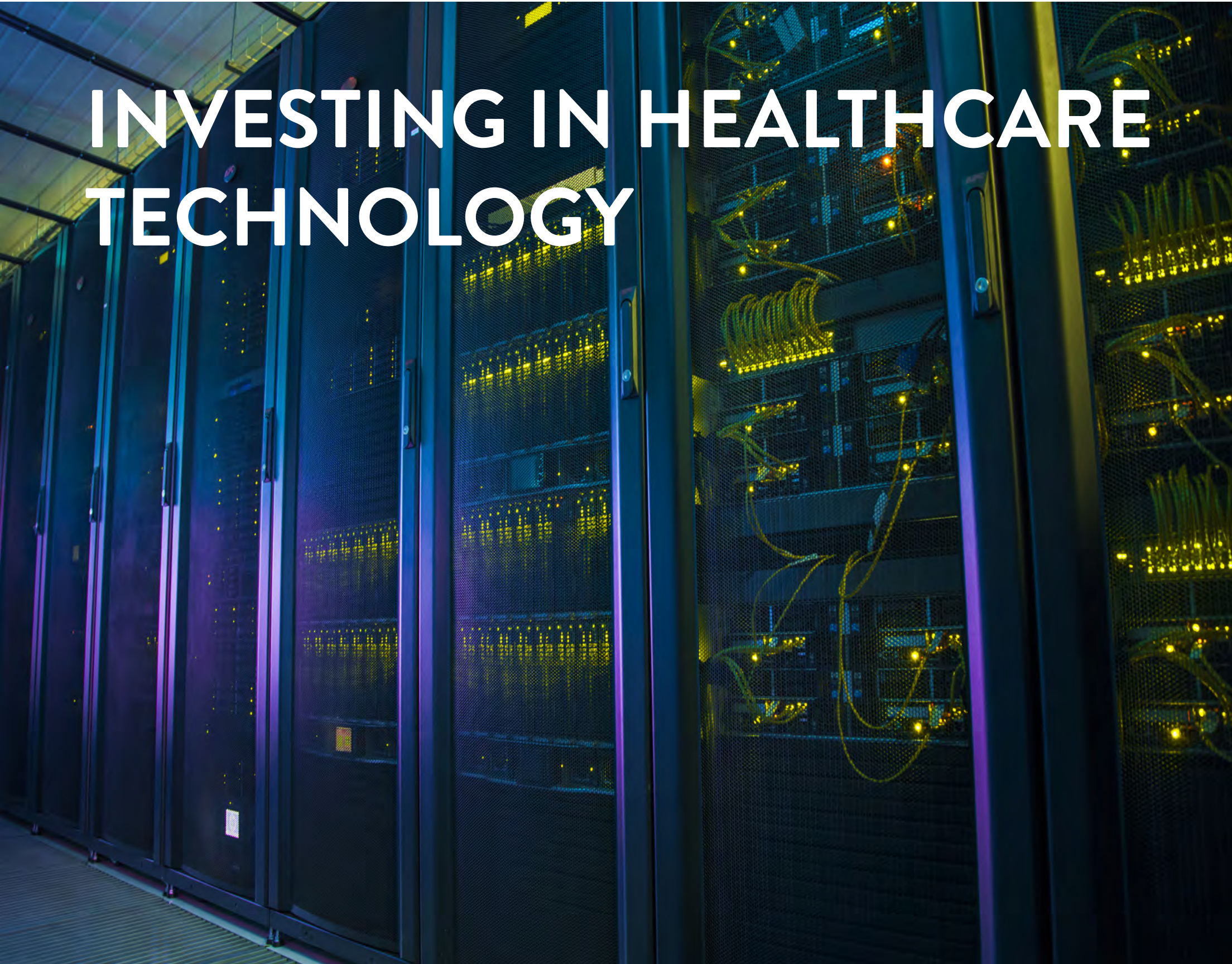
Flagler Hospital also opened an outpatient behavioral health clinic in October 2015. This clinic features board-certified psychiatrists, who work with patients to develop customized treatment plans within a private office setting. Key goals are to reduce unnecessary ER visits and hospital re-admissions within one month of an initial hospital visit.

## Transitional Care

Research shows that about one in five patients are readmitted within 30 days. In order to address this issue, FCHA and Flagler Hospital are developing the Flagler Care Center, opening in Fall 2016. The clinic is not a replacement for a patient's primary care provider, but is meant to serve as a supplement, especially in those first days after a patient leaves the hospital. The clinic will work closely with the primary care physician and provide patients with information regarding the hospitalization and the transition into the home setting. The clinic will also serve as a bridge for those who do not already have a primary care physician



# INVESTING IN HEALTHCARE TECHNOLOGY





Population health technology platforms are used to provide care coordinators and care teams with secure internet-based access to comprehensive financial and clinical information. These platforms access clinical data and other patient data from multiple sources. They also give users easy access to predictive analysis, population risk stratification, hospital admission data, disease registries and referral data. The platform seamlessly connects to data warehouses that store third-party information and should allow third-party applications to be integrated to increase the functionality with ease.

### Patient Portal:

Engaged patients follow their providers' recommendations. However, to fully engage patients in their care, you must equip them with tools to more easily connect with their care teams.



The Allscripts FollowMyHealth® patient engagement platform gives patient and their families the opportunity stay connected with their physicians and become active members of their care team.

Since launching the patient portal in July 2014, **4,788** patients have accessed their electronic medical record and further engaged in their health.



### Emmi Solutions:

As hospitals and health systems transition from volume- to value-based delivery systems, they face numerous challenges along the way. But, no matter the challenge, patient engagement plays an increasingly important role in helping organizations achieve their goals and lowering costs.

Emmi Solutions allows people to be more active participants in their health and wellbeing. Patients are assigned videos to help them better understand procedures and diagnoses, which in turn decreases anxiety and directly engages them in their healthcare. Since launching the program in January 2015, over **4,000** Flagler Hospital patients have completed an assigned EMMI program. Of these patients, **81%** reported that their opinion of their healthcare organization was improved after watching the program and **94%** of patients reported that the Emmi program answered questions they had that they would've normally called to discuss with their physician. After watching the program, **92%** of participants reported that they will take new action in managing their health.

*Emmi Education Program Screenshot*



### ***Telemedicine:***

Flagler Hospital is excited to connect further with Wolfson Children's Hospital and Baptist Health through our telemedicine program. The highly-trained physicians in the Flagler Hospital ER will soon be able to connect to specialists at Baptist Health and Wolfson Children's Hospital for consults on certain pediatric cases as well as adult cases of possible strokes and neurological diseases.

In the summer of 2016, a pilot program will begin with Visi Mobile, a wearable device worn around the wrist which allows clinicians to be in touch with their patients and check on their vital signs at any given moment. The Visi Mobile is capable of monitoring ECG, heart rate, pulse rate, blood pressure, respiration rate and body temperature. In addition, this technological device is able to transmit data in a wireless manner, so vital signs can be analyzed on a remote computer or portable tablet.

### ***First Coast Care Connect:***



Flagler Hospital and First Coast Health Alliance have contracted with dbMotion/Allscripts to help develop and implement a comprehensive, single record for our patients with an innovative new capability called a private health information exchange. The primary objective of this new initiative is to shift patient care from a location and event focused experience to a patient-centered model, with a single patient record available at all points in the continuum of care. This partnership is called First Coast Care Connect.

### ***Shared Care Plan:***

The First Coast Health Alliance Care Coordination Team use shared care plans to understand their patients' values, needs and circumstances while helping them achieve personal health goals.

Shared care plans facilitate communication between patients and healthcare professionals to support long-term planned care for patients with chronic illnesses. The shared care plan provides a snapshot of the patient for everyone in the continuum of care and allows everyone to be on the same page.

The shared care plan is a living document that delineates patients' short- and long-term health goals and informs future medical care so it can be aligned with patients' priorities. To establish baseline goals, care coordinators ask a series of questions that clarify where patients want to be with their health in three and six months. While these short-term goals can be adjusted as needed, they provide an opportunity for patients to engage proactively in their care.

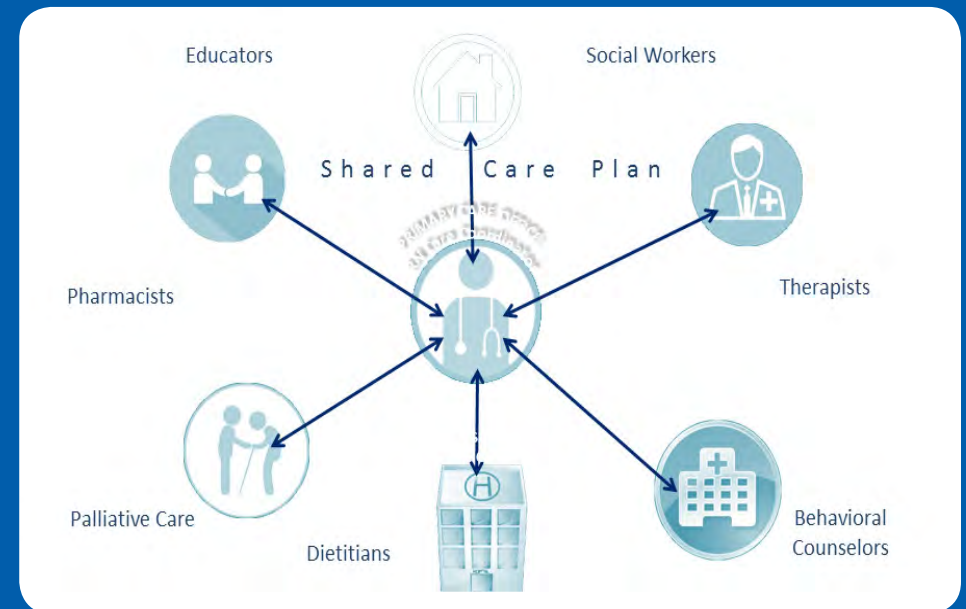




The shared care plan is a living document that delineates patients' short- and long-term health goals and informs future medical care so it can be aligned with patients' priorities. To establish baseline goals, care coordinators ask a series of questions that clarify where patients want to be with their health in three and six months. While these short-term goals can be adjusted as needed, they provide an opportunity for patients to engage proactively in their care.

In conjunction with ascertaining health goals, caregivers gather other information that may factor into treatment plans. The conversation touches on a number of topics, including what medications patients take and who is responsible for patients' medical care. In addition to asking questions pertaining to patients' circumstances at home, health coaches note language, financial and other barriers to accessing care.

Using shared care plans, providers are able to develop treatment plans based on a more complete picture of each patient. Information contained within shared care plans gives providers a thorough overview of all socioeconomic factors that may influence patient health. Taking into consideration every aspect of a patient's circumstances helps meet patient preferences and deliver better care.



Because shared care plans are tailored to patients' health, individual circumstances and other factors, the document evolves as providers learn more about a patient. If, for instance, socioeconomic situations change, presenting or removing barriers that previously affected treatment plans, providers amend the document and realign the patient's medical regimen accordingly.

Shared care plans also reflect a patient's medical progress. As an example, at the initial goal-setting session, a patient may mention that he or she cannot take many medications at once and will not comply with requests to do so. Health coaches note this, and providers, after consulting the shared care plan, can prescribe the medications that will be most effective in treating the patient's condition. Additionally, providers can establish a medication schedule that will help the patient maintain the regimen and potentially increase the number of medications he or she is comfortable taking.

# A COMMITMENT TO QUALITY





Every American has their own definition of high-quality healthcare. For some, their definition revolves around access to the physician or hospital of their choice and for others it means access to specific types of treatment. In recent years, there has been a great deal of attention paid to defining healthcare quality so that we, as a nation, can work together to improve care.

In 2001, the highly regarded Institute of Medicine (IOM) of the National Academy of Sciences issued a landmark report—Crossing the Quality Chasm: A New Health System for the 21st Century—that called on the nation to aggressively address the dramatic deficiencies in the quality of healthcare delivered in the U.S. The IOM defined quality healthcare as *“safe, effective, patient-centered, timely, efficient and equitable.”*

The Agency for Healthcare Research and Quality (AHRQ), the federal government’s leading agency charged with improving the quality, safety, efficiency and effectiveness of healthcare for all Americans, defines quality healthcare *“as doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”*

FCHA supports both definitions as they provide a clear picture of good quality healthcare. It is based on scientific and medical evidence, it takes the specific details of a patient’s life into consideration and it is aimed at improving the health and life of the patient being treated. FCHA’s commitment to quality and the science of measuring quality is a key component of every service, contract, and strategic decision made by the organization.

### A few of the key quality highlights over the past year include the following:

- Fifteen-member Quality Committee
- Expansion of the population health and care coordination strategy
- Development of a preferred network for SNF, home health and hospice agencies
- Established a transition team focusing on individual care plans for patients transitioning from the inpatient setting to home health, SNF, or rehab
- Successful reporting of the 33 GPRO Quality Measures in the Medicare Shared Savings Program (100% score)
- Successful completion of the random quality audit for the Medicare Shared Savings Program (1 of 30 in the country)
- Florida Blue Primary Care Quality Performance: 2 standard deviations better than the mean for all PCP’s in Florida
- Hospital Quality and Efficiency Program (HQEP): 8 of 9 Quality Gate Measures met

## FCHA Profitability

FCHA was formed in May of 2013 to foster collaboration among independent physicians and Flagler Hospital in a way that will increase both the quality and efficiency of patient-centered care. This partnership between the hospital and some 186 local physicians was created to ensure that the provision of care in the region is managed locally by local providers.

2015 marked the first year of profitability. The revenue contributions from the Florida Blue and HQEP contracts were received in 2015 positioning the organization to provide distribution payments totaling **\$1.7M** to FCHA physician members.



## Medicare Shared Savings Program

FCHA entered the Track 1 (no downside risk) Medicare Shared Savings ACO Program (MSSP) effective Jan 1, 2014 and is presently serving over 10,200 Medicare beneficiaries. The MSSP agreement requires quality reporting through the GPRO web interface with a total of 33 clinical and patient satisfaction measures. The initial cost benchmark was based on 2011, 2012, and 2013 paid claims and has proven to be challenging to achieve due to the declining trend that occurred during this period. Although FCHA did not generate a shared savings incentive in year one of the program, the implementation of the care coordination program and post-acute preferred network is demonstrating efficiencies for future savings opportunities.

### 2015 Program Highlights

- Successful GPRO reporting with a 100% score for reporting in year one.
- No financial incentive payment earned in 2015. \$7.3 million above the Savings Rate Benchmark established by CMS
- Major areas of opportunity include
  - Post-acute spending / utilization
  - Part B spending / utilization
  - Hospital / inpatient admits per 1,000

FCHA successfully reported on the 33 Quality and Customer Service Metrics included in the MSSP program receiving a 100% score in the report only year of the contract. In addition, FCHA successfully completed the GPRO audit as the alliance was 1 of 30 randomly selected ACO's for audit in 2015. The GPRO 2016 reporting ended in March with year two results expected soon.



## Hospital Quality and Efficiency Program

The CMS waivers associated with the Medicare Shared Savings Program and the clinically integrated network of FCHA enabled Flagler Hospital to partner with FCHA on new Hospital Quality and Efficiency initiatives. These new waivers allow gainsharing opportunities between Flagler Hospital and FCHA member physicians. The initial HQEP program, HQEP 1.0, identified nine quality gate measures and **\$7.2 million** in savings opportunities. The financial highlights of the HQEP program include:

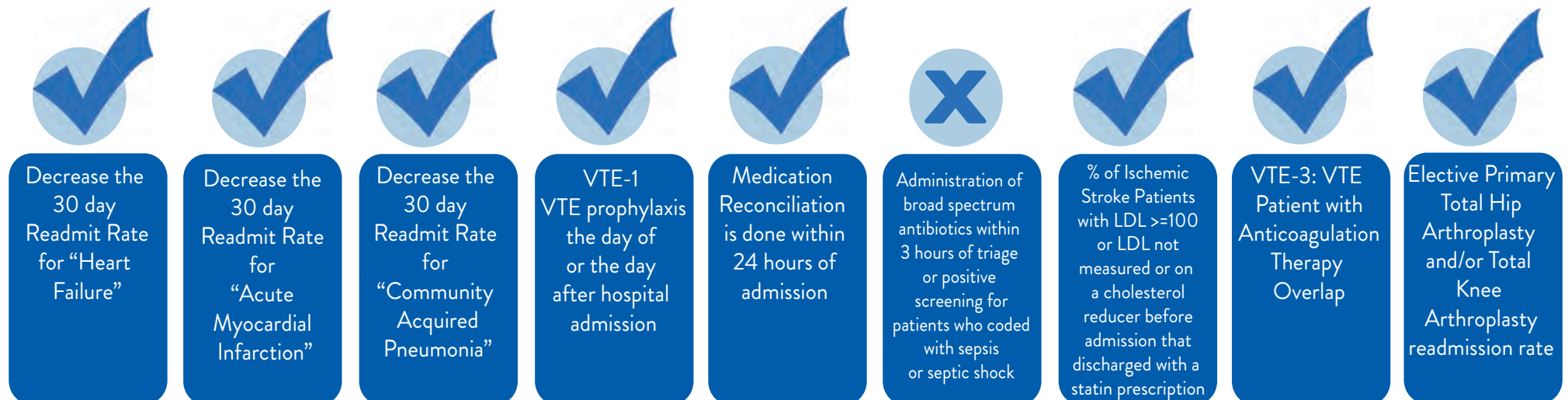
### HQEP 1.0 (Phase I): 2015

- \$3.1 million savings generated via the length of stay initiative
- Gainshare Split: \$1.5 million FCHA Gainshare and \$1.6 million Flagler Hospital
- Flagler Hospital Geometric Mean Length of Stay observed to expected ratio improvement (1.29 to 1.14)
- Additional Gainshare opportunities of \$2.3 million related to 1.0 initiatives are in progress (CRM/HCAP/Sepsis/Ortho/Trauma)

### HQEP 2.0 (Phase II): 2016

- New HQEP 2.0 initiatives estimated at \$4-5 million
- Key areas of initiative focus in HQEP 2.0 include (LOS, Flagler Hospital Health Claims Trend, Clinical Variation, IP resource utilization, Perioperative Throughput, PCP Quality/Access, OB/GYN)

The Hospital Quality and Efficiency Program includes quality gate measures prior to any gainsharing between Flagler Hospital and Florida Blue. FCHA and Flagler Hospital identified key quality areas to focus on in 2015 and established dedicated multidisciplinary workgroups. The graphic below provides a summary of the HQEP Quality measures with eight of the nine measures exceeding the performance target. Our overall score on year 1 was 88.89%



## Florida Blue Total Cost of Care Program

FCHA presently participates in a Florida Blue total cost of care shared savings agreement with over 7,000 self-insured and fully insured members in St. Johns and Putnam counties. The agreement includes both a quality and efficiency component with FCHA exceeding performance standards in both areas.

The FCHA total cost of care shared savings agreement with Florida Blue includes a quality component in order to participate in any shared savings that are generated. The FCHA primary care network performed at more than two standard deviations better than the mean for all PCP's in Florida.

In 2015, **\$2.4 million** in total savings were generated. This year it is estimated that total savings will reach \$3.4 million with an additional 2,300 members of the Flagler Hospital health plan being included in a HQEP initiative.

## Preferred Provider Network

As part of FCHA's strategy to provide the best patient care at the best value, FCHA conducted an evaluation of our post-acute care network. This evaluation into scope of services, quality and value, led to the establishment of FCHA's Preferred Provider Network. By working more closely together, the network helps support a smooth transition between healthcare providers, paving the way for improved health outcomes through communication and continuity of care.

### Preferred Skilled Nursing Facilities:

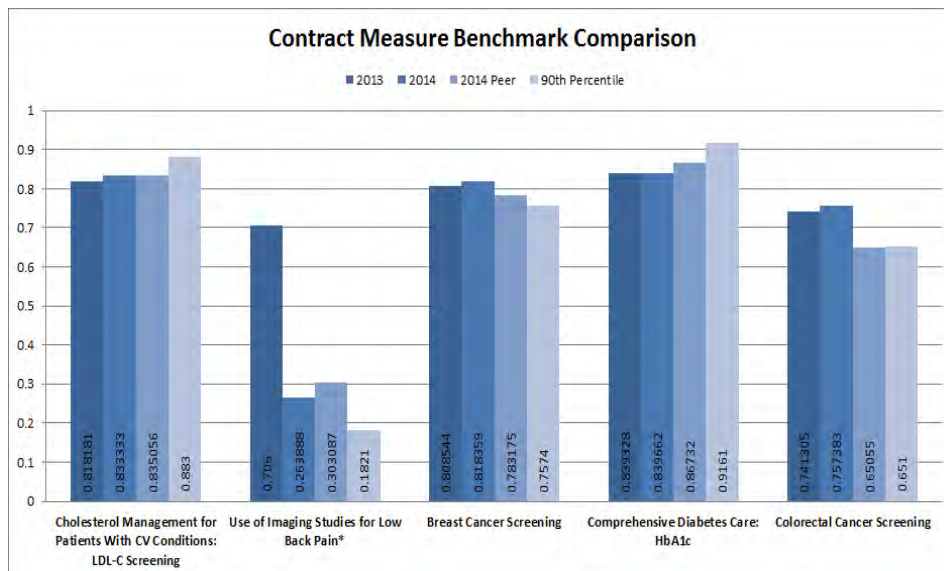
- Bayview Healthcare
- St. Augustine Health & Rehabilitation Center
- The Ponce Therapy Care Center
- Palatka Health Care Center

### Preferred Home Health Facilities:

- Bayview Healthcare
- Brooks Americare
- Community Home Health / Almost Family
- Precise Home Care
- Welcome Homecare
- Amedisys (pending proposed contract approval)

### Preferred Hospice Facilities:

- Community Hospice of Northeast Florida (for St Johns and Duval Counties service areas)
- Haven Hospice (for Putnam County service area)





## Bundled Payment Care Initiative

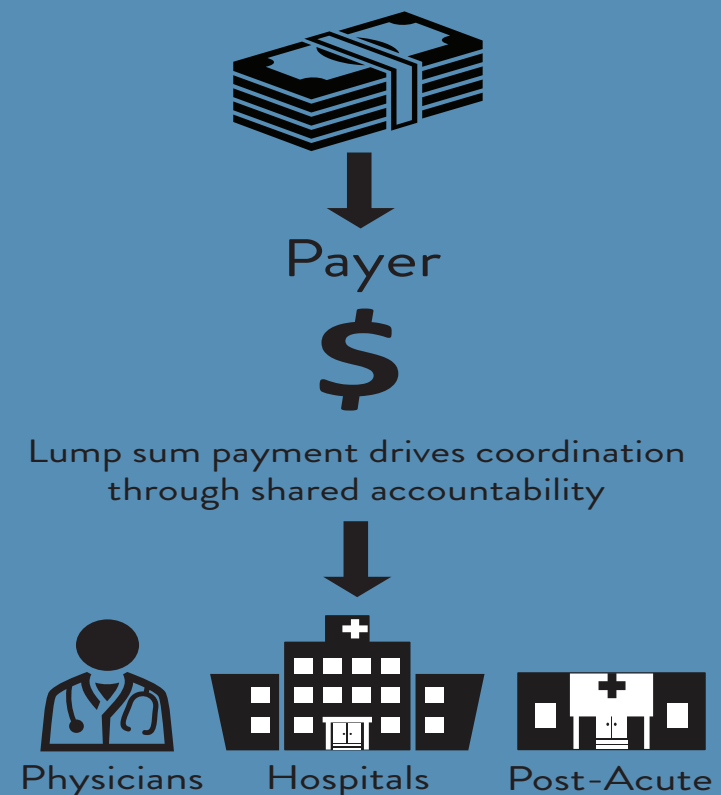
Flagler Hospital partnered with FCHA Orthopedic Surgeons to enter the CMS bundled payment initiative. Flagler Hospital is the risk bearing entity and is working collaboratively with the FCHA Orthopedic Surgeons, FCHA preferred post-acute network, and the consulting arm of Brooks Rehabilitation in serving the orthopedic patients.

Under this new payment model, Flagler Hospital and FCHA are responsible for the Total Cost of Care (TCC) for Medicare beneficiaries from the time of discharge through 60 days post-discharge (episode of care). As we shift away from fee-for-service and closer to value-based payments, providers across the episode of care work together to improve quality and patient outcomes.

This initiative saved approximately **\$50,000** in the first quarter, with expected savings to total \$200,000 - \$300,000 by the end of the first year. A major driver in this initiative is caring for our patients in the right setting. The use of skilled nursing facilities post-discharge has drastically decreased by **57%**. Readmission rates have also been positively impacted. Historically, the readmission rate for this group of patients was 11%, after just a few months, the readmission rate has fallen to **7.04%**.

### Cost and Care Included:

- Inpatient Rehabilitation
- Skilled Nursing Facility
- Home Health Agency
- Hospital Outpatient
- Physician Services
- Outpatient Therapy
- Clinical Laboratory
- Durable Medical Equipment
- Part B Drugs
- Acute Hospital Admission
- Long-Term Care Hospital





# DELIVERING VALUE





# Employer Solutions

FCHA realizes the market is shifting and a new healthcare consumer is emerging that has different wants, needs and expectations. Today's consumer wants tailored care, convenient access, transparent costs and increased value. FCHA recognizes that employers are key stakeholders in the healthcare ecosystem and as healthcare costs for employers continue to rise, it is important for employers to work more directly with providers to transform the payment and delivery systems for healthcare.

In 2015, FCHA entered its first employer contract with Flagler Hospital, covering 2,200 lives. In the first year alone, over **\$1 million in savings** were identified and were made possible by partnering to manage costs. The tiered benefit design uses our high-performing provider network and offers a lower deductible and copay for our employees. It also encourages use of primary care services, wellness and use of our personal health portal.

Dedicated care coordinators also work with medium and high-risk beneficiaries to make sure they receive the right care, at the right time to keep our employees healthy and ultimately reduce costs.

FCHA is uniquely positioned to become a highly-valued partner for employers in St. Johns County. Investments in the FCHA clinically integrated network, experience with tiered benefit designs, investments in wellness offerings within the Flagler Hospital self-insured employee health plan, and opportunities for an extended network via Coastal Community Health will allow FCHA to develop new solutions for employers in the market.

FCHA will focus on developing an employer solutions portfolio in the next 24 months that will include telemedicine offerings, wellness and care coordination offerings, and self-insured health plan benefit designs leveraging the FCHA network.



# Community Partnerships

Flagler Hospital serves as the hub of healthcare in our community. One of the most critical determinants of health is access to health services. Lack of access, or limited access, to health services greatly impacts an individual's health status. Access is more than just having an insurance card. It is more than getting care in an emergency room. Access is having a regular, reliable source of quality preventive and primary healthcare.

## Azalea Health

Without access to a medical home, many St. Johns County residents use the Flagler Hospital Emergency Care Center as their primary care provider. Primary care-related emergency department utilization, including for conditions that are preventable or treatable with appropriate primary care, is associated with decreased efficiency of and increased costs to the health system.



To increase access to healthcare services in our community, Flagler Hospital and Azalea Health, St. Johns County's Federally Qualified Health Center (FQHC), have partnered to provide a seamless transition for patients without a primary care physician from the Flagler Hospital Emergency Care Center (ECC) to Azalea Health.

This partnership between Flagler Hospital and Azalea Health allows for increased access to primary care through coordination. During the first quarter of the referral program, **754** patients were referred to Azalea Health for follow-up care after visiting the Flagler ECC. After discharge, **41%** of referred patients spoke with an Azalea Health Care Navigator about what to expect after their discharge, **30%** of which, received follow-up care at Azalea Health within 7 days. Over half of the patients that made follow-up appointments with Azalea received further care, potentially eliminating a readmission to the Flagler ECC.

## Wildflower Clinic



Flagler Hospital partners with the Wildflower Chronic Care Clinic by providing grant funding, diabetic testing supplies, lab work and radiology exams. This effort has resulted in **79%** of patients improving their HbA1c, **100%** of patients receiving their annual diabetic foot exam and **74%** of patients achieving their target blood pressure in 2015. In addition to its support of the chronic care clinic, Flagler Hospital also covers the necessary laboratory and radiology exams provided to all the Wildflower Clinic's patients at no cost.



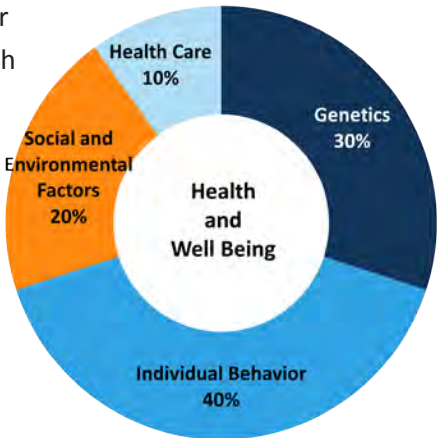


# Addressing Our Community's Health

Flagler Hospital is committed to addressing our community's health-related needs through:

- FCHA Physician Network
- Care Coordination
- Early detection community screenings
- Disease prevention and management

The focus of these efforts is to provide quality care to patients by coordinating care between medical providers across the continuum of care. New research indicates that by focusing on patients immediate health needs, we are addressing **less than 50%** of factors that determine their overall health. In order to make an impact on the overall health of the community, and become a national model for community-based health, we must enhance our focus to improve access and coordination of available community resources by addressing social determinants of health.



Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				
Health Outcomes					
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations					

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health are economic and social conditions that influence the health of people and communities.

Compelling evidence has revealed the impact of unmet social needs on people's health and longevity, and on health care spending:

- More illness. Poor health is closely tied to inadequate housing, food insecurity, and unemployment or underemployment
- Shorter life expectancy. Better-educated adults have longer life expectancies.
- Increased health care spending. Unmet social needs are associated with higher rates of emergency room use, hospital admissions, and readmissions.

To further support Flagler Hospital's efforts to become our community's partner for population health, a network of community resource providers that address social determinants of health by serving as the unifying body, or "hub", of community resources for all St. Johns County residents will be created. This establishment will achieve better health outcomes for St. Johns County through increased **coordination** and **access** to community resources.



# Looking Ahead

As we move toward the future together in an evolving industry, we will create a nimble clinically integrated network positioned to participate in new value-based programs, meet the needs of employers struggling with increased healthcare costs, and improve the health and vitality of our community.

## Meeting the Demands of MACRA

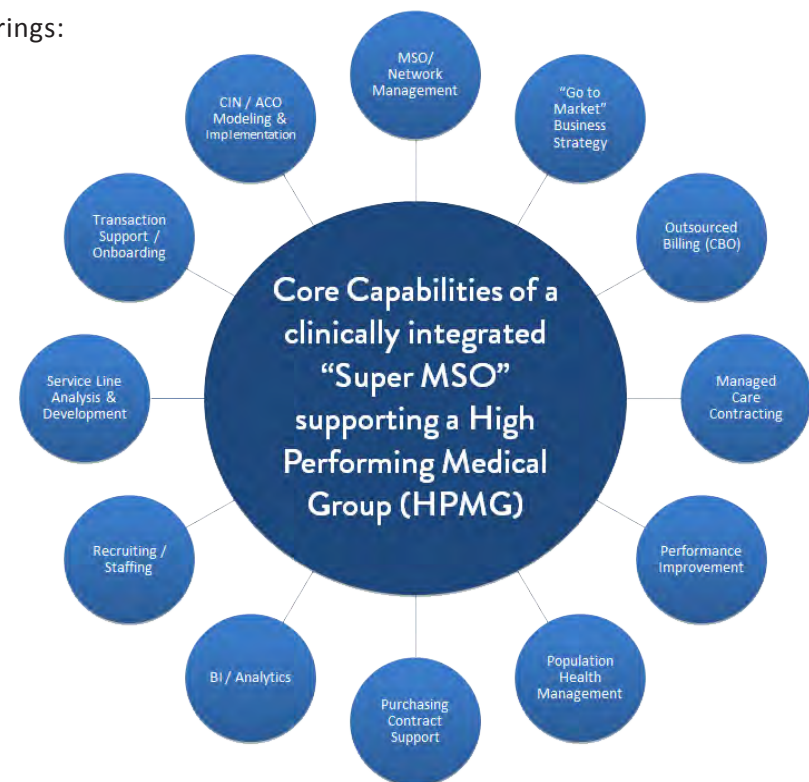
The recent MACRA and MIPS guidance and definition of qualifying Alternative Payment Models support the 2015 announcement that stated the HSS goal of tying 30% of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments. FCHA will continue to develop infrastructure and programs that enable the network to participate in the value based programs

FCHA's leadership recognizes the uncertainty and likely financial hardship associated with this legislation and will be working over the next year to ensure membership is sheltered from any negative impact.

## Physician Practice Support

With over 80 practices represented in the FCHA network, the network is positioned to create a management service organization to assist with the administrative functions of operating a practice. Establishing an MSO will support FCHA's goal to help our members thrive. In order to sustain our membership we must also increase our physician's profitability, which may include reducing operating costs and top-line revenue.

Over the next 24 months in concert with our Coastal Community Health partners we will be evaluating and putting together an MSO offering which would include but would not be limited to the following service offerings:



Through this structure, FCHA leadership looks to preserve the independent practice of medicine in our community.



## Transforming Our Care Processes

Medicare spending in the last few years of life continues to grow exponentially. Roughly one of every four Medicare dollars – \$125 billion annually – is spent on those 5% of Medicare patients in their final year. According to the Dartmouth Atlas of Health Care, Flagler Hospital spends 42% more than the national average when it comes to spending during the last 2 years of life.

	Hospital Care Intensity Index, Last 2 Years of Life, by component
<b>Flagler Hospital</b>	<b>1.42</b>
National Average	1.00
90th Percentile	1.44
50th Percentile	0.92
10th Percentile	.63

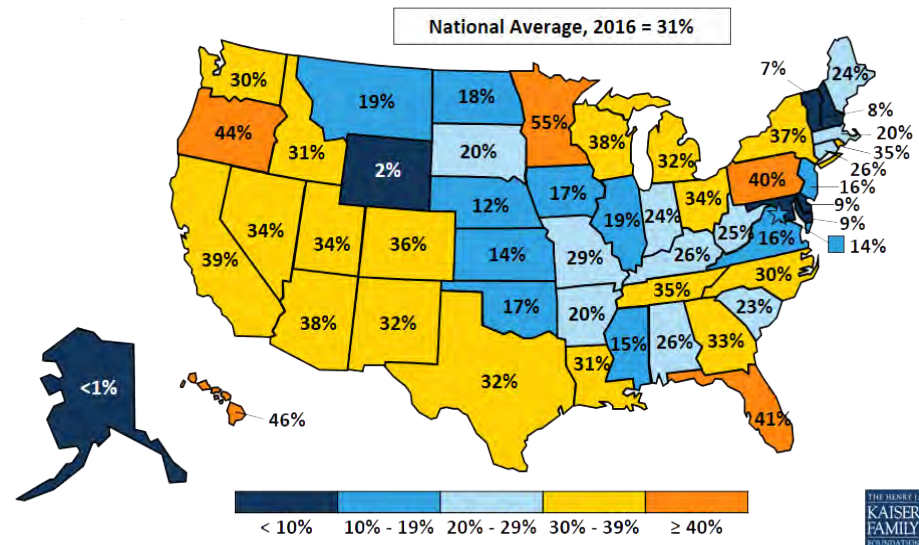
To combat this, FCHA, Flagler Hospital and Community Hospice of Northeast Florida is developing an Advanced Illness Management program (AIM) to make the last 6-18 months of life more personal, caring and economical. Establishing an Advanced Illness Management program (AIM) helps improve the quality of care for patients in the advanced stages of chronic illness, helping to reduce health care costs while increasing the quality of life for patients.

## Medicare Advantage Program

The St. Johns County total Medicare Population and Medicare Advantage enrollment continue to experience sustained growth rates. The projected growth in the St. Johns County Medicare population will enable FCHA the opportunity to deploy a narrow-network provider solution customized for our service area. The Medicare Advantage program offers a tighter alignment of services within the contracted provider network which will further strengthen clinical integration and efficiency opportunities.

Since 2013, the number of Medicare Eligible enrolled in a Medicare Advantage plan in St. Johns County has increased from 7,182 to **11,023**. The Medicare Advantage penetration rate of the eligible population in St. Johns County has also grown from 18.8% in 2013 to **23.7%**.

FCHA will be evaluating strategic partnering opportunities to develop and launch a Medicare Advantage product powered by the FCHA network over the next 24 months.



Share of Medicare Beneficiaries Enrolled in Medicare Private Plans, by State, 2016

