# FINANCIAL AND OPERATIONAL IMPROVEMENT

## *CAH OPPORTUNITIES*

*2015 Flex Program Reverse Site Visit*

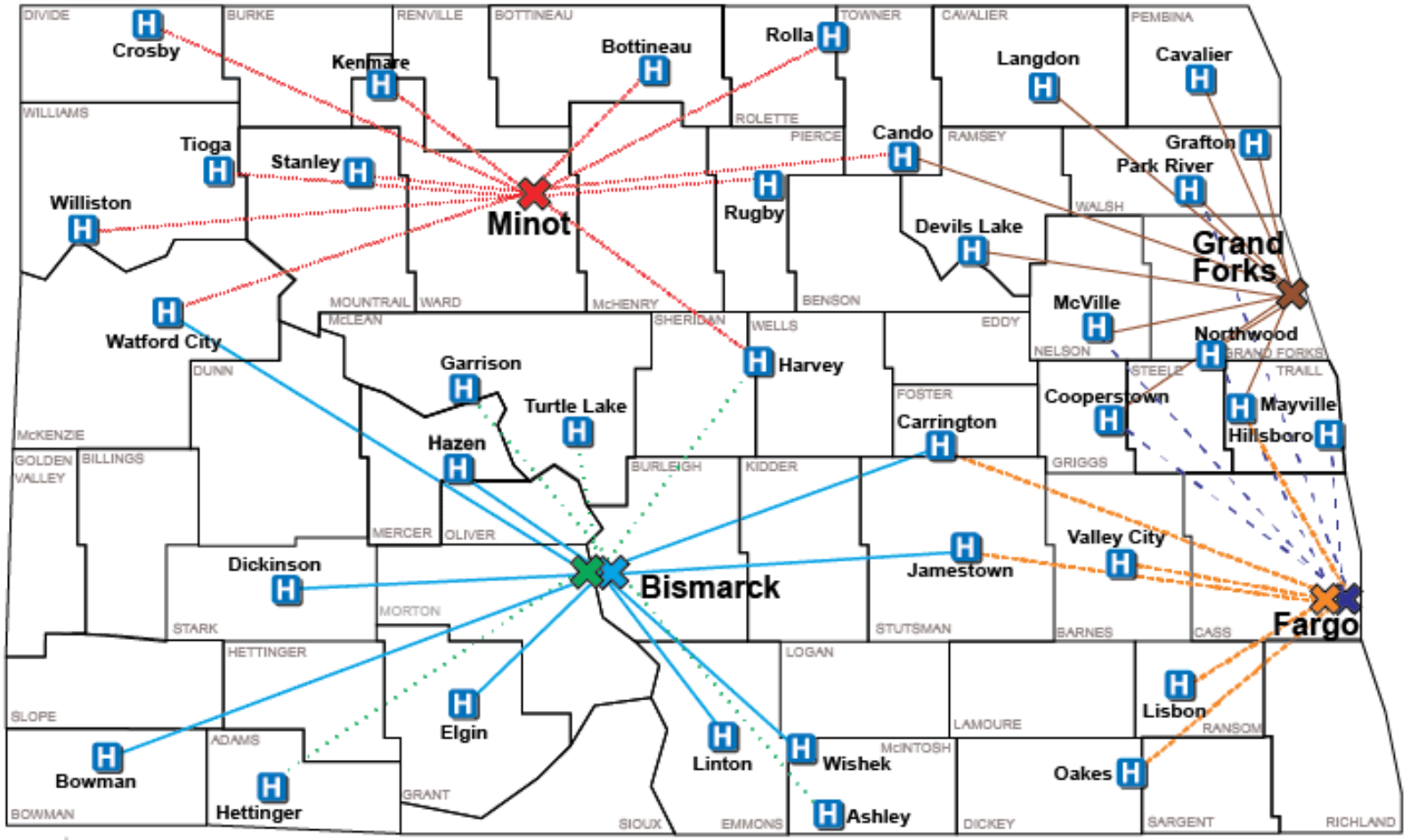
*Pathways to Value*

*June 23, 2015*

# Agenda

- ND CAHs achieving improvement through sharing of financial information
- ND Community Health Needs Assessments
- Rural Safety Net Providers
- Collaboration – An option or a necessity?
- A CAH/FQHC collaboration success story
- Opportunities for financial and operational improvements

# North Dakota Critical Access Hospitals & Referral Centers




11/13

Center for Rural Health
University of North Dakota
School of Medicine & Health Sciences

**Referral Centers**

Trinity Hospital
Altru Hospital
St. Alexius Medical Center
Sanford Health
Sanford Bismarck Medical Center & St. Alexius
Sanford & Essentia Health
Critical Access Hospitals H

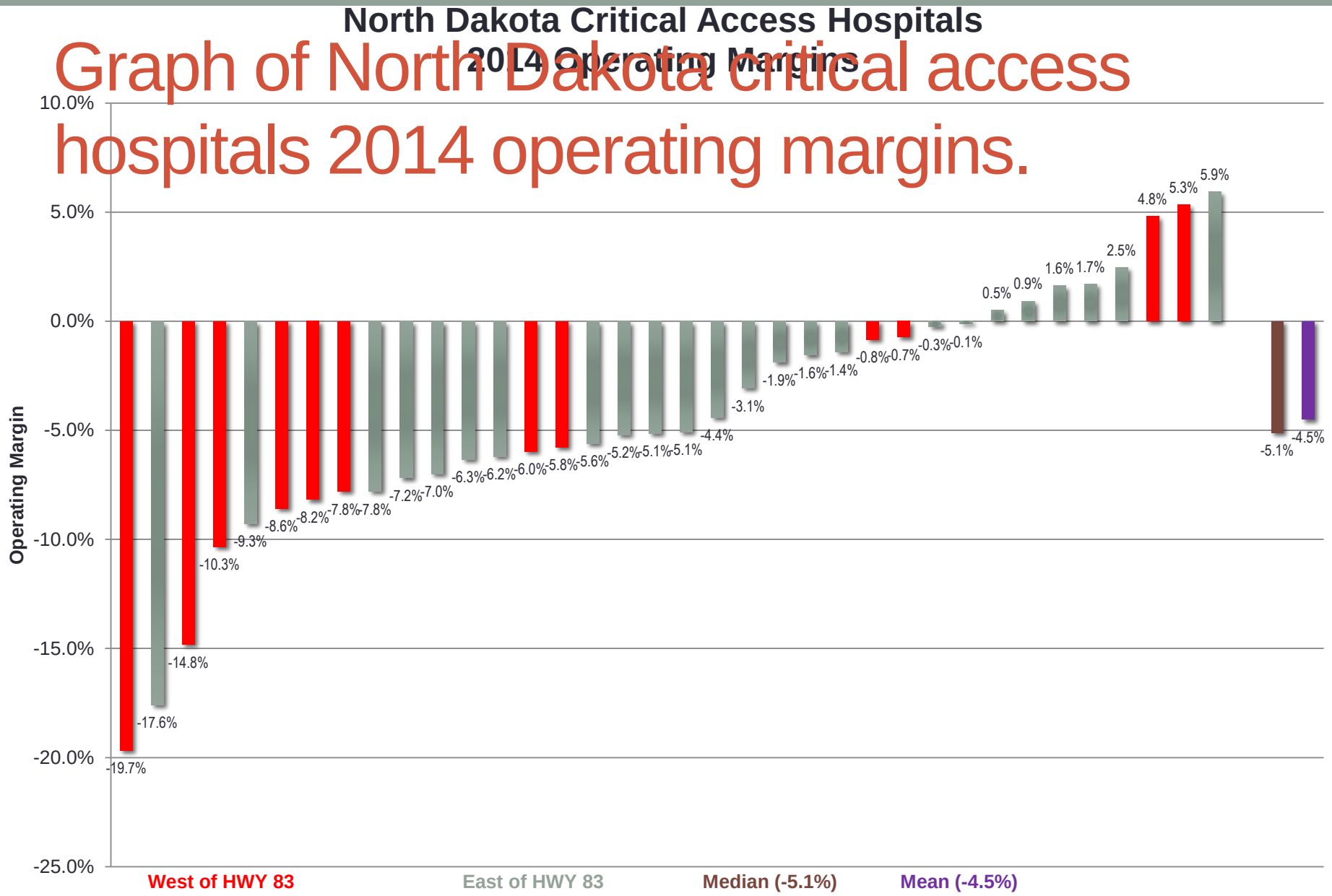
# North Dakota CAH Financial Analysis Calendar 2014

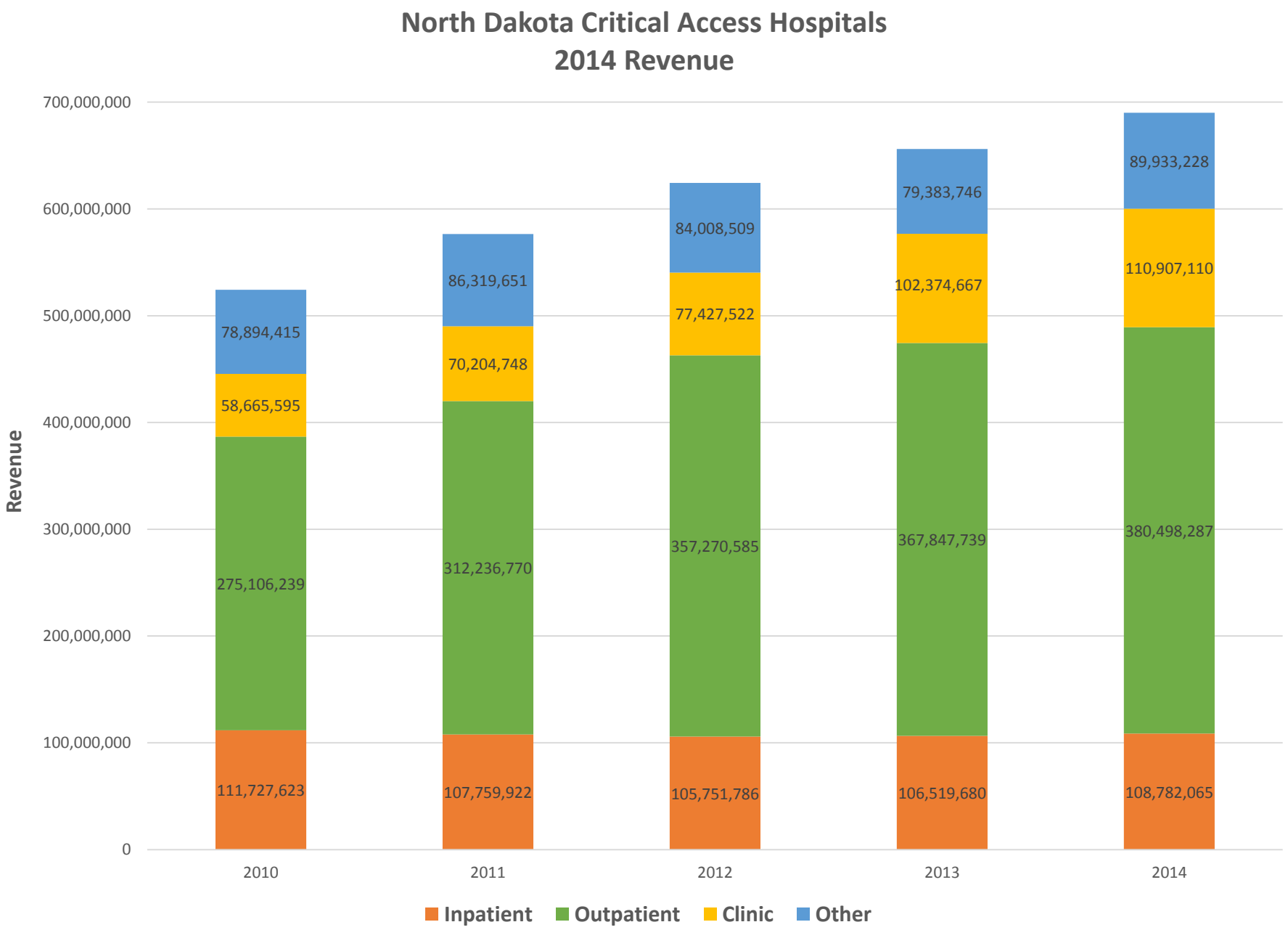
- Reason for gathering data
- Have gathered data for 8 years
- 2014 observations
  - 32 of 36 Facilities Own/Operate a Clinic
  - 32 Facilities Who Own/Operate Clinics, Operate 57 Clinics
  - 42 of the 57 Clinics Are Rural Health Clinics (RHCs)
  - 14 of 36 Facilities Own/Operate a Nursing Home – 604 Beds
  - 9 Facilities Own and Operate the Local Ambulance
  - 2 Facilities Own and Operate Home Care/Visiting Nurse

# North Dakota Critical Access Hospitals
# Statement of Operations Analysis, Comparing 2010 to 2014

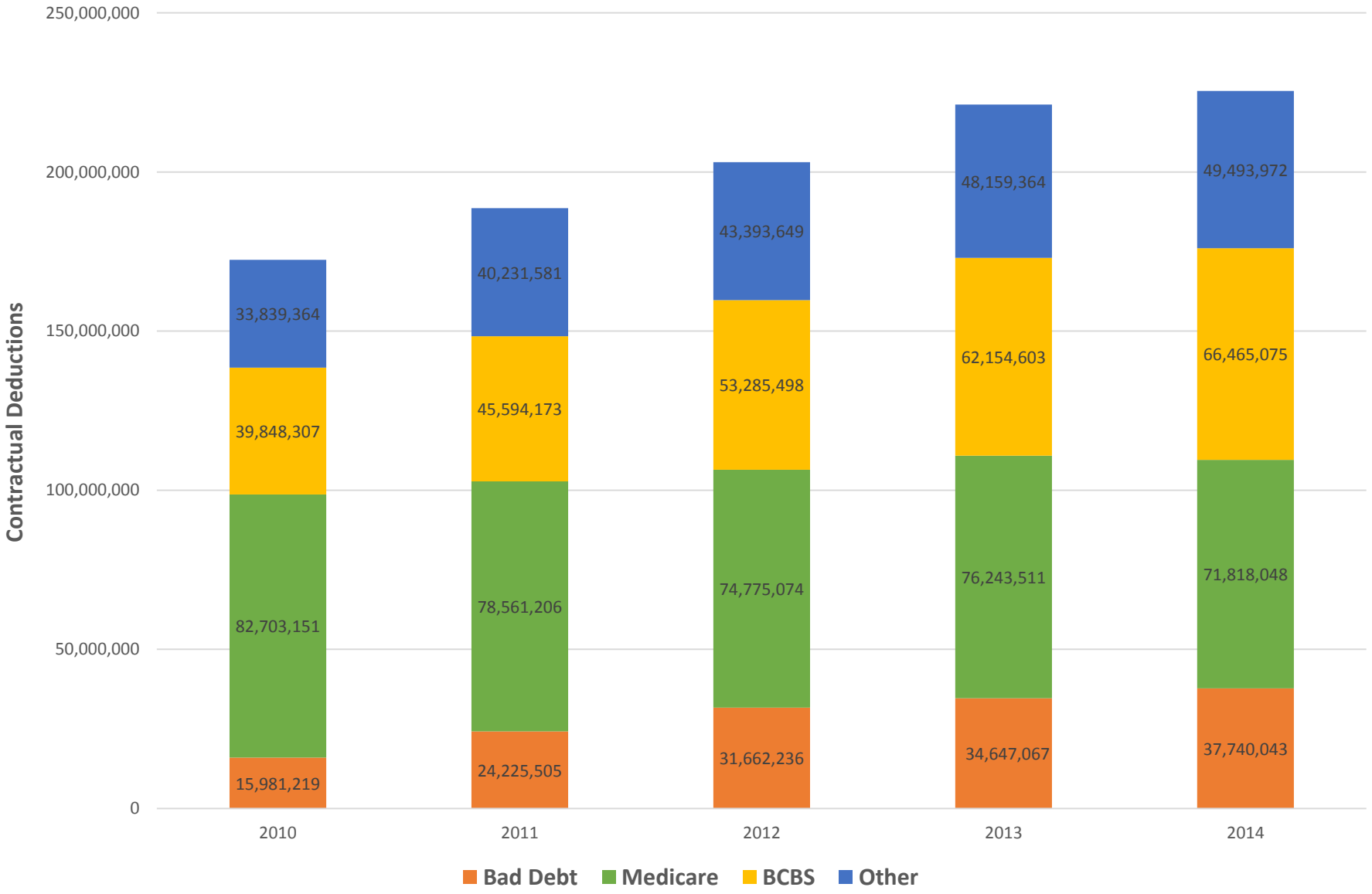
| | 36 Facilities 2010 Total | 36 Facilities 2014 Total | Variance % 2010 - 2014 |
|---|---|---|---|
| Operating Revenue | $537,401,689 | $708,815,428 | + 31.6% |
| Contractual Deductions | -$156,390,822 | -$187,777,096 | + 19.8% |
| Bad Debt/Uncompensated | - $15,981,219 | - $37,740,043 | +136.2% |
| Net Revenue | $365,029,648 | $483,298,288 | + 24.7% |
| | | | |
| Expenses | $368,653,823 | $505,107,418 | + 37.0% |
| Operating Margin | -$3,624,175 | -$21,809,130 | -501.8% |
| **Operating Margin Mean%** | ***-0.7%*** | ***-4.5%*** | |
| **Operating Margin Median%** | ***- 1.4%*** | ***-5.1%*** | |
| | | | |
| Non Operating Rev. | - $ 2,639,921 | $31,768,771 | +1303.4% |
| NET Income/Loss | - $ 6,264,096 | $ 9,959,642 | +259.0% |
| ***Net Margin Mean %*** | ***-1.2%*** | ***2.1%*** | |
| ***Net Margin Median %*** | ***-0.7%*** | ***-0.3%*** | |

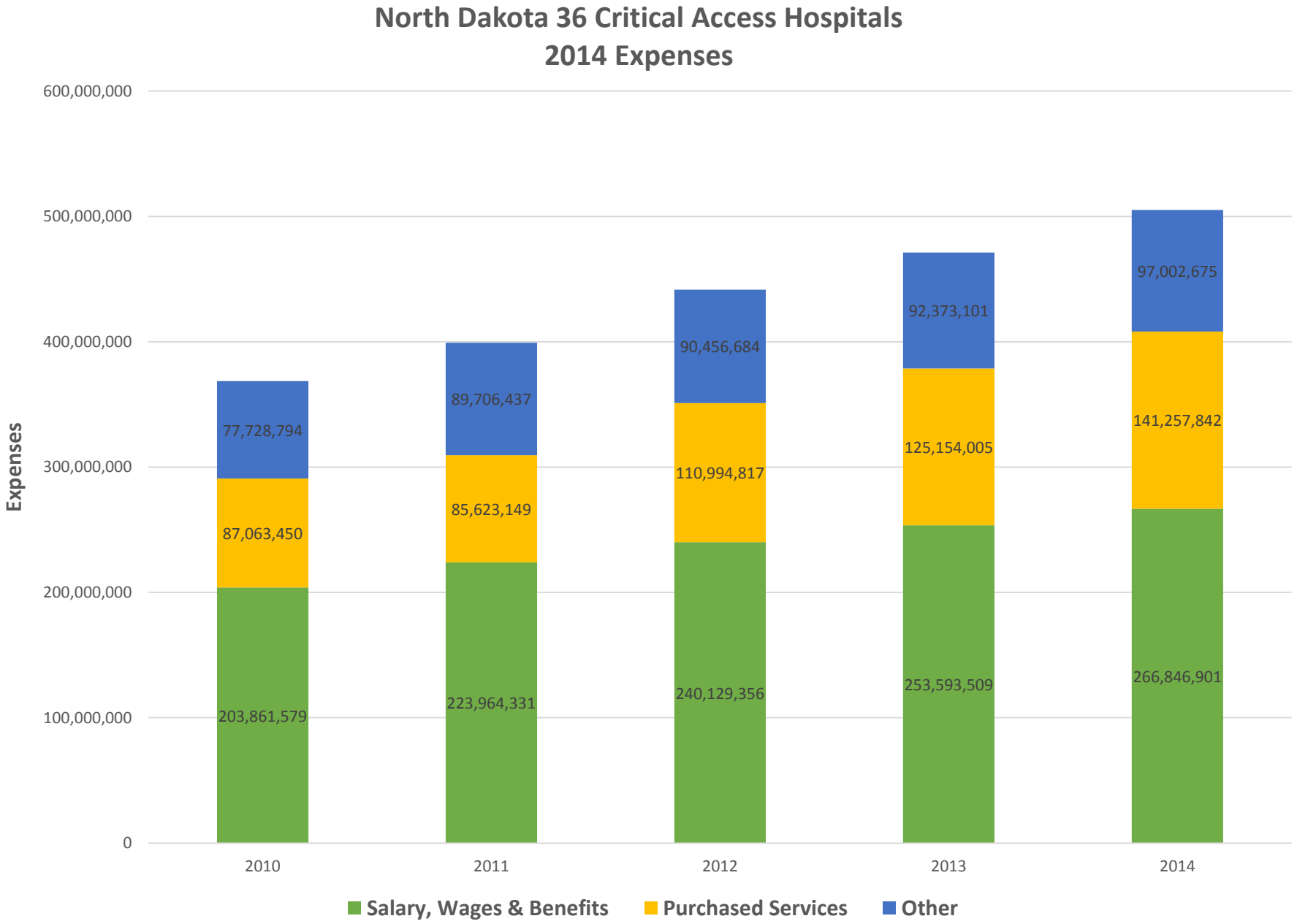
# Graph of North Dakota critical access hospitals 2014 operating margins.



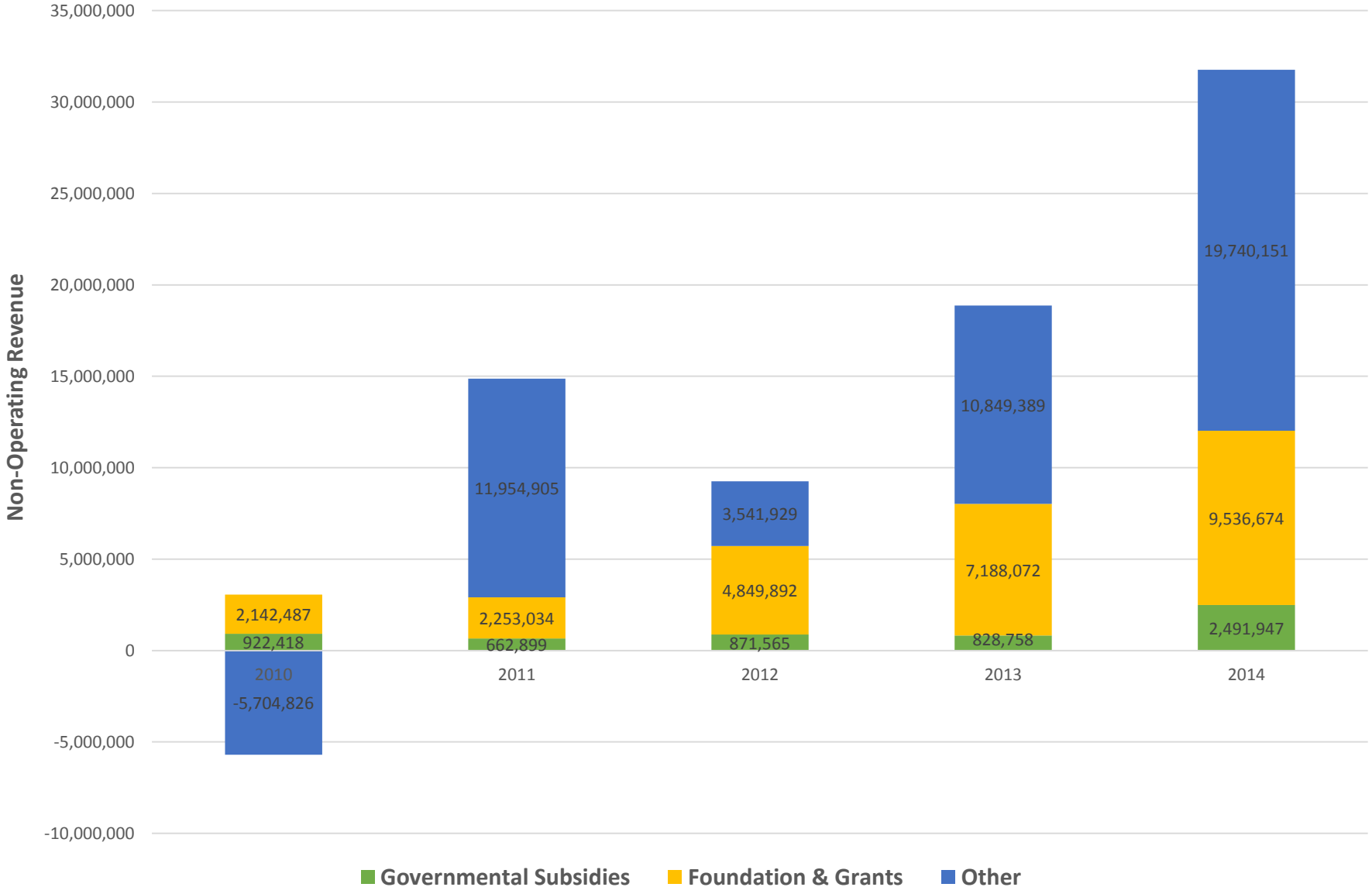

North Dakota Critical Access Hospitals
2014 Revenue
Revenue
700,000,000
600,000,000
500,000,000
400,000,000
300,000,000
200,000,000
100,000,000
0
2010
2011
2012
2013
2014
78,894,415
58,665,595
275,106,239
111,727,623
86,319,651
70,204,748
312,236,770
107,759,922
84,008,509
77,427,522
357,270,585
105,751,786
79,383,746
102,374,667
367,847,739
106,519,680
89,933,228
110,907,110
380,498,287
108,782,065
Inpatient
Outpatient
Clinic
Other

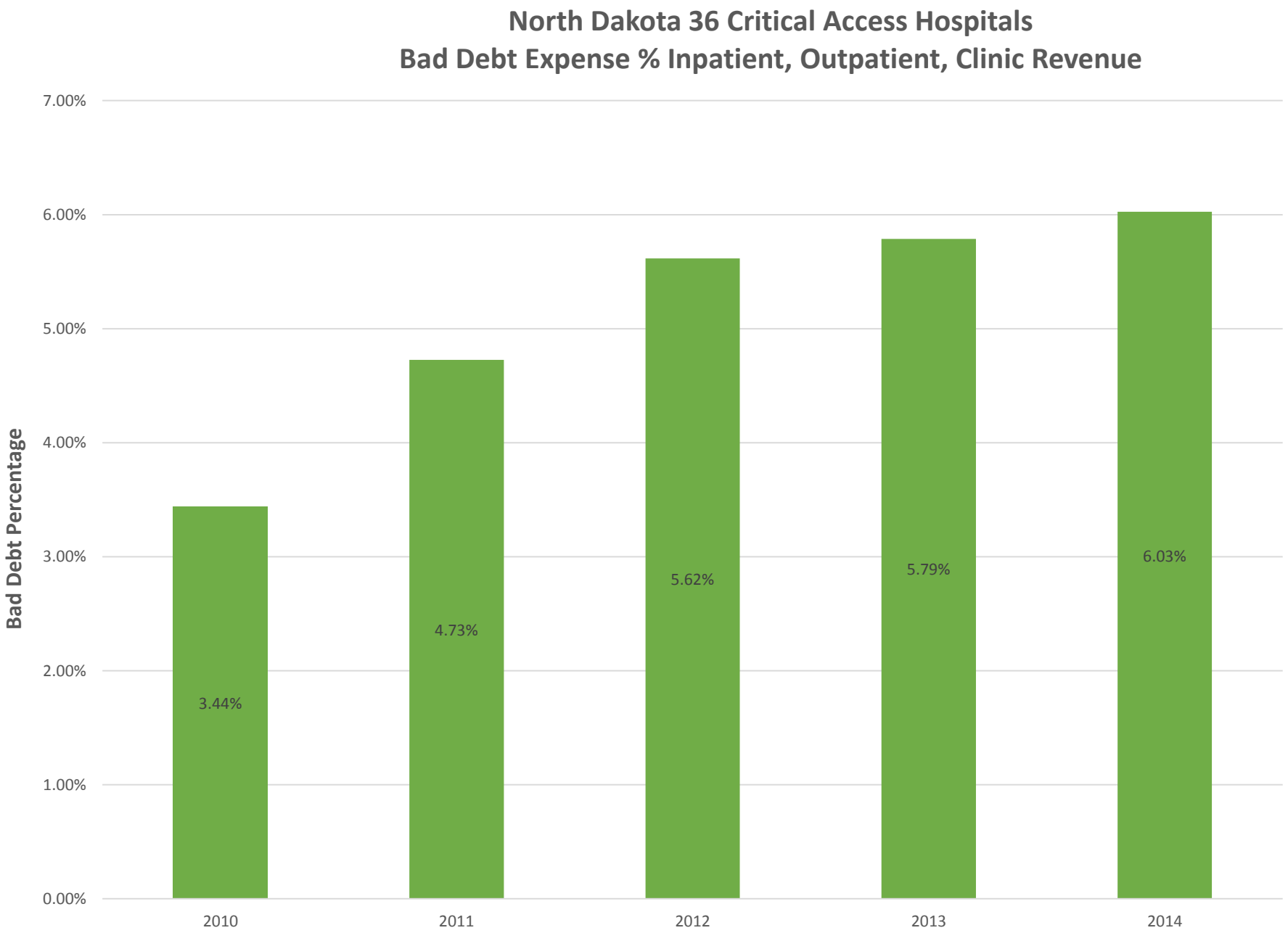
# North Dakota Critical Access Hospitals
## 2014 Contractual Deductions




North Dakota 36 Critical Access Hospitals
2014 Expenses
Expenses
600,000,000
500,000,000
400,000,000
300,000,000
200,000,000
100,000,000
0
77,728,794
87,063,450
203,861,579
89,706,437
85,623,149
223,964,331
90,456,684
110,994,817
240,129,356
92,373,101
125,154,005
253,593,509
97,002,675
141,257,842
266,846,901
2010
2011
2012
2013
2014
Salary, Wages & Benefits
Purchased Services
Other

# North Dakota 36 Critical Access Hospitals
# 2014 Non-Operating Revenue




North Dakota 36 Critical Access Hospitals
Bad Debt Expense % Inpatient, Outpatient, Clinic Revenue
Bad Debt Percentage
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
3.44%
4.73%
5.62%
5.79%
6.03%
2010
2011
2012
2013
2014

# Benefits Realized from CAH Financial Analysis

- You're not alone!!!
- Negotiations with Third Party Payers
- Community Awareness
  - Foundations, Cities, Counties
- Legislative Advocacy
  - RHC Reimbursement
  - CAH Reimbursement
  - Loan Repayment
  - Infrastructure Loan Fund
  - Energy Impact Grants
- Has helped improve sustainability

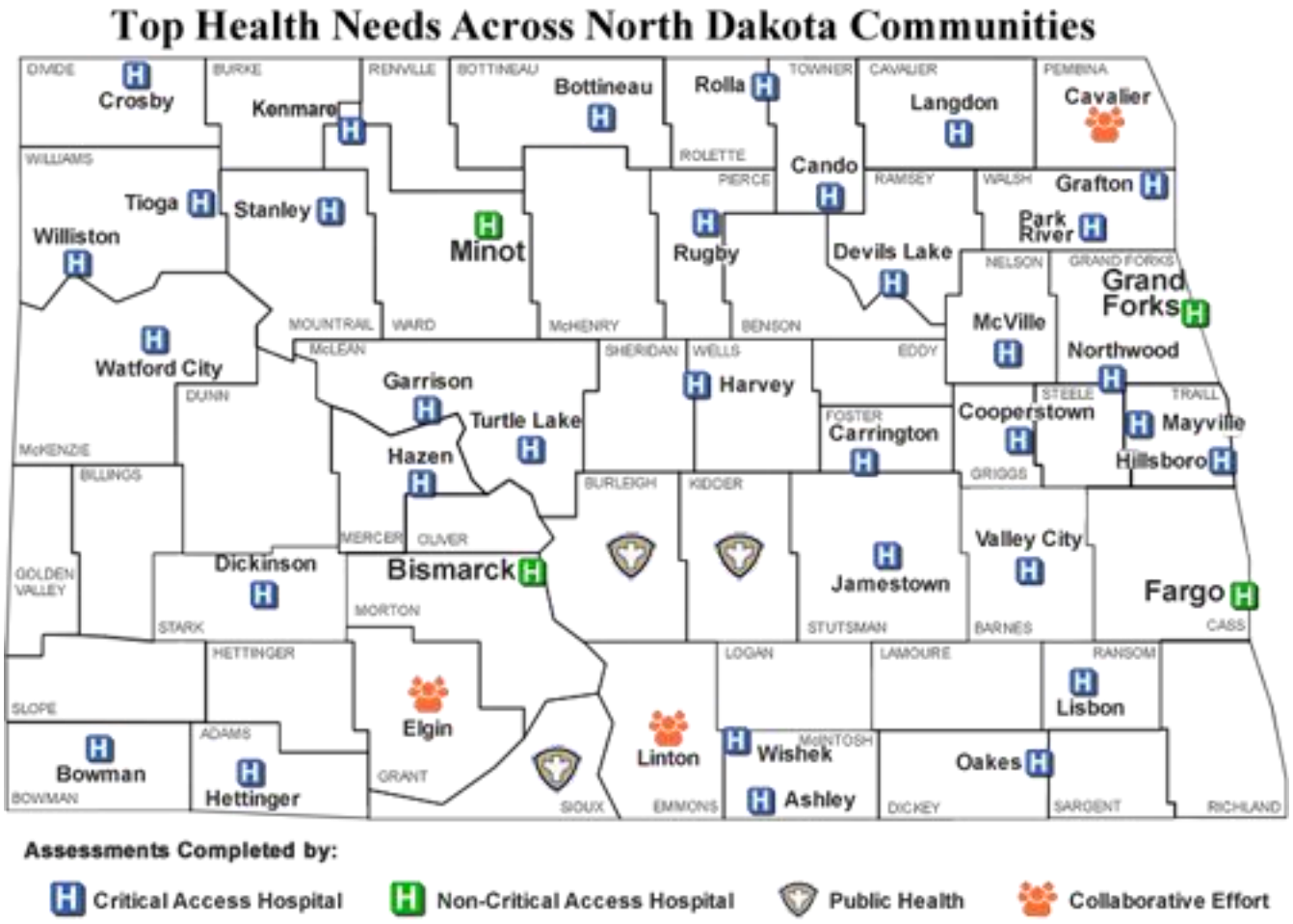
# North Dakota Center for Rural Health Community Health Needs Assessment

*Community Health Needs Assessments are a requirement and a necessity for healthcare providers!*

## What is a Community Health Needs Assessment?

A community health needs assessment is a systematic process involving the community to identify and analyze community health needs. The process provides a way for communities to prioritize health needs, and to plan and act upon unmet community health needs.

To view and compare individual communities' identified needs, click on the map below.



## Sakakawea Medical Center

http://www.sakmedcenter.org
City: Hazen
County: Mercer
Phone: 701-748-7240
Fax: 701-748-5757
Type: Hospital - Critical Access Hospital

- View Hospital Profile
- Economic Impact
- Community Needs Health Assessment
  - Report

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## Sanford Bismarck Medical Center

http://www.bismarck.sanfordhealth.org
City: Bismarck
County: Burleigh
Phone: 701-323-6000
Fax: 701-323-5221
Type: Hospital - Acute

- Community Needs Health Assessment
  - Report
  - Implementation Strategy

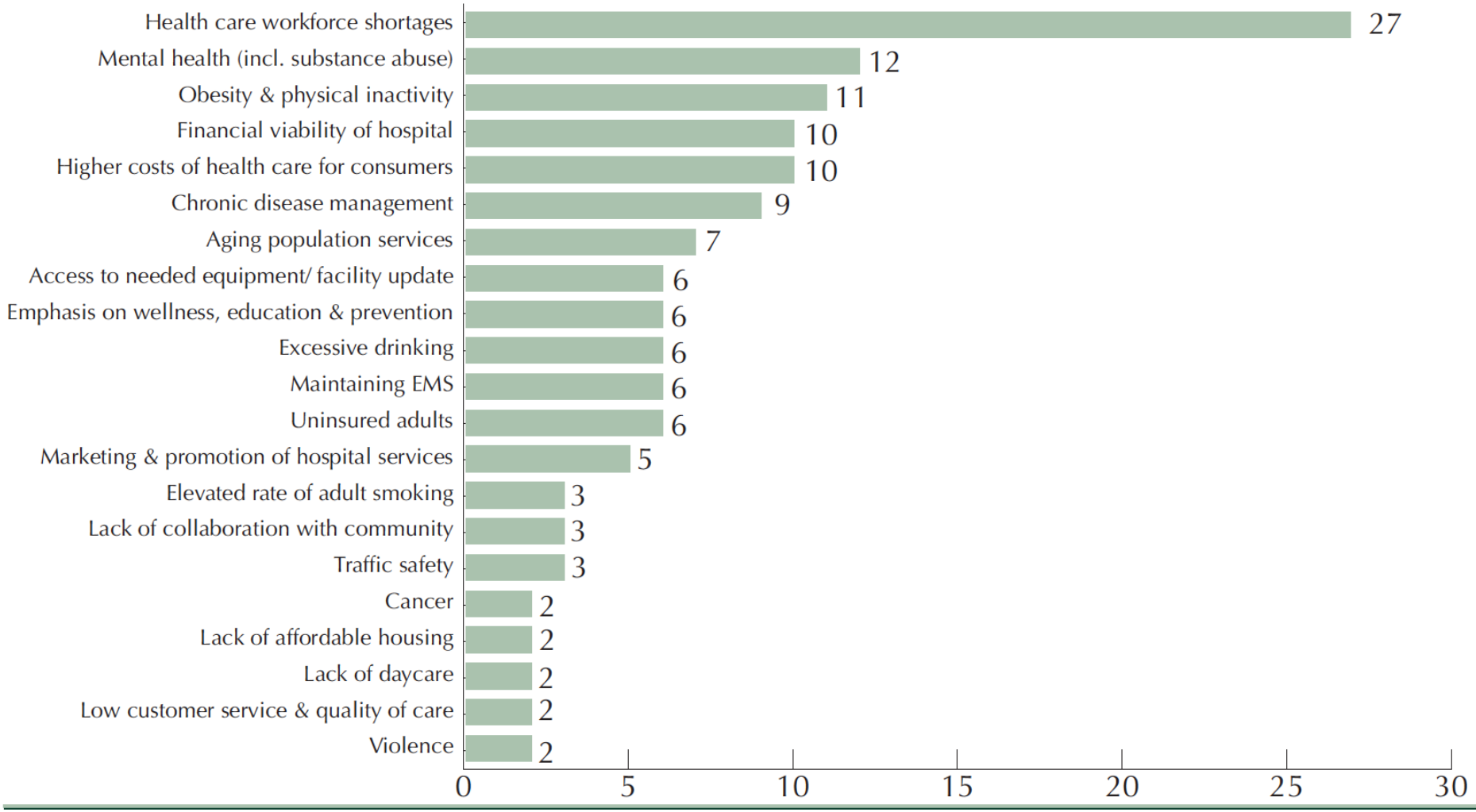
# Compare Most Significant Health Needs by Community

Select up to three communities to compare the most current significant health needs. To compare more communities, please see this printable spreadsheet listing most significant health needs for all communities.

- [ ] Ashley - CAH
- [ ] Bismarck - Non-CAH
- [ ] Bottineau - CAH
- [ ] Bowman - CAH
- [ ] Burleigh Co. - Public Health
- [ ] Cando - CAH
- [ ] Carrington - CAH
- [ ] Cavalier - Collaborative
- [ ] Cooperstown - CAH
- [ ] Crosby - CAH
- [ ] Devils Lake - CAH
- [ ] Dickinson - CAH
- [ ] Elgin - Collaborative
- [ ] Fargo - Non-CAH
- [ ] Garrison - CAH
- [ ] Grafton - CAH
- [ ] Grand Forks - Non-CAH
- [ ] Harvey - CAH
- [ ] Hazen - CAH
- [ ] Hettinger - CAH
- [ ] Hillsboro - CAH
- [ ] Jamestown - CAH
- [ ] Kenmare - CAH
- [ ] Kidder County - Public Health
- [ ] Langdon - CAH
- [ ] Linton - Collaborative
- [ ] Lisbon - CAH
- [ ] Mayville - CAH
- [ ] McVille - CAH
- [ ] Minot - Non-CAH
- [ ] Northwood - CAH
- [ ] Oakes - CAH
- [ ] Park River - CAH
- [ ] Rolla - CAH
- [ ] Rugby - CAH
- [ ] Sioux County - Public Health
- [ ] Stanley - CAH
- [ ] Tioga - CAH
- [ ] Turtle Lake - CAH
- [ ] Valley City - CAH
- [ ] Watford City - CAH
- [ ] Williston - CAH
- [ ] Wishek - CAH

Compare Needs | Clear Checkboxes

## Health Needs Most Frequently Prioritized in CHNAs in Rural Communities

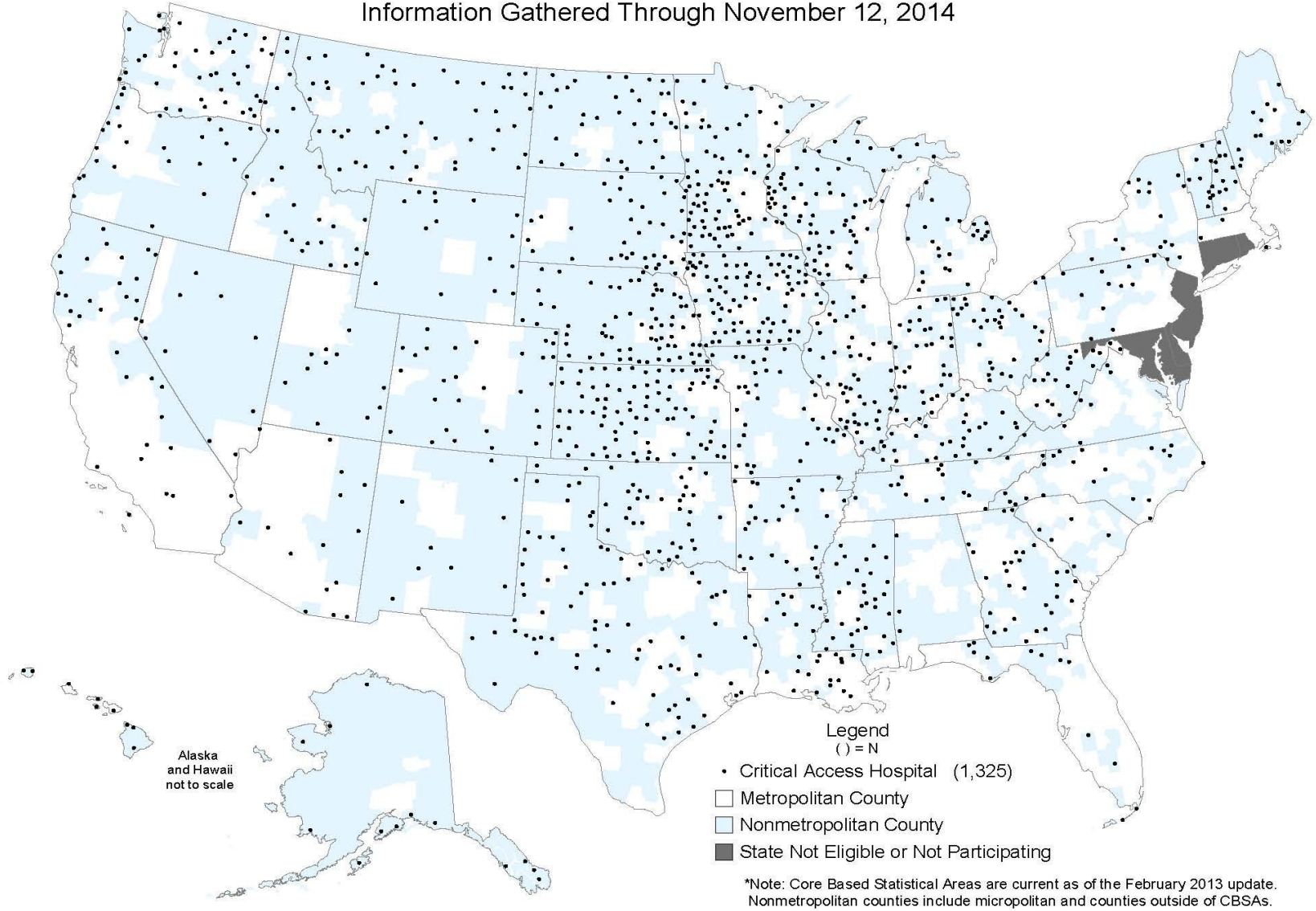


# Rural Safety Net Providers

- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Provider Collaboration – an option or necessity?

# Location of Critical Access Hospitals

Information Gathered Through November 12, 2014




*Note: Core Based Statistical Areas are current as of the February 2013 update. Nonmetropolitan counties include micropolitan and counties outside of CBSAs.

Sources: US Census Bureau, 2013; CMS Regional Office, ORHP, and State Offices Coordinating with MRHFP, 2014.

Produced By: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

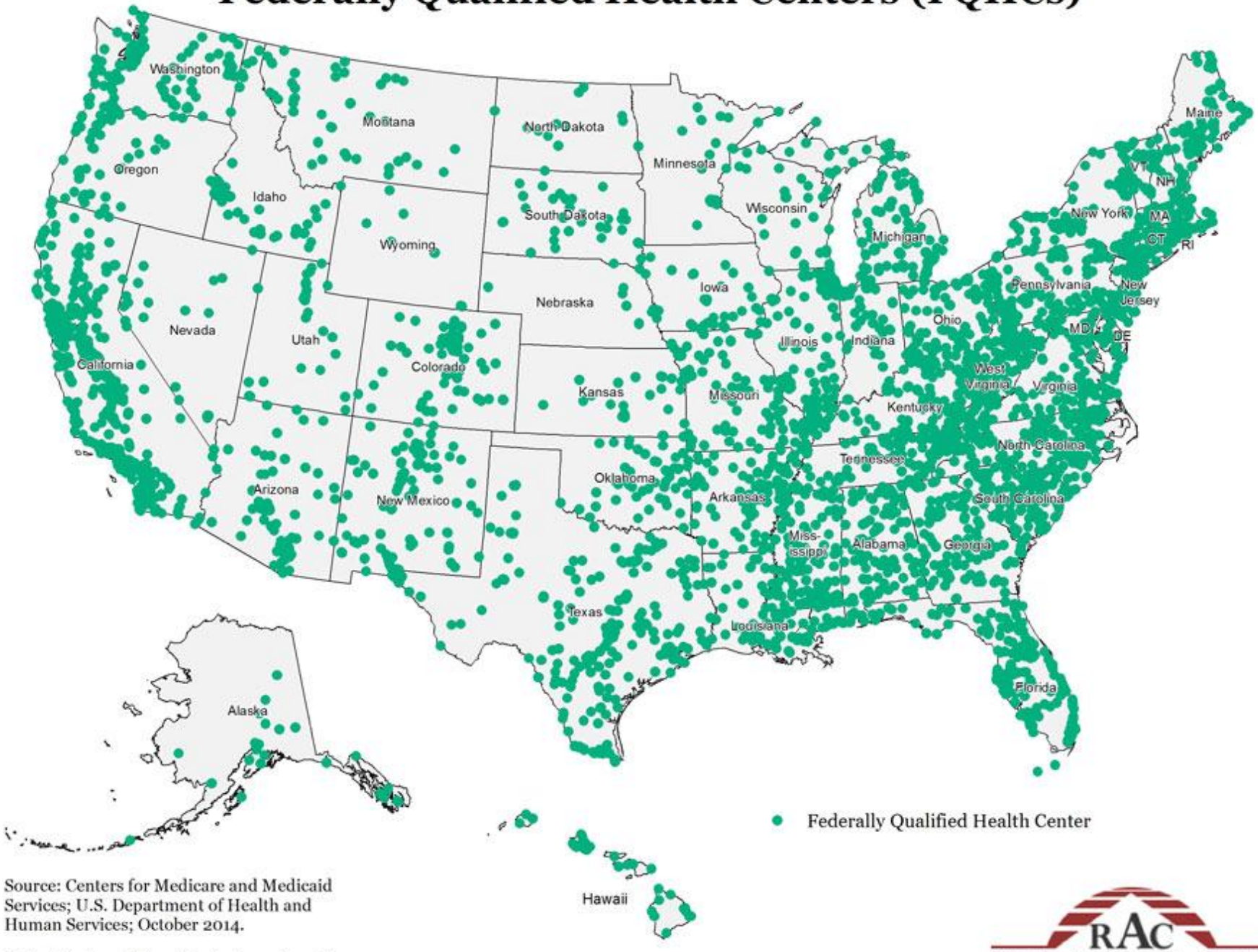
# Rural Health Clinics (RHCs)


Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; Quarter 2, 2011.

Note: Alaska and Hawaii not shown to scale

RAC
Rural Assistance Center

# Federally Qualified Health Centers (FQHCs)




Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; October 2014.

Note: Alaska and Hawaii not shown to scale

RAC
Rural Assistance Center

# Barriers to Collaboration

# Inherent barriers to collaboration

- Regulatory/reimbursement silos
  - Hospitals, RHCs, FQHCs, privately owned clinics
  - Autonomy of Public Health
  - “Pervasive Conflict of Interest”
- Personalities and miss-directed priorities often the problem
  - CAH, CHC, RHC, Pubic Health
  - Governance, leadership, providers
- Other issues in rural/frontier areas
  - Economic factors
  - Market Share
  - Financial Viability
  - Workforce
  - Lack of collaborative community health needs assessment and strategic planning

# Our Organizations

## CHC

11

Coal Country Community Health Center - Beulah

## CAH

13

Sakakawea Medical Center - Hazen

# Our Organizations

- **Service Area - Rural**
  - West central North Dakota, edge of the Bakken
  - Population - approximately 11,000
  - Major industry – Energy (Coal, Power generation)
  - Facilities/communities located 9 miles apart
  - Located 75 miles Northwest of Bismarck
- **SMC (Sakakawea Medical Center)**
  - Not For Profit Corporation located in Hazen, ND
  - 25 bed CAH designated in 2001
  - Hospice, Home Health, Basic Care, Provider Based RHC
- **CCCHC (Coal Country Community Health Center)**
  - Not For Profit Corporation located in Beulah, ND
  - Designated as an FQHC in 2003
  - Clinic previously owned and operated by Medcenter One
  - Additional service delivery site in Center, ND (25 miles)

# SMC/CCCHC Historical Relationship

# SMC/CCCHC Historical Relationship

- Community Rivalry
- Poster child of CAH/CHC conflict & competition
- Prior CEOs had miss-guided motives
- Hospital protecting it's territory
- Duplication of primary care (RHC & CHC in Beulah)
- Duplication of ancillary services
  - CT, Ultrasound, Mammo, Bone Density, PT, Stress Test
- Maintained relationships with different tertiary provider
- Lack of common Mission/Vision, lack of trust
- CHC did not work well with public health
- Providers did work together well

# Where Are We Today

- Working together we are greater than the sum of our parts
- Maintain our separate organizations
- Share staff and resources
- Transparency – integrated governance
  - 2 Health center Board members serve on the hospital Board
  - 2 Hospital Board members serve on the health center Board
  - Joint Board meetings are held periodically
  - Public health director is a member of the health center Board
- Unique shared leadership model
  - Shared CEO for the last 4+ years
  - Separate reporting structure to each Board of Directors
  - Developed an Administrative Services Agreement
  - Developed a Memorandum of Understanding

# Where Are We Today – (cont'd)

- Providers from both organizations help with ER staffing
- Position of strength when negotiating with tertiary
- Well positioned for transition from volume to value
- Collaborative Community Health Needs Assessment
  - Hospital, CHC, Public Health, Nursing Home, Ambulance
  - Surveys, Focus Groups, Interviews, Health Rankings, etc.
- Collaborative Strategic Planning
  - Collective and facility specific Strategic Planning
  - Community Health Improvement Plan
  - Patient Centered Medical Neighborhood
  - Integration of primary care and behavioral health

# Why has our collaboration been important?

- Transitioned from a culture of..
  - *Reasons we can't work together to how can we do even more!*
- Joint Mission Statement:
  - *"Working together as partners to enhance the lives of area residents by providing a neighborhood of patient centered healthcare services that promote wellness, prevention and care coordination"*
- Enhanced quality of care – patient centered medical neighborhood of care
- Improved combined financial position ***(2011 to 2014)***
  - Days Cash on Hand increased from **54 days to 100 days**
  - Net Revenue increased by 39%, while expenses increased by 20%
  - Combined Net Margin improved from **-2.2% to +11.1%**
  - Health Center and Hospital have equally benefited

# Closing Thoughts…

- Quality Improvement is achieved in a variety of ways
  - Clinical, Customer Satisfaction, Financial, Operational
- Provider collaboration in the future is essential
  - Improves healthcare
  - Improves population health
  - Reduces Cost
- Community Health Needs Assessments that include all local stakeholders provides the greatest opportunity to identify areas for improvement
- Strategic strategic planning and community health planning is the most effective way to improve healthcare services and the health of the population served

***"Local Challenges Need Local Solutions Developed by Local People"***

# Thanks for letting me share my thoughts!

- **Questions?**

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**Cell 701-880-1440**