2017 FLEX PROGRAM
REVERSE SITE VISIT
BETHESDA, MD

CAH/FQHC Collaboration

"A Community’s Success Story"

Coal Country Community Health Center
Sakakawea Medical Center
Presentation Agenda & Objectives

- Rural safety net providers
- Our communities and organizations
- Our collaboration
- Community Health Needs Assessment & Planning
- Community Health Improvement Plan
- Patient centered medical neighborhood of care
- ACO Participation
Critical Access Hospitals

*Note: Alaska and Hawaii not to scale

Source(s): HRSA Data Warehouse, U.S. Department of Health and Human Services, September 2016
Rural Health Clinics

Note: Alaska and Hawaii not to scale
Source(s): HRSA Data Warehouse, U.S. Department of Health and Human Services, December 2016
Federally Qualified Health Centers (FQHCs)

Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; October 2015.

Note: Alaska and Hawaii not shown to scale.
North Dakota Hospitals

North Dakota Critical Access Hospitals & Referral Centers

[Map showing critical access hospitals and referral centers in North Dakota]
Obstacles to CAH/FQHC Collaboration

- Personalities and misdirected priorities
  - Governance, providers, leadership
  - CAH, FQHC, Both?
  - Communities

- Unique issues in rural areas
  - Duplication of primary care services
  - Duplication of ancillary services
  - Hospital ER coverage and inpatient services
  - Economic factors, workforce, market share
  - Financial Viability/Survival

- Regulations
- Reimbursement – (form follows finance)
Silos of Healthcare Delivery & Payment
Our Organizations

Federally Qualified Health Center

Beulah, Hazen, Killdeer, and Center, ND

Critical Access Hospital

Coal Country Community Health Center - Beulah

Sakakawea Medical Center - Hazen
Our Organizations

• **SMC (Sakakawea Medical Center)**
  - 13 bed Critical Access Hospital designated in 2001
  - Not For Profit Corporation located in Hazen, ND
  - Hospice, Home Health, Basic Care

• **CCCHC (Coal Country Community Health Center)**
  - Designated as an FQHC in 2003
  - Not For Profit Corporation located in Beulah, ND
  - Service delivery sites in Beulah, Center, Killdeer and Hazen

• **Service Area - Rural**
  - Beulah & Hazen located 9 miles apart, 75 miles NW of Bismarck
  - West central North Dakota, edge of the Bakken
  - Population - approximately 15,000
  - Major industry – Energy (Coal, Power generation)
Our Partner Organizations

- **Knife River Care Center**
  - 86 bed skilled nursing facility in Beulah

- **Hill Top Home of Comfort**
  - 55 bed skilled nursing facility in Killdeer

- **Southwestern District Health Unit**
  - Eight county multi-district local public health unit

- **Custer Health**
  - Five county multi-district local public health unit

- **Mercer County Ambulance**
  - Four ambulance unit servicing 1,000 square miles
  - Located in Beulah and Hazen
SMC/CCCHC Historical Relationship
SMC/CCCHC Historical Relationship

- Poster child of CAH/CHC conflict & competition
- Prior organization leadership had misguided motives
- Duplication of primary care services
- Duplication of ancillary services
- Relationships maintained with different tertiary providers
- CCCHC did not work closely with public health
- Lack of common Mission/Vision, lack of trust
How did we step off the curb?

- CCCHC Organization Challenges
- Medical Director Leadership
- Interim Leadership Provided
- Shared CEO
- Integrated Governance
- Committed staff
- Medical Staff Support
- Community Support
- HRSA Support
  BPHC, ORHP
- Leave the past in the past...
- Common goal of patient/family centered care
- Realized, “working together we are greater than the sum of our parts!!”
Where Are We Today – 2017 & Beyond

• Organization & Governance - transparency
  o Both organizations are independent non profit corporations
  o Shared CEO reports independently to each Board
  o Bylaws of both organizations were revised to reflect new goals
    ➢ Two health center board members serve on the hospital board
    ➢ Two hospital board members serve on the health center board
    ➢ Transparency of actions and initiatives
  o Joint Board meetings held periodically
  o Public Health CEO serves on the health center Board of Directors
  o CEO and other staff serve on local EMS Board of Directors
  o CEO serves on nursing home Board of Directors
  o Former LTC Board chair serves on FQHC and CAH Board
Where Are We Today  (continued)

- **Joint Mission:**
  “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”

- **Patient Centered Medical Neighborhood of Care**

- **Take advantage of CAH & FQHC Program Benefits**

- **Improved Clinical Outcomes**

- **Improved collective financial performance (2011 to 2016)**
  - Days Cash on Hand increased from 54 days to 124 days
  - Net Revenue increased by 53%, expenses increase only 30%
  - Net Margin increased from -2.2% to +11.7%
  - Health Center and Hospital have equally benefited
Our Collaborative Journey…

• Collaborative Community Health Needs Assessment
  o Hospital, Community Health Center, Public Health, Long Term Care, Ambulance
  o Initially done collaboratively in 2012
  o Updated in 2016 to include new service areas
    ➢ Community group
    ➢ Key informant interviews & Focus group interview
    ➢ Survey – paper and online
    ➢ Secondary data – demographic info, County Health Rankings, etc.

• Development of Joint Strategic Plan
  ➢ Collaborative service area goals
  ➢ Individual organization goals
  ➢ Collaborative community health improvement committee
Collaborative Strategic Planning Initiatives

• Availability of Local Day Care
  • Cooperative day care developed
    • Energy industry, hospital, health center, nursing home, school, local bank

• Improve Population Health
  o Community Wellness–Businesses–CAH, CHC, LTC, Public Health, EMS
  o Patient Centered Medical Neighborhood – CAH, CHC, Public Health, LTC SNF
  o Behavioral Health / Primary Care Integration
  o Transportation
  o Preventative and Chronic Disease Measures

• Enhance Community Awareness of Local Services
• Maintain Adequate Human and Facility Infrastructure
  o Collaborative recruitment and retention plan
  o Scrubs Camp
  o Satellite Nursing Program
  o Collaborative provider needs assessment
  o Collaborative facility planning

• Monitor and Adapt to Changes in Healthcare Delivery
  o Federal changes and initiatives
  o State healthcare infrastructure
  o Joint advocacy and monitoring of local impact
Our Collaborative Journey… (cont.)

• Community Health Improvement Plan
  o CHIP Planning Group – leaders/health professionals from all 6 organizations
  o Working document that drives our innovative approach to improving the health of the population we serve
    ➢ Developed goals, objectives, and evidence-based strategies to address priority issues
    ➢ Ongoing implementation of the CHIP with evaluation activities monthly – celebrate successes and share lessons learned with our community
  o Work groups developed
    ➢ Wellness, Prevention,
    ➢ Care Coordination
    ➢ Medical Neighborhood Transitions of Care Protocol
Our Journey Continues…

- Development of a comprehensive and active work group
  - Population / Behavioral Health Committee – meets monthly
    - CAH
    - FQHC
    - LTC
    - Public health
    - Local EMS
    - NDSU Extension Center
    - Local Retail Pharmacies
CHIP Drives Change
Improved Outcomes Realized Through Population Health Committee

Cancer Screening Rates

- **CRCS**
- **Breast**
- **Cervical**

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<th>Breast</th>
<th>Cervical</th>
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Comprehensive Care Coordination – Today and in the Collaborative Future

• Patient Centered Medical Neighborhood Partners
  o LTC & Public Health
  o Coal Country Community Health Center – primary care
    ➢ RN Chronic Care Coordinators
    ➢ Community Care Coordination
    ➢ Behavioral Health Care Coordination
      ▪ Medication Assisted Therapy – Suboxone
      ▪ Primary care / behavioral health integration
    ➢ School based care
      ▪ Behavioral health pilot project
  o Sakakawea Medical Center
    ➢ Hospital Care Coordinator - Transitions of care upon discharge
    ➢ ER discharge and follow-up
    ➢ Home Health or Hospice
Transitions of Care – Today and in the Collaborative Future…

- Patient Centered Medical Neighborhood Partners
  - Home & Community Based Service
    - Community Care Coordination
  - Visiting Specialists
    - Psychology, Cardiology, Pulmonology, Orthopedic, Audiology, OB/GYN
  - Custer Health – Public Health
    - Home & community based services – “health promotion, prevention, and protection”
    - School district liaison
  - Knife River Care Center – Skilled Nursing Facility
    - Nursing home provider rounds – includes care coordinator
    - ER visit and acute care follow-up, etc.
    - Communication gaps
Accountable Care Organization (ACO)??
Accountable Care Organization

• Our Collaboration made participation in an ACO Possible
• Realized that the train has left the station
• Worked with Caravan Health assistance
  • CMS AIM Funding & ACO MSSP application
• High Sierra Northern Plains ACO (ND and California)
• Collaboratively learned Volume to Value based payment
• Accountable Care Organization (ACO)
  o “A group of health care providers who come together to coordinate the quality and cost of care provided to the patients that are attributed to the ACO”
• Types of CMS ACOs
  o Pioneer ACO, Advanced Payment ACO, Next Generation, Medicare Shared Savings Program, Medicare/Medicaid ACO
Medicare Shared Savings Program

- **ACO Investment Model (AIM)**
  - Prepayment from CMS for future savings
  - Encouraged ACO participation of rural providers

- **Beneficiary Attribution**
  - Assigned to ACO provider where majority of primary care services were provided
  - Must have at least 5,000 attributed lives

- **Payment**
  - Fee for Service or Cost Based Reimbursement
  - Historical Benchmark data used to determine future savings
  - Access to utilization, cost and trends
  - Share in savings realized by Medicare
How Does “Shared Savings” Work?

All existing reimbursement stays the same!

ACO’s Baseline Spending per Patient - based on previous 3 years, for all ACO participants

ACO’s Year 1 Spending per Patient

$10,000

$9,500

$500

$250

$200

Quality Score Adjusted Shared Savings

xQ
Attributes of our ACO Participation

• Benefits
  o Annual Wellness Visits
  o Care Coordination, all payer types
  o Integration of Primary Care and Behavioral Health
  o Transitions of Care, primary care, hospital, LTC, Home Health, Home, etc.
  o Quadruple Aim
    ➢ Improve Patient Outcomes
    ➢ Improve Patient Experience / Satisfaction
    ➢ Lower Costs
    ➢ Improve Provider / Care Team Satisfaction

• Results
  o Better coordination of care between all transitions of care
  o Long term care quality measures
    ➢ ER visits, readmissions
  o Example of Hospital ER, primary care, EMS coordination
Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County
(counties with more than 1 percent of an ACO’s assigned beneficiaries)
Summary

• Collaboration Among our Healthcare Entities was Key to our Success
• Integrated Governance and Leadership was Vital
• Collaborative Community Health Needs Assessment was Essential
• Health Care Providers Work Together in Strategic Planning
• Community Health Improvement Plan – keep it ongoing!
  • Community Wellness, Preventative Health
  • Care Coordination for Patients with Chronic Conditions
  • Effective Management of Transitions of Care
  • Effective Utilization of Community Resources
    • Hospital, clinic, physician engagement, long term care, public health, EMS, home and community based services, patient and family
• Success is a Community Responsibility
  • “Local Challenges Need Local Solutions Developed by Local People”
Thanks for Listening!

• "Take a method and try it. If it fails, admit it frankly, and try another. But by all means try something."

   ~ President Franklin D. Roosevelt ~

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Questions?