An Alternative ACO Model for Independent Community Health Centers & Community Hospitals

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Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
Background Information on Maine
Some Facts

- Oldest State in the Nation
- Population – 1.3 million
- Rural – Northern
- Industry
  - Logging/Mills
  - Potatoes
  - Lobster
  - Blueberries
- Vacation
- National Parks
  - Acadia
  - Baxter
Healthcare in Maine

- 19 Federal Qualified Health Centers
- 36 Hospitals
  - 1 Tertiary
  - 3 Psychiatric
  - 1 Rehab
  - 15 Critical Access
- Health Information Exchange (Health InfoNet)

Maine Healthcare Issues

- Substance Use Disorder
- Behavioral Health
- Elders
- Cancer
Bangor

- Regional Service Center
- Level 2 Trauma Center – EMMC
- SJH – Community Hospital
- PCHC – Largest FQHC in State
- “Duck of Justice” – Bangor Police
- Waterfront Concerts: Arts
- And.........

Paul Bunyan Statue
We have an Anthem “We Are Bangor”: How to Say Bangor, Maine
CCPM’s Foundation
Two Mission Partners
Partnership rooted in strong history, ties & commonalities:

• SJH helped found PCHC in the 1990s
• Common mission – passionate dedication to quality health care for all
• Common emphasis on local community – more than corporate focus
• Both high quality and cost effective
• Common leadership cultures
Clinical Integration: What is it?

In 2015, SJH and PCHC committed organizations to Clinical Integration to enhance the health of our patients and communities, and to reduce unnecessary duplication and costs.

“Triple Aim”
Key Drivers of PCHC & SJH Success

• Shared Values & Trust – Open Conversation
• Bi-Weekly meeting between Senior Leaders
• Early Success:
  – SJH patients referred to PCHC Walk-Ins
  – Clinical Programs – Antibiotic Stewardship
  – Shared Clinical Services
    • Infection Control
    • Pharmacy Residents
    • Behavioral Health
    • Joint CMEs
    • Improved Patient Access
• Integrated Quality Department for Outpatient Services
• Shared Leadership Developing New ACO-CCPM
• SJH & PCHC are Preferred Providers
  – Shared Commitment to hold each other accountable
The Future of Health Care Reimbursement – Value-Based

• CMS rapid to Value Based Payment
• MaineCare – similar
  – Accountable Communities (ACO)
  – Health Homes & Behavioral Health Homes
• Commercial Payers Adopting Shared Savings
• All are pilots based on Value, Outcomes
  – Key pilots are ACO/shared savings
Maine ACO Models

Different models
  – Appropriate in different circumstances

• Hospital Systems, Affiliates, Related
• Maine FQHC Association
• CCPM
  – 8 FQHCs and 3 Community Hospitals
Why the CCPM ACO Model?

• Five CCPM members left other models – not a “culture fit”, didn’t feel “at home”
• For *independent*, non-profit, *values*-based, *community*-focused organizations
• For CHCs wanting to work closely with community hospitals
• Not “top down” - equal votes/influence
• Community Hospitals recognize that the partnership is critical for their survival
• Not “top heavy”
  – Costs affordable – about $4pmpy
  – Shared savings
    • 100% go to member orgs
    • Based on attributed lives
    • All in together, regardless of quality outcomes
    • Builds partnership & investment
• “Skin in” – real involvement, sharing
  – Bi-monthly CEO meetings
  – Monthly various clinical leader meetings
• Choice - don’t have to join every program
Membership of CCPM

- Cary Medical Center
  Caribou

- DFD Russel Medical Center
  Turner • Leeds • Monmouth

- Fish River Rural Health
  Eagle Lake • Fort Kent • Madawaska

- Greater Portland Health
  Portland • South Portland

- Hometown Health Center
  Newport • Canaan • Dexter
  Dover-Foxcroft • Pittsfield

- Katahdin Valley Health Center
  Millinocket • Ashland • Houlton
  Island Falls • Patten • Brownville

- Millinocket Regional Hospital
  Millinocket

- Nasson Health Care
  Springvale • North Berwick

- PCHC
  Bangor • Brewer • Old Town
  Belfast • Winterport • Jackman

- Pines Health Services
  Caribou • Presque Isle • Van Buren

- St. Joseph Healthcare
  Bangor • Brewer • Hampden
Membership of CCPM: Community Health Centers

- DFD Russell Medical Center
- Fish River Rural Health
- Greater Portland Health
- Hometown Health Center
- Katahdin Valley Health Center
- Nasson Health Center
- Penobscot Community Health Center
- Pines Health Services
Membership of CCPM: Community Hospitals

- Cary Medical Center
- Millinocket Regional Hospital
- St. Joseph Health Care
Principles of CCPM

• Readiness
  – EMR, care management, PCMH, HIN
• Transparency of data, results
• Share best practices
• No risks right now – but coming, and want to be ready
Current CCPM Shared Savings Plans

- MaineCare Accountable Coms. – 2nd year, all
- Medicare Shared Savings – 2nd year, most
- Cigna Shared Savings - 2nd year, most
- Aetna – start Jan. 2017, all
- Medicare Advantage – likely Jan. 2017
- Anthem – April 2017, most

- Total attributed lives in 2017 – about 70,000
Corporate Structure

- LLC
- Each org, one vote
- Elected Officers:
  - Chair: Ken Schmidt (PCHC - FQHC)
  - Treasurer: Jim Davis (Pines - FQHC)
- CCPM Staff Officers
  - CEO: Ken Schmidt
  - CMO: Dave Koffman, MD (St. Joseph Hospital)
  - CQO: Theresa Knowles, FNP-C (PCHC)
  - Chief Compliance Officer: Lori Dwyer, Esq. (PCHC)
• Other CCPM staff
  – HRSA 3 year grant $200,000/year
    • 2 Performance Coaches
    • Data Analyst/Infometrics
  – Quality Staff (PCHC)
  – Accounting, grants, admin support - PCHC
  – HIN grant from RWJF supports HIN staff
    • Bring all onto bi-directional HIN
    • And HIN analytics tool
    • Bring 2 CAPs social determinants data on HIN
Committee Structure

- Finance & Operations
- Quality & Clinical Integration
- Care Management
- Medication Use
- Data/IT
- Compliance
Budget

• About half million/year, including $200,000 HRSA grant

• Contributions by member orgs
  – About $4 per attributed life, per year
  – So if org has 3,000 patients in various shared savings programs
  – They contribute $12,000/year
Returns on Member Contributions

- Most programs provide a PMPM (per member per month) payment
- Opportunities for shared savings
  - Distributed based on attributions
The “Four Paths” For Community & Critical Access Hospitals

- Closure
- Severe Downsizing and Cost Shedding
- Merger
- Partnership
- Growth
What Did the Hospitals Choose?

• Growth & Access based on what is needed in the community.
• Partnership – Limited resources.
• “Everyone pays the same taxes….they deserve the same healthcare.” Bob Peterson, CEO Millinocket Regional Hospital
• Stop thinking like an acute care hospital:
  – Need to focus on what is best for the community.
ACA Payment Charges

• Population Health - ??
  – Volume to Value

• Inpatient admissions decreasing, revenue decreasing.
  – How do we maintain the infrastructure of EDs, Maternity, Emergency Response, Specialties?

• Care for elders.
Freshman Year at ACO University!

- Paradigm Shift to Value
- Use of Analytics
- Proactive Care vs. Reactive Care
- Prediction and Prevention
- Best Practice
Why CCPM?

• Partnership with FQHC’s
• Primary Care Volume = Leverage with Payers
• The Opportunity to Learn and Practice
• Forced Engagement of Providers and Staff
• Shared Savings Model vs. Risk Model
Report Card on CCPM

• Our Partners? A+
• Our Progression Toward Better Patient Management? A
• Our Progress in the Use of Analytics? B+
• Identification of Best Practices? A
• Standardization to Best Practice? B+
• Leverage with Payers? B
• Decision to Join CCPM? A+!!
Benefits of Membership for Rural Health Centers

Contributed from Audie Horn, Jr., PA-C, DFAAPA, Clinical Practice Director
Katahdin Valley Health Center
Support

• Having the expertise of multiple individuals and organizations.
• This means that you do not have to constantly “reinvent the wheel.”
• One of the biggest problems in rural health is to become insular.
• Having peers from a number of organizations keeps us fresh and thinking.
How has this influenced Katahdin Valley Health Center

• Now tracking & reporting on goals.
• Forces us to take a hard look at where we are, versus where we want to be.
• The result is clear focus on areas that can improve our patient care and the lives of our patients.
Clinical Goals of CCPM

- Cervical Cancer Screenings 70%
- Breast Cancer Screenings 80%
- Diabetes: Annual Nephropathy Screening 90%
- Diabetes: HgbA1C <9% 88%
- Diabetes: Annual Eye Exam 90%
- Persistent Asthma with Controller Med 90%
- Use of Aspirin/Antithrombotic in IVD 90%
- ER Utilization <165/1000
- BP Control >80%
- Increased Patient Access >80%
How Has KVHC been Impacted by CCPM Involvement

• More focused on the measures that we are tracking.
• We have seen significant improvement in those areas.
• Resulted in KVHC receiving a recent grant. KVHC exceeded the State in all 16 quality measures and exceeded Federal levels on 15 of 16 measures.
In Closing...The Future

• New relationships with payors
• Joint care management model
• Regional specialty program
  – GI – HepC
  – Rheumatology, Endocrinology
• Standing together to support our communities.........
Questions/Comments

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