Successful Practices in Accountable Care:
Coal Country Community Health Center

Health Center Profile

Health Center: Coal Country Community Health Center

Location: Beulah, Center, Hazen, and Killdeer, North Dakota

Number of Unique Patients Served: 9,800

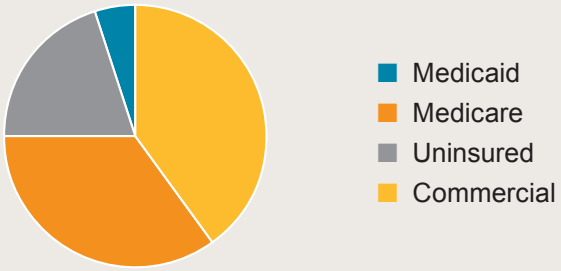
Number of Sites: 4

Services Offered: Primary care and behavioral health including medication-assisted therapy

Certifications: PCMH Level 2

Unique Feature: Recognized nationally for colorectal screening rates and collaborative efforts

Payer mix (approximate): 40% Commercial, 35% Medicare, 20% Uninsured, 5% Other (including Medicaid)



Source:

A Vision For Collaboration

At the heart of accountable care is the idea that partnerships can help to improve the quality of care and lower the total cost of care. Today, Coal Country Health Center (a Federally Qualified Health Center (FQHC)) and Sakakawea Medical Center (a critical access hospital) are a model for how this partnership can be achieved. According to Darrold Bertsch, the shared chief executive officer of both organizations, the partnership has resulted in improved financial performance and healthcare delivery, as evidenced by **improved health outcomes** and **increased patient satisfaction**.

What has made this partnership so innovative, beyond overcoming a challenging history of competition, is the development of a Patient Centered Medical Neighborhood of care. This partnership was the foundation for a collaborative community health needs assessment and health improvement plan as well as participation in an accountable care organization.

History

Coal Country Community Health Center (CCCHC) and Sakakawea Medical Center (SMC) did not have the harmonious relationship they benefit from today. There was vast duplication between the two organizations and a natural sense of competition that comes from being only nine miles apart from one another in a rural area with limited population. As described by Darrold, “this duplication of services created financial hardships and mistrust.” It wasn’t until CCCHC was experiencing financial challenges in 2011 that the organizations considered approaching one another about the competitive situation and a possible collaborative solution. The discussions and partnership process has shown that one reason CCCHC and SMC, as well as other hospitals and health centers probably face the problem of competition for patients, services, and workforce, is a lack of understanding. Both health centers and hospitals have unique regulatory requirements and operational needs, so understanding those specific needs can help reduce the amount of friction in developing partnerships.

One of the first things the health center and hospital did in approaching a partnership was to insist on transparency, commonality of goals, and consistency of information. Both organizations wanted to do what was best for the community and believed they were doing the right thing based on the information they had, but that information was not reflective of the community as a whole. By opening up the information, both organizations were able to better optimize the operations and make decisions to benefit both organizations and ultimately the populations they serve.

After they both looked at the information, they brought in a consultant to conduct independent interviews and financial analysis. The consultant presented recommendations to both the board of the health center and the board of the hospital and validated their plan for collaboration. Their plan required stabilizing the revenue cycle staff and hiring additional billers, addressing workforce issues, and improving morale at both organizations. Key to the idea of collaboration was interdependence in operations, governance, and contracts. Their interdependence included reciprocity of governance representation, a Memorandum of Understanding, and an administrative services agreement. They also developed a shared mission statement. In formalizing and developing the function to partner, they were able to create momentum and measure positive changes. They determined that the best way to continue the momentum was to continue to collaborate.

Continuing the Momentum

Both the hospital and the health center were required to do a needs assessment. It became yet another area in which collaboration was not only possible but resulted in a stronger outcome. The two organizations in 2011/2012 facilitated a Collaborative Community Health Needs Assessment. The assessment measured the needs for all area healthcare providers including the public health unit, emergency management services, and skilled nursing facility. It allowed all organizations involved to have a better understanding of the community, and provided a more complete picture of their population.

With a better understanding of the population, they were able to create not just patient centered medical homes but a patient centered medical community. They used the needs assessment as the basis for a strategic plan and community health improvement plan. Staff from all organizations involved in both the assessment and plan make up the Comprehensive Care Coordination Committee, which continues to meet monthly to discuss implementation, measure progress, and adjust priorities accordingly. As health centers consider the total cost of care, a collaborative assessment and plan such as what CCCHC and SMC implemented, may increase understanding and address the totality.

Growing Stronger Together

From 2011 to 2015, the organizations developed the foundation for working together. It was slow and methodical and allowed them to share in the growth. One example is the health center's assistance in the shift from volume to value-based payment. The health center had a robust patient centered medical home (PCMH) model in place, but the hospital did not have the staff or expertise to convert to that model. Even though they were separate entities, the leadership had both clinics begin working together. This exchange provided the hospital with the staff and expertise to move towards the PCMH model and was the foundation and education for participation in an Accountable Care Organization (ACO).

In 2015, the two organizations found a partner who was able to provide them with assistance in participation in a Medicare Shared Savings Program ACO. As of 2016, they have been approved to participate. They also received ACO Investment Model funding, which helped develop the

framework. Using their collaboration as the foundation, both organizations promote wellness, prevention, and coordination of care for all patients. Together, they have implemented a comprehensive model of care coordination, which has resulted in a reduction in admissions and ER visit rates by 25.71% and 9.81% respectively. The coordination of care is essential to success in the ACO model and yet another benefit of their mutual understanding and interdependent partnership.

Key Takeaways

What was key to the collaboration was keeping the patient and community needs as a focus. This is evident in the shared mission statement of Coal Country Community Health Center and Sakakawea Medical Center stating they are "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" and they truly embody that mission. As CCCHC and SMC face challenges, they understand their history, take notice of the success they have been able to achieve together, and continue to push forward in innovation.

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