WELCOME
February 18, 2014
INTRODUCTIONS

Dan Sisto, Chair
North Country Health Systems Redesign Commission
NORTH COUNTRY HEALTH SYSTEMS

REDESIGN COMMISSION

St. Lawrence County Health Providers

David Acker, President and CEO
Canton-Potsdam Hospital and
St. Lawrence Health System, Inc.

Anthony G. Collins, President
Clarkson University

William Fox, President
St. Lawrence University

Stephen Knight, CEO
Clarkson University

Avery Marzulla, Physician Assistant
Community Health Center of the North Country

Anne Richey, Executive Director
Community Health Center of the North Country
St. Lawrence Health System
St. Lawrence Health System

St. Lawrence Health System Presentation to North Country Health Systems Redesign Commission

February 18, 2014 Meeting
St. Lawrence County population dynamics have historically impeded county collaboration.
Access to subspecialty and tertiary services is the worst in NYS

- SLC is fundamentally different than other NC counties, due to geography, number of hospitals, and tertiary referral patterns.
- SLC does not naturally append itself to either east or west.
- Carving SLC into pieces erodes critical mass needed to support high quality system of care.

Given the geography and existing referral patterns within the County, strong relationships with tertiary hospitals in both Syracuse and Vermont are imperative.
While the population has remained static, declines in manufacturing and education growth have impacted SLC

- The total population of 112,000 is virtually unchanged over the past ten years, however, some towns have experienced substantial population declines while others have grown.
- The County has no single large population center or hub, which impedes consolidation or rationalization of services.
- Largely as a result, the County now has five hospitals, ranging from small to very small/critical access status.
- As each hospital attempts to meet its service area needs, the County’s broader health care needs are underserved, while the area suffers from excess beds and physician shortages.
- The home base for each hospital other than CPH is decreasing, as Canton and Potsdam’s education sector remains strong while local manufacturing continues to struggle in other communities.

Largest declines =
Largest increase =
### Excess Hospital Capacity in St. Lawrence County

<table>
<thead>
<tr>
<th></th>
<th>Beds</th>
<th>ADC</th>
<th>Current Need</th>
<th>Excess Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Mental Health beds</td>
<td>52</td>
<td>45</td>
<td>57</td>
<td>(5)</td>
</tr>
<tr>
<td>Total Rehab beds</td>
<td>15</td>
<td>3</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Total OB beds</td>
<td>21</td>
<td>8</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Total Med Surg beds</td>
<td>211</td>
<td>101</td>
<td>135</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>105*</td>
<td>106*</td>
</tr>
<tr>
<td>Totals</td>
<td>299</td>
<td>157</td>
<td>202</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>172*</td>
<td>122*</td>
</tr>
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</table>

- 2008 – 2013 SLC Acute Admissions dropped by 2,267 or 20%.
- Duplication of Services and Inefficient Use of Resources Add Needless Cost to the System and Threaten the Liability of all SLC Hospitals.
- No SLC Hospital has the physical space to meet even these declining bed needs.

*Based on Average Length of Stay of 4.31. Using CPH ALOS Med Surg excess beds increase from 76 to 106.

**Clifton-Fine Hospital excluded because they have special use beds and minimal inpatient acute utilization.
The Consequence of Excess Capacity

- Small Hospitals Nationwide typically incur significant financial losses in the operation of OB and ICU Units.
- A minimum of 1,200 deliveries per year is needed to operate an OB Unit on a breakeven bases. In 2012 there were 1,030 deliveries in St. Lawrence County.
- The average daily census in the county’s OB Units is as follows:
  - CPH 3.1 patients per day
  - CHMC 2.8 patients per day
  - MMH 1.9 patients per day
- In 2013 CPH had expenses of $1,967,000 in operating its eight bed OB Unit and revenues of $960,000, a loss of just over $1,000,000.
January 1, 2013 Quality and Regulatory Status at EJ Noble Hospital

- 7 Department of Health Plans of Correction
- Serious Joint Commission concerns to address
- Immediate jeopardy – scheduled to lose Medicare license on 3/10/13 with interim survey to occur on 1/23/13
The intersection of financial performance and quality care has been demonstrated at EJ Noble Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Profit/Loss</th>
<th>Operating Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($5,200,000)</td>
<td>(43.9%)</td>
</tr>
<tr>
<td>2012</td>
<td>($4,790,000)</td>
<td>(28.9%)</td>
</tr>
<tr>
<td>2011</td>
<td>($1,544,000)</td>
<td>(8.7%)</td>
</tr>
<tr>
<td>2010</td>
<td>($501,000)</td>
<td>(2.6%)</td>
</tr>
<tr>
<td>2009</td>
<td>$781,000</td>
<td>4%</td>
</tr>
<tr>
<td>2008</td>
<td>$212,000</td>
<td>1.2%</td>
</tr>
<tr>
<td>2007</td>
<td>($242,000)</td>
<td>(1.5%)</td>
</tr>
<tr>
<td>2006</td>
<td>($786,000)</td>
<td>(5.3%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Profit/Loss</th>
<th>Operating Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>($391,000)</td>
<td>(2.6%)</td>
</tr>
<tr>
<td>2004</td>
<td>($1,388,000)</td>
<td>(10%)</td>
</tr>
<tr>
<td>2003</td>
<td>($486,000)</td>
<td>(3.4%)</td>
</tr>
<tr>
<td>2002</td>
<td>$318,000</td>
<td>2.4%</td>
</tr>
<tr>
<td>2001</td>
<td>($7,000)</td>
<td>0</td>
</tr>
<tr>
<td>2000</td>
<td>($579,000)</td>
<td>(4%)</td>
</tr>
<tr>
<td>1999</td>
<td>($186,000)</td>
<td>(.17%)</td>
</tr>
</tbody>
</table>
As well as at its affiliated Nursing Home

**Kinney Nursing Home Profit/Loss**

<table>
<thead>
<tr>
<th>Year</th>
<th>Profit/Loss</th>
<th>Operating Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>($20,000)</td>
<td>-0.7%</td>
</tr>
<tr>
<td>2011</td>
<td>($335,000)</td>
<td>-12%</td>
</tr>
<tr>
<td>2010</td>
<td>($481,000)</td>
<td>-18%</td>
</tr>
<tr>
<td>2009</td>
<td>$13,000</td>
<td>+0.4%</td>
</tr>
<tr>
<td>2008</td>
<td>($107,000)</td>
<td>-4%</td>
</tr>
<tr>
<td>2007</td>
<td>($185,000)</td>
<td>-7%</td>
</tr>
<tr>
<td>2006</td>
<td>($160,000)</td>
<td>-7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Profit/Loss</th>
<th>Operating Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>($22,000)</td>
<td>-1%</td>
</tr>
<tr>
<td>2004</td>
<td>($245,000)</td>
<td>-12%</td>
</tr>
<tr>
<td>2003</td>
<td>($198,000)</td>
<td>-9%</td>
</tr>
<tr>
<td>2002</td>
<td>($327,000)</td>
<td>-16%</td>
</tr>
<tr>
<td>2001</td>
<td>($609,000)</td>
<td>-37%</td>
</tr>
<tr>
<td>2000</td>
<td>($177,000)</td>
<td>-9%</td>
</tr>
<tr>
<td>1999</td>
<td>($62,000)</td>
<td>-3%</td>
</tr>
</tbody>
</table>
## St. Lawrence County Health Rankings

<table>
<thead>
<tr>
<th>Category</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcomes</td>
<td>57 of 62</td>
</tr>
<tr>
<td>Mortality</td>
<td>53 of 62</td>
</tr>
<tr>
<td>Morbidity</td>
<td>57 of 62</td>
</tr>
<tr>
<td>Health Behaviors</td>
<td>59 of 62</td>
</tr>
<tr>
<td>Clinical Care</td>
<td>53 of 62</td>
</tr>
<tr>
<td>Social &amp; Economic Factors</td>
<td>58 of 62</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>32 of 62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>National %</th>
<th>NYS %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature Death</td>
<td>+26%</td>
<td>+18%</td>
</tr>
<tr>
<td>Smoking</td>
<td>+108%</td>
<td>+50%</td>
</tr>
<tr>
<td>Obesity</td>
<td>+28%</td>
<td>+28%</td>
</tr>
<tr>
<td>Excessive Drinking</td>
<td>+186%</td>
<td>+18%</td>
</tr>
<tr>
<td>Preventable Admits</td>
<td>+97%</td>
<td>+44%</td>
</tr>
<tr>
<td>Physical Inactivity</td>
<td>-48%</td>
<td>-24%</td>
</tr>
<tr>
<td>Primary Care Physicians per 100K</td>
<td>-271%</td>
<td>-219%</td>
</tr>
</tbody>
</table>

Data Source: Robert Wood Johnson Foundation
In the three largest North Country counties, residents use local County hospitals for nearly all the non-tertiary care services.
On a consolidated basis, St. Lawrence County has substantial critical mass

2012 Net Revenue

St. Lawrence County: $258.0M
  CPH: $93.4M
  GH: $17.9M
  CHMC: $96.9M
  MMH: $43.9M
  CFH: $5.9M

Franklin County: $148.5M
  AHMC: $63.6M
  AMC: $84.9M

Clinton County: $274.0M
  CVPH: $274.0M

Jefferson County: $229.4M
  SMC: $181.5M
  CAH: $36.5M
  RH: $11.4M

Essex County: $29.2M
  MLH: $11.2M
  ECH: $18.0M

Lewis County: $52.3M
  LCGH: $52.3M
Planning Standards

Population Requirement

- **80,000+**
- **70,000**
- **40,000**
- **20,000**
- **10,000**
- **2,000**

**St. Lawrence Co**
(112,000)

- Neurosurgery
- Allergy
- Endocrinology
- Infectious Disease
- Rheumatology
- Pulmonary, Nephrology
- Vascular Surgery
- Hematology/Oncology
- GI, Dermatology, ENT
- Urology, Neurology
- Cardiology
- Ophthalmology, Orthopedics
- OB/GYN, General Surgery
- Psychiatry, Pediatrics
- Family Practice / Internal Medicine

**PSA/SSA**
(55,000)

- Generally well supplied, except for pending retirements
- Ongoing shortages
- Entirely lacking or significant shortages

**Potsdam**
(15,000)

**17 of 126 | NORTH COUNTRY HEALTH SYSTEMS**
SLHS has put into place the building blocks of a sustainable Healthcare System for the future

- Innovation in new models of care and payment illustrations:
  1. Urgent Care Center to reduce unnecessary ED utilization, improve access, at lower cost, and provide currently unavailable “retail medicine”.
  2. Creation of ten provider primary care facility, with unique “classroom within a clinic” for Clarkson PA students, referral coordination and outpatient care management team. PCMH Certification expected 8/1/14.
  3. Created Health Coaches Curriculum for Community Health students at SUNY Potsdam. To begin teaching St. Lawrence University pre-med student in the Fall.
  4. Participation in CMS Model II on the payment program that began 1/1/14. Smallest hospital in NYS to participate in a CMS bundled payment demonstration project.

- Building collaborative relationship illustrations:
  1. Northern Lights, a home health agency formed by CPH, CHMC, Hospice, and United Helpers.
  2. Partnership with United Helpers and Community Health Center of the North Country led to preservation of healthcare services in Gouverneur.
  3. Long standing and deepening relationships with all four local universities.
  4. Strong affiliation with FAHC with current focus on Quality and Cardiology.
  5. SUNY Upstate partnering in Pathology and Obstetrics.
SLHS has put into place the building blocks of a sustainable Healthcare System for the future

<table>
<thead>
<tr>
<th>CPH</th>
<th>2007</th>
<th>2013</th>
<th>SLHS</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>41 Full Time</td>
<td>64 Full Time</td>
<td>Physicians</td>
<td>72 Full Time</td>
</tr>
<tr>
<td>Mid Level Providers</td>
<td>15 Full Time</td>
<td>33 Full Time</td>
<td>Mid Level Providers</td>
<td>41 Full Time</td>
</tr>
<tr>
<td>Total Providers</td>
<td>56</td>
<td>97</td>
<td>Total Providers</td>
<td>113</td>
</tr>
</tbody>
</table>

- Creating a diverse, deep, and high quality system of providers
- Financial strength – consistently positive operating margins and strong balance sheet.
- Investments in IT – the smallest and one of only 32 hospital awarded HIMSS level 6 status.
- Advances in Quality – excellent quality ratings improve annually.
- Nationally Recognized in Patient Safety and Process Improvement Initiatives
Conceptual Components of a Consolidated Facility on a Central Site

Initial phases to include:

- Emergency Room with an Observation Unit and Level III Trauma Designation
- Nine bed Critical Care Unit
- Twenty inpatient surgical beds with needed operating rooms
- Twelve bed Obstetrical Unit
- Specialty physician office space, with focus on County-wide specialty needs
- Coordinated transport services

Cost of preliminary phases estimated at $50 to $60 million
Canton is the logical site for centralization of high acuity, capital intensive care.

- The historical referral patterns and immense geography of St. Lawrence County does not lend itself to being appended to either an eastern or western pillar.
- There is a vibrant employer base in the county that needs a strong local healthcare system to support it.
- The critical mass of providers, medical spending, and size of population is so substantial that it requires a pillar in the middle to support it.
SLHS has been created to serve as a catalyst for reforming the health care delivery system in St. Lawrence County.

**St. Lawrence Health System**

- **Canton-Potsdam Hospital**
- **Gouverneur Hospital**
- **Additional Members TBD**
- **Additional Members TBD**

**Purpose:**

- Create sustainable platform for critical services by reducing unnecessary costs
- Critical mass for continued growth in physician specialists
- Broader population base provides financial support for innovative care models and population health initiatives
- Creation of new partnerships
- Significantly reduce physician on-call burden by improving physician recruitment
- Realize economies of scale and reduce inefficiencies

- No single current entity will have majority control.
- Open to hospitals and non-acute health care members.
Community Health Center of the North Country
Federally Qualified Health Center since 2007

Executive Director – Anne Richey
Medical Director- Dr. Andrew Williams MD, FACP
Director of Clinical Services – Darlene Bertolozzi
Our Mission

Provide comprehensive, accessible health and human services in the counties of Northern New York and to offer services to people of all income levels with a special commitment to low income, medically underserved individuals & people with disabilities.
Who We Are

• Cerebral Palsy Association of the North County was established in 1975
• Became an article 28 clinic in 1987
• Became an FQHC in 2007
• 3 FQHCs in Canton, Gouverneur, & Malone
• 1 non FQHC in Watertown
• Counties served: St. Lawrence, Jefferson, & Franklin
Operating Budget

Total Operating Budget 20.1 Million

- Residential Services: 32%
- Clinic: 41%
- Family Services: 17%
- CDPAP: 10%
Our Locations

- A) 380 County Route 51, Malone, NY 12953
- B) 4 Commerce Lane, Canton, NY 13617
- C) 77 West Barney Street, Gouverneur, NY 13642
- D) 167 Polk Street, Watertown, NY 13601
What We Offer

• Services: Primary Care, Dental services, Mental Health, Physical Therapy, Optometry, Orthopedics and Foot Care

• Wide array of services for people with developmental disabilities

• Consumer directed home care program (CDPAP)

• Clinic Case Management at our 3 FQHC locations

• Sliding Fee Scale available—patients who are at or below 200% of the poverty level
Our Staff

• 580 total employees
  – 98: Clinic staff (including 26 Health Care Providers)
  – 300: Consumer Directed Person Assistant Program/CDPAP (home care)
  – 182: OPWDD funded programs for people with developmental disabilities
Patients
Insurance Companies

- 38% Private
- 33% Medicare
- 19% Medicaid
- 10% Uninsured
Our Patients

- Total Patients in 2013: 10,988
  - New Patients: Over 3,000
  - Patients under 19: 4,136
    - Last year: 2,377
  - Patients Over 60: 2,360
    - Last year: 1,292
- Projected Patients for 2014: 16,000

- Medical Conditions:
  - Asthma: 415
  - Diabetes: 1009
  - Hypertension: 1953
  - Depression: 983
  - HIV/Aids: 2
  - Heart Disease: 502
  - MH disorders: 1739
  - Substance abuse: 144
Location of Patients We Serve

- Gouverneur area-29%
- Massena area-20%
- Malone area-16%
- Ogdensburg area-15%
- Canton area-14%
- Other-6%
Our Partners in Health

- St. Lawrence Health System – Canton Potsdam Hospital / Gouverneur Hospital
- Claxton-Hepburn Medical Center
- Massena Memorial Hospital
- Alice Hyde Medical Center
- St. Lawrence Health Initiative
- Health Center Network of New York (HCNNY)
- Community Health Care Association of New York State (CHCANYS)
- Clarkson University
Accomplishments

- May 2011: Implemented an EHR
- September 2013: Became an NCQA Patient Centered Medical Home (PCMH) Level 3 at our Canton location
  - Improved Population Health
  - Improved Access to Care
  - Offered Continuous-Comprehensive Care
  - Better Coordination of care
- October 2013: Expanded Primary Care Services to Gouverneur
  - Collaboration with CPH and United Helpers
- 2013: Completed Stage 1 Meaningful Use Requirements
  (Currently working on Stage 2)
  - Demonstrated meaningful use of our EHR for a large portion of our patient populations
  - Provide patients with electronic access to their medical information
Quality Care-2013

• Screening Rate for Breast Cancer increased by 25%
• Screening Rate for Cervical Cancer increased by 16%
• Hypertensive Patients:
  – Over 70% have controlled BP
• Diabetic Patients:
  – Over 55% have controlled A1C
Challenges

• Recruiting/retaining quality providers
• Transportation
Potential Solutions

• Recruitment/Retaining Quality Providers:
  – Loan repayment incentives
  – Recognition of LMSWs for reimbursement from all payers
  – Regional economic development

• Transportation
  – Regionalizing DSS transportation coordination
  – Enhanced reimbursement rates for home visits
  – Expand service areas
Next Steps

• Expand services to Ogdensburg and Massena
  – 5 year goal to open sites in Ogdensburg and Massena to expand high value and advanced primary care services to these regions

• Develop and strengthen our existing partnerships with healthcare providers in the area

• Strengthen relationships with local academic institutions

• Becoming a PCMH at our other 2 sites

• Completing Stage 2 of Meaningful Use

• Further increase our cancer screening rates
Summary

- Provide high value care to a large geographic region
- Created strong collaborations with neighboring hospitals
- Recognized as PCMH, level 3
- Plans to expand services to Ogdensburg and Massena
United Helpers
North Country Health Systems Redesign

BY:
Steve Knight
NORTH COUNTRY HEALTH SYSTEMS

Caring for Our Community

Outpatient Physical Therapy

Companion Services

Certified Home Care

People HELPING People

Subacute Rehabilitation

Assisted Living

serving St. Lawrence County

Family Housing

Intermediate Care Facilities

Childrens’ Therapy

serving nearly 1000 people everyday

United Helpers

Since 1898

Skilled Nursing

more than 100 YEARS of Service

Health Care and Rehabilitation Centers

Pre-School Program & Early Intervention

Strong Roots

peace of mind

community partners

committed to quality

Speech & Occupational Therapy

Day Habilitation

Subsidized Senior/Disabled Housing

Adult Residence

Enriched Housing

Speech & Occupational Therapy

Outpatient Physical Therapy

Licensed Home Care

Intensive Supportive Housing

Homes and Services for Developmentally Disabled

MOSAIC

A United Helpers Community Services

Housekeeping

Mental Health Services
Vision 2010

Governance:
"This encourages the Board to view their responsibilities organizationally and promotes cooperation."

Organizational Culture:
"There is an understanding that the United Helpers companies exist for the purpose of serving people in need and everyone works to enhance the quality of the lives of the people we serve."

Market (growth)
Many of our services were originally established on institutional acute care models. We recognize that today’s customer clearly prefers easily accessible services that do not severely alter “life flow.” We develop our services and renovate/construct buildings based on a residential/social model as opposed to the institutional model. We organize and deliver services around people’s normal daily routines rather than at the convenience of a facility or the staff.

Partnerships:
We recognize the need to develop relationships with other professionals or organizations in order to provide optimal cost-effective services. In fact, many grants and funding sources require partnerships as a prerequisite for consideration.

United Helpers regularly utilizes the expertise of trade associations, clinical consultants, trainers, hospitals and various other organizations and professionals when appropriate. We are open to establishing new relationships as strategic alliances could prove indispensable.

Commitment to Excellence (Quality):
While our minimum standards for quality are guided by regulatory agencies, we take a more pro-active approach. United Helpers uses additional quality indicators to measure levels of excellence.
Human Resources (People):
Personnel selection and retention are organizational priorities as well as having the right people in the right positions.

Resource Management:
We recognize the trend of continually decreasing government reimbursement and accept the necessity for fiscal imagination and an increased commitment to the entrepreneurial spirit.

Technology:
UH recognizes its dependence on technology. Our ability to keep up with technology enhances the effectiveness of our services to our customers.

Fund Development:
There is a renewed, organizational commitment to significantly increasing the endowment by 2015.
We’re usually a quiet company, but there’s a lot going on.

United Helpers
Since 1898

In the world of health and human services, we offer plenty of help. Now we’ve made it even easier to find it. United Helpers has reorganized to better serve the North Country. Call us today or visit us online to learn more about any of our services.

(315) 393-3074  www.unitedhelpers.org  (800) 838-8553
United Helpers’ Pillars

1. Quality
2. Service
3. Financial
4. People
5. Growth
6. Sustainability
Key Points

- UH supports the triple aim and NYS DOH's efforts to reform health care delivery
- UH has been working on and positioning itself to deliver the triple aim for years
- UH provides a vast array of post-acute services
- UH understands (so we think) the many redundancies, inconsistencies and costs associated with the current post-acute system
- UH is subject to and understands a multitude of reimbursement methodologies
- UH understands (so we think) SLC's post-acute needs
Key Point

- UH has Seen the power of meaningful collaboration first hand and is willing to do more...
Triple Aim

- Better Care
- Better Health
- Lower Cost
As part of the Commission’s long-range planning and due diligence, I believe that there is value in investigating alternative care delivery models and systems.

I suggest a St. Lawrence County-wide demonstration project.
Advanced Rural Model
Innovation

1. Directional
2. Intersectional

Too Fast?
ARM’s Goals and Priorities

- **Fix the fundamental problems in our existing systems**
- Assign a high-level DOH employee to the project
- Assign staff from elected officials’ offices
- Inclusive process
- Transparency at all levels (State, County, Private)
- A commitment to the Triple Aim at all levels
- Accountability at all levels
- Meaningful collaboration
- Attain a deep understanding of how the existing SLC health system operates
- Use knowledge to "Redesign" a flexible, responsive, quality and cost effective system of care and services
Why can we use medication certified aides in some of our programs and not in others? **In fact, some of the “others” have better RN supervision.**

Why do I get $40.56/day for our adult home and the SLPC gets over $800/day? **Reimbursement discrepancies abound with no correlation to value.**

Why does the ALP program require an agency to deal with three separate state agencies who are not coordinated? **Three sets of regulations, two separate surveys.**

Why can’t enriched housing services be aggregated together to serve multiple sites in an efficient manner?

**One operating certificate, multiple levels of care and community service…**
Meaningful Collaboration

NYS Agencies

Same Goal

Triple Aim (Innovation)

Operators

Legislators
Thank You
NORTH COUNTRY HEALTH SYSTEMS
REDESIGN COMMISSION
Dr. John Brumsted, President and CEO
Fletcher Allen and Fletcher Allen Partners

Stephens Mundy, President
Community Providers, Inc.
Longstanding Affiliations and Partnerships

- Affiliated with Alice Hyde since January 1, 2002
- Affiliated with Canton-Potsdam since June 1, 2005
- Partnering with Inter-Lakes Health since June 30, 2010
- Through these relationships, we manage an extensive regional network of services, including:
  - Regular outreach clinics provided by Fletcher Allen specialists
  - Continuing medical education workshops
  - Telemedicine services
  - Ongoing exchange of clinical information and best practices
Fletcher Allen Partners: Leading in an Era of Reform
Integration Drivers

- Health Care Reform challenges:
  - Shifting from fee-for-service to a value-based, population health model.
  - Declining reimbursement
  - Changing relationships between hospitals, doctors
  - Technology – time and resources to keep pace

- Achieving the triple aim: better care, better health and lower costs

- Elements of success = financial strength, capital capacity, improving quality and access, and controlling costs

Conclusion: We are stronger together.
Our Philosophy

- Mission: We are committed to the development of an Integrated Delivery System that provides high-value health care to the communities we serve and enhances our academic mission.

- How do we achieve this?
  - Right-size the delivery system by redistributing services so that patients receive the right care, at the right time, as close to home as possible, at the lowest cost.
Fletcher Allen Partners – Shared Objectives

- To establish an integrated regional health care system under the common control of Fletcher Allen Partners which shall align the missions, clinical services and economic interests of the members as health care providers.

- To engage in collaborative regional planning to develop a highly coordinated health care network that will improve the quality, increase the efficiencies and lower the costs of health care delivery in the communities served.

- To provide Fletcher Allen Partners with sufficient corporate authority to assure that the Shared Objectives can be promoted fully and that the aligned economic interests and missions of the members are fostered and pursued.
Shared Objectives (continued)

- To provide high quality, cost-effective services to the communities we serve.
- To increase community access to needed health care services throughout the system.
- To support local access to primary and subspecialty care.
- To promote excellent relationships by system members with physicians and other providers.
- To develop system-wide clinical, quality and operational standards that are consistent with best practices, centers of excellence, increased use of electronic health records, and enhanced physician recruitment.
Fletcher Allen Partners: Who We Are Today

- 3 Community Hospitals (VT and NY)
- 1 Academic Medical Center
- 1,063 Physicians
  - 812 Specialists
  - 251 Primary Care Providers
- 1,161 Licensed IP Beds
- 37,766 IP Discharges
- 933,583 OP Encounters
- 651,688 Professional Office Visits
Strategic Areas of Focus

- Governance
- Clinical Integration
- Academic Model
- Physician Alignment
- Value-Based Care
- Growth
- Branding
Clinical Integration: Service Line Integration

- Cardiovascular integration
  - Keep NNY PCI patients at CVPH
    - CVPH has earned top 5% distinction in PCI
  - Consolidate cardiovascular surgery at Fletcher Allen
    - Just approved by NYSDOH
  - Forming NNY cardiology service
    - *This is the first of many service lines we will integrate, ensuring appropriate care in the appropriate location for our patients.*
Clinical Integration: Quality/Practice Standardization

- The Jeffords Institute for Quality and Operational Effectiveness
  - 20+ year history of practice standardization – measurement, clinician engagement, skilled quality consultants
  - Results: UHC top performance on quality and efficiency
    - Fletcher Allen ranked top 10 nationally, #1 for patient safety
    - Fletcher Allen ranked #2 supply chain performance; FAP has realized supply chain savings of $4.63 million since the beginning of calendar year 2013
  - Results: Only 13 of 404 regions nationwide have lower Medicare service use than Burlington (see appendix)
- UHC benchmarking across the system
- System quality dashboard
- Service line consistent quality and efficiency processes and measurement
Academic Model

- Develop, secure funding and begin application process for the Family Medicine Residency Program at CVPH
  - Business plan developed, currently securing funding
  - Program slated to begin 2016 with 4-6 residents
  - Objective: to train skilled primary care physicians to serve North Country; 60% of residents practice where they trained
- Explore potential clerkships to ED at CVPH and CVMC; OB clerkship to CVPH
- Develop and implement plans for system-wide clinical trials network
Physician Alignment

- Aligned physician workforce ensures improved access and enhanced quality of care.
  - Many specialty providers at CVMC and CVPH are now employed by the University of Vermont Medical Group (UVMMG).
  - Physician Leadership Council developing a regional provider workforce plan to ensure the right care is being delivered in the right places to support population health, and creating the vision for a cohesive structure supporting community and faculty physicians.
Value-Based Care: Migrating to Value-Based Contracts

- Building the networks
  - OneCare Vermont
  - Adirondacks ACO
- Building the care model
  - Transforming primary care delivery
  - AHI PCMH pilot project
- Building supportive financial analytics
- Migration of patient populations underway
Extensive use of clinical decision support tools
- HealthFortis to guide the selection of evidence-based radiologic studies
- Removal of inappropriate labs from order sets (Choosing Wisely Campaign)

Standardization of Primary Care Practice around established best practices
- AHI PCMH pilot with dramatic change documented
- Transforming primary care delivery
Value-Based Care: AHI Reduced Utilization

Pediatric Patients Cumulative BMI Improvements

- Birth - Age 6
- Age 7 - 12
- Age 13 - 19

Graph showing improvements in BMI for different age groups from 2012 to Q2 2013.
CVPH All Cause, ALL DRG, 30 Day Internal Readmission Rate by Month, 1/2009 - 12/2013

Value-Based Care: AHI Reduced Utilization
Value-Based Care: AHI Reduced Utilization

Risk Adjusted and Trended Spending
Per Member Per Month
Commercial - 43,000 lives

- 2009: $460
- 2010: $450
- 2011: $440
- 2012: $410
Value-Based Care: AHI Reduced Utilization

Risk Adjusted and Trended Spending
Per Member Per Month
Medicaid HMO – 21,000 lives

- $330
- $340
- $350
- $360
- $370
- $380
- $390
- $400

2009 2010 2011 2012
Value-Based Care: BUN Tests Per 1000 Patient Days
Value-Based Care: Leveraging Big Data

- Northern New England Accountable Care Collaborative (NNEACC)
  - Eastern Maine, MaineHealth, Dartmouth-Hitchcock, Fletcher Allen
  - Database of claims and EHR inputs
  - Software and data analytics
- Business Intelligence at CVPH and Fletcher Allen
  - Common data center in development
Fletcher Allen is working with HIXNY through its partnership with Vermont Information Technology Leaders (VITL), the Vermont equivalent of HIXNY.

VITL is working closely with HIXNY to create an interstate electronic highway to exchange patient information securely between New York and Vermont providers.

Fletcher Allen Partners CIO Chuck Podesta sits on the VITL Board and CVPH CIO Wouter Rietsema, MD is on the HIXNY Board.
Growth: Examples of MOUs with North Country Hospitals

- **Inter-Lakes Health (ILH)**
  - Actively helping ILH restructure into an integrated, sustainable clinical and financial model of healthcare delivery
  - Goal to bring ILH under CPI management, potentially join FAP via CPI in 2015

- **Alice Hyde**
  - Looking at changes in structure and designation so that this organization could potentially come into FAP through CPI; committed to working together to help create an integrated delivery system
Lessons Learned in Building an Integrated Network

- Need a strong Board, executive leadership and shared vision
- Culture change takes time, trust and willingness to embrace change
- Resources – human and financial – are critical
Opportunities to Partner to Transform Care in the North Country
ILH Restructuring

- We anticipate significant costs to our health network to restructure operations at Inter-Lakes Health. This is a worthwhile investment to ensure the survival of this valuable critical-access hospital.
  - Request openness to an innovative model to right-size the capacity at this organization.
  - Refinancing or forgiving some of the $20M debt would be hugely helpful.
  - The emergency department at ILH needs a $3M renovation to operate a standalone service.

(Waiver 1.01, 1.03, 1.09, 1.10)
Meaningful investment to meet the primary care needs of the North Country – also a financial commitment with upfront and ongoing costs.

- Startup costs - $500K to hire the program director and program coordinator
- $1.6M for first 3 years of program
- Ongoing annual cost from 2020 is $700K
- Looking at 340(b) program, FAP commitment, grants, State funding and philanthropic support
  (Waiver 1.03, 1.04, 1.06)
**Additional Areas of Support**

- **Expediting regulatory approvals**
  - Just received NYSDOH approval to consolidate cardiothoracic surgery at Fletcher Allen and operate a standalone PCI program at CVPH. Anticipate future service line integration will necessitate similar review, and appreciate the ability to expedite these review processes with the State.
  
  *(Waiver 1.01, 1.03)*

- **EMS hospital-hospital transfers**
  - With greater connectivity between VT and NY hospitals, we need a robust transport system for patients. We need help with ambulance planning and a coordinated EMS system.

  *(Waiver 1.04)*
Additional Areas of Support

- Telemedicine: Need to address questions on licensing, credentialing and payment.
  - Does a Vermont provider need a New York license to treat a NY patient from their desk in VT?
  - What is the payment mechanism for providing these consults? (Waiver 1.05, 1.09)
- Extend and expand the Adirondack Medical Home Pilot (Waiver 1.03, 1.04)
- Request a broad and flexible definition of “safety net provider” under the NY DSRIP that would include Fletcher Allen Partners hospitals and affiliates.
Questions?
Appendix
Cost-effective care for NNY patients

- Fletcher Allen and our Fletcher Allen Partners hospitals (CVPH, Elizabethtown and CVMC) treat approximately 39% of patients in Clinton, Essex, Franklin and St. Lawrence counties.

- We treat approximately 59% of patients in these counties when we include care provided by our clinical affiliates at Alice Hyde, Canton-Potsdam and Inter-Lakes Health.

- We provide 90% of tertiary care for patients in these four counties.

Data provided by the Healthcare Association of New York State and compared on a Federal DRG basis with comparable average lengths of stay.
Fletcher Allen is a high-performing provider

- 2008 commercial claims data compared Hospital Service Areas in Vermont, Maine and New Hampshire
  - Burlington HSA had lowest ED use
  - Burlington HSA had lowest potentially avoidable ED use
  - Burlington HSA had lowest 30-day inpatient readmission rate in Vermont
  - Burlington HSA had the lowest rate of hospitalization for ambulatory care sensitive conditions

Onpoint Health Data • Tri-State Variation in Health Services Utilization & Expenditures in Northern New England, June 2010
<table>
<thead>
<tr>
<th>State</th>
<th>Area Name</th>
<th>Service Use per Beneficiary as % of Nat’l Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL</td>
<td>Miami-Ft. Lauderdale-Pompano Beach</td>
<td>139%</td>
</tr>
<tr>
<td>MA</td>
<td>MA, non-metro areas</td>
<td>108%</td>
</tr>
<tr>
<td>MA</td>
<td>Springfield</td>
<td>91%</td>
</tr>
<tr>
<td>ME</td>
<td>ME, non-metro areas</td>
<td>88%</td>
</tr>
<tr>
<td>ME</td>
<td>Portland-S. Portland-Biddeford</td>
<td>88%</td>
</tr>
<tr>
<td>NH</td>
<td>NH, non-metro areas</td>
<td>91%</td>
</tr>
<tr>
<td>NH</td>
<td>Manchester-Nashua</td>
<td>92%</td>
</tr>
<tr>
<td>NY</td>
<td>NY, non-metro areas</td>
<td>84%</td>
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<td>NY</td>
<td>Albany-Schenectady-Troy</td>
<td>88%</td>
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<tr>
<td>NY</td>
<td>Glens Falls</td>
<td>85%</td>
</tr>
<tr>
<td>VT</td>
<td>VT, non-metro areas</td>
<td>85%</td>
</tr>
<tr>
<td>VT</td>
<td>Burlington-S. Burlington</td>
<td>82%</td>
</tr>
</tbody>
</table>

Only 13 of 404 regions have lower service use than Burlington – that means only 3.2% are doing better. Only 37 of 404 regions have lower service use than the rest of Vermont. Of the 404 regions, only 23 had a service use of 82% or better – that puts Burlington in the top 6% nationally. Of the 404 regions, only 47 had a service use of 85% or better – that puts Vermont (as a whole) in the top 12%.

### Comparison of Fletcher Allen with UHC Hospitals

#### Selected Quality of Care and Cost Measures (2009)

<table>
<thead>
<tr>
<th>Category</th>
<th>Fletcher Allen Health Care</th>
<th>UHC Full Member Hospitals (Median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions (lower is better)</td>
<td>4.24%</td>
<td>5.39%</td>
</tr>
<tr>
<td>CMS 26 Composite Care Measure (higher is better)</td>
<td>91.1</td>
<td>87.9</td>
</tr>
<tr>
<td>Heart Attack Composite</td>
<td>97.5</td>
<td>95.4</td>
</tr>
<tr>
<td>Heart Failure Composite</td>
<td>90.2</td>
<td>87.8</td>
</tr>
<tr>
<td>Pneumonia Composite</td>
<td>86.4</td>
<td>79.3</td>
</tr>
<tr>
<td>Surgical Care Composite</td>
<td>87.0</td>
<td>86.1</td>
</tr>
<tr>
<td>Risk-adjusted Mortality Ratio (lower is better)</td>
<td>1.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Risk-adjusted cost per Inpatient Discharge</td>
<td>$7,133</td>
<td>$10,575</td>
</tr>
<tr>
<td>Observed to Expected Cost Ratio</td>
<td>0.81</td>
<td>1.16</td>
</tr>
<tr>
<td>Average Length-of-Stay</td>
<td>5.04 days</td>
<td>5.60 days</td>
</tr>
</tbody>
</table>

Source: Arrowhead Health Analytics Report on Health Care Costs and Cost Growth in Vermont, University Healthsystem Consortium