Orcas Island Health Care District
Summary of Board Working Session
June 11th, 2018

The following items have been identified as consensus reached working assumptions. They are not final decisions of the board and may be modified as the board further defines community needs.

Items in italics have a follow up/research task identified.

Upcoming Critical Path Dates

- UW clinic fiscal period ends June 30th and OMF has indicated it cannot fund operations beyond this period.
- OMF does not have funds to support its operating costs beyond June 30th and is looking to transfer the building to the PHD by August 1st.
- Loan from the county to cover pre-levy expenses requires passage of a 2019 levy rate prior to the distribution of the 2nd $200K loan draw. The PHD anticipates funds are needed in the October/November timeframe.
- 2019 budget hearing and certification in November.

Nature of Services to be Secured

For the next two years, the health care district will focus on funding the two largest existing primary care practices – UW Clinic and Orcas Family Heath Center (OFHC).

Funded practices will be asked to support industry standards for maximum # of days prior to gaining access to a provider for routine appointments as well as be designed to support seasonal fluctuations in population and visitors.

Funded practices will be encouraged to evaluate how expanded hours, 1-day hour shifts (10-7 versus 8-5), or Saturday hours might be incorporated into their service delivery model.

Funded practices will be encouraged to move from a silo view of the island health care system to a system view of whole health collaboration. Some examples include:

- post procedure follow-up from mainland referrals and treatments
- transfers from EMS with no requirement as to where patient receives primary care
- collaboration with broader community (e.g. OCRC, Compass Health, EMS, Sheriff's Department, Ray's Pharmacy, etc.) to address mental health, opioid dependency, etc.
- cross practice collaboration to minimize referrals to EMS and medivac instances
- addressing chronic health issues (e.g. diabetes, congestive heart failure, COPD)

The district will define an island appropriate acute/urgent care system in collaboration with EMS and the two clinics. The clinics will be expected to be staffed/managed to accommodate a reasonable level of same day urgent care patients during regular operating hours. The system will likely include a collaborative cross practice (including EMS) method for supporting after-hours acute/urgent care and must include access to an on-site provider (MD, NP) if initial triage by an appropriate provider, determines an in-clinic visit is needed. On call provider must be willing/able to see patients of either

practice and patients who receive primary care off island when initial triage determines an in-clinic visit is needed.

Providers will be asked to determine the cost associated with delivering this system of urgent after-hours care.

Statistics Needed to inform discussions:

- *Volume of patients whose treatments initiate with EMS but who could be referred to on island clinic versus being flown off*
- *Volume of patients treated by EMS*
- *Number of patients referred by clinics to EMS for urgent care during regular hours*
- *Number of patients referred by clinics to EMS for urgent care after regular hours*
- *Number of medivacs for urgent care that could have been seen on island*

Funded practices will be asked to employ personnel who possess a skillset broad enough to deliver both primary and urgent care in a more traditional "Family Care" model. Those skills must include but are not limited to:

- *Acute illnesses – asthma, infections, etc.*
- *Injury – lacerations, sutures, X-ray, advanced trauma life support*
- *Orthopedics – simple castings*
- *Preventative care*
- *Blood draws, IVs*
- *Post procedure follow up referral*
- *OB/Gyn*
- *Pediatrics*
- *Gerontology*

The district acknowledges that there may be additional training required to support this level of training. (*Research – Explore what skill sets family care schools are currently training*).

The district would like to have a voice in determining the necessary staff level/skill composition, in order to deliver desired model.

The board discussed long term options (beyond 2 years) for funding clinics and some of the pros and cons associated with any long-term plan funding two clinics. The primary benefit of two clinics was believed to be that citizens would have multiple options to select the clinic that best matches their philosophy on health care. The primary disadvantage is believed to be the dual overhead and excess costs.

General consensus was that there is some value to the community to continue funding the two-clinic model in order to retain choice of provider and clinic but the board would continue to emphasize diligent efforts to identify cost sharing opportunities to reduce over-all funding needs. If sufficient opportunities could not be achieved, moving to a one clinic model would have to be considered. Cost reduction opportunities considered were:

- Shared facilities
- Shared urgent/acute after-hours care system (with EMS)

- Shared laboratory services
- Shared X-Ray and ultrasound services
- Shared administrative staffing
- Shared billing

Additional discussion included the need to define a "Plan B" to be considered if either or both of the existing clinics is not willing or able to provide the services/model the district wishes to purchase.

Funded practices will be expected to meet regularly with each other and representatives from PHD and EMS, to evaluate how current practices/policies are working and where modifications may be needed.

More information is needed from both practices to describe their charity care programs including:

- *How it works – what is the process patients have to follow to receive care under these programs*
- *What are the parameters for a patient to qualify*
- *How many patients have applied for this program and how many have qualified.*
- *What are the primary reasons for non-qualification.*

Funding for at least the first two years will be focused toward the two largest medical practices however if needs assessment indicates a strong preference for supporting other forms, such as naturopathy, we will work to quantify the associated costs.

<u>Metrics</u>

The district will work collaboratively with funded practices to develop mutually agreed upon customer satisfaction and operational metrics which will be included in all funding contracts. The right balance of encouraging cost efficiency while achieving high customer satisfaction will need to be struck.

The district would like to include incentives and penalties in the contracts to encourage a focus on the care elements measured/prioritized in the metrics.

Metrics for consideration included:

Customer Satisfaction

- Satisfaction with provider – initial visit and follow-up
- Satisfaction with clinic – professionalism, time to get an appointment, time in waiting area, and time in appointment, etc.
- Satisfaction with treatment prescribed
- Staff's perception of quality of service provided

Operational/Financial Metrics

- Staffing Efficiency
  - Worked RVU's – general agreement that an RVU metric~~s~~ is appropriate. Set at clinic level versus individual practitioner level.
  - *Industry standards for # of patients per provider*
  - *Industry standards for number of providers for a particular population size.*
  - *Industry standards for # of support staff per provider or per patient population*
  - How will these need to be adjusted to deal with our seasonal population and visitors?

- Other cost efficiency metrics
  - Consider overhead cost per patient as a way of measuring overhead cost
  - Consider establishing incentives for cost savings where clinic can get a "bonus" equal to a % of the amount saved. Care would be needed to make sure that these are true savings/process improvements not just inflating the budget in order to be able to claim cost savings or as a result of equipment paid for by the PHD.

Community Health

Quality of Care metric – longer term goal to work to identify a way to measure overall health metric such as:

- *Reduction in # of non-acute care visits by EMS?*
- *Reduction in # of crisis interventions for chronic care conditions*
- *Reduction in # of repeat hospitalizations due to after care coordination issues?*
- *Reduction in opioid overdoses/suicides?*

Approach for implementing metrics

- *Communicate with clinics the category of metrics we are considering:*
  - *Customer Satisfaction*
  - *Staffing Efficiency*
  - *Other Cost Efficiency*
  - *Overall Community Health*
- *Ask clinics to respond with:*
  - *The metrics they are currently tracking – including clear description of what it does/does not measure.*
  - *The last 12 months results*
  - *Any feedback on the categories we have identified – additions, changes, etc.*
- Based on the responses:
  - Identify additional metrics needed.
  - Identify best approach to further define each metric including how to engage members of the community who might have experience/value added to the process.

Other factors considered:

- District would like metrics standardized between the two practices.
- Who captures patient feedback – direct to PHD or via clinic?
- Timing of feedback is important – more likely to get a response if you ask immediately but too early does not give time to measure quality of the follow up from provider.
- Find a way to track feedback from community members who would like to access a clinic but did not due to frustration with process, lack of availability, etc.
- Would like to capture feedback of EMS satisfaction in working with the clinics.
- How do you measure quality of care and topics such as healthy lifestyle, chemical dependency, etc. We could start with asking the clinics how they are meeting the quality standards for the insurers you contract with?

Other Goals

Ask clinics to assist with community health needs assessment

Hospital affiliation??? (I don't have any notes on this topic)

Get clinics to assist in higher Medicare reimbursement rates – *need to clarify if this is an advocacy role or other?*

- Rural Health Clinic status
    - *Ask UW and OMF (Alan Safer?) to share their analysis on cost/benefit of participating in program.*
    - *Ask OFHC to quantify their costs of participating and the associated additional revenue earned.*
    - *Need to understand the criteria for qualifying for this program – are we reaching the limit on # of providers.*
    - *Evaluate if consolidating practices into one facility could result in loss of RHC designation for OFHC.*

Contracts

Initial approach will be to develop Interim Funding Agreements between the PHD, the two clinics and OMF. Pegi will work with our attorney to develop draft agreements. Some provisions to consider for inclusion in these agreements are:

- All contract changes must be in writing
- Agreement to maximum payouts based on mutually agreed upon 2019 budget

Immediately begin contract discussions with both clinics for contracts through:

- June 30th, 2020 for UW
- September 30th, 2020 for OFHC

General agreement to support funding both practices in October

PHD will create initial draft of contract

Goal is to start with a standardized contract for both providers but acknowledge that it is likely the~~y~~ final contracts will have some variation.

Board will identify a contract negotiation team consisting of two members of the board. Board members will identify the skill set needed. Based on those requirements team members will be selected.