

# CHANGING ROLES OF PCAS/HCCNS

Shelly Ten Napel, MSW, MPP

CEO, Community Healthcare Association of the Dakotas



***"First you listen, then  
you learn, then you  
help, and only then do  
you lead."***

***-George Washington***



# LEADERSHIP IN A PANDEMIC

1

First, stop everything you are doing.

2

Figure out what you should be doing instead.

3

Figure out how to do it – staff and operations



***"Messy Middle"***  
*-Brene Brown*



# PANDEMIC PARTNERSHIPS

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## NORTH DAKOTA & SOUTH DAKOTA

Bright red and getting redder – Trump won by 33.3 and 26.2 percentage points respectively

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High level – somewhat similar responses

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Below the surface – very different responses

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South Dakota begins to show us what a public health response would look like in a state that doesn't see a positive role for government – government as other/outside/oppressive

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# NORTH DAKOTA VS. SOUTH DAKOTA

NORTH DAKOTA		SOUTH DAKOTA
Regional public health units	← PUBLIC HEALTH CAPACITY →	No local public health except in Sioux Falls
Testing events (health centers have big role) and increased public health lab capacity	← TESTING →	Leave it to the private sector. Begging for hot-spotting support, but to no avail
Early focus on tracing, now announced that they are only contact tracing for schools and nursing homes	← CONTACT TRACING →	Limited contact tracing capacity, but little communication



# NORTH DAKOTA VS. SOUTH DAKOTA

NORTH DAKOTA		SOUTH DAKOTA
Worked with CHCs to set up quarantine sites for homeless/vulnerable pops	← VULNERABLE POPULATIONS →	Almost no resources to support quarantine for vulnerable groups and nursing homes responsible for own testing
Used for COVID-19 response	← CARES ACT FUNDS →	Largely unspent, using funds to promote large, super-spreader events and tourism
Set up staffing agencies and \$10m to in-locums	← STAFFING CHALLENGES →	



# NORTH DAKOTA VS. SOUTH DAKOTA

## NORTH DAKOTA

Developed strong partnerships  
with public health

← FOR THE PCA,  
A VERY DIFFERENT  
EXPERIENCE WITH  
PARTNERSHIPS →

## SOUTH DAKOTA

Less opportunity to work  
together

Rural Experience: CHCs HAD to be part of the solution





# HOW DOES THE STORY END?

Public/community health “chasm” to collaboration

*Alignment on “upstream” focus*

*Shared community needs assessments*

Showing the value of local/community-based health care?

Connection between PCA/HCCN

Other partnerships – housing, nutrition, case management

Telehealth reimbursement?

More insight into health disparities?

PCAs that have become better communicators?

## WHAT NEXT?





# Health Center Partners of Southern California

## Introduction

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Presented by:  
Sparkle Barnes – Chief Strategy Officer

# A Family of Companies....



HEALTH CENTER PARTNERS  
of Southern California



The mission is **righteous**. The work **imperative**. The impact **profound**.



**HEALTH CENTER PARTNERS**  
of Southern California

- Regional PCA of 16 primary care organizations
- Voice and advocate for its members
- Training and technical assistance
- Serving the health needs of communities in southern California

San Diego, Riverside & Imperial Counties



## 3 County Region

San Diego County = 3,338,330

Riverside County = 2,470,546

Imperial County = 181,215

**5,990,091**  
**Total Population**  
**of Service Area**

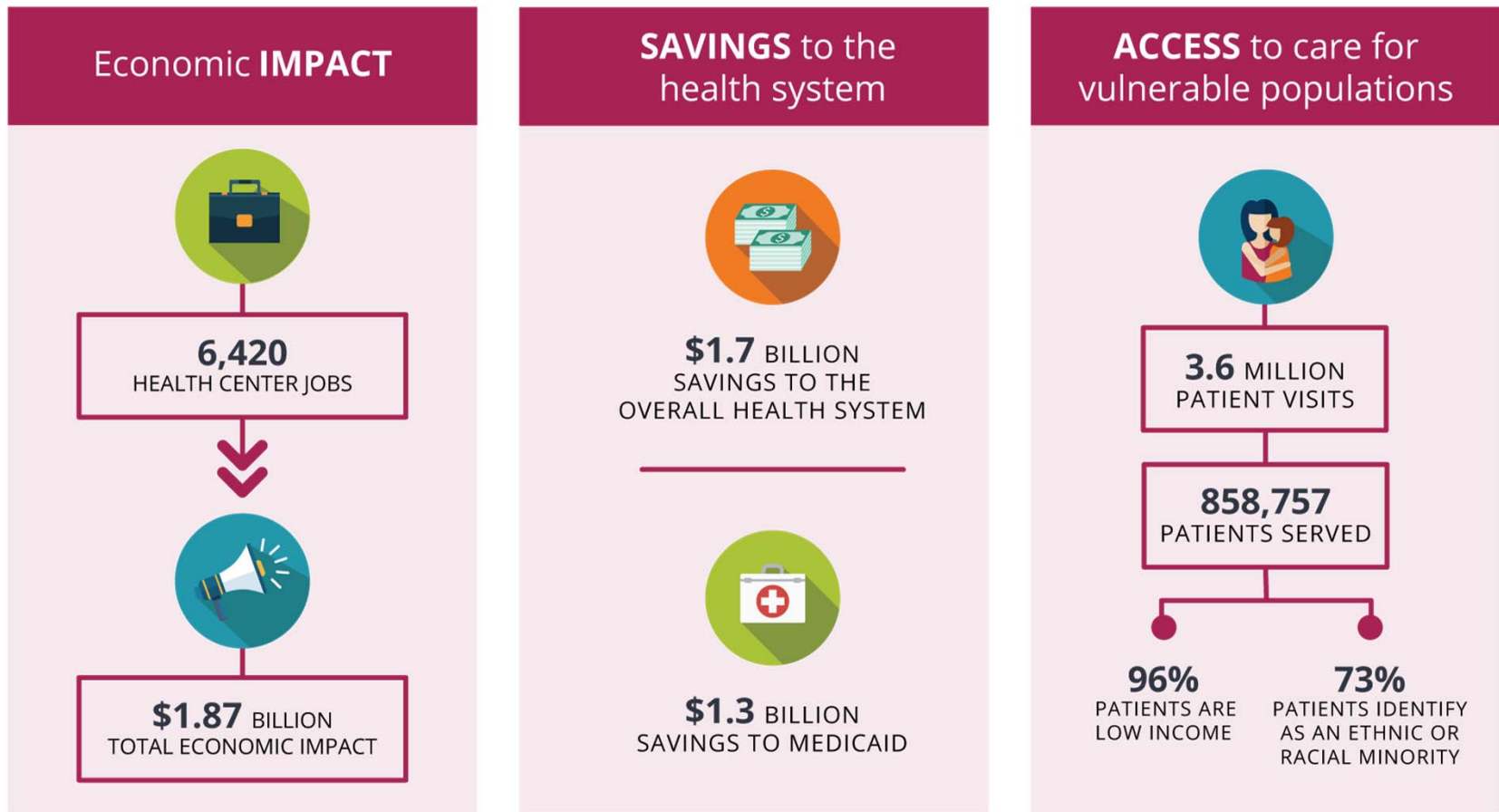
[www.census.gov](http://www.census.gov)



# OUR MEMBERS... 160 Sites Of Care In Five Counties



# Annual Economic Impact: HCP Members



# Our Value-based Model



**INTEGRATED**  
**HEALTH PARTNERS**  
of Southern California







- Region's leading clinically integrated primary care network.
- Brings together 9 community health center members representing more than 449,000 low income and underinsured patients in San Diego and Riverside Counties.
- Launched in March 2016.
- Positions IHP members as the health care hub.

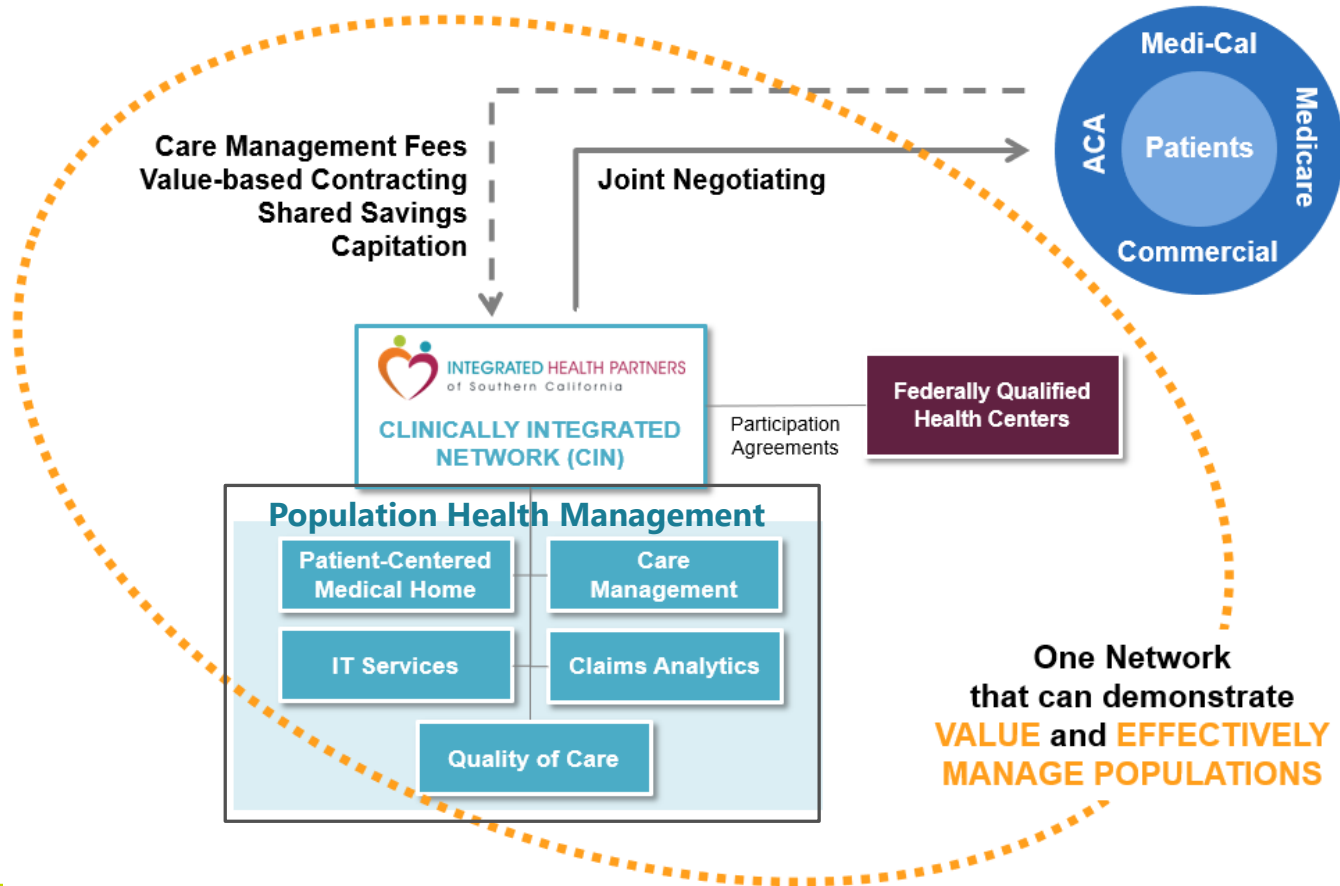
# Why Integrated Health Partners?

**IHP is a powerful advocate for primary health care service providers and their patients, striving to create a stronger health care safety net by:**

- Delivering higher quality of care and achieving new levels of performance and accountability.
- Developing stronger relationships with payers while improving the network's ability to perform at optimal efficiency in managed care contracts.
- Helping FQHCs respond to the changing environment for payment reform.



# IHP's Value Proposition



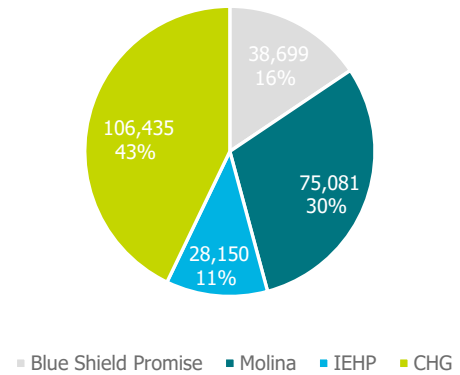
\*Source: Premier, Population Health Informatics & Technology Overview

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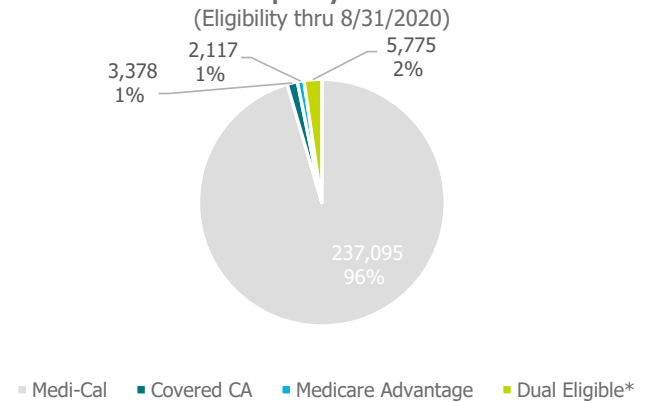
### 9 Health Center Members:

Health Center	IHP Enrolled Members <i>(Eligibility thru 08/31/2020)</i>	Total CHC Patients <i>(OSHDP, CY 2018)</i>
Community Health Systems, Inc.	8,546	26,543
Imperial Beach Community Clinic	11,327	9,864
Neighborhood Healthcare	58,945	75,172
North County Health Services	45,192	82,138
San Diego American Indian Health Center	1,618	4,182
San Diego Family Care	21,581	29,646
San Ysidro Health Center*	64,648	128,007
St. Vincent de Paul Village	800	2,424
Vista Community Clinic	35,666	86,314
<b>Total (including 42 'Unassigned PCP' IHP members)</b>	<b>248,365</b>	<b>444,290</b>

IHP Member Enrollment, by Health Plan  
(Eligibility thru 8/31/2020)



IHP Membership by Line of Business  
(Eligibility thru 8/31/2020)



\*Includes Medi-Medi and Cal-MediConnect eligible members



# Integrated Health Partners

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## **Presented by:**

Henry Tuttle – President & Chief Executive Officer

Tracy Garmer – Chief Operations Officer

Sarah Cho – VP, Clinical Transformation and Health Informatics

## **Topics:**

- ✓ IHP Network – current state
- ✓ IHP Network opportunities
  - ✓ Partnership RFI
  - ✓ Path to risk
  - ✓ Network transformation
  - ✓ Technology and informatics