



NATIONAL ASSOCIATION OF

Community Health Centers

Important Content Note:

This technical assistance resource was developed prior to the August 2017 release of the Health Center Compliance Manual by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). The BPHC Compliance Manual, issued August 2017, indicates where PINS, PALs and other program guidance are now superseded or subsumed by the BPHC Compliance Manual.

See: <https://bphc.hrsa.gov/programrequirements/pdf/healthcentercompliancemanual.pdf>



Successful Practices in Accountable Care: Mountain Family Health Centers

Health Center Profile

Health Center: Mountain Family Health Centers

Location: Colorado

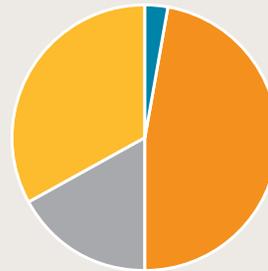
Number of unique patients served: 28,000

Number of sites: 4 sites located in Basalt, Glenwood Springs, Rifle, and Edwards

Services offered: Acute Care, Primary Care, Chronic Illness Care, Internal Medicine, Orthopedic Services, Pediatrics, Behavioral Health Services, Dental Services (Rifle), Prenatal and OB Services (Edwards), Care Coordination

Certifications: NCQA Patient-Centered Medical Home Level 3

Payer mix (approximate): 47% Medicaid, 33% Uninsured (down from 48% before Medicaid expansion), 17% Commercial, 3% Medicare/CHIP



■ Medicare/CHIP
■ Medicaid
■ Commercial
■ Uninsured

Source: Brooks, R. (2016 May 16). Telephone Interview

Laying the Foundation

Mountain Family Health Centers (MFHC) is a health center program grantee located in western Colorado between Vail and Aspen. Since opening in 1978, MFHC has expanded to include four sites spanning 150 miles and serving approximately 15,000 patients each year. Over the past four years, this organization has committed itself to implementing a care model that promotes value rather than volume-based care. Despite major challenges including financial instability, a changing state payment landscape, and an expensive commercial health insurance market, MFHC is well on its way to achieving its goal of having majority value-based contracts. The story of how this organization was able to make this transition imparts many lessons, particularly for health centers who are wondering how to begin moving toward value-based care. This document is primarily based on an interview with Mr. Ross Brooks, Chief Executive Officer of Mountain Family Health Centers and Dr. Amy Ryn, DO, the Chief Medical Officer. Any data and figures are shared with permission. Quotes have been edited for clarity.

Getting Out of the Financial Hole

When Ross Brooks became CEO in 2012, MFHC was in what he calls “a financial mess.” At the time, the health center had a deficit of almost \$500,000. To help recover, MFHC tightened all vendor contracts, froze salary increases and hiring, froze employee retirement contributions, and reduced non-strategic travel. They also began implementing productivity standards for all care teams. For example, care teams were expected to see an average of 22 patients a day and there were financial incentives for reaching 3,400 or more visits per year. These standards were not popular among staff. Mr. Brooks had a goal that once the health center was financially stable, MFHC would move towards a value-based system of providing care and create contracts to reward this new system.

Moving to the Next Level

For two years, MFHC worked to regain financial stability and by 2014, finances were stable. MFHC was ready to start moving towards a value-based model of care. They decided to pursue a value-based contract with Rocky Mountain Health Plans (RMHP), a non-profit health insurance provider with lines of business that serve commercial, Medicaid, Medicare, and Child Health Plan Plus (CHP+) populations¹. Additionally, RMHP is one of seven Regional Care Collaborative Organizations that comprise Colorado Medicaid's Accountable Care Collaborative, which is designed to create medical homes for Medicaid beneficiaries and improve transitions of care.

In this contract, known as Payment Reform in Medicaid Expansion (PRIME), Mountain Family Health Centers receives a global capitated payment with incentives for improving population health and lowering cost for a population of Medicaid patients. The health center has an opportunity to share in the savings based on cost control, patient engagement, and quality improvement measures. According to Mr. Brooks, this contract was the basis that allowed them to shift towards value-based care and away from volume.

A Shift in Priorities

With the PRIME contract in place, MFHC made other changes, including decreasing the number of patients seen per day for each provider and decreasing their overall patient panel sizes. They were able to do this because of an increase in their Medicaid population size due to expansion and a decrease in the uninsured population. As the Medicaid population grew, they were able to reduce patient panels. Other changes that made this transition possible was a simplified workflow, maximization of EHR capabilities, and hiring of additional staff. Mr. Brooks notes that MFHC made significant investments in hiring staff, about 15-20 people total, in varying roles including behavioral health providers,

community health workers, patient navigators, complex care coordinators, and quality improvement program experts. MFHC receives approximately \$1 million annually from Rocky Mountain Health Plans in operations funding to support these positions.

One of the biggest changes that MFHC made was to move away from using volume-based incentives and toward using only quality-related incentives for all of their care teams. These new incentives are tied to measures from both the Uniform Data System (UDS) and the PRIME contract and are chosen based upon priorities identified by MFHC senior leadership and a provider leadership committee each fiscal year. Some examples of the measures from the 2015 fiscal year are cervical cancer screening, colorectal cancer screening, and BMI (Adult and Pediatric), all of which have seen improvements in the past year. Amy Ryn, DO, Chief Medical Officer of MFHC notes that although new priorities are identified annually, MFHC makes an effort to maintain the progress made on all measures. Once a measure is identified and progress is made, they try not to lose ground even after new measures are added.

She says:

[It] is important to make the habit, rather than [approaching it as if]... it's just this little project and it's done. No, if we're going to improve our colorectal cancer screening, we really have to figure out how to do that and then implement the workflows and then keep them [improving] rather than sliding back.

1 About RMHP. Rocky Mountain Health Plans. Retrieved from: <http://www.rmhp.org/about-rmhp>

Challenges, Rewards, and Lessons Learned

Challenges

One of the more difficult challenges to overcome was the ingrained idea of volume-based productivity as the standard for success. Mr. Brooks says it acted as a “security blanket” for all providers because it was what they had known for so long. Mr. Brooks and Dr. Ryn agree that implementing change management processes was key to overcoming this and is something that continues in the present day. For example, there was a major focus on training when the new incentives were first implemented. The Quality Improvement (QI) team, which includes a QI/ Compliance Manager, QI Coordinator, and Compliance Coordinator, traveled to each site to provide training to staff on the new measure implementation. They also used their provider leadership committee, made up of the Medical Directors from each site as well as the CMO, Behavioral Health Manager, and an alternative medicine provider, to disseminate information to all physicians.

Mr. Brooks says:

For the most part I would say our team is collectively on board with the movement. Once providers started to see that having behavioral health as part of the team, complex care nurses as part of the team, and patient navigators as part of the team it helped their patients improve and also helped them get home a little earlier at night, it became an easier sell at that point.

Another challenge that MFHC continues to face is what Mr. Brooks describes as “trying to execute the future you want to see.” MFHC is in the process of trying to move to a value-based system even though the majority of their contracts are volume based. Therefore, their ongoing challenge is to try to move payers towards value-based

contracts. They approach this by partnering with their PCA, payers such as Rocky Mountain Health Plans, and other providers to push for value-based contracts

Rewards

Mr. Brooks says the biggest reward has been bringing the joy back into health care delivery for providers. “[We want to make it so that] for doctors, nurses, dentists, behavioral health providers, administrators, community health workers, it is joyful to work in the healthcare industry,” he says. MFHC has seen improved provider happiness and a drop in turnover rates in the last two years, although it is too early to determine if this a long term trend. In 2015, MFHC was recognized as one of the best companies to work for in Colorado by ColoradoBiz Magazine².

Additionally, since implementing this new approach they have seen improvements in their UDS measures. As of April 2016, they have met or exceeded clinical performance goals for measures on childhood immunizations, diabetic control, hypertension control, tobacco screening and cessation, child weight assess & counseling, adult weight assess & follow-up, depression screening and follow-up, 1st trimester entry into care, births > 2,500 grams, and CAD lipid lowering. The total cost of care has also decreased. In 2015, the total cost of care at MFHC was \$146 per member per month, compared to \$166 Per Member Per month in 2014.

² Ryckman, L. (2015 Oct 30). Best Companies to Work For 2015: Mountain Family Health Centers. ColoradoBiz. Retrieved from <http://www.cobizmag.com>

Next Steps

Mountain Family has several priorities for the future. First, they want to move more of their Medicaid population into the PRIME contract. Second, they want to begin to conceptualize the funding they receive to care for uninsured patients as a primary care capitation payment with small quality improvement awards. In doing this, they hope to extend the methods they have been using with their PRIME population to their uninsured population.

Lastly, they are working with hospitals in their area to move towards a value-based payment system for Medicare patients. Because of MFHC's low market share, the commercial market is the lowest priority. In 2 years, Mr. Brooks hopes to have at least 50% value-based contracts. He says, "I think we're moving towards why people went into healthcare in the first place, which is to improve the health of their friends, neighbors, and family members and that's very rewarding to see in action."

This document was produced by the National Association of Community Health Centers.

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