American Hospital Association

Yuma Hospital District – Yuma, Colorado

How a Patient-Centered Medical Home Opened the Door to Health Reform

Sometimes leadership means knowing when to follow someone else's lead.

John Gardner, FACHE, CEO of Yuma Hospital District in Yuma, Colorado, chose to do just that. He simply said "yes" at the right time, a decision that has put him, his hospital, and his community way out in front of the crowd. Through his leadership, Yuma District Hospital, a 12-bed public, nonprofit critical access hospital, is now well positioned to improve outcomes, expand access, and reduce costs. On top of those benefits, Mr. Gardner also discovered a new revenue stream – reimbursement from the state of Colorado for serving as a primary care medical provider (PCMP) and medical home for Medicaid patients.

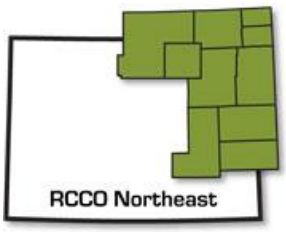
Colorado Accountable Care Collaborative

A PCMP is a Medicaid client's main health care provider. It is a Medicaid client's medical home, where he or she will get most of their health care. When a Medicaid client needs specialist care, the PCMP will help him or her find the right specialist. All clients enrolled in the Colorado Accountable Care Collaborative (ACC) have a PCMP.

When the State of Colorado Department of Health Care Policy and Financing was looking to improve quality while reducing costs for its Medicaid program, it looked toward an accountable care model for the fledgling Colorado ACC, which is a new Medicaid program using three major components: primary care providers, regional care coordination organizations, and a statewide data and analytics contractor to achieve two central goals:

1. Improving health outcomes for Medicaid clients
2. Controlling costs through all of the following:
    - Integrating the principles of a patient-centered medical home (PCMH) model
    - Applying best practices in care coordination and medical management
    - Combining unprecedented access to client data to move away from the current system of fragmented volume-driven, sick care and toward an outcomes-based, efficient, health improvement model of care

Colorado cast its net wide to establish several Regional Care Coordination Organizations (RCCO) to provide medical management, care coordination, and provider support. Colorado Access was contracted for the northeast (see map) to establish a Medicaid ACO using a primary care case management model. Yuma District Hospital's PCMH fit the model perfectly, and John Gardner led by following as a partner in Colorado Access.



'It Sounded Like a Good Idea…'

Mr. Gardner and his board were originally motivated to transform Yuma Hospital District's clinics into PCMHs because they were intrigued by the possibility that this could be the best way to care for their patients. But also entering into the decision was "significant community dissatisfaction with the way things were going." Like other rural towns historically, Mr. Gardner says that Yuma previously had "docs who lived in the community, worked 120 hours a week, never said no to anybody for anything… In order to get new physicians to come to 'frontier-land,' we looked at a model where they could live on the 'front range,' near the mountains or in the mountains. I ended up with four part-time physicians who split the week" – not an ideal situation under any circumstances.

Mr. Gardner's PCMH journey began four years ago, when several "safety net" clinics in Colorado were selected by the Colorado Community Health Network to take part in a five-year demonstration project initiated and funded by Qualis Health in Washington State, The Commonwealth Fund, and the MacColl Center for Health Care Innovation at the Group Health Research Institute. The Safety Net Medical Home Initiative focuses on helping primary care safety net sites become high-performing PCMHs and "achieve benchmark levels of quality, efficiency, and patient experience." Its goal is "to develop and demonstrate a replicable and sustainable implementation model for medical home transformation."

Through this initiative, the Colorado Community Health Network, a group of mostly federally qualified health centers (FQHCs), provided technical assistance for these clinics to become PCMHs. Mr. Gardner explains how Yuma got involved in the initiative: "Somewhere along the line, somebody said, 'We ought to have an RHC (rural health center) in this mix. They're safety net providers too.' So they came to us and asked if we'd be interested in getting technical assistance to do a PCMH. At that point I didn't know what it was, but it sounded like a good idea, so I said okay."

Yuma Clinic

Baby Steps

However, PCMHs are structured, monitored, measured, and carefully reviewed by the National Committee for Quality Assurance (NCQA). The care management activities of the PCMH must be thoroughly understood and integrated into the functions of the provider in order to obtain certification by NCQA.

Yuma has been "baby-stepping," Mr. Gardner says. The hospital is starting with patients who have diabetes, hypertension, or a combination of both. These patients, he says, constitute a "fairly large part of our population." Staff have spent the past three years working with consultants to get the Yuma clinics organized around NCQA standards for a certified PCMH. Yuma has developed provider teams and a process for assigning patients to those teams; they've hired two patient navigators who have been extensively trained in health coaching; and Yuma's IT department has been actively involved in creating new ways to track and monitor patients.

Mr. Gardner emphasizes that care coordination in a PCMH requires thoroughness and clarity. "The key is, you've got to be organized to do this right," he says. "You've got to get all your processes in place – communications, information management – that's all got to be there. You'll get eaten alive if you don't have that stuff in place."

Akron Clinic

What could happen? "You won't be able to adequately manage your patients. These patients are difficult. They need behavioral and social support," the kind of assistance that a nearby health and social service agency, North Colorado Health Alliance (the Alliance), will provide to Yuma's clinics. This is a benefit of being part of the RCCO – a community service organization handles the non-medical elements that impact health, like behavioral health care, arranging for transportation, helping with financial management, "the whole gamut of social barriers that can get in the way of good health," Mr. Gardner adds. Plus, the Alliance will initially supply someone to help Yuma plug into those resources when needed.

Going through this medical home process, he reports, helped them create communication systems to make sure there were good patient hand-offs. "Now we can tell a patient, 'Mrs. Smith, your physicians are Dr. A and Dr. B' – there'll be some consistency. And our patients are starting to see that. Mrs. Smith may have really wanted to see Dr. A, but he's only there on Monday and Tuesday, and she's sick on Friday. But Dr. B comes in to see her, and he knows all about her. She doesn't have to re-tell her story every time."

Mr. Gardner is convinced that the certification process, while demanding, "was necessary to get everybody to really understand what the heck we were doing and why we were doing it. It was an

incredible educational experience for all of the management and providers. We wouldn't be where we are today if we didn't go through that process."

More Reimbursement, Better Data, Higher Quality, Lower Costs
Colorado Access will pay participating PCMHs $2 per member per month, plus another $1 per month if some "pretty reasonable" goals are met: reductions in 30-day readmissions, ED visits, and high-cost imaging. "The nice thing is," according to Mr. Gardner, "they are region-wide goals, so I don't have to be so rigid. If other clinics in the region are managing their patients well, I still benefit." On the other hand, if the region's goals are not met – even if Yuma itself meets them – no one in the region receives the additional incentive payment. Yuma will continue to be reimbursed on a fee-for-service basis for medical care provided to Medicaid patients. PCMH services include only patient care management.

Another huge advantage of being part of the RCCO is access to the wealth of data available to help with patient care management. "They've got some data analytics capabilities that there's no way we could match. So they're going to give us a lot of the analytics to help us drill down with this patient population to figure out where the 'problem children' are, in terms of case management." After looking at the data and identifying this high-risk pool of people who could benefit from patient care management, "then we'll sit down as a team to develop an action plan for these challenging patients." Mr. Gardner estimates that approximately 25% would need care management – so Yuma Hospital District can (1) deliver the kind of services these people really need, and (2) help reduce the financial burden they represent to the provider and to the state of Colorado.

Looking Toward the Future
Mr. Gardner explains that, currently, the hospital has no obligations to refer to partners in the RCCO, and only loose-knit connections exist with other hospitals or systems; specialists come in from two or three different systems throughout the month. As of now, nothing's exclusive.

But he predicts that "once we've addressed all the low-hanging fruit in terms of opportunities to reduce costs, then [the RCCO] may go after more of the value-driven referrals." High-cost, low-value procedures like CT scanning and MRIs already require a pre-authorization. Mr. Gardner explains that the state had wanted to institute a pre-authorization process for any referral to a specialist, but a recent statewide meeting seemed to stop that, for the moment. "For us out in the rural areas," he says, "that would be horrible."

By assisting Medicaid clients in getting connected to a primary care medical provider as their medical home and by ensuring that medical, specialty, mental health care, and other related services are well coordinated, clients' experience in the health care system will improve. By having a primary source of medical care that attends to both sick care and wellness and prevention activities, the overall health of Medicaid clients will improve. When clients are more satisfied and empowered in their health care decisions and overall health improves, the total cost of care is reduced.

What does the future hold for the RCCO and the PCMH model? Mr. Gardner guesses that, if enough providers buy into it, in three or four years, they'll be more into value-based purchasing, "if it gets traction." When he thinks in terms of access to care, Mr. Gardner views these changes positively. "They may give our community a little more stability," he says.

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