Strengthening Primary Care for Patients:

Rocky Mountain Health Plans | Grand Junction, Colo.

Background

Grand Junction, Colo., has for years been lauded as a prototype of what U.S. health care should be: a community that consistently provides high-quality care at among the lowest costs in the nation,[1] with average per capita Medicare spending almost 27 percent lower than the national average.[2] Rocky Mountain Health Plans (RMHP), given its high market share, community-based focus and close alignment with providers, is one of the main forces that contributes to these low costs and high levels of access.[3]

At RMHP, providers are paid similar enhanced rates for publicly insured patients in a risk-sharing system that integrates commercial patients, improving health equity for all in the community.[4] The plan shares individual provider performance data with physicians in the Mesa County Physicians Independent Practice Association (MCPIPA), which reduces utilization due to peer review and simultaneously rewards providers for quality performance with incentive programs.

Because RMHP is a nonprofit, unspent funds are returned to providers at the end of each year, rewarding them for efficiency.[1] Primary care providers are reimbursed for visiting patients in the hospital and supporting transitions of care, which improves follow-up care and readmission rates, and prenatal care is available to all women in Mesa County.[3]

Implementation

RMHP has been involved in several initiatives to transform primary care in the community.

Expanded Care Model

In 2000, RMHP began a pilot project to improve management of chronically ill patients by training 80 primary care physicians on the Expanded Care Model (ECM), previously known as the Chronic Care Model, and paying them bonuses for meeting

Initiative Titles: Community Care Model; Colorado Beacon Consortium; Comprehensive Primary Care initiative

Beacon Program
Start Date: 2010
Practices: 51
Physicians: 153
Covered Lives: Over 200,000

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quality outcomes related to diabetes.[5] The ECM, which was developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute, combines clinical information systems, decision support, delivery system design, self-management support and community and organizational leadership to create a patient-centered, proactive health care team to care for patients with chronic diseases.[4]

RMHP supported provider skill-building in the areas of patient self-management, asynchronous planning and continuity, "in-between visits," patient registries and integration of community resources. The plan built an electronic registry of patients that physicians could access and included information on best practices and evidence-based medicine around several parameters, including diabetic retinal exams, blood pressure, peripheral neuropathy exams and hemoglobin $HbA1_c$ levels. RMHP paid physicians an average of $5,000 per provider per year for meeting quality goals.

Their work with the ECM led to significant improvements in care quality, including reductions in $HbA1_c$ levels, reductions in cholesterol and blood pressure and increases in the number of patients taking a daily aspirin.[5] The pilot project earned RMHP the 2006 America's Health Insurance Plans Foundation Chronic Care Award.

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Medicaid Regional Care Coordination Organization

The Medicaid Accountable Care Collaborative program is designed to establish accountability for cost management and health improvement among Medicaid populations, while improving patient experience, access to care, care coordination and medical management.[6] RMHP is one of the Regional Care Collaborative Organizations (RCCO) implementing this program, and is working with local public health agencies, federally qualified health centers, hospital districts and foundations to create community care teams.

Each care team is structured to include a trans-disciplinary mix of behavioral, social and health and wellness skills, along with non-licensed community health workers ("promotoras") to extend the reach of primary care medical homes. The teams are integrated PCMH participants, but link navigation, transportation, mental health and substance abuse services well beyond the walls of the office setting. RMHP does not employ team members; rather, teams are funded by RMHP through community delegation agreements, with additional financial and operational support by participating physicians, hospitals and local agencies.

Through its role as a RCCO, RMHP assists patients in navigating the Medicaid program, and aids providers who are seeking help in contending with state administrative systems and processes. It is assisting practices with the transformation process and supports providers with care coordination resources by working collaboratively with medical and behavioral health providers to ensure that members have access to appropriate services. RMHP is receiving data from the Colorado Department of Health Care Policy and Financing, which administers Medicaid in the state, and provides analytic tools and supports to practices and teams so that they can risk-stratify the patient population and target their activities effectively.

Colorado Beacon Consortium

In 2010, Grand Junction, Colo., and the surrounding six rural counties were chosen as one of 17 Beacon Communities by the Office of the National Coordinator for Health Information Technology in the Department of Health and Human Services. Rocky Mountain Health Plans serves as the lead grantee to build and strengthen local health information technology infrastructure and test innovative approaches to improve health care quality and cost.[7] The three-year, $12 million grant aims to transform practices by improving care coordination and care transitions, supporting the health of the entire community.

Most of the grant went toward the expansion of infrastructure within Quality Health Network (QHN), a regional health information exchange in western Colorado. QHN now supports advanced population health and care management tools, in addition to traditional health information exchange routing and alert functions. Additional Beacon funds go to support practice transformation and broad-based learning collaborative systems throughout the seven-county region.

Quality Improvement Advisors (QIAs) lead transformation efforts among the Beacon practices. Although they are based in the RMHP office, QIAs are assigned to practices and visit twice a week, helping staff redesign work flows to increase the efficiency and quality of care delivered. The QIAs regularly review data with their primary care partners to identify gaps in care and areas of improvement for all patients in Beacon practices, not just those with RMHP insurance. They also meet regularly to discuss experiences across the different practices.

Applying Lessons Learned

Through the Beacon program, RMHP reinforced the importance of interventions in primary care offices, transformation through PDSA (Plan-Do-Study-Act) cycles and population management.

RMHP is piloting a continuation of the program among ten Beacon practices through its Masters 2013 initiative, for which it is offering financial support to practices to provide focused care management to 20 of their patients, with a focus on decreasing total cost of care. RMHP functions as a technical advisor and business associate to the practices and supports measurement and data extraction across the entire patient panel without "payer segmentation." For example, when practices set up programs for communicating with emergency departments and hospitals, those technologies and work flows are applied to all patients.

> Rocky Mountain Health Plans is applying the lessons it has learned in each program to further transform primary care in the Grand Junction, Colo. region.

RMHP is also paying QIAs to facilitate transformation in practices that were not part of the Beacon consortium through its Foundations course, mimicking the process each Beacon practice went through and encouraging development of care teams and use of PDSA cycles to improve quality metrics.

In addition, Rocky Mountain Health Plans is one of two facilitators of the Centers for Medicare and Medicaid Service's Comprehensive Primary Care initiative (CPCi) in Colorado, with oversight over the western part of the state, where RMHP is located.[8] The CPCi is a multi-payer initiative to strengthen primary care through bonuses to primary care physicians who coordinate care for their Medicare patients; fourteen practices and five payers (public and private) are part of the initiative in western Colorado. CPCi milestones that RMHP is working on together with practices include care management, quarterly quality metric reporting and collaboration. QIAs are involved with the CPCi practices, building on their experience with the Beacon program.

With regards to care collaboration, RMHP is encouraging use of electronic medical records and coordination among sites of care such as primary care offices, emergency rooms and hospitals. The plan wants to ensure that primary care physicians can interface with hospitalists during admission and that primary care providers are given information upon patients' discharge from the hospital. It is focusing on ensuring that information is not only received by each provider, but also acted upon in an efficient, targeted manner.

Sustainability

RMHP and the QIAs have been able to benefit from the experience gained in each successive program; their work with Beacon sites is currently being applied to the CPCi and Masters practices and will inform future practice transformation efforts. It is also funding learning collaboratives for all practices involved in these programs — Beacon, CPCi, Masters and Foundations — for further sharing of best practices.

One way RMHP is ensuring sustainability is by not prescribing the specific actions that clinics must take. The QIAs work as advisors in each clinic through a consulting role; rather than defining which specific reforms must be implemented, they help practices achieve goals that are set out by providers and staff. For example, if a clinic aims to improve end-of-life care and increase use of advance directives, its designated QIA has the capability to interface with other QIAs and community-based organizations to facilitate their implementation.

Outcomes

A 12-month analysis of the first two groups of practices engaged in the Beacon program found increases in patients with low cholesterol (39 to 53 percent), increases in tobacco counseling (from 25 to over 50 percent of patients) and increases in depression screening for diabetes.[7]

Scale

RMHP recognizes that not all practices want to transform through these programs or in the same timeframe. Therefore, it is rolling in programs gradually and allowing practices to join when they are ready. For example, in July 2013, RMHP will be launching a new program to encourage development of care plans for high-risk patients and will give practices that are currently unaffiliated with one of the transformation initiatives lists of high-risk patients. Eventually, it wants to incorporate all practices on the Western Slope in its service area to the Foundations program.

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[1] Scanlon, Bill. "Grand Junction, CO: Still the Health Care Poster Child." *Kaiser Health News*. 19 August 2010.
[2] Bodenheimer, Thomas and West, David. "Low-Cost Lessons from Grand Junction, Colorado." *New England Journal of Medicine*. 363 (2010): 1391-1393.
[3] Riccardi, Nicholas. "Grand Junction a Microcosm of Efficient Healthcare." *Los Angeles Times*. 14 August 2009.
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[5] Sipkoff, Martin. "Rocky Mountain's Success with Chronic Care Model." *Managed Care*. November 2006.
[6] "Provider FAQs". Rocky Mountain Health Plans. <http://acc.rmhp.org/providers_support/provider_faq.aspx>
[7] "Colorado Beacon Consortium." Office of the National Coordinator for Health Information Technology. 25 October 2012. <http://www.healthit.gov/sites/default/files/beacon-factsheet-colorado.pdf>
[8] "HealthTeamWorks, Rocky Mountain Health Plans to Coach Colorado CPCi Practices." HealthTeamWorks. <http://www.healthteamworks.org/news/coaching-cpci-practices.html>

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.

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