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**Successful Practices**

**IN**

**Accountable Care**

Numbers 1-24



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**El Rio Community Health Center**

**Sunset Community Health Center**

**Mountain Family Health Centers**

**Carolina Medical Home Network**

**Alcona Health Center**

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**Piedmont Health Services, Inc.'s PACE Program**

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**Understanding Risk**

**Provider HealthLink, LLC**

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**Iowa Primary Care Association**

**Successful Practices in Accountable Care: Model for Value Based Care and Contracting**

**Arizona Alliance For Community Health Centers: Oral Health for Whole Person Care**



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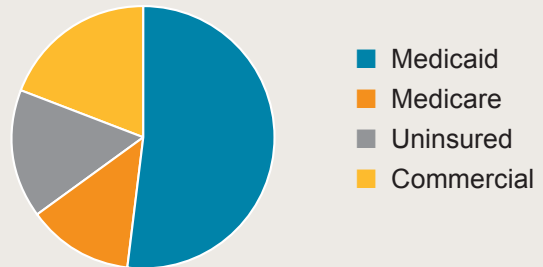


# Successful Practices in Accountable Care: El Rio Community Health Center

## Health Center Profile

**Health Center:** El Rio Community Health Center  
**Location:** Tucson, AZ  
**Number of unique patients served:** Over 85,000  
**Number of sites:** 14  
**Services offered:** Primary care, OB/GYN, Homeless care, Dental, Integrated SMI/PC Clinic, HIV/AIDS specialty care  
**Certifications:** NCQA PCMH Level 3  
**Unique Features:** Call center; group visits for new patients

**Payer mix (approximate):** 52% Medicaid, 13% Medicare, 19% commercial, 16% Uninsured (down from 30% before Medicaid Expansion)



Source: Johnson, N. (2016 January 22). Telephone Interview.

## Laying the Foundation

El Rio Community Health Center is a large, urban health center in Tucson, Arizona that began seeing patients in the early 1970s. Over the last several years, El Rio has become known for innovative practices and strong partnerships with local hospitals and managed care plans leading to outstanding clinical quality as well as reductions in overall costs. However, it wasn't always this way and El Rio's story of its journey to improve patient care is worth sharing.

About three years ago, El Rio began a shift toward population health. According to El Rio's CEO Nancy Johnson, the executive leadership saw a need to identify high risk patients as well as optimize the health of all patients through patient centered, coordinated care. It was around this same time that El Rio began to redefine its Medicaid managed care contracting relationship with UnitedHealthcare® (United) to be focused on patient-centered medical home. Once El Rio started down this path, United provided analytics tools to identify the patients predicted to have high expenditures using claims

data from previous years. Learning these skills led to better care management for all El Rio patients.

## Better Care Coordination by Assessing Risk

In addition to using the complex data analytics provided by United and other payers to manage existing patients, El Rio started stratifying patients at the moment they establish care. The low risk or healthy patients receive outreach and engagement around annual visits, immunizations, and health education opportunities. The middle group of patients tend to have risk factors for, or show signs of, early disease onset. They are connected to resources focused on prevention of disease progression. The third group of patients are high risk and very complex. They also tend to be highest service utilizers. Care for this group usually requires a team approach to decide how to best allocate resources for patient care.

Creating this stratification helps direct patients to the services they need in a timely manner which, in turn, enhances the patient experience. For example, El Rio

offers new patient group visits for what they consider their healthiest patients, defined as having 3 medications or less. During these visits they are able to meet the provider and care team, see the facilities, and have their initial clinical intake completed. Not only does this help with scheduling issues, but, more importantly, it allows each new patient to have the best possible experience establishing care.

To further underscore this point, Dr. Johnson said:

*“We have so many patients trying to establish care and ... you want them to see the depth and breadth of services that are available for them. You want them to feel welcome, you want them to have that world class experience and because of the demand we just weren’t having enough new patient appointments available and time we wanted to spend with people wanting to join El Rio as patients. So that’s why we started crafting these [visits] at our major health center [site].”*

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## Navigating Payer Relationships

Dr. Johnson considers El Rio’s partnership with United to be a good one. As result, the relationship has endured for many years and has led to the development of several different lines of business. The current Medicaid managed care contracting methodology, which has about 22,000 members, contains a Per Member Per Month (PM/PM) payment with additional incentives around indicators from the Health Effectiveness Data and Information Set (HEDIS) and utilization measures such as ER visits and hospital readmissions. As mentioned previously, El Rio receives detailed analytics from United about these patients, but they also provide additional resources.

When El Rio was initially looking into population health management of patients, United offered to provide additional nursing staff for utilization review and follow up. El Rio preferred to have United work within their existing model of care. This would allow El Rio to use their existing relationships with both patients and community partners, which they felt would be most effective. Dr. Johnson describes it this way:

*“We [told] United: ‘We know these patients.’ Our nurses, our care coordinators, our end care coordinators ... usually know these patients. They have much more influence over patient engagement, patient adherence to their medicines, keeping their appointments, all those sort of things so... we prefer if you work and support us within our system.”*

United was willing to work within El Rio’s existing model of care rather than switch to a more centralized model. United provided a population health manager to work with existing El Rio nursing staff on a weekly basis. As a result, El Rio thoroughly understood the data it was receiving from the plan which improved care coordination. With this critical patient level data, El Rio staff was able to practice population health and demonstrated high performance on many measures including a nearly 25% decrease in hospitalizations and emergency room use.

El Rio is now mirroring the process used with United with other payers and on all patients. They share gross data with health plans to demonstrate what they have been able to achieve. This data demonstrates the effectiveness of having Health Center staff working directly with patients versus hiring more on the payer side. Some payers are willing to try this more decentralized model while others are more hesitant. Either way, El Rio is confident they are providing high quality care and continue to reach out to payers willing to partner.

When asked what she thinks payers want to see first and foremost from a health center when developing a contracting relationship, Dr. Johnson discussed several areas:

*“I think you first have to demonstrate you’re in a growth mode, you’re willing to provide easy access... [and] have the capacity to see [patients] in a timely fashion. I think the payer is looking for someone who is willing to engage around quality improvement, who wants to be data driven... the payers are looking for people who will look at the data, who will create operational change to achieve the outcomes, and who, I think, are willing to try new things.”*

Lastly, El Rio believes the key to its success is understanding its own performance data as much as possible and being prepared to find the resources needed to improve your outcomes. Dr. Johnson says, “[W]e spend time talking to [payers] about resources we need for our patients, how they might look at their benefits, [and] what might help in reaching some of our shared goals.”

## Next Steps

The local health department in Pima County recently released its 2016 Community Health Needs Assessment and identified four key areas of priority: addressing anxiety and depression spectrum disorders, substance abuse and dependency, injuries and accidents, and diabetes. As a major provider of care in Pima County, El Rio feels that they are currently on the right track in addressing many of these issues. For example, all patients have a depression and substance abuse screen regularly. Behavioral health services are integrated into primary care and there is a large initiative around diabetes through a clinical pharmacy based model.

In its evolving relationship with United and other payers, El Rio is constantly refining its methods and making improvements to its care model, while also seeking opportunities for earning revenue. In the future, Dr. Johnson would also like to begin gathering data to study the impact of El Rio’s current interventions around social determinants of health on the health status and service utilization of patients. Lastly, El Rio is currently having conversations with United about telehealth initiatives that they want to implement with certain classes of patients, including e-visits.

As you can see, there are many exciting things on the horizon as El Rio continues to grow and innovate. Dr. Johnson’s passion for this work could be felt throughout our conversation but is best summed up by this quote: “We’re excited to continually grow... [We] started out in 1970 as the last place to get care if everybody else fails you, and it’s so nice to see the health center as being the provider of choice and place that you want to go to get care.”

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

For more information contact:

Ashlee Wimberly at [awimberly@nachc.com](mailto:awimberly@nachc.com)

Special Thank you to:

Nancy Johnson, CEO, El Rio Community Health Center

Dr. Johnson may be reached at [nancy@elrio.org](mailto:nancy@elrio.org)

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## Successful Practices in Accountable Care: Sunset Community Health Center

### Health Center Profile

**Health Center:** Sunset Community Health Center, Inc.

**Location:** Yuma County, Arizona

**Number of unique patients served:** 28,000

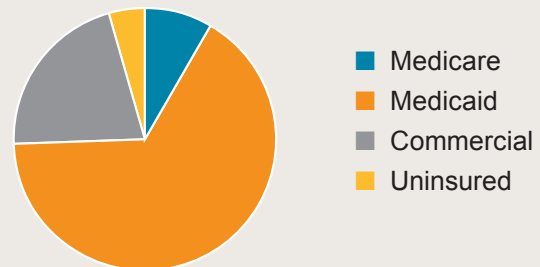
**Number of sites:** 5 main sites, 4 school based health sites

**Services offered:** Pediatrics, Internal Medicine, Family Medicine, OB/GYN, Dental, Behavioral Health services, & enabling services (CHW education, eligibility, and outreach)

**Certifications:** NCQA Patient-Centered Medical Home Level 3

Source: Rogers, D. (2016 February 11). Telephone Interview

**Payer mix (approximate):** 8.6% Medicare, 66.1% Medicaid, 20.9% Commercial, 4.4% Uninsured (down from 12-14% before Medicaid Expansion)



### Laying the Foundation

Sunset Community Health Center, Inc. (Sunset) is a Federally Qualified Community Health Center (FQHC) located in the southwest corner of Arizona. It is the largest provider of primary care in Yuma County, serving approximately 28,000 patients across nine sites. It is also the largest Medicaid primary care provider in the county.

Sunset's largest Medicaid managed care contract is with UnitedHealthcare® (United), which also happens to be the largest Medicaid Managed Care Organization in Arizona in terms of enrolled members. The evolution of this contract tells the story of how this health center was able to implement changes in its care delivery model to achieve meaningful results in a relatively short period of time. There are also valuable lessons to be learned from how Sunset approached the contract negotiation process and its relationship with this payer. This document is primarily based on a phone interview with David Rogers, the CEO of Sunset. Any data and figures are shared with permission. The quotes have been edited for clarity.

### Pre-Accountable Care at Sunset

In the summer of 2009, the leadership of Sunset had a meeting with representatives from United. Per David Rogers, "It did not go well." At the time, Sunset had a capitated payment arrangement with United but was only seeing about 70% of their attributed patient population. United wanted Sunset to be more aggressive and see more patients, and recommended changing the care delivery model to improve access. United's target penetration rate for Sunset was 92-95%, and wanted it to focus on high care utilizers.

Because of the perceived low penetration rate, Sunset was unable to accept new United members and mandated targets were set by United. The targets included four areas of focus: improving access to care by increasing the number of same day appointments, reducing non-emergent ER visits, reducing admissions and readmissions, and improving care of high-risk patients by increasing the number who have a primary care physician visit within 90 days. Furthermore, if Sunset was



not successful at improving access for assigned United patients, it would be moved from its capitated payment to a fee-for-service model. Sunset wanted to serve as many of these patients as possible, but needed assistance building that capacity. Needless to say, the staff felt misunderstood.

**Mr. Rogers says:**

*“I obviously was defensive of my organization, because I know we work really hard ...and we were providing a lot of patient care and for them to come in and imply and suggest that we completely revamp our system and cater towards that Medicaid population when we had another 10,000 patients to see as well... we took offense to that.”*

At the same time, however, the issues pointed out during the meeting by United were not surprising to Sunset’s staff. They were aware of the problems with declining membership, patient access, and patient follow-up. In fact, they had already started to make changes including changing their EHR template to better accommodate ER and Inpatient discharges. “We were very protective of that payment arrangement at that time... And, quite honestly, what they wanted us to do, we were already working on, but we weren’t really communicating that effectively,” Mr. Rogers says.

Challenges aside, the meeting was a move in the right direction. According to Mr. Rogers, it was clear that neither party had a very good understanding of the other side’s perspective. United did not understand the challenges that Sunset faced as a health center. For example, Sunset had recently lost several providers and was in the process of trying to replace them. This was affecting their ability to see more patients. On the other hand, Sunset did not understand the pressures United faced. In spite of this, there was a willingness on both

sides to take the needed steps to increase the number of United patients being seen by Sunset’s providers. Mr. Rogers says, “At the end of the day, they still have a different mission than we do... and there has to be a balance between what their needs are and what our needs are and a true commitment to making changes that... reduce costs, improve the quality of care, and improve access.” The shared goal of and renewed commitment to communication and building trust were key to repairing this relationship and achieving results.

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## Time for a Change

Sunset and United identified several areas of improvement to help address the issues they were facing and are listed below.

### UnitedHealthcare/Sunset Post Meeting Goals:

- Improve access to primary care
  - Increase membership
  - Reduce avoidable ER visits
  - Reduce avoidable Readmissions
- Obtain Level 3 PCMH Certification
- Better Sharing of Information
- Improve high-risk patient care

### Improve Access to Primary Care

Sunset changed its care model to improve access for Emergency Room (ER) and hospital discharges, including adding more same day appointments. They also expanded their physical space by adding more exam rooms. In support of this effort, United agreed to provide web-based data for its membership and assistance with the modification of Sunset’s Electronic Health Record (EHR) template to accommodate ER and hospital discharges. In addition to the EHR changes, they began using i2i and AZARA population health management software.

United also provided a Utilization Review (UR) Nurse at the local hospital specifically assigned to Sunset's membership. This UR Nurse was responsible for providing timely information on hospital admissions and discharges and had direct access into Sunset's appointment scheduling system, which could now accommodate additional patient visits.

### **Better Sharing of Information**

Sunset and United began meeting monthly to review Sunset's "scorecard", which shows Sunset's progress on agreed upon targets. Initially, these meetings included United's local plan CEO, CMO, project manager and care manager, as well as Sunset's CEO, CMO, Quality manager, COO, and outreach manager. They continue to meet to this day, although, executive level staff have phased out over time.

Mr. Rogers worked hard to create and maintain relationships with members of the leadership at the health plan, but he also brought in members of his staff so they would build these relationships too. In the early months, he traveled three hours to Phoenix to have breakfast with the CEO of the plan once a month. They would talk about how things were going and what each needed to be successful. Through these conversations, both sides were better able to understand and meet each other's needs.

### **Improve High-risk patient care**

In addition to increasing the number of United patients receiving care, Sunset also wanted to focus on improving care for high-risk patients. United provided Sunset with reports on high-risk patients using its predictive modeling tool. This practice continues to this day. Also, Sunset developed and implemented a care management team by hiring 4 chronic disease specialists for patient outreach and a RN Care Manager for discharge planning. These individuals have medical backgrounds and an understanding of the care requirements for high-risk patients. They conducted phone outreach to encourage patients to come to the clinic for regular care instead

of going to the ER. Mr. Rogers notes that hiring these new staff members and the resource allocation with existing staff was a costly endeavor (close to \$500,000). However, there was significant return on this investment, both in shared savings as well as improvement in quality outcomes. Most importantly, by building the expertise needed in house, he reduced his dependency on payers for information.

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## **Results**

Once Sunset began implementing changes in late 2009, it took about 9 months to see improvements. In the first year, Sunset was able to improve access to sites by almost 20%. They achieved this by increasing the number of same day slots and improving seven day follow up for ER and hospital discharges. In the first two years, avoidable ER visits were reduced by over 18%.

There were also many improvements from a process standpoint. Thanks to United, they were now receiving daily discharge information. Thanks to growth in Sunset's outreach team, they are effectively managing more of the sickest patients. Since they began this endeavor, they have seen a nearly 10 percent reduction in non-emergent ER visits and an astounding 25 percent reduction in hospital readmissions for their patients.

In 2012, Sunset was also able to move to a shared savings arrangement with United for its member patients. The shared savings is based on quality metrics, requiring Sunset to identify the sickest patients and work to better manage their care. Mr. Rogers estimates about 5 percent of this patient population is considered high risk (a standard industry number for an average patient panel). However, this small group accounts for approximately 60-70% of overall costs. To target them, Sunset used data provided by United to identify the highest risk cohorts and began working with the patients individually. As a result, United was willing to increase attributed Medicaid lives to Sunset thereby improving revenue. In 2009, Sunset saw 13,000 United patients, but today they see

over 21,000. The key to this growth has been increased capacity in terms of staff, physical space, and increased efficiency. The next step in this process is to extend the outreach strategies and population management system to all patients, including uninsured, other Medicaid and commercial clients.

**Mr. Rogers says:**

*“We’ve seen tremendous improvement. It has really benefited us, not just as having an opportunity to have some upside revenue or some additional revenue through shared savings, but I think that it’s helped us see what we’ve needed to modify not just for this project, but it’s all worked seamlessly with Patient Centered Medical Home, with Meaningful Use with capturing the information in our electronic health record. It’s all worked really well to help us stay on target with those initiatives.”*

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## Lessons Learned

When asked about the lessons learned, Mr. Rogers is very forthcoming; not only about where Sunset was but about the process it took to get where it is now. There have been many lessons learned on the path to accountable care.

**Lesson #1:** Know Your Contracts – The first lesson comes from the initial conversation between Sunset and United. From the Health Center perspective, they had little understanding of their capitated payment arrangement with United and of managed care in general. This made it difficult for Sunset to understand what was expected of them. They also had little understanding of what data they had and how they used it. “We were put in a position to rely on their data not ours,” Mr. Rogers says.

**Lesson #2:** Know Your Payers – this lesson relates to relationship building; Mr. Rogers recommends that health centers build relationships with individuals at the plan level who can influence decisions. The key is to focus on areas where the missions of the two organizations align: cost reduction, improved quality of care, and improved access. He also believes it is important to insist on working together to set baselines and targets. Again, this requires the Health Center to really know its data and understand its patient rosters/ panels.

**Lesson #3:** Patient Outreach – Mr. Rogers says the key to moving toward true population health management is outreach. He recommends investing in community health workers for outreach, and nurses for care management. This requires many phone calls but the key is to allow staff doing the outreach to also make appointments. He also recommends using population health management software as an add-on to your EHR.

**Mr. Rogers says:**

*“It [population health management software] allows you to implement interventions that are necessary to improve a particular area that you may be struggling with. Before, we never knew how bad we were doing...because we didn’t have any information to tell us that... Once a year, you’d run your numbers for your UDS... and ...hope they were going to work out ok so you really weren’t staying on top of it. I think with these new patient population strategies that we’re deploying we’re able to look at that stuff on a weekly, monthly, quarterly basis and so you make the adjustments much more timely which allows you to stay on target with your upward trends and improving clinical measures.”*

## Conclusion

Sunset Community Health Center was able to move from minimally understanding population health and managed care to negotiating a value-based payment contract with shared savings for its United Medicaid managed care contract. Several factors contributed to this successful transition. First, they were willing to change their model of care to improve access. They added appointment slots and increased patient outreach and follow up. Second, they invested in additional staff to improve patient care.

Although this required significant upfront investment, the improvement in quality outcomes was well worth it. Also, by building the expertise in house, Sunset was less dependent on the payer for information. Sustainability is important because plan leadership and even the plan itself can change very quickly. Lastly, Sunset committed to building relationships with United to help foster communication and trust. Underlying all of this was Sunset's commitment to providing excellent patient care, which will continue to be at the forefront of anything they do.

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

For more information contact: Ashlee Wimberly at [awimberly@nachc.com](mailto:awimberly@nachc.com)

Special Thanks to David Rogers, CEO of Sunset Community Health Center

Mr. Rogers can be reached at [drogers@sunset-chc.org](mailto:drogers@sunset-chc.org)

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# Successful Practices in Accountable Care: Mountain Family Health Centers

## Health Center Profile

**Health Center:** Mountain Family Health Centers

**Location:** Colorado

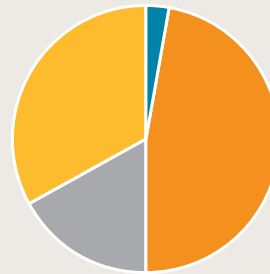
**Number of unique patients served:** 28,000

**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.

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## 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+) populations<sup>1</sup>. 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.

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## 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.*

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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 Magazine<sup>2</sup>.

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, 1<sup>st</sup> 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.

<sup>2</sup> 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.

Author: Ashlee Wimberly

For more information contact:

Shawn Frick, AVP, PCA and Network Relations at [sfrick@nachc.com](mailto:sfrick@nachc.com)

Special Thanks to

Ross Brooks, CEO of Mountain Family Health Centers

and

Amy Ryn, DO, CMO of Mountain Family Health Centers

Mr. Brooks can be reached at [RBrooks@mountainfamily.org](mailto:RBrooks@mountainfamily.org)

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



# Successful Practices in Accountable Care: Carolina Medical Home Network

## ACO Profile

**ACO Name:** Carolina Medical Home Network

**Location:** North Carolina

**ACO Type:** Health Center led (100% board representation)

**Member Health Centers:** Advance Community Health, Gaston Family Health Services, Goshen Medical Center Inc., Piedmont Health, Roanoke Chowan Community Health Center, Rural Health Group

**Medicare Shared Savings Program established:** 2015

**Number of attributed Medicare lives:** Approx. 15,000

Source: Eick, R. (2016 June 3). Telephone Interview

## Laying the Foundation

Carolina Medical Home Network (CMHN) is a health center-led accountable care organization (ACO) made up of six North Carolina health centers. Since January 2015, CMHN has participated in the Medicare Shared Savings Program (MSSP), which was established by the Affordable Care Act to “facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs<sup>1</sup>.” ACOs in the MSSP are responsible for improving care coordination, increasing quality, and decreasing the cost of care for an attributed population of Medicare patients (“attribution is the process of assigning patients to a primary care physician in a population health program). If they are able to achieve the required level of savings, the Centers for Medicaid and Medicare Services will give the ACO a share of the savings.

The MSSP gives participants an opportunity to test value-based models of care and offers unique benefits and challenges, particularly for health centers. As a fairly new MSSP participant, CMHN has a unique perspective on the application process, the implementation phase of the ACO, and goals for the future. The content of this paper is based on an interview with Dr. Robert Eick, MD, MPH, Executive Director of Carolina Medical Home Network. All data has been shared with permission. Quotes have been edited for clarity.

## Why the MSSP?

The North Carolina Community Health Center Association (NCCHCA) has played an important role in the development of this ACO. The process began in 2013 when the PCA formed an independent practice association (IPA) with 27 of its health centers in anticipation of Medicaid Managed Care in NC. The goal

1 Medicare Shared Savings Program. Centers for Medicare and Medicaid Services. Retrieved from: <https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/sharedsavingsprogram/index.html>

was to position health centers to have a stronger collective voice to approach negotiation with managed care plans. In 2014, the PCA and four members of the IPA formed Carolina Medical Home Network. According to Dr. Eick, they decided to pursue the MSSP to “help health centers get their feet wet in value-based care in a way that they have some skin in the game at least from an upside risk standpoint and that they could get shared savings if they performed well.”

They also understood that none of the health centers were in a position to participate in a fully capitated model, where they could be subject to large financial losses if they performed below a certain benchmark. By starting with the Medicare population, which is only 12% of the payer mix statewide, health centers could take on a reasonable amount of risk but would not be subject to any risk for at least three years. Additionally, the PCA had also laid important groundwork in terms of IT infrastructure through its Health Center Controlled Network. Because of this work, they were able to look at data on their population and were on the verge of being able to use that data on the ground to directly impact patient care.

Dr. Eick says:

*“The MSSP aligned with what we saw going forward as being important in terms of bridging the gap between having good clinical and claims data but then actually using that on the ground to improve patient care, utilization, and so on.”*

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## Building the ACO

CMHN considered many options when it came to how to manage its operations and ultimately decided to control it internally and not use a third party administrator, as many other Health Center led ACOs have done. Although they worked with a consultant to prepare the application, the majority of the work for the ACO was done in house. Dr. Eick says that there are several benefits to doing it this way, including having the autonomy to manage the ACO in the way that they wanted, being able to address issues that arise quickly, and having the opportunity to learn the

process. Dr. Eick notes that the drawback to this is there are time constraints due to the small size of their team. However, they are currently increasing their capacity. In January 2016, CMHN received ACO Investment Model (AIM) funding from CMMI. This funding has allowed them to hire a dedicated project manager (in process at the time of interview) as well as a care coordination manager who is located at the central office and works solely with 6 ACO members.

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## A Focus on Care Coordination

Care coordination is a key element of the Medicare Shared Savings Program. Based on managed care discussions held via the PCA, leadership understood early on that in-house care coordination was a priority for health centers. Therefore, in addition to the coordination manager that resides in the central office, there are individual care coordinators at each site dedicated to the Medicare population. Work at the central office focuses on data collection and applying it to care coordination and transitions of care while the staff at the individual health centers focuses on day-to-day operations.

The AIM funding defrayed the cost of implementing this. In fact, over 70% of the \$2.5 million dollars in AIM funding went directly to the health centers for care coordination. Dr. Eick says that this funding has been “pivotal in terms of actually enabling the health centers to clinically make a difference on the ground with the patients in the ACO.” They are now focusing on how to keep this sustainable once the funding ends. This strategy includes focusing on annual wellness visits, which reimburse well, and chronic care management billing (\$42 per member/per month), as revenue sources to support this work long term.

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## Data and Outcomes

The North Carolina PCA and HCCN have a strong working relationship focused around data utilization. In 2012, the PCA began to connect the safety net data to state health information exchange (HIE) claims. By connecting the HIE and data warehouse they were able to build a central

repository for health center data. Today, about of half the PCA members are connected. The data warehouse contains clinical EMR data and through their analytics partner, they also have access to Medicaid claims data (about 150,000 lives).

By participating in the MSSP, they now also have access to Medicare claims data for their attributed patient population across the across entire spectrum of care. They also have access to hospital feeds, which are updated several times per day, and provide information on admissions, discharges, ER visits and covers 85% of the Medicaid population of the state. Dr. Eick says this has helped them see when dually eligible patients are in the hospital so they can follow up and assist with transitions of care. Moving forward, CMHN is focusing on building internal capacity to analyze data, including claims, census, and UDS, to achieve a more complete picture of population health. This is happening in tandem with the next round of HCCN funding from the HRSA's Bureau of Primary Health Care.

The ACO reported on quality measures for the previous year in March 2016. Although the final results haven't been released by CMS, the preliminary data from quality scores and the patient satisfaction survey looks promising. Dr. Eick notes that of the measures that come directly from the EMR and where there are benchmarks, they performed better than the 50th percentile on the large majority. He also says that there is a benefit to participating as health centers because many of the MSSP measures are similar to what is captured by the Uniform Data System (UDS).

## Lessons Learned

Dr. Eick notes that there have been several lessons learned throughout this process.

**Lesson 1 - Leveraging health center strengths** - When bringing together multiple FQHCs, there are similarities but each also has its own culture and way of doing things. For the beginning of this process, it was evident that a major key to success would be getting them to work together and taking advantage of each health center's strengths.

Also, the MSSP application aligns well with what health centers are good at- Patient Centered Medical Home, population health management (particularly engaging subpopulations), and providing more holistic care (primary care, dentistry, behavioral health).

**Lesson 2 - Importance of data and applying it on the ground** - Dr. Eick says that through this process, they have identified clear areas for the ACO that are important. "For example, 40% of our ACO patients have diabetes, so there are certain measures that are very important because such a large part of our population has that condition and there are many comorbidities that come along with that," Dr. Eick says. Therefore, they have prioritized not only collecting data on these patients, but also using that data to inform their care.

Dr. Eick also highlighted the importance of being able to accurately capture data on patient populations served by health centers. This means focusing on proper coding, billing, and documentation. He says:

*"From an FQHC standpoint, anecdotally people have been saying 'our patients are sicker and more complex than the average private practice patient'. What we are realizing is it's key to have the data to back that up. It's not sufficient just to have this anecdotal evidence."*

**Lesson 3 - The process takes time** - Dr. Eick says "You hear people say that it takes about 18 months until you feel like you have your feet under you. We went into it thinking that we would move faster than that, but in actuality, the 18-month timeframe seems pretty true in terms of trying to sort everything out." The lessons learned during the initial months have been invaluable. He says:

*"This is helping our health centers and us identify and refine skillsets or capacities that are important for succeeding in value based healthcare. This is a relatively low risk way of doing that in anticipation of Medicaid reform... With that in mind, I see our ACO continuing forward, possibly adding other health centers... and continuing to deploy the capacity we are building"*

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

For more information contact:

Julie Bindelglass at [jbindelglass@nachc.com](mailto:jbindelglass@nachc.com)

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Robert A. Eick, MD, MPH

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## Successful Practices in Accountable Care: Alcona Health Center

### Health Center Profile

**Health Center:** Alcona Health Center

**Location:** Alpena, MI

**Number of unique patients served:** Over 27,000

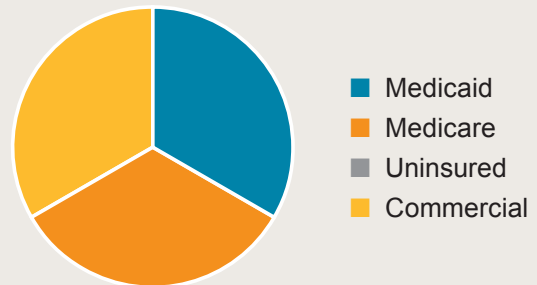
**Number of sites:** 18

**Services offered:** Medical, pharmacy, dental, behavioral health, pediatrics

**Certifications:** NCQA PCMH Level 2

**Unique Features:** Children's advocacy center

**Payer mix (approximate):** 33% Medicaid, 33% Medicare, 33% commercial, small portion uninsured



Source: Baumgardner, C. (2016 June 23). Telephone Interview.

### Laying the Foundation

Alcona Health Center (Alcona) is a Federally Qualified Health Center (FQHC) located in Michigan. With 18 sites across Michigan, Alcona serves over 27,000 patients. It is a level two Patient Centered Medical Home (PCMH). Approximately five years ago, the Chief Operating Officer (COO) of Alcona was serving on the state rural health association board when the discussion of Medicare accountable care organizations and rural health was discussed. The COO brought the conversation back to Chris Baumgardner, the CEO of Alcona, who in turn brought the subject to the Health Center's Board. In Chris's words, the idea of a Medicare ACO was an easy sell because it was "what we were already doing" with a large Medicare practice already established.

Initially, Alcona attempted to create their own Medicare ACO by working with an attorney to create a separate LLC (the Northern Michigan ACO). The Northern Michigan ACO consisted of Alcona, two other FQHCs, and two private practices. During this time they also worked with the Centers for Medicare & Medicaid Services to update

their information technology system. However, this attempt was unsuccessful due to problems the ACO faced in adequately attributing its patients. The algorithm used to calculate attribution only counted approximately 1,500 of their 7,000 Medicare patients. One attribution challenge they faced was having many "snow birds" who, once attributed, could leave making it difficult to accurately predict their numbers or retain them in subsequent years.

After the initial unsuccessful attempt, Alcona's lawyer reached out to discuss the possibility of joining the National Rural Accountable Care Consortium (NRACC) and its partner company, Caravan Health. NRACC had the resources to establish the ACO as well as support the work. Working with Lynn Barr at NRACC, Alcona continued on the accountable care journey.

Alcona's relationship with the other members of the ACO faced significant challenges at the beginning. In particular, after the first year, Alcona's participation was threatened due to the realization they were a significantly higher cost provider when compared to the other members of the ACO. Specifically, the Alcona providers were referring to a lot of high-cost specialists as well as using high-



cost services such as radiology. Rather than removing Alcona from the ACO, NRACC instead worked with Alcona to reduce costs through care coordination. One example Chris provided, which she says is indicative of the importance of accountability within an ACO, was hiring a new person to be in charge of the care coordination program to further progress and achieve greater results. Additional issues overcome during this time resulted in their hospital partners becoming stronger proponents of the FQHC model and creating strong physician champions.

Alcona has learned their patient population tends to face many chronic health issues, be older, utilize more services, and nearly one-third is on disability. Participating in the ACO has allowed Alcona to receive and utilize data to better understand their patient population and deliver care in a more effective manner.

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## Data Management and Analysis

When they first began the accountable care process, Alcona was using SuccessEHS which Chris said was good for collecting data but was only able to provide a flat file transfer back making it difficult to understand and utilize the data. By transitioning to the Lightbeam system utilized by NRACC and the ACO, Alcona is now able to receive information specific to their health center, passed through Medicare, and broken down by patient and practitioner. Alcona now receives a data feed monthly, if not weekly. They have been able to risk stratify their patients by a variety of factors, of which Chris says hospital utilization was key. One of the key lessons Alcona has learned is they “do not know what they do not know” and through better EHR utilization they have been able to better understand their population, including the critical fact that approximately 1/3 is on disability as noted earlier. Alcona now has a better understanding of patient needs.

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## Better Care Coordination

As a PCMH, Alcona had already been practicing care coordination; however, as Chris Baumgardner explained, “it was in a haphazard manner”. Caravan health provided the tools and training for nurses at Alcona to do better care coordination, contacting patients and working with local hospitals, in a more effective manner. This has been one of the key changes for Alcona. In some cases Caravan health will provide staff for care coordination; however, Chris warns that it has to be “culture change from the inside of the organization” in order for the efforts to be successful. It also helped Alcona to remember the patients, not the potential for financial gain, were at the core of their efforts.

Chris stated that the key elements of care coordination were successful

- chronic disease management through trusting relationships,
- patient-centered care using health coaching,
- partnering with primary care providers for a coordinated plan of care,
- connecting patients with community resources,
- optimally managing transitions of care, and
- avoiding duplication of services.

She says all of the elements and benefits coming from care coordination rely on patient engagement.

## Annual Wellness Visits

One of the other efforts Chris highlighted was Alcona's increased focus on annual wellness visits. She says they were previously completing two a day where they now are doing approximately two hundred! Moreover, the data shows not only is it a great revenue generator, it allows for better care. It required a team effort to increase their efforts in this area.

Alcona alerted providers to educate their patients on the importance of annual wellness visits, the nursing staff then followed-up with the patients to schedule appointments and take care of the administrative portion in advance by the phone. By eliminating the administrative portion of the visit, doctors were able to provide more hands-on care to more patients.

This is one of the other key lessons Alcona learned in the process of working with an ACO, which is simple solutions are often the best solution.

## Next Steps

Although Emergency Room utilization is still high in the Michigan area, through care coordination efforts Alcona is positive this will change in the near future. Alcona also plans to do greater inpatient follow-up, patient education, and address hospice costs. In the coming months, Alcona will learn how they performed on their quality measures and expects to see some reduced costs although they still do not expect to receive shared savings. Chris was quick to caution that an FQHC looking to participate in an ACO will not see savings for quite some time and this is a much longer process. When Alcona receives shared savings they look forward to sharing it with their staff to demonstrate the reward and payoff for the work put in by all to improve care.

Alcona is using the Accountable Care Organization as an opportunity to prepare for alternative payment models (APM). Michigan is one of a few states that will receive training and technical assistance from the National Academy for State Health Policy and Alcona plans to use one of their sites to beta test and further study APM. They are also under a state innovation model.

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

For more information contact:

Ashlee Wimberly at [awimberly@nachc.com](mailto:awimberly@nachc.com)

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Christine Baumgardner, Executive Director, Alcona Citizens for Health, Inc.

Ms. Baumgardner may be reached at [cbaumgard@alconahc.org](mailto:cbaumgard@alconahc.org)

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## Successful Practices in Accountable Care: Community Health Centers, Inc.

### Health Center Profile

**Health Center:** Community Health Centers, Inc

**Location:** Winter Garden, FL

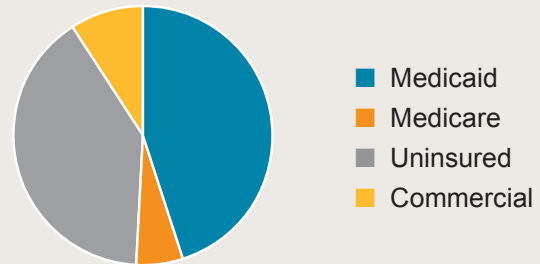
**Number of unique patients served:** Over 54,000

**Number of sites:** 10

**Services offered:** Family medicine, internal medicine, pediatric medicine, obstetrics, gynecology, optometry, behavioral health, adult and pediatric dentistry, pharmacy, family planning, lab, x-ray

**Certifications:** The Joint Commission Accredited, AAAHC Accredited, PCMH Level II

**Payer mix (approximate):** 45% Medicaid, 6% Medicare, 9% commercial, 40% uninsured



Source: Blankenship, Lyn (July 6, 2016). Telephone Interview.

### Laying the Foundation

Community Health Centers, Inc. (the Health Center) is a health center with locations in Central Florida that began its operations in 1972. In addition to providing care to over 54,000 patients, the Health Center's use of data has emerged as a telling story of accountable care. The Health Center was not satisfied with 100% utilization of electronic health records (EHR) for medical, dental, and pharmacy. Instead, they worked with their EHR provider, eClinical Works (eCW), to better understand their patient population and provide better care.

### The Need for Codes

The Health Center works with over 20 managed care plans regularly. Monthly, they meet with representatives from some of these plans to review their patient charts and evaluate quality measures with the assistance of auditors. During one of these monthly meetings, approximately

two years ago, one of the plans highlighted the need to add billing codes to their claims. This had resulted in poor performance on several HEDIS measures. The Health Center assigned their billing department the responsibility of ensuring that the most accurate CPT and ICD9 codes reflected the patient's medical record and were captured on the payers claim. This was incredibly labor intensive for their already overtaxed billing department requiring the billing department to review every single chart. Lyn Blankenship, an information services analyst with the Health Center, stated that each of the managed care plans was interested in different measures which added complexity to an already difficult process. At the outset, there was no financial incentive for the billing department or Health Center to take on this process; however, looking towards the future, the Health Center wanted to be a good partner with their Managed Care Organizations.

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## Certifying the Coders

Additional funding has led the Health Center's centralized billing department to train motivated candidates to become certified coders. As certified coders, the billing department was able to review the chart for documentation and add the proper codes to the EHR ensuring a consistent and easier workflow for the providers, more time for care for the patients, and proper compensation from the payers. The certified coders also developed templates in the EHR system which guided the process of patient care from both the provider and payer perspective. The excitement from staff has concluded with positive outcomes as it has elevated their level of knowledge and increased performance overall.

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## Establishing a Pilot Program

Ms. Blankenship, upon seeing the difficulty the billing department had with manually managing the process of adding the billing codes to the claims, contacted eCW for assistance. eCW contacted the ten largest health plans in Central Florida to see who would be interested in piloting a population health tool utilizing the Health Center's patient population. They also researched the HEDIS measures required by the top four health plans. Wellcare responded positively to the idea and established a pilot program under which Wellcare and CHC, Inc. had access to a population health dashboard created by eCW. The Dashboard provided both parties with data on the selected measures (diabetes screening and control, eye exams, lead screening, childhood immunizations, HPV vaccine, influenza, breast/cervical screening, hemoglobin A1c, and hypertension, among others) and allowed them to "drill down" by patient or provider. EclinicalWorks also took on the responsibility of adding the billing code, freeing up CHC, Inc. to provide better care to their patients.

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## Lessons Learned

The pilot program was a success in finding areas for improvement, creating goals for the future, and learning key lessons in accountable care.

Going forward they hope to increase their amount of "smart" data, such as pre-populated billing codes in the EHR system. They also hope to expand the amount of data available in the dashboard and utilize similar programs with other plans. They want to create buttons in their EHR which make it easier for providers to input data and allow them to focus on patient care. Finally, they want to create a data repository.

They are also in the process of hiring a RN utilization manager who will be responsible for overseeing the LPM case managers and patient care specialists. That structured department will allow all patients to receive the same coordinated care, driven by the data.

As a result of this process, the Health Center learned to establish clear and efficient processes in order to protect their workflow. By protecting their workflow, they aim to minimize any disruption to patient care and keep changes to things that the providers would normally be doing as part of their process of providing patient care. As part of this initiative, the Health Center realized the importance of having everyone at the table when changes to the process are suggested. They also learned the importance of data validation. When they are adding new data they want to ensure that it is mapped and structured. As an organization, they also review the data frequently to ensure its quality and usefulness.

Overall, by adding the codes to the claims, establishing efficient workflows, and better understanding their patients, the Health Center was able to better provide for their population and make progress towards the triple aim.

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

For more information contact:

Julie Bindelglass at [jbindelglass@nachc.com](mailto:jbindelglass@nachc.com)

Special Thank you to:

Lyn Blankenship, Information Services Analyst at CHC, Inc.

Ms. Blankenship may be reached at [l.blankenship@chcfl.org](mailto:l.blankenship@chcfl.org)

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# Successful Practices in Accountable Care: Piedmont Health Services, Inc.'s PACE Program

## Health Center Profile

**Health Center:** Piedmont Health Services, Inc.

**Location:** Alamance, Caswell, Chatham, Lee, Orange, Person, and Randolph counties in North Carolina

**Number of unique patients served:** 42,000

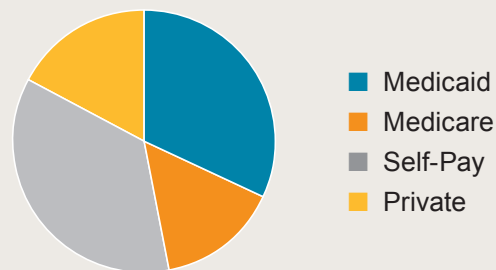
**Number of sites:** 10 + 2 SeniorCare locations

**Services offered:** Primary Care including prenatal, pediatric, adult, 6 dental locations, nutritional and behavioral health, case management/community care link, substance abuse pilot program, 7 pharmacies, 3 WIC offices; PACE sites offer additional services such as therapy, rehabilitation, and transportation.

**Certifications:** The Joint Commission Accredited, AAAHC Accredited, PCMH Level II

**Unique Feature:** Second PACE program in NC; Serves a large refugee resettlement program.

**Payer mix (approximate):** 32% Medicaid, 15% Medicare, 36% Self-Pay, 17% Private



Source: Toomey, B. and De Vries, A. (2016 December 20). Telephone Interview. Ratcliffe, M. (2017 January 17). Telephone Interview.

## Medicare's Program of All-Inclusive Care for the Elderly ("PACE")

The PACE program is a partnership between CMS, State Medicaid agencies, and providers that delivers in-home, comprehensive and intensive primary care services to the elderly and frail populations on a level with the care generally provided at nursing homes. Enabling these patients to remain in their homes and communities for as long as possible offers qualitative, cost-effective care and a vastly improved quality of life. Eligible patients are over 55, require the level of care required under the State Medicaid plan for coverage of nursing facility services, reside in the service area of the PACE organization, and must be able to live in a community setting without jeopardizing his or her health or safety (42 CFR 460.150(b)(c)).

As a comprehensive care plan, all aspects of patient health are provided through the PACE providers, including the addition of home safety measures (such as building

a ramp) and medical transportation. The PACE program is reimbursed for provided care through a capitated fee from Medicare, Medicaid or both when the patient is dually eligible. For the purposes of efficiency and collaboration, PACE programs have a limited approved service area, minimizing the travel time and efforts participants have to expend on care while living at home and allowing providers to work with defined population bases and partnership opportunities.

## Piedmont Health Services

Piedmont Health Services (PHS) is a Community Health Center in North Carolina with twelve locations across the state, two of which are designated as PACE service sites. PHS serves over 42,000 unique patients annually and has served 500 PACE patients cumulatively since the program's inception in 2008. Piedmont opened its first separate SeniorCare facility in Burlington, NC to serve the PACE program in 2008, and following its success, opened its second SeniorCare location in Pittsboro in 2014. The



program continues to grow at a rate of five to six patients per month on top of the program's 275 current enrollees. As the program continues to grow, PHS is focused on provider utilization, managing their relationships with specialists, educating the community, and looking to utilize a similar model of service delivery for their patients not enrolled in the PACE program.

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## Why Did PHS Join the PACE Program?

The main reason why PHS began exploring the PACE program was its organizational mission. The aging population in rural NC was growing more isolated due to decreasing family growth rates and the departure of younger members to urban areas. The community's age 65+ population far outnumbered its smaller under 18 population. Brian Toomey, PHS' Chief Executive Officer, saw the PACE program as a way to keep community members living in the community rather than in nursing homes. Toomey saw this as a natural extension of the role of a Community Health Center: to be there and care for the community, regardless of a patient's age.

Additionally, the program has several practical benefits. The typical enrollee in the PACE program is 77 years old, with ten medical diagnoses, six daily activity assistance requirements, and ten medications. During their time on the program, which averages about 42 months, patients average one hospitalization and one nursing home visit per year. Patient satisfaction for PACE is extremely high and scores in the areas of infections, falls, wound care, dementia and depression improve almost immediately because the patient is at home. The program structure of home care and capitated payments aligns the patients, family members and caregivers in a way that encourages patient and family engagement. In North Carolina, the cost of care for the PACE program is at least 5% lower, as the reimbursement rate is 95% of the Nursing Home rate. The 95% reimbursement is spent more efficiently as well, wholly invested into primary and preventative care

activities. PHS strongly believes that the PACE program is a great way to move towards the Triple Aim, providing better quality care for satisfied patients at a lower cost.

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## Program Integration

One of the most important differences between the PACE program and Health Center care is the reimbursement structure. The PACE program pays the health center a capitated rate per patient, and PHS quickly found that maintaining fee-for-service and PACE care in one location is nearly impossible because of the different mindsets they require. The PACE provider must maintain patient's health and safety in the community, providing comprehensive primary, preventative, home safety, DME, social and quality of life services, many of which need to be contracted out. As a result, for many services, the PACE provider takes on the role of an MCO, contracting with and paying the claims of local hospitals and organizations for services not provided in-house. This model raises the risk level PHS has had to take on through the program, but PHS maintains that this is a benefit rather than a drawback. PHS is in a strong position going forward by being well versed in a risk-based environment.

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## Participating in the PACE Program

The suggested first step towards participating in the PACE program is to join the National PACE Association (NPA) as an exploratory member, which costs \$3,000 a year. Due to the wide range of services it is expected to provide to participants, the PACE program requires a significant outlay of capital upfront and can take between 18 and 30 months to become profitable. As a result, it is essential for a health center to make sure it has the capabilities to operate successfully within the program requirements. PHS applied for and received a grant from a local organization to carry out a \$25,000 feasibility study to educate PHS' choice to pursue the PACE program.

Following an intense, nearly two-year education period for Board Members, Executive Leadership and staff, PHS' Board of Directors formally approved the launch of the program. To build the first location and maintain operations for the time it took to break even, PHS partnered with CMS, local organizations and foundations, and sought lenders open to partnering with the program. In all, it took about \$3.5 million to set up the first site and break-even, and PHS began seeing profits in 13 months on the program. Since then the program has opened a second location, and regional assignments ensure that PHS can continue to develop the program's capacity over time.

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## **Piedmont's Recommendations:**

### ***Pre-Education:***

In building the program from scratch, PHS learned some lessons about implementation. One lesson learned was the value of pre-program education. Joining the National PACE Association as an exploratory member was a huge help for PHS, giving the leadership access to education, examples, and experts to help their decision-making. Brian emphasized the importance of engaging in the feasibility study prior to opening the first site, as it showed PHS the prospective service area and the potentially eligible population. PHS made the strategic decision to educate the entire organization so that the program would not be an unpleasant surprise for anyone; when the Board decided to launch the program, it was an educated decision.

### ***State Landscape and Risk Assessment:***

It is very important to take into account the state landscape, the capital outlay, and the staffing requirements. The PACE program is a partnership with the State Medicaid Agency and each PACE program works with a specific region, so state landscapes matter. The capital outlay is significant, and finding partners for the funding is important. Program staffing is significant as

well: if the average provider ratio is one provider per 1,200 to 2,000 patients, in the PACE program it is one provider to 85 patients. Staffing is also incredibly important in terms of risk management. PHS maintains a re-insurance plan to balance the PACE program's risk level and generally aims for a 3% operating margin, but from its initial experience, PHS learned that a leaner staff could raise risk factors and lead to caregiver burnout.

### ***Partnerships:***

Partnerships are a crucial factor in a successful PACE program and seeking regional foundations and organizations for funding, consulting and collaboration is very important. In addition to serving as contractors for services, resources like Senior Centers, Hospitals, Rehab facilities, and other organizations are very helpful for the all-encompassing, comprehensive level of service required under the PACE program. Not to be forgotten, internal referrals and services are a significant help to the program as well. Community Health Centers are very well placed to have a PACE program; they are already in a primary care model and can draw on internal patients and services as the programs is established.

### ***Commitment:***

Finally, making the commitment to do the program right is vital. Health Centers are often the first responders in healthcare issues, and tackling the cost and quality of care for aging populations is today's issue. The PACE program tackles that challenge, excites providers and raises satisfaction. PHS hired a full-time employee to oversee the development of the PACE program, educated its leadership and took steps to balance the risk of the program. The result of PHS' commitment to doing it right is a strong, qualitative and cost-effective program serving a growing number of patients in five North Carolina counties.

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

For more information contact:

Julie Bindelglass, Specialist, Provider Networks,  
[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Brian Toomey, Chief Executive Officer, Piedmont Health Services, Inc.,  
[ToomeyB@Piedmonthhealth.org](mailto:ToomeyB@Piedmonthhealth.org)

Abigail De Vries, Medical Director, Piedmont Health Services, Inc.,  
[DeVriesA@Piedmonthhealth.org](mailto:DeVriesA@Piedmonthhealth.org)

Marianne Ratcliff, Executive Director, Piedmonth Health Senior Care,  
[RatclifM@Piedmonthhealth.org](mailto:RatclifM@Piedmonthhealth.org)

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



## Successful Practices in Accountable Care: Centerprise, Inc.

### Company Profile

**Company Name:** Centerprise, Inc.



**Founded:** 2014

**Location:** Milford, Ohio

**Consulting Services Offered:** population health strategies, revenue cycle management, insurance billing, professional and consulting services

**Shannon Nielson:** Shannon serves as Vice President of Consulting Services and leads Centerprise's consulting arm, working with practices, hospitals, and large organizations in value based transformation and revenue cycle management. She has extensive experience leading organizations through practice transformation processes including Patient Center Medical Home (PCMH), Meaningful Use and EHR, Comprehensive Care Initiatives and Accountable Care Organizations.

Because of increased funding and an accompanying increase in expectations, health centers are justifiably concerned when it comes to new trends and buzzwords. They often view a new initiative or program as one more task for an already overburdened workforce and another reason for patients to be dissatisfied. The result is a narrow focus on satisfying requirements with the minimum disruption and cost rather than the most effective way to accomplish the program goals. Population health, however, is not a new trend or buzzword but rather a framework that positions a health center to be successful in the work they are already doing. When viewed through that lens, population health and its core competencies can open up a health center to greater success.

Health centers across the country have had the opportunity to work with Shannon Nielson, Senior Vice President of Consulting Services at Centerprise, Inc., implementing population health strategies. There are many key lessons to learn from Shannon's work and she was willing to share some of them with us. Shannon described the following top six areas she focuses on when working with health centers and how they work together to improve patient care, workflow design and quality of care.

### The Primary Health Center Obstacle When Implementing Population Health

A common misconception is that population health is simply the process of becoming a Patient Centered Medical Home (PCMH). In fact, according to Shannon, a health center's primary challenge in implementing population health initiatives is understanding what population health is beyond the c-suite. Shannon defined population health as a focus on the health outcomes of a group of individuals. In order to have a successful population health program, health centers need to understand how it plays into the strategic vision, connects with ongoing initiatives, and impacts the day-to-day operations. A great way to clear this misconception is to create a value-based statement, which walks through relevant definitions and the impact of interventions regarding the triple aim. Different than a simple mission statement, the value-based statement reflects the overall work breakdown for the practice and how each component positively impacts others.

In her experience, Shannon has found health centers are more successful when they consider the intent of the requirements they are trying to meet as well as how they fit within the value the health center is trying to provide. By assessing the intent behind the requirements, a health center can understand how population health models operate, successfully project their information technology needs, drive patient centered access, maximize care coordination efforts, implement team based care, and see an improvement in both quality and performance measures.

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*Shannon Recommends: Instead of this being a c-suite only process, have the entire health center's staff work together to draft a value statement to guide their decisions and actions.*

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## Information Technology (IT) Needs

Essential to a population health initiative is the technology infrastructure to understand the current patients a health center sees, the larger population in the community as well as patients assigned via a managed care. Health centers must begin with an optimized Electronic Medical Records (EMR) based on efficient workflows, standardized documentation, and validated data. The ability to identify high-risk, high-cost patients requires refined and accurate data systems capable of targeting these specific patient populations. After an optimized EMR is in place, health centers need to have a data analytics solution that is visually appealing and user-friendly for patient engagement and front-line provider use.

With an optimized EMR and a data analytics tool in place, health centers should consider a strong data aggregation tool that can interface with multiple EMRs to better understand the patients not currently visiting the health center. Shannon also recommends investment in a robust quality improvement/data analytics team to pull together

the data, financial and operational aspects of the initiative. Shannon has found that connectivity and integration are at the heart of the IT needs for a population health program.

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*Shannon Recommends: Consider the patient portal as a part of a high functioning care team and utilize it accordingly.*

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## Patient Centered Access

Patient Centered Access is a core competency for population health. According to Shannon, there is a wide range of ways to approach access, but it boils down to one basic premise: get in the mind of your patients. One practice Centerprise encourages is to survey patients outside of the traditional patient satisfaction survey to get the patient's perspectives on their own behavior. For instance: *What does 'access' mean to health center patients? Why do patients use or not use the portal? What are deciding factors in their visitation schedule?* This simple survey allows a health center to understand the patient's perspective around access and involves the population in defining what access means for them. Shannon mentions one practice which has a quarterly open house for new patients to meet all members of the care team over punch and cookies. Patients take advantage of the opportunity to learn about the care team, portal and tour the facility. This sort of activity increases access and team based care concepts.

The other tool she recommends using is a manually created "third next available" report. A third next available report measures the average length of time between the day a patient makes a request for a specific type of appointment and the third available appointment open for the specific type requested. This report more accurately reflects appointment availability due to cancellations. By more accurately measuring the demand of patients, and understanding that demand, health center can position themselves to successfully deliver patient care. Patient centered access drives many of the other interventions

which have proven essential for population health such as care coordination.

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*Shannon Recommends: Utilize surveys and a “third next available” report to better understand patients’ desire for access.*

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## Care Coordination

No other intervention has the ability to hit all the goals of the triple aim (improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care) as care coordination, and it is an essential part of population health. Quite simply, patient behavior outside the “four walls” of the health center is just as important as the care received inside it. It is care coordination that provides patients with the continuous, longitudinal support between physical encounters. Care coordination is the connector between all of the providers and services patients use to improve their health. A proper care coordination program reduces emergency room visits, improves patient’s medication compliance, and ensures better clinical outcomes. This leads to improved patient and provider experiences as well.

Some challenges that health centers face in establishing a care coordination program are the costs and IT needs. Often care coordinators do not have a structured way to document and import information into and integrated a patient’s record. They also do not have easy access to information outside of the health center. In order to overcome these challenges, Shannon recommends forming relationships with community providers and exploring other partnerships. The skills gained in forming relationships outside of the health center are easily transferable to the work necessary inside the health center to provide team based care.

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*Shannon Recommends: Hire care coordinators willing to serve as partners for the patients and the providers.*

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## Team Based Care and Transparency

Population health strategies require a shift in mindset for care providers, so involving all health center staff in the initiative is very important. All members of a health center’s staff need to be involved from the planning process through implementation and review to foster a collaborative approach. In fact, one of the greatest opportunities, Shannon explained, is when a practice has staff who do not understand on the changes and were not included in the process. To involve all staff, the executive team needs to be transparent in sharing baseline data and provide regular updates. In sharing data, staff can understand both areas for improvement and the fruits of their labors, ushering in the capability for greater change.

This is true of financial pieces as well; these are not separate conversations in value based or population health models and should not be treated as such. Clinical teams usually have no idea how much money their performance impacts revenue or how much money health centers may forego as a result. Aligning the financial and value-based aspects of the system can only happen through transparency. Shannon recommended taking a similar approach for staff engagement as used for patient engagement, such as motivational interviewing. In doing so, a health center can utilize skills they have already learned to affirm that the process will deliver the outcomes and build trust.

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*Shannon Recommends: Focus on building a team that is integrated and flexible in their approach.*

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## Quality Improvement and Performance Measurements

Population health programs are long-term efforts. Properly implemented plans may see improved patient retention rates within the first six months. However, clinical measures may take a longer time to quantify depending on their relevant population. While an improvement may be sustainable after six months, it will take eighteen to twenty-four months to be consistent and reliable. The best way to observe these changes is to benchmark against yourself (past years' UDS data), similar organizations, and other health centers in your state.

By focusing on population health, a health center can learn key skills essential to many accountable care platforms. Understanding IT needs, providing patient centered access, coordinating care, providing team based care, and focusing on quality improvements are competencies necessary to achieve the triple aim and transferable in a rapidly changing care delivery system.

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*Shannon Recommends: Remember that clinical data is seasonal and change takes time.*

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For more information contact:

Julie Bindelglass, Specialist, Provider Networks,  
[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Shannon Nielson, Vice President of Consulting Services, Centerprise, Inc.,  
[SNielson@centerpriseinc.com](mailto:SNielson@centerpriseinc.com)

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## Successful Practices in Accountable Care: Understanding Risk

### Company Profile

**Company Name:** Optum®

**Website:** www.optum.com

**Location:** Eden Prairie, MN

**Company Overview:** Optum® is a health services and innovation company on a mission to help make the health system work better for everyone. They combine data and analytics with technology and expertise to power modern health care.

Source: Ellertson, N (2017 January 18) Telephone Interview.

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*“Risk is the chance that any activity or action could happen and harm you. Almost everything we do has an associated risk. Living is a risky business.”*

*Royal College of Obstetricians and Gynecologists 2010*

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**As one might expect, centers exposed to financial risk have the greatest impetus to think differently about managing their population health.** Take, for instance, the following three scenarios “ABC Health Center” could find itself considering as the health center transitions towards value-based payment:

1. ABC Health Center has been approached by a Managed Care Organization that for years has been paying fee-for-service. The MCO is now looking to enter into a risk-based contract with ABC Health Center.
2. ABC Health Center is part of a group of health centers considering forming a messenger model Independent Physician Association (IPA). After achieving clinical integration, the IPA is looking at contracts containing “downside risk” meaning the potential to lose money.
3. ABC Health Center is part of an Accountable Care Organization (ACO) participating in the Medicare

Shared Saving Program (MSSP). While the ACO is currently “upside-risk” only or no risk, in a couple of years they will be moving to downside risk. ABC is considering how the benchmarks will change in that environment.

In all three scenarios, ABC Health Center needs to better understand risk and how it will impact their practice and population. Based on the vast experience of Optum®, this paper will provide ABC Health Center with some of the tools and expertise necessary to analyze and prepare for risk-based contracting.

Natalie Ellertson, Vice President of Clinical Improvement Solutions at Optum® has counseled many health centers about how to understand and accept risk. She has found when providers play a role in their patient’s health care beyond simply delivering services, they achieve more effective care coordination, better management of benefits, and increased engagement, which contributes to efforts to achieve the quadruple aim which is at the heart

of accountable care. The quadruple aim seeks to improve the patient experience of care, improve the health of populations, reduce the per capita cost of healthcare, and improve the work life of clinicians and staff.

Utilizing nearly 30 years of experience in federal, state and local government funded programs, Natalie works to build and operate clinical management programs for Medicaid recipients served by both Managed Care Organizations (MCOs) and Accountable Care Organizations (ACOs). The key to these clinical management programs is risk. By better understanding and accepting risk, and using the unique skills actuaries bring to the table, health centers can improve patient experience, achieve population health goals and reduce the per capita cost of care.

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## Understanding Risk

The simplest way to describe risk in a health care setting is the financial burden accepted by a health center for the services provided compared to the amount of reimbursement the health center can expect in return. This can often include some guessing as to the range and quantity of services the patients may use, which is why health centers have to think about the array, location, amount and cost of services a patient might need. Managing risk requires health centers to think beyond their own four walls to consider other options outside what they typically deliver.

However, health centers have an advantage by already providing many ancillary services and are already working with other social service providers. This makes them uniquely qualified to understand patient needs and potentially manage risk. Based on her experience, Natalie recommends Health Centers find ways to work together as clinically integrated networks. Information technology (IT) and care management requirements are most effective and affordable when centers aggregate resources and learn from each other. Leveraging these relationships are

critical skills to master as health centers begin to think about risk.

In her vast experience, Natalie has worked with many risk-based contracts and has identified five key considerations.

### Key Considerations for Risk-Based Contracts

Health centers should be able to understand and answer all of these questions before they move forward with a risk-based contract:

- 1. Attribution**  
Does a health center know which patients they are responsible for from the payer?
- 2. Total Cost of Care**  
Does the contract define total cost of care? What is and what is not included within that cost (primary care, specialty care, acute care, pharmaceutical etc...)?
- 3. Historic Utilization**  
Has the historic utilization of services and cost been considered for the population to be served?
- 4. Risk Adjustment**  
Is there a risk adjustment based on the health status of the population?
- 5. Data Sharing**  
Exactly what data will be shared with the health center, how often will it be shared, and in what format will it be shared with the payer partner?

These five considerations, when combined, provide a health center an advantage - to follow the money to understand how it was spent in the past and how it can be accounted for in the future. This helps ensure the health center gets paid appropriately for the care provided and balances the risk the health center is taking on.

## The Role of the Actuary

In order to successfully take on risk, planning is key. Capital planning should have a significant part, and two areas where Natalie strongly recommends investing are actuarial and legal services. These services better prepare health centers for entering risk-based (value based) contracts.

An actuary can play a key role in helping health centers understand, accept, and manage risk. Actuaries help practices understand the population that could be attributed to them by defining their historical data and usage to project future care and costs. An actuary's expertise can help a health center answer the key questions outlined for risk-based contracts above. In the end, Actuaries can help determine if the health center is getting a "good" or "bad" deal and, therefore, determine whether the operation is a good risk (make money) or bad risk (lose money).

Actuaries are also able to risk adjust by helping health centers create clinical policies and procedures to reduce the cost of care. Natalie warns that practices can find themselves in trouble if they enter into a value-based contract without understanding the risk they are accepting. Actuaries, particularly those able to communicate important concepts in a way staff and boards can understand, are a key piece of the puzzle when it comes to preparing for the future.

## Accepting Risk

With thin margins, health centers tend to be risk adverse, but if conceived correctly and with an appropriate quality care delivery system in place, risk-based contracts should lead to better patient outcomes and better quality of life for underserved populations. However, doing so requires the education of staff and boards about the financial and operational implications. A health center can successfully manage risk by focusing on the following four areas.

### Key Strategies for Managing Risk

#### 1. Strong Population Health Analytics

##### Infrastructure

Basic EMRs do not provide a thorough, comprehensive population health picture.

In Natalie's experience, a best practice for incorporating risk programs into health center systems is to work with technologies that can effectively combine clinical and claims information, which provides a broader understanding of the population.

#### 2. Thoughtful Care Management Programming

The care management program should be built on the plans for total cost reduction and addressing areas of large spending as identified through population health analytics.

#### 3. Adaptable Practice

The practice must be able to change through care management and population health strategies.

#### 4. Governance

The governance structure must be able to understand and act upon data they receive in terms of health center performance.

Risk, for many, is a new and frightening consideration; however with proper preparation a health center can utilize risk to better serve their patients and population. Like ABC Health Center, providers will increasingly be in a situation where they are faced with the question of risk-based contracting. By understanding the key considerations and strategies, they will be better prepared to face the future.

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

For more information contact:

Julie Bindelglass, Specialist, Provider Networks,  
[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Natalie Ellertson, VP, Clinical Improvement Programs, Optum  
[natalie.ellertson@optum.com](mailto:natalie.ellertson@optum.com)

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## Successful Practices in Accountable Care: Provider HealthLink, LLC

### IPA Profile

**Name:** Provider HealthLink, LLC

**Location:** Georgia

**Partners:** Georgia Primary Care Association, Kearny Street Consulting, 27 Health Centers

**Year Established:** 2008

**Approximate Number of Members:** 60,000

**Managed Care Organization Contracts:** Amerigroup, WellCare of Georgia, Inc, Peach State Health Plan, CareSource (Starting July 2017)

### The Early Discussions – An Emphasis on Expertise

In 2008, David Smith (President, Kearny Street Consulting) began a conversation with the Georgia Primary Care Association (GAPHC) about how their members could maximize their reimbursements. His proposal, based on his over 35 years of experience working with plans in the Medicaid market, was for the members of the GAPHC to come together to form an Independent Practice Association (IPA) that would be called Provider Health Link (PHL). In doing so, member health centers would be able to join with other health centers to create a larger system and negotiate better rates and contracts. To date, 27 of the 34 members of GAPHC have joined PHL, which has contracts with three Medicaid Managed Care Organizations (MCOs).

The discussion with Dave came at a time when many of the GAPHC members were looking to come together to deliver quality care in a cost-efficient manner. IPAs were something that many members were familiar with as other states began developing them. Some of the members of the GAPHC had previously attempted to form an IPA,

invested in the process and without the guidance or structure needed, lost money. This was in mind as the Georgia PCA approached key individuals and then the larger group about the possibility. Unlike the previous experience, PHL required no financial outlay from the health centers and came with both guidance and structure. David Smith, having worked with the PCA and other health centers previously, was a known commodity and his relationships with the members and the plans made him an ideal partner in this endeavor. Dave and his consulting firm, Kearny Street Consulting, not only had relationships with MCOs but also had knowledge of reinsurance and state insurance regulation. The expertise of Dave and his partners was a key factor in the decision-making process.

After much discussion, all of the members came to a decision that PHL, with help from Kearny Consulting, was a benefit that the PCA should offer its members. Once the decision was made, 18 health centers decided to join PHL, with additional centers joining each year after. Kearny Consulting provided the administrative functions for the IPA and helped in the development. The decision to join was also based on the landscape in Georgia at the time. In 2008, when these discussions were ongoing, Georgia was

providing grants to help grow and improve the Medicaid system. The relationship between health centers and both the state Medicaid office and plans were challenges that the members also considered.

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## The Benefits of an IPA – The Importance of Partnership

### Financial

1. Uniform contracts
2. Unique terms for unique services
3. Negotiating power
4. Pharmacy cost improvements

### Quality

1. Faster credentialing of providers
2. New ideas on reducing ER costs
3. Committees to improve quality/HEDIS/STAR score
4. Education for members

As an IPA, PHL utilizes their relationships with the MCOs to negotiate a uniform contract which all members then have the ability to sign individually with the MCO at more favorable terms than if they attempted to negotiate as a single entity. By joining together, the health centers are able to negotiate for the inclusion of terms in the uniform contract that are unique to health center services and challenges. There is also greater leverage in working as a group to address issues that arise. The IPA has worked to assist in pharmacy cost improvements and to advocate favorable terms for dual eligibles (patients covered by both Medicare and Medicaid). The financial relationships and partnerships have led to the IPA disbursing over \$6 million dollars in the past nine years to health center members. In

partnering to reduce costs, the IPA's members were able to participate in the savings through incentive payments.

In addition to financial benefits, the IPA has seen improvements in quality as well. PHL and GAPHC have collectively looked at clinical programs and partnered to provide education to their members. Together they work to generate ideas on reducing emergency room costs, establish quality committees, and achieve clinical integration. The IPA requires any partnering MCO to commit to monthly meetings to review performance and develop joint strategies to improve performance. By working together, the members benefit from shared knowledge and best practices.

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## Keys to Successful Participation

- Commitment
- Consistency
- Cooperation

The incentives for health centers that participate in the IPA are a mix of financial and quality improvement. As a result, the health centers that became part of the IPA early on in 2008 have gained the most experience to be successful in their efforts. The lessons they have learned by participating in an IPA, such as ways to address preventable costs and information technology infrastructure changes, have also made IPA members comfortable in the process of forming an MSSP Accountable Care Organization (ACO). There is a level of trust and an understanding of accountable care by those who were willing to commit to trying something new.

Instead of working with distinct MCOs with conflicting policies, members of the IPA were able to work with PHL to increase consistency across the board. PHL has uniform communication with each MCO. Members are able to identify larger issues to resolve that effect more than one center. By being clinically integrated, health



centers are able to utilize consistency to provide better quality care.

The greatest benefits are also seen as a result of those who were willing to work together. By cooperating with other health centers and forming partnerships, members of the IPA are able to advocate for contracts and policies that benefit them and recognize the unique challenges health centers face. The cooperation is also key when members of the IPA began to consider forming an MSSP ACO because they had already learned how to work together as peers to implement change. As a result of the changes an IPA requires, health centers in Georgia have come together to help one another out.

## Going Forward

By ensuring commitment, consistency, and cooperation, the IPA, and its members have been successful over the past nine years. The next step for the IPA is to obtain additional health center members. They are also at the beginning of a new contract period for MCOs and will be soon implementing a contract with a fourth Medicaid MCO. The IPA, utilizing their experience, has learned to be more specific in the expectations of both the members and the MCOs. As the CEO of GAPHC stated, “the goals of an IPA are consistent, it is the tools that they use to achieve the financial and clinical benefits that are our main concerns now.” How primary care is practiced is changing, health centers that are able to learn and partner with one another (such as through an IPA) are most likely to be able to keep up with the changes.

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

For more information contact:

Julie Bindelglass, Specialist, Provider Networks,  
[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Duane Kavka, Executive Director, Georgia Primary Care Association  
[dkavka@gaphc.org](mailto:dkavka@gaphc.org)

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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: Waianae Coast Comprehensive Health Center

## Health Center Profile

**Health Center:** Waianae Coast Comprehensive Health Center

**Location:** Waianae, HI

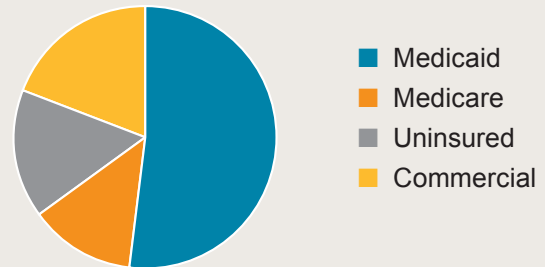
**Number of Unique Patients Served:** Over 36,000

**Number of Sites:** 7

**Services Offered:** Comprehensive primary care, dental care, emergency medicine, family practice, general practice, pediatrics, pharmacy, women's health

**Unique Feature:** Largest Native Hawaiian Provider

**Payer mix (approximate):** 57% Medicaid, 11% Medicare, 23% commercial, 9% Uninsured



Source: Bettini, R. (2017 March 31). Interview.

## A Historic Perspective

Rich Bettini, President and Chief Executive Officer of Waianae Coast Comprehensive Health Center (Waianae), believes that everyone has a role to play in managing the patient's total cost of care. In 1994, when a waiver was approved in Hawaii that allowed organizations to demonstrate the efficacy of a managed care approach to state funded health care services, Waianae, along with the other Hawaii Health Centers, came together to create AlohaCare. AlohaCare is a health plan that provides coverages for approximately 70,000 Medicare and Medicaid beneficiaries in Hawaii. In participating in AlohaCare, Waianae took the first step towards accountable care.

Total Cost of Care (TCOC) - Total cost of care accounts for 100 percent of the care provided to a patient for a specific period of time (ex. 12 months). Services that contribute to the TCOC include inpatient, outpatient, clinic, ancillary, pharmacy, behavioral health, vision, dental, lab, radiology, etc.

However, as the national landscape began to change, Waianae saw that participating in AlohaCare simply would not be enough. At the National Pay for Performance Summit in 2006, Waianae noted that there was a movement towards quality improvement with the need to control the rise in health care costs. In response, Waianae brought together the Centers for Medicare & Medicaid Services (CMS), the National Quality Center (NQF), the Commonwealth Fund, and 75 consumer board members from more than 30 health centers. At that conference, the National Committee for Quality Assurance (NCQA) presented on the concept of the health home. The reaction from attendees was that health home standards being proposed by NCQA were too narrow when applied to the high-need population served by health centers in Hawaii. Over the following five years, Waianae continued to convene national conferences with at least 50% consumer board member participation in order to answer two key questions (1) who will develop performance measures and (2) who will share in the savings. Having an emphasis on consumer board members allowed Waianae to develop community based answers to the questions, keeping the mission of health centers at heart. Based on the

input and feedback from the community they were able to understand how best to operationalize the necessary changes and they saw less resistance to change. They used the lessons learned from running AlohaCare (an emphasis on reducing preventable costs, the need to address social determinants of health, and the importance of investing in health information technology) in responding to those key questions and developing a new accountable system.

#### Key Lessons Learned:

1. Health centers must address **preventable costs**
2. Networks must consider **social determinants of health** in their standards and measurements
3. **Health information technology** is a key driver of change
4. Consulting the **community** is essential

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## Engaging the Consumer

By engaging and putting an emphasis on the feedback from the consumer board members, Waianae developed four supplemental standards relevant to health homes in underserved communities and reflective of the population served. The standards are integrated and comprehensive and measure how healthcare homes provide care in high-poverty communities. The four standards are care enabling services, cultural proficiency, community involvement, and workforce and economic development. *These standards reflect the unique challenges of health centers, their strength as compared with other primary care providers, and the hidden value that health centers provide in addressing social determinants of health.* Waianae was able to build a case for provider participation on the wisdom of the community.

#### Supplemental Health Home Standards

- Community Engagement
- Workforce and Economic Development
- Cultural Proficiency
- Care Enabling Services

Utilizing these standards as the basis, Waianae, along with Koolauloa Community Health and Wellness Center and Waimanalo Health Center, formed the Accountable Health Care Alliance of Rural Oahu (AHARO). AHARO is a “virtual accountable care organization” meaning that they are consolidated through health information technology and analysis towards the goals of accountable care, quality care and reduced costs - due primarily because of geographical constraints. Waianae, and their partners, realized technology was going to lead to more precise measurements of the relative value health centers offer. With the more precise measurement of value, the health centers wanted to ensure they were being valued fairly, taking into account the unique challenges, costs, and payments. The implementation of Electronic Health Records (EHR) allowed for better cost analysis and was the impetus to change.

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## Engaging The Plans

Waianae worked with four Medicaid plans to identify preventable costs (that do no harm when controlled) and align incentive based contracts to address them. One of the first measures they attempted to address was low acuity emergency room visits (ex. abdominal pain, cold symptoms, fever/chills, dizzy spells, congestion, etc.). They created an accountable care dashboard to measure trends and determine if reducing low acuity emergency room visits would impact the total cost of care. Using hospital discharge summaries Waianae was able to follow up with the patients and determine the reason why the patient went to the emergency room instead of their primary care provider. In their study they found that the majority of patients went to the emergency room for primary care between 5 pm and midnight because the health center was closed. As a result, Waianae opened two urgent care sites and measured the impact on the total cost of care utilizing plan data. They determined that health centers are best positioned to expand their volume in order to reduce hospital emergency room visits for medically complex patients which reduces the total cost of care. *By engaging the Medicaid plans from the start, they were able to align their actions around common goals and negotiate a share in the savings.*

With the amount saved on the total cost of care, AHARO reached out to their community board members once more to determine how best to reinvest the shared savings. Community boards selected preventative projects such as school based outreach, workforce programs, and cultural proficiency training which are all related to the supplemental health home standards they identified at the beginning of Waianae's journey.

## Engaging Their Partners in the Process

As a virtual ACO, AHARO is based on partnerships. In addition to working with the health plans to determine what the preventable costs are, they also work to determine what entity or partnership of organizations are best positions to address those costs while also improving quality. AHARO is selective in their partnerships. They look for entities they can have an open and honest discussion with and they look for partners willing to find common objectives. Engaging, first, their community board members, and then, the health plans, has served them well so far. AHARO will continue to engage community partners to maximize their strength and reach the goal of a comprehensive system of population-based accountable care.

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For more information contact:

Julie Bindelglass, Specialist, Provider Networks,  
[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Rich Bettini, President and Chief Executive Officer, Waianae Coast Comprehensive Health Center  
[rbettini@wcchc.com](mailto:rbettini@wcchc.com)

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# Successful Practices in Accountable Care: Aledade

## Company Profile

**Name:** Aledade

**Headquarters Location:** Bethesda, MD

**Year Founded:** 2014

**Number of Employees:** approximately 200

**Services Offered:** ACO administration, population health tool, practice transformation specialists, provider workgroups, legal support, tool kits

**Unique Feature:** blend of technology and healthcare company

**ACO Demographics:** 18 with 230,000 attributed Medicare beneficiaries

Since their founding in 2014, Aledade has focused on independent primary care. The independent nature of practices is fundamental to what they see as the ability to create change. Aledade has chosen to work with FQHCs because, although they are independent, as a model they are complex and provide a wide range of services. In the company's experience, many health centers have already embarked on the work of improving the quality of care. It is because health centers now have a focus on the cost of care that Aledade is determined in their work with FQHCs to make them financially viable in an ever-changing payment environment.

By empowering and supporting primary care providers like FQHCs, Aledade sees the path towards providing the best quality care to patients and the lowest cost. They support those goals by engaging in practice transformation through a variety of methods. All of Aledade's methods are centered on better understanding through education and data. Aledade does this by providing FQHCs a unique blend of technology and health care to inform their

decisions and help health centers better understand their patient population and, as a result, make decisions that help change the way care is delivered.

## The Need For Education

As Aledade suggests, the way health care is delivered and paid for is constantly evolving. However, changing the way that health centers get paid also requires changing the way health centers operate and think. Aledade has found this change creates a strong need for information sharing and communication not just at the executive level, but at all levels of a health center. What happens in the exam room has strong effects on what happens at all levels of a health center's operation and financial performance. Being able to impact what happens in the exam room begins with being able to share the right information with the providers. In Aledade's experience working with FQHCs, one of the biggest challenges they have is getting information directly to the providers, particularly because so many health

centers have multiple sites. Specifically, they have faced challenges with navigating the organizational structure and negotiating demanding priorities. However, with the exception of the communication piece, many of the health centers Aledade works with are participating in programs that make them well suited to embark on this practice transformation journey. In their experience, health centers are engaging in programs focused on care management and improving quality measures typically considered in ACOs, which sets them up to be successful in such programs as compared to larger hospital groups or even private practices.

One of the ways in which Aledade addresses the communication challenge is by working with state Primary Care Associations (PCAs). The PCAs are a known entity to the health centers and the providers, so working with the PCAs allows Aledade to bridge the gap in knowledge and gain perspective on the environment in which health centers operate. They provide Aledade with expert advice on how health centers function, the realistic challenges they face (a reality check of sorts), and the resources needed. The PCAs also help Aledade approach the health centers with a provider-focus, which is key for managing the changes necessary. Aledade recognizes that providers are the core of the services health centers provide and that focusing on their needs, processes, and outcomes can impact the health center overall.

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## Annual Wellness Visits

A necessary change that Aledade highly encourages all health centers to consider as they embark on the journey towards accountable care is increasing the number of Annual Wellness Visits (AWVs) they provide each year to their Medicare fee for service patients. Even if a health center is currently doing AWVs, having a more robust plan for AWVs is essential to understanding and providing better care. The AWV Aledade recommends is

not about checking boxes or a pro-forma encounter but rather provides a comprehensive understanding of the individual patient – their preventative screenings, social determinants of health, medicine reconciliation, etc. This visit establishes a baseline for the patient's health status and needs. With a clear baseline, providers can develop care plans that address the most pressing issues for the patients and improve overall health. In those health centers that implemented AWVs, fall risk screen increased from approximately 25% to over 90%. They also saw increases in clinical depression screenings and follow-up, pneumococcal vaccinations for patients 65 plus years, colorectal cancer screenings, and high blood pressure screenings and subsequent control, demonstrating the value of AWVs. The AWV is also a way for health centers to clarify and improve their billing and coding. As a result of proper billing for over 5,000 AWVs, one group of health centers was able to increase their bottom line by over \$1 million collectively, leading to increased quality of care to more patients down the line. Aledade finds that issues in coding are a significant flaw that impedes progress and a challenge that many providers confront as the way they are paid charges. It is essential to have accurate codes and to consider the activities in the exam room as part of a larger system.

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## Data For Better Health

With accurate codes, health centers gain a better understanding of their population, which is the first step in improving their population's health. However, Aledade states simply having data (coding and quality) is not enough. The data must be actionable in order to improve upon it. Aledade provides health centers with a dashboard and toolkits to engage in robust analysis. By engaging in analysis at the provider and health center level, health center teams are able to understand what the data means, how to implement better work flows for better outcomes, and the larger picture of what care and payment can

create, such as in the case of Monongahela Valley Association of Health Centers. Monongahela Valley was able to connect to the West Virginia Health Information Exchange and receive information on hospital admissions, transfers, and emergency department activity. With this information, they were able to transform their transitions of care (TOC) with patients. They can now follow up with patients who were in the Emergency Department leading to fewer admissions and a reduction in readmissions.

Aledade has monthly meetings with health center clinical leads in which they use data to drive the conversation. During the meeting, they collaboratively review the data to get a real-time picture of how the health centers are doing and what they can do to improve. This one-on-one approach allows health center staff to participate in targeted transformation and stay on top of changes. It allows the health center to dig deep on the practical and operational implications of what they are doing. By seeing

the effect, health centers are able to change the cause and enhance the care they are providing to those who need it most.

By improving the data they collect, understanding that data, and communicating changes in a clear manner, a health center can embark upon the process of improvement with greater success. Aledade also provides practice transformation specialists that visit health centers and work with the providers one-on-one. The specialists embed in the health center to meet them where they are. They also support pre-existing provider work groups by creating specialized data-driven toolkits. The toolkits help health centers to improve their processes and include everything from scripts for the front-desk to supporting electronic health record use. With this support, the transformation and improvement key to any health center's accountable care efforts can be achieved.

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For more information contact:

Julie Bindelglass, Specialist, Provider Networks,  
[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

John Torontow, MD, MPH, Medical Director, Mid Atlantic Region, Aledade  
[jtorontow@aledade.com](mailto:jtorontow@aledade.com)

Colleen Wagner, ACO Director, Aledade  
[cwagner@aledade.com](mailto:cwagner@aledade.com);

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# Successful Practices in Accountable Care: Coal Country Community Health Center

## Health Center Profile

**Health Center:** Coal Country Community Health Center

**Location:** Beulah, Center, Hazen, and Killdeer, North Dakota

**Number of Unique Patients Served:** 9,800

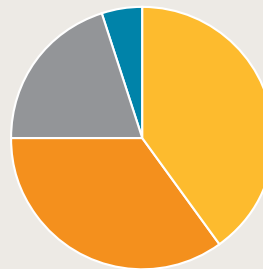
**Number of Sites:** 4

**Services Offered:** Primary care and behavioral health including medication-assisted therapy

**Certifications:** PCMH Level 2

**Unique Feature:** Recognized nationally for colorectal screening rates and collaborative efforts

**Payer mix (approximate):** 40% Commercial, 35% Medicare, 20% Uninsured, 5% Other (including Medicaid)



■ Medicaid  
■ Medicare  
■ Uninsured  
■ Commercial

Source:

## A Vision For Collaboration

At the heart of accountable care is the idea that partnerships can help to improve the quality of care and lower the total cost of care. Today, Coal Country Health Center (a Federally Qualified Health Center (FQHC)) and Sakakawea Medical Center (a critical access hospital) are a model for how this partnership can be achieved. According to Darrold Bertsch, the shared chief executive officer of both organizations, the partnership has resulted in improved financial performance and healthcare delivery, as evidenced by **improved health outcomes** and **increased patient satisfaction**.

What has made this partnership so innovative, beyond overcoming a challenging history of competition, is the development of a Patient Centered Medical Neighborhood of care. This partnership was the foundation for a collaborative community health needs assessment and health improvement plan as well as participation in an accountable care organization.

## History

Coal Country Community Health Center (CCCHC) and Sakakawea Medical Center (SMC) did not have the harmonious relationship they benefit from today. There was vast duplication between the two organizations and a natural sense of competition that comes from being only nine miles apart from one another in a rural area with limited population. As described by Darrold, “this duplication of services created financial hardships and mistrust.” It wasn’t until CCCHC was experiencing financial challenges in 2011 that the organizations considered approaching one another about the competitive situation and a possible collaborative solution. The discussions and partnership process has shown that one reason CCCHC and SMC, as well as other hospitals and health centers probably face the problem of competition for patients, services, and workforce, is a lack of understanding. Both health centers and hospitals have unique regulatory requirements and operational needs, so understanding those specific needs can help reduce the amount of friction in developing partnerships.

One of the first things the health center and hospital did in approaching a partnership was to insist on transparency, commonality of goals, and consistency of information. Both organizations wanted to do what was best for the community and believed they were doing the right thing based on the information they had, but that information was not reflective of the community as a whole. By opening up the information, both organizations were able to better optimize the operations and make decisions to benefit both organizations and ultimately the populations they serve.

After they both looked at the information, they brought in a consultant to conduct independent interviews and financial analysis. The consultant presented recommendations to both the board of the health center and the board of the hospital and validated their plan for collaboration. Their plan required stabilizing the revenue cycle staff and hiring additional billers, addressing workforce issues, and improving morale at both organizations. Key to the idea of collaboration was interdependence in operations, governance, and contracts. Their interdependence included reciprocity of governance representation, a Memorandum of Understanding, and an administrative services agreement. They also developed a shared mission statement. In formalizing and developing the function to partner, they were able to create momentum and measure positive changes. They determined that the best way to continue the momentum was to continue to collaborate.

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## Continuing the Momentum

Both the hospital and the health center were required to do a needs assessment. It became yet another area in which collaboration was not only possible but resulted in a stronger outcome. The two organizations in 2011/2012 facilitated a Collaborative Community Health Needs Assessment. The assessment measured the needs for all area healthcare providers including the public health unit,

emergency management services, and skilled nursing facility. It allowed all organizations involved to have a better understanding of the community, and provided a more complete picture of their population.

With a better understanding of the population, they were able to create not just patient centered medical homes but a patient centered medical community. They used the needs assessment as the basis for a strategic plan and community health improvement plan. Staff from all organizations involved in both the assessment and plan make up the Comprehensive Care Coordination Committee, which continues to meet monthly to discuss implementation, measure progress, and adjust priorities accordingly. As health centers consider the total cost of care, a collaborative assessment and plan such as what CCCHC and SMC implemented, may increase understanding and address the totality.

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## Growing Stronger Together

From 2011 to 2015, the organizations developed the foundation for working together. It was slow and methodical and allowed them to share in the growth. One example is the health center's assistance in the shift from volume to value-based payment. The health center had a robust patient centered medical home (PCMH) model in place, but the hospital did not have the staff or expertise to convert to that model. Even though they were separate entities, the leadership had both clinics begin working together. This exchange provided the hospital with the staff and expertise to move towards the PCMH model and was the foundation and education for participation in an Accountable Care Organization (ACO).

In 2015, the two organizations found a partner who was able to provide them with assistance in participation in a Medicare Shared Savings Program ACO. As of 2016, they have been approved to participate. They also received ACO Investment Model funding, which helped develop the

framework. Using their collaboration as the foundation, both organizations promote wellness, prevention, and coordination of care for all patients. Together, they have implemented a comprehensive model of care coordination, which has resulted in a reduction in admissions and ER visit rates by 25.71% and 9.81% respectively. The coordination of care is essential to success in the ACO model and yet another benefit of their mutual understanding and interdependent partnership.

## Key Takeaways

What was key to the collaboration was keeping the patient and community needs as a focus. This is evident in the shared mission statement of Coal Country Community Health Center and Sakakawea Medical Center stating they are “Working together as partners to enhance the lives of area residents by providing a neighborhood of patient centered healthcare services that promote wellness, prevention and care coordination” and they truly embody that mission. As CCCHC and SMC face challenges, they understand their history, take notice of the success they have been able to achieve together, and continue to push forward in innovation.

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For more information contact:

Julie Bindelglass, Specialist, Provider Networks,  
[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Darrold Bertsch, CEO, Sakakawea Medical Center  
Coal Country Community Health Center  
[dbertsch@smcnd.org](mailto:dbertsch@smcnd.org)

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## Successful Practices in Accountable Care: Alliance Chicago

### HCCN Profile

**Name:** AllianceChicago

**Year Established:** 1997

**Founding Members:** Erie Family Health Center, Heartland Alliance Health, Howard Brown Health, Near North Health Service Corporation

**Services Provided:** Health care collaboration focused on quality improvement, health information technology and data warehouse to support a common electronic health record, and health research and education

**Current engagement:** More than 50 health centers, 1.2 million patients, 20 funders, 20 research affiliations

### Driving Towards Integration

Since its founding in 1997, AllianceChicago has embraced the idea that health centers working together as a network could leverage partnerships to improve the health of their communities. As health centers contemplate how to get ahead of the change from volume to value that is beginning in the health care delivery world, network-like deep collaborations are an essential strategy.

AllianceChicago had developed a strong foundation in data and developed a nuanced understanding of how the different centers performed individually and began to evaluate how they could perform together as a health center controlled network. The leadership of AllianceChicago realized in late 2015/early 2016 that based on their work to date and the marketplace, they had an opportunity to create lasting change by bringing the health centers together into a clinically integrated network.

Key to this decision to integrate was the recognition that together the health centers presented a stronger negotiating force and significant efficiencies. Clinical integration, which required organizing their physicians

into an interdependent system, would allow the health centers to address population health: for example, integrated health centers could negotiate and participate in value-based contracts to improve upon the quality of care provided. Building on the health centers' work in practice transformation, quality improvement, and clinical collaboration, they created relationships among the health centers, developing an extensive network of service delivery sites, uniform clinical protocols/standards, a shared clinical information system, and collaborative partnerships, all of which were assets as they embarked on accountable care efforts. This pre-existing work, guided by AllianceChicago, created the opportunity for potential financial incentives through clinical integration, such as negotiating more favorable contracts, establishing better rates, and accessing new sources of revenue. These potential financial incentives are in line with the mission of the health center program because these additional funds could then be invested back into the health centers to support the care they deliver, thus creating a positive feedback loop for the Network and participating health centers.

### **Five Local Drivers Towards Clinical Integration**

- Implementation of Medicaid Managed Care has fragmented Health Center Medicaid populations among multiple payers
- Increasing clinical, administrative, and documentation on clinical staff, misaligned with patient needs and clinician judgment, along with production requirements under fee for service - Increasing clinical and administrative tasks, such as documentation, on clinical staff, which is often misaligned with patient needs and clinician judgment, along with production requirements under fee for service
- Costs to achieve quality initiatives and care coordination reimbursement may almost offset or even exceed payments
- Fee for service reimbursement models only reward defined billable services delivered by defined billable providers
- Typical utilization management of managed care restricts access to needed/desired care for patients in the larger health system

Perhaps more important than the financial incentive, though, was the opportunity to improve patient quality of care, access to care, and patient satisfaction. The health center leaders noted that while cost-based fee for service payments had provided them with financial stability in order to deliver services, it also limited their ability to impact the care they were able to provide. Transitioning to new forms of payment would allow health centers to fundamentally alter the way they provide care by allowing them to participate in driving and shaping the full spectrum of care. The health center and network leadership soon realized that there were five key factors driving them toward clinical integration. Several themes and challenges emerged from those drivers including inefficiency,

conflicting priorities, increased demands on workforce, and the inability to innovate, all of which were opposite of the quadruple aim and the mission of the health centers. The leadership decided that clinical integration would allow them to utilize their assets to overcome the challenges they were facing.

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## **The Process of Integration**

Once the leadership of AllianceChicago and its member organizations decided to consider clinical integration, AllianceChicago explored what others - including health centers, PCAs, HCCNs, and private practices - were doing in the space. They received recommendations from consultants, learned about the legal and clinical requirements, and then put together an application to participate in the Medicare Shared Savings Program (MSSP). AllianceChicago saw the MSSP ACO application as a foundational opportunity to prototype governance and infrastructure, as well as practice consensus building. Today they still view it as a tremendous learning opportunity. Specifically, they learned that health centers struggle with receiving data about and understanding the patients that are attributed to them, despite having a good amount of data on the care they provide. The health centers did not fully understand what occurs once a patient leaves the office; most significantly, AllianceChicago discovered that primary care management, specifically controlling costs while the patient is within the health center, is crucial. This application process made the health centers eager to get access to full claims data in order to better understand the total cost of care for the patients they serve.

When the MSSP did not proceed because of attribution challenges, the network looked towards the private investment world to evaluate other potential business models. They wanted to emulate the private sector's ability to move nimbly while still meeting the federal requirements

### **The Seven Key Prerequisites**

- Characterization of the existing clinical delivery system
- Regulatory compliance
- Decision making control
- Board of manager buy-in
- Clinical partnerships
- Data collection and analysis
- Resources

for health center program grantees. They put together a rough plan that included several key prerequisites. Since then AllianceChicago defined a legal pathway that allows them to remain in compliance with 330 statutory and other regulatory as well as anti-trust concerns. The legal pathway consisted of a separate legal entity to engage in single point contracting, enter into agreements with investors, and hire expertise as needed. They have streamlined the decision-making process and secured trusted legal counsel. AllianceChicago's board affirms their commitment through resolutions reflecting their practice in consensus building. Additionally, they have begun the process of engaging clinical leadership by meeting with providers to discuss the need for collaborative relationships. Since this change will also require a change of workflows and culture, AllianceChicago prioritized meeting with and gaining buy-in from clinical leaders in the health centers. Finally, after borrowing core staff time from AllianceChicago to support planning efforts, they invested in full-time, dedicated staff to the development of the integration and resulting payment model. These achievements have led to an infrastructure that the Network's health centers can leveraged in many different ways. It has also had an impact at the health center level by exposing the centers to new types of contract review

and analysis. As the delivery of and payment for health care continue to change, health centers will increasingly see new forms of contracts. Exposure to and education about contracting allows health centers to stay ahead of the curve and ensure that they are making sound decisions that best serve their patients.

### **Roadmap Towards Integration**

In securing trusted legal counsel, AllianceChicago also gained additional expertise on the steps necessary to form a clinically integrated network and confidence in their planning. Working together with their attorney, they put together an internal worksheet of key considerations. The legal considerations were clinical practice standards, clinical information systems, participation criteria, utilization control mechanisms, employing centralized staff, patient satisfaction, financial incentives, branding with payors, and demonstrating efficiencies. The worksheet they developed allows them to track their progress internally and better understand associated operational, financial, and legal considerations. This document provides the network with both an educational tool in bringing partners on board and a measure for what the next steps are.

While AllianceChicago has not yet achieved full clinical integration yet, their motivation, achievements, and future are clear. As a network, they continue to work incrementally to improve their quality and cost of care because it allows the network health centers to better serve their patients and communities. AllianceChicago recognized early on that working together could create achievable, positive change for all sides of the health care equation. Clinically integrated networks simply represent the next way in which the health centers can work together to increase efficiencies and quality, reduce cost, strengthen their financial position, and ultimately, better provide for their population.

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

For more information contact:

Julie Bindelglass, Specialist, Provider Networks

[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Fred Rachman, MD, Chief Executive Officer, AllianceChicago

[frachman@alliancechicago.org](mailto:frachman@alliancechicago.org)

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# Successful Practices in Accountable Care: Health Center Partners of Southern California

## Company Profile

**Name:** Health Center Partners of Southern California (HCP), parent company of Health Quality Partners of Southern California (HQP), Integrated Health Partners of Southern California (IHP), and CNECT

**Membership:** A consortium of 17 private, non-profit primary health care organizations (Borrego Health, Clínicas de Salud del Pueblo, Inc., Community Health Systems, Inc., Imperial Beach Health Center, Indian Health Council, Inc., La Maestra Community Health Centers, Mountain Health, Neighborhood Healthcare, North County Health Services, Operation Samahan Health Centers, Planned Parenthood of the Pacific Southwest, San Diego American Indian Health Center, San Diego Family Care, San Ysidro Health Center, Southern Indian Health Council, Sycuan Medical/Dental Clinic, and Vista Community Clinic) in San Diego, Riverside, and Imperial County which operate over 133 sites

**Patients served:** In 2016, HCP member community health centers served over 868,000 patients with 2.68 million patient encounters

**Mission:** Be the thought leader and innovative influencer of change in the primary care marketplace, informing and inspiring our members and partners to enrich the patient experience and improve the human condition

**Strategic initiatives:** innovation and thought leadership, policy, advocacy, and communication, clinical care coordination and quality improvement, and resource development

## The Role of Consortium

According to Henry Tuttle, President and Chief Executive Officer of Health Center Partners of Southern California (HCP), members of HCP expect the organization to be always a step ahead of them. The organization's vision to "serve as the nexus for our members and partners to transform primary care through the power of innovation and collaborations," acknowledges and takes on this charge. The power of innovation and collaboration allows the consortium to remain ahead of the curve to benefit their members. Health Center Partners created a family of four companies through which they promote humanity, leadership, excellence, courage, and trust- their unifying values. The symbiotic relationships and synergy among the companies allows the Consortium to offer its members, as a benefit of membership, a wide variety of interoperable services including advocacy and research as well as enterprise-wide support.

Health Center Partners serves as the parent company for its subsidiaries: Integrated Health Partners of Southern California (ICP), Health Quality Partners of Southern California (HQP), and CNECT, their group purchasing organization. While HCP primarily focuses on their extensive advocacy efforts, they also provide support for the Covered California Navigator Program, Emergency Preparedness and Response Program, and are the recipient of a Health Center Controlled Network (HCCN) grant from the Bureau of Primary Health Care. As an HCCN, HCP focuses on the goals of addressing population health, health outcomes, and utilization of technology across their member health centers. They have worked as an organization to share lessons learned from one provider to the next to support all member health centers.

As a consortium, HCP focuses on how health centers can best work together and collaborate to achieve the goals



of accountable care because HCP understands health centers have the ability to meet the healthcare needs of a specific population while simultaneously reaching the goals of improving health and patient experiences, as well as reducing overall costs when done collectively. HCP has found that accountable care efforts require innovation and the ability to define and demonstrate one's value, which in turn necessitates coordination.

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## **Innovation as a Foundation**

Health Quality Partners of Southern California (HQP) is the innovation hub of HCP. Focused on program development and implementation, research and development, and shared services, HQP allows the consortium to test models, document and publish scalable and sustainable outcomes, and share the results of their research with members to define and improve the standard of care. By creating a safe space for members to try, fail, and improve, they have created a culture of change that has had a demonstrated result on the Healthcare Effectiveness Data and Information Set (HEDIS) scores of their clinically integrated network, Integrated Health Partners of Southern California (IHP). Marked improvement over the last few years has resulted in IHP becoming the leader in the areas of quality outcomes payers rely on. IHP handles the managed care contracting, quality and performance improvement, and data informatics and analysis functions on behalf of their members. By unifying and encouraging collaboration between this family of companies, HCP has been able to implement and manage process changes that allow their member health centers to improve on the quality and cost of care they provide. Health Center Partner's innovative process, for example, linking research at HQP to experimentation and application with IHP, demonstrates how effective health centers can be when coordination and collaboration are foundational.

Kevin Mattson, President and Chief Executive Officer of San Ysidro Health Center and Chair of HCP's Board of Directors, also acknowledged the power of collaborating with other health centers in encouraging innovation. According to Mr. Mattson, the benefit of the network of organizations is two-fold: cost savings and the value of the masses. He provided the example of care coordination at his health center. As a single health center, it is unlikely that San Ysidro would be able to afford to invest in a staff position (let alone multiple staff positions) dedicated to care coordination full time. By sharing the costs of staffing, all of the member health centers are able to afford this vital service. This sharing is more economically efficient and frees up resources for further innovations. They are also able to leverage the value of masses through additional negotiating power as a single entity. Through concerted collaboration, they are able to become more efficient and as a result, provide better care.

Health Center Partners also serves as the thought leader and convener for primary care in San Diego County, CA. Their hard earned-respect, incredible reputation, and high expectations have not kept them from continuing to adapt, in fact, it is what drives them to continue being responsive to their members. HCP annually assesses their members to customize an experience to their needs. This annual assessment guides the leadership of HCP as they review and choose what they will continue to offer and in what format; this way they can ensure they are providing value to their members. For example, HCP had been performing credentialing services and after hours triage. After a particular year's assessment, HCP leadership decided to move some of those services into the shared services function of HQP and others were discontinued based on member needs. In their own strategic work as a company and by risking their legacy to respond to their members' needs, HCP exemplifies what they expect from their members - which they willingly continue to discover and grow together. Dedication to exploration and innovation

is necessary for the shift from volume to value and the pursuit of accountable care.

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## Defining and Demonstrating Value

Beyond their work in the area of innovation, Health Center Partners also supports their members in efforts to define and demonstrate their value. Henry Tuttle states that a benefit the consortium provides their members is access to an expanded universe of connections they might not have on their own such as private funders, payors, and suppliers. HCP has increasingly focused on utilizing those connections for resource development through contracting in recent years. To make certain they provide the best possible contract offerings to their members, HCP prioritizes resources for their members that help them to define their value as well as support for their members in demonstrating value. They also frequently communicate new contract offerings and modifications to existing offers to their members.

With HCP's work around health information technology, HQP's work around quality improvement, and IHP's work around data informatics and analysis, members of the consortium have access to a vast amount of information about their performance. Since data is only as good as the information it provides, Health Center Partners works with their members to not only access their data, but more importantly to translate their data into value statements. Their members learn which services are driving HEDIS scores and as a result reducing their high-cost services; this way, members can more directly see how their work via their data can influence their community's health. The consortium provides unblinded data on more than eight clinical outcomes regularly to measure progress and share best practices. As a clinically integrated network, the Clinicians Committee creates performance goals and clinical measures for grants each year that continue to

get tougher, while still achievable, and push members to improve by owning and utilizing their data. Health Center Partners also produce gaps in care reports that help health centers better understand how they can improve their metrics, the care they provide, and as a result, their value.

Health Center Partners also provides education for all members on how to demonstrate their value to partners (such as Medicare, Medicaid, and private insurance companies) because HCP acknowledges the necessity to earn and maintain value for long-term stability. HCP members demonstrate value through their connections and work as a network, which allows them to leverage economies of scale. They also provide members with the ability to participate in group purchasing contracts through CNECT, which often lowers the price for all members when compared to individual purchasing by a single health center. As an advocacy organization as well as a network that provides assistance with managed care contracting, Health Center Partners has experience in leveraging the experiences of their members and partners to benefit the consortium as a whole. This experience allows them to develop and provide specialized storytelling training to their members, which they can then use to bring their quantitative or less easily translatable data to life. Health Center Partners continues to evaluate the value their members are able to provide and assist them in understanding how best to tell their story in order to prepare for changes in care delivery and payment.

By working together as a coordination consortium, encouraging innovation, and defining and demonstrating value, the members of Health Center Partners are prepared for whatever changes may come in the health center program. The organization, thanks to the structure, goals, and its members, remains one step ahead.

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For more information contact:

Julie Bindelglass, Specialist, Provider Networks

[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Henry Tuttle, President and Chief Executive Officer, Health Center Partners of Southern California

[htuttle@hcpsocial.org](mailto:htuttle@hcpsocial.org)

And

Kevin Mattson, President and Chief Executive Officer, San Ysidro Health Center, Board Chair,  
Health Center Partners of Southern California

[kmattson@syhealth.org](mailto:kmattson@syhealth.org)

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# Successful Practices in Accountable Care: Massachusetts League of Community Health Centers

## Company Profile

### Massachusetts League of Community Health Centers (the League)

**Founded:** 1972, one of the first state Primary Care Associations (PCAs)

**Location:** Boston, MA

**Members:** 52 community health centers with more than 300 access sites

**Services:** analysis, training and education, workforce development, clinical quality, information technology development

**Also includes:** Massachusetts' Health Center Controlled Network (HCCN)

## Program Profile

### MassHealth Accountable Care Organizations (ACOs)

**Basis:** 1115 Waiver, effective July 1, 2017

**Eligible Lives:** 1.2 million

**Number of ACOs:** 17

**ACO Start Date:** March 1, 2018

## Support at the State

Massachusetts has 1.9 million members of MassHealth, the state Medicaid program, of which 1.2 million are eligible to participate in managed care. As a result, the state negotiated a 5-year 1115 waiver, effective July 1, 2017.

The waiver allows the state to engage in a demonstration project in line with the objectives of the state Medicaid program and further, includes \$1.8 billion of investment funds. The 1115 waiver seeks to “transform the delivery of care for most MassHealth members and to change how that care is paid for, with the goals of improving quality and establishing greater control over spending.” (<https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver>). Improving quality and reducing cost are two key tenants of accountable care which the Massachusetts League of Community Health Centers (the League) supports, especially the introduction of new care delivery methods for many of the patients served by Massachusetts health centers.

As part of the 1115 waiver, the state introduced the concept of accountable care organizations (ACOs). Defined by the state of Massachusetts as, “provider led organizations that coordinate care, have an enhanced role for primary care, and are paid based on care outcomes versus the volume of

## MassHealth ACOs

- Atrius Health
- Baystate Health Care Alliance
- Beth Israel Deaconess Care Organization
- Boston Accountable Care Organization
- Cambridge Health Alliance
- Children’s Hospital Integrated Care Organization
- Community Care Cooperative\*
- Health Collaborative of the Berkshires
- Lahey Health
- Mercy Health Accountable Care Organization
- Merrimack Valley ACO
- Partners HealthCare ACO
- Reliant Medical Group
- Signature Healthcare Corporation
- Southcoast Health Network
- Steward Medicaid Care Network
- Wellforce

\* indicates all FQHC ACO

services provided.”(<https://www.mass.gov/masshealth-innovations>). They also provided the framework for three different types of ACOs: Accountable Care Partnership Plans, Primary Care ACOs, and Managed Care Organization (MCO) Administered ACOs, which were all effective March 1, 2018. Overall, 17 ACOs were created among these three (3) types. Health centers are participating and leading in the 13 Accountable Care Partnership Plans and the three (3) Primary Care ACOs. The Accountable Care Partnership Plans exclusively partner with one specific MCO and utilize that MCO’s network of providers to provide integrated and coordinated care. The three (3) Primary Care ACOs contract directly with MassHealth. One unique Primary Care ACO is Community Care Cooperative, which is composed exclusively of 13 Federally Qualified Health Centers (FQHCs) from across the state.

With the waiver having been approved on November 4, 2016, effective July 1, 2017, and the 17 Accountable Care Organizations launching March 1, 2018. The League and many health centers participated in the state’s MassHealth stakeholder work groups, committees and councils, which helped prepare for implementation and served as a venue for the PCA, HCCN, and health centers to become involved in the process with the state and have their perspective taken into consideration. The League was grateful for the state’s focus on primary care and their responsiveness in the process. The extensive preparation time and health center voice resulted in a deeper understanding of health center operations and overall engagement of health centers in the development of the ACO measurements. The support at the state level and the partnership between the state’s Medicaid office, PCA, and HCCN made the implementation process smoother than expected in a complicated and often confusing process.

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## **Team Based Care Requires Team Based Support**

Similar to the partnership between the state and the PCA/HCCN, which was essential for ensuring a smooth implementation, the PCA enhanced internal collaboration and communication focused on ACO and new health plans just as accountable care requires all parts working in coordination. In February, the League started an internal cross-divisional workgroup with representation from all divisions including policy, clinical, health informatics, and workforce. The work-group meetings, which began weekly and have transitioned to twice a month, allow the members an opportunity to share what they are working on related to ACOs, provide updates from their division, and identify state-level activities such as policies that might impact the ACOs’ activities on health centers. This time allows them to discuss and disseminate information they hear from individual health plans and health centers, and focus on the internal education needed for the PCA and HCCN staff. The PCA found this time to be beneficial as an additional way to ensure they are providing timely and helpful support to their health centers. They recommend starting similar workgroups for accountable care efforts as early in the process as possible. The efforts of the ACOs cross many different areas and therefore need to be supported by similar cross-cutting approaches.

The League also appointed one person to serve as the internal point of contact for all MassHealth ACO efforts. That individual knows and speaks the language of ACOs and serves as the “go to” person for questions, of which there are many. It provides for feedback and clarity when there are many new and moving parts. Having one person who is aware and connected to all levels of PCA staff helps to connect the right people and create the best team possible, similar to how a care coordinator might assist a patient in a health center.

## Considerations for Implementation

Any significant change to the payment and care delivery system for some 1.2 million Medicaid members and the providers that serve them is going to come with challenges. Attribution (the process of assigning individual members to providers) was a crucial and sometimes complicated process. For March 1, MassHealth developed a “special assignment” process, which was designed to maintain members’ relationship with their PCP whenever possible. While this process worked smoothly for many members, there were members whose plan assignment was not with their desired PCP, which has been a point of confusion and concern for some health center patients and health centers. Because of the volume of the member transition and the significant changes, from March 1 to July 1 of this year the state allowed for an extended Plan Selection Period so that members could change plans and select the option that was best for them and their care needs. As of July 1, 2018, most managed-care eligible members entered the Fixed Enrollment Period, which means a member cannot change plans until the next Plan Selection Period, which will begin on March 1, 2019, unless they meet and go through an exceptions process. Fixed Enrollment is still a new process (this is only the second time it has been implemented for managed-care eligible members) so everyone is still learning and working through this new process and any challenges impacting members, health centers and plans. The PCA, and its affiliated Health Center Controlled Network, are supporting health centers with training and support for ongoing ACO implementation. The resources they are able to provide to implement the necessary systems changes are made possible in part through an allocation of funds from a Delivery System Reform Incentive Payment (DSRIP) program. The League also supports health centers with workforce initiatives as the main facilitator of a student

loan repayment program. Health centers had to, and continue to, engage in extensive internal education efforts for providers, staff at every level across the health center, and board members about new health plan options.

With support from the state, the PCA, and the health centers, the MassHealth managed care eligible patients in Massachusetts are experiencing a new level of coordinated and comprehensive care. These partnerships and efforts are not without challenges, but over the next five years are expected to result in better quality care and better managed costs for the health care system overall.

### Domains of ACO Measurements

1. Prevention and Wellness
2. Chronic Disease Management
3. Behavioral Health / Substance Use Disorder
4. Long-Term Services and Supports
5. Avoidable Utilization
6. Progress Towards Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services
7. Member Care Experience

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

For more information contact:

Julie Balter, Specialist, Provider Networks

[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Liz Sanchez, MPH, Senior Manager, Policy & Health Access

Massachusetts League of Community Health Centers

[lsanchez@massleague.org](mailto:lsanchez@massleague.org)

And

Diana Erani, MBA, Vice President, Health Informatics

Massachusetts League of Community Health Centers

[derani@massleague.org](mailto:derani@massleague.org)

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# Successful Practices in Accountable Care: Robust Use of Data and Information Health Choice Network

## Company Profile

**Name:** Health Choice Network

**Membership:** 63 Safety Net Organizations in 21 States

**Patients served:** 1,014,481 Patients in 2017

**Total Patient Visits:** 3,892,63 in 2017

**Mission:** Delivering technology solutions to improve health outcomes.

**Core Values:** Integrity, Customer-Focused, Results Driven, Career Growth for Employees, and Work-Life Balance



## Building a Business Strategy

Health centers face challenges every day. They are challenged to evolve and grow in a marketplace that is increasingly competitive. Surviving and thriving in this environment requires health centers to think strategically about how they are operating. One of the lessons health center controlled network Health Choice Network (HCN) has found in serving their 63 customers, including 27 health centers in nine states, is that thinking strategically about operations translates into building a business strategy. A business strategy should look at not just balance sheets and income statements, but should take a holistic approach that also includes looking at the local marketplace in a targeted manner. It also requires considering potential “competitors” such as private physicians who open urgent care centers nearby. There are lessons that can be learned by comparing health centers to their peers.

One of the lessons Health Choice Network learned in assisting their members in building business strategies

is to “invest in the best”. Based on the 330 grant funding, capital improvement funding, quality improvement grants, Federal Tort Claims Act coverage and 340B benefits, health centers have many opportunities to make strategic investment in human and technical resources that can assist them in providing high quality, comprehensive care. Because of the funding health centers receive, they should be the best in quality and have the best resources. Those resources should support the business strategy and allow health centers to continuously improve, market their services, and as a result assist health centers in achieving the quadruple aim.

## Demonstrating Return on Investment

As health centers face challenging times, they are increasingly being asked to demonstrate the return on investment they are able to provide for the resources they receive from partners. Health Choice Network supports their members in using data and information to answer



those questions. Cost data in particular has been helpful as health centers, in comparison to the local emergency room, are less expensive. Health Choice Network is able to use the data obtained from centers to help make this point to health center partners- like insurers. With this information, insurers are paying rates that are competitive in the local marketplace.

The data also demonstrates a return in the quality of care that health centers are able to provide. For example, in 2018, all of the Health Choice Network members received HRSA quality awards. Health centers able to capitalize on the data they receive to improve quality of care are able to in turn demonstrate a greater Return on Investment. According to HCN, quality is more than the clinical metrics that the centers report. It should also take into consideration patient (or customer) feedback, such as the stars a patient awards on Google Maps or the review they leave on Yelp. Health centers should look to all types of information as they position themselves in the marketplace.

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## Addressing Workforce Concerns

A core value of HCN is “we facilitate career growth for our employees.” They state, “our continued success requires us to provide the opportunity for education and development needed to help our employees grow. We will take advantage of those opportunities and keep learning to improve our skills and produce high quality work.” HCN believes investing in staff at all levels is a key component of accountable care and paying staff well, plus incentivizing with benefits, results in high quality care.

There are also ways to address potential issues before they arise if data is trended to predict a problem before it occurs. With good, clean data and the ability to compare information over time, potential issues can be spotted and

solutions can be planned. For example, data analysis can show issues with team make up or reporting structures. It can identify individuals that need training or additional assistance.

Training and assistance is also key to the success of health centers going forward, as is succession planning. Increasingly the data is showing issues of provider burnout. Succession planning can ensure continuity as provider burnout is addressed. Accountable care also requires providers and staff working at the top of their license and additional investment in training can help to achieve that goal. It can also have a direct impact on the return on investment with training on topics such as customer service and workflow operations.

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## Going Forward: Future of Data for Providers of Choice

Health centers are continuously aiming to be providers of choice. Not only does this require a culture and mindset shift through asking questions and challenging the status quo, but it requires thinking strategically about the data that they obtain and how they utilize it. One example is using data to address care gaps. Based on Health Choice Network’s experience, addressing care gaps requires a tactical approach. Similar to demonstrating return on investment, it is wise to assign a cost to missed opportunities for care. The math to determine the cost takes into consideration known data factors such as touch points, hourly benefits and salary, information technology infrastructure cost per user. For no show appointments, health centers can factor in potential Prospective Payment System rates. It is not just about the amount billed. The cost calculation considers incidental expenses. For Health Choice Network they are able to utilize the data they have to create formulas in a dashboard and show the impact of missed opportunities. These dashboards help health centers to be strategic in addressing care gaps.

However, it also requires having robust data. Health Choice Network chooses to focus on Healthcare Effectiveness Data and Information Set (HEDIS), rather than only Uniform Data System or Patient Centered Medical Home. They chose this focus because it requires billing, collecting, coding, and documenting as interrelated factors rather than a singular focus. Having interrelated factors in their data makes it more accurate, comprehensive, and cohesive resulting in more robust information. With that data, health centers are able to address gaps in care, workforce concerns, and demonstrate return on investment.

The one area in which Health Choice Network sees challenges in data is the timeliness of receiving the data. Many health centers have to rely on out of date data, from

months before, that doesn't allow them to be innovative and adaptive. For health centers seeking to improve population health, enhance the patient experience, improve provider satisfaction, and reduce cost, they need to have data that allows them to be responsive and continuously improve. In order to be responsive, they need to have data that is as close to real-time, or immediate, as possible.

With real-time, robust data utilized strategically, health centers can be providers of choice that provide high-quality comprehensive care, regardless of ability to pay. Health Choice Network helps their members to deliver on the mission of the health center program and drive towards the future through the use of robust data and information.

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For more information contact:

Julie Balter, Specialist, Provider Networks

[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Alejandro [Alex] Romillo, President / CEO

[aromillo@hcnetwork.org](mailto:aromillo@hcnetwork.org)

[www.hcnetwork.org](http://www.hcnetwork.org)

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## Successful Practices in Accountable Care: Miami Beach Community Health Center

### Health Center Profile

**Name:** Miami Beach Community Health Center

**Location:** 11645 Biscayne Boulevard, Suite 207,  
North Miami, FL 33181

**Patients Served:**

**Services Provided:** Adult health, behavioral health,  
dental, health education, pediatric, vision

**Patient Mix:**

**Awards:** 2017 HRSA Health Center Quality Leader

### Background – Driving Towards Risk

In 2012, a managed care company presented Miami Beach Health Center (MBHC) with a contract. The only potential problem for MBHC was that the contract required them to take on full risk when they had previously only participated in contracts where the risk was partial and they only shared in the upside portion. MBHC, faced with this choice, ultimately decided to participate in the contract and as a result, learn how to manage their risk. They chose this for two reasons. The first reason was that the health center leadership felt that Medicaid managed care, which was increasingly present in the state, was changing the paradigm and soon they would be forced to accept risk or face losing patients, payers, and financial opportunities. The second reason, and one that was increasingly compelling, came from the results of a few internal “thought experiments”. Within the health center, the senior leadership decided to calculate what the impact of accepting or not accepting the contract would be on their revenue. Based on those calculations, which looked at payments received on a fee for service basis

and projected capitation payments as well as factors such as age and disease states of their then-current patient population, the decision was clear. Rejecting the contract would have caused the health center to lose approximately \$1 million in revenue. The “thought experiments” also showed that rejecting the contract would not save anything in overhead and would have likely changed their payer mix to reduce the number of privately insured patients resulting in even greater expenses. Once MBHC accepted the contract, and the risk that came with it, the health center utilized the contract as a mechanism to drive learning how to take care of patients in managed care.

The process of learning however was not always smooth and to-date, they claim that many of the lessons learned were through trial and error. When they reached out to many experienced members in the field of managed care, including managed care company employees who had worked with other providers before, they actually found that many did not understand the unique challenges of health centers nor the crucial differences between health centers and other providers. MBHC quickly learned the importance of finding partners and models that understood the statutory requirements of the section 330 grant and

### **Considerations for a Full Risk Contract (from MBHC's experience)**

- Payments received on a fee for service basis
- Projected capitation payments
- Total payments received from the Managed Care Organization (MCO) if already contracted
- Risk factors such as age and disease states which will impact future Medical Loss Ratios (MLRs)
- Monthly income statements from MCO
- Detailed claims
- Pharmacy coverage
- Any known future increases or decreased in MCO payments

the pre-existing FQHC prospective payment system, which will affect the transition to managed care. Several of the lessons they learned through experience had to do with gaps in care, which they now excel at addressing, and panel management.

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## **Resources Required**

Members of MBHC's senior leadership team share that while it is not "hard" work, there is a lot of work that one must do under full risk. They provide the example of a pediatric patient who is required to get a series of vaccines. That patient (or the parent/guardian of the patient) needs to be informed and the vaccines need to be addressed when they are in the health center. Following up with the patient to visit the health center requires effort; specifically, it requires every member of the health center from the front desk staff to the providers, including the board and the leadership, to understand all of the requirements so that the entire health center can provide a consistent message and care. Since missing one vaccine can have a domino effect, staff need to understand

the implication of each task. Of the 450 employees at the health center, everyone has to understand "some medicine" such as what the HEDIS score means (Healthcare Effectiveness Data and Information Set) in order to understand the implication of how their part of the process affects the patient in the end. To help educate all of the employees specifically on the impact of their work, they held a round of ten meetings on different measures and metrics to help provide a deeper understanding and answer questions. They continue to provide training on a regular basis as needs shift and new priorities emerge.

Miami Beach Health Center also created a 'gadabase' (their term for a database of gaps in care) document in which they list every single gap for every single population they serve and assign each gap to someone on the care team. In addition to the education around the gadabase, they held meetings with each department to explain the importance in addressing the gaps in care. Addressing the gaps in care isn't simply about managing their risk or the financial implications but rather about the importance of providing excellent care to their patients. The employees at MBHC are proud of the care they are able to provide, not just because of their high quality scores and resulting financial gains from the contract, but because each day they know their patients are receiving the best possible care. By focusing on the impact to patient care over financial implications, MBHC has been successful in getting all of their employees on board with a new way of managing their patient population, even though it was a lot of work requiring a lot of time.

In focusing on compliance, and what measures are needed to push the needle, MBHC was able to improve on their quality. MBHC encourages health centers to look at their numbers and see actionable next steps: who needs potential screenings, why those screenings haven't occurred, and what can we do to get this patient in for a screening? They recommend constant quality improvement cycles with a focus on educating patients, motivating providers, and sharing potential burdens. The quality improvement cycles should include a role for

everyone in the organization from the front desk to the senior leadership. Large-scale participation is essential and they have found these quality improvement cycles to be key in their rising quality scores and successful participation in risk-based contracts.

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## Putting It Together

As Mark Delvaux, Chief Financial Officer of MBHC, stated at the 2018 Policy and Issues Forum, “if we say “no” to every MCO who wants risk, one day there will be no one

left to say no to.” As one of the primary reasons driving them to accept risk over three years ago, they have continued to see a shift towards risk-based contracting. After learning how to manage risk, they have found their relationships with managed care plans have never been better. They also realized that both the managed care plans and the health center have the same objective of increasing the quality of care, improving the health of populations, and reducing the per capita cost of care, even if for different reasons. All parties agree that working towards that shared objective has been mutually beneficial.

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

For more information contact:

Julie Bindelglass, Specialist, Provider Networks

[JBindelglass@nachc.com](mailto:JBindelglass@nachc.com)

Special Thanks to:

Mark Delvaux, Chief Financial Officer, Miami Beach Community Health Center, Inc.

[MDelvaux@HCNetwork.org](mailto:MDelvaux@HCNetwork.org)

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# Successful Practices in Accountable Care: Financial and Operational Analysis, Management and Strategy

## Capital Link

### Company Profile

**Name:** Capital Link

**Description:** Capital Link is a national, non-profit organization that has worked with hundreds of community health centers and Primary Care Associations (PCAs) for over 20 years to plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate value. Established through the health center movement, Capital Link is dedicated to strengthening health centers—financially and operationally—in a rapidly changing marketplace. Capital Link provides an extensive range of services to health centers and PCAs, customized according to need, including: Growth Planning, Capital Planning and Financing Assistance Services; Metrics and Analytical Services; and Performance Improvement Services.

**Key Topics:** Capital project planning and financing, financial and operational performance improvement, national financial and operational trends, operations and facilities planning



## The Importance of Financial and Operational Analysis, Management and Strategy

As new opportunities arise for health centers to reform the way in which they receive reimbursement for comprehensive, culturally competent, and high-quality primary health care services they provide, they must be able to analyze and manage the financial and operational effects of such opportunities. Some of the key considerations are up-front costs of participation, system-level utilization and cost data for patient participants, payment timing and methodology as it impacts revenue cycle management, capacity for performance-based contracts, expertise and experience. One strategy for preparing includes leveraging state and local assistance and funding to support the activity. A great example of implementing this strategy is the technical assistance Capital Link has provided to the community health centers of California in coordination with the Community Clinic

Association of Los Angeles County (CCALAC) since 2015. The program, Advancing Financial and Operational Strength (AFOS), provides health center staff from all levels of the organization, not simply the Chief Financial Officer, with financial and operational benchmarking assistance, tools, and training. With these tools and trainings, health centers have leveraged their knowledge to be better prepared regardless of the payment reform opportunity they are considering or implementing.

## History of Advancing Financial and Operational Strength (AFOS) Program

In 2015, there major shifts in the safety net in Los Angeles, California. CCALAC, the Health Center Controlled Network (HCCN) in the area saw a 100 % increase in Federally Qualified Health Center (FQHC) program grantees and an over 100% increase in sites. There was turnover in staffing and leadership as well as payment

reform opportunities. During this same time, Capital Link shared their expertise from years of working in the field entitled “Failure to Thrive”. This session combined with an examination of financial measures from the field (CFO roundtables sharing unblinded data starting in 2014) led CCALAC to seek out a partner who could help their health centers to thrive and be ready for reform. To support this new program, CCALAC leveraged willing local partners such as a local nonprofit hospital and a local public health plan to obtain the expertise of Capital Link in order to advance their health centers.

The program was envisioned as a one-year test sponsored by Cedars-Sinai, LA Care Health Plan, and Blue Shield of California Foundation. It developed into a comprehensive program, focused on understanding, developing action plans, implementation and monitoring. By bringing in staff from all departments, it assisted in developing common vocabulary, communication, and understanding. This company-wide focus on financial sustainability is viewed by Capital Link as a key for ensuring ongoing access to quality care.

The understanding portion of AFOS focused on assessments and training on metrics and benchmarking and seen as the “100 Series” or baseline knowledge. It helps health centers to understand the current status, opportunities, and challenges and they are assisted in this work by the analysis and support provided by Capital Link. This baseline allows health centers to take the next step towards developing action plans. During this “200 Series”, Capital Link provides training and strategies for improvement, encouraging health centers to prepare for the future. Finally, health centers are able to implement their action plans and monitor in order to adjust as needed. Capital Link provides technical assistance, support, and tracking during this “300 Series” to ensure health centers thrive using their newly gained understanding.



## The First Few Years

During the first year, 32 CCALAC health center members participated. Guided by the leadership of CCALAC a range of executive staff and Board members came together in large group, in-person trainings to learn about financial and operation metrics/benchmarking, drivers of health center success, team-based care, and change management. During that first year, they learned there was a strong interest in communication across position types and centers. They also learned many centers needed extra assistance to understand rapidly as fast growth was happening.

The program continued to grow and was able to sustain itself past the first year. In year 2, 43 health centers participated. The format also expanded to include small group trainings and webinars, in addition to the technical assistance and large group trainings of the first year. Capital Link and CCLAC were also excited to expand the content to include strategic and operational agility, productivity, revenue cycle management, and scheduling strategies. The participants, and the needs they were beginning to see as they considered how to thrive in a rapidly changing environment, influenced these

topics. AFOS began to evolve to focus on a hands-on, action-oriented approach that provided strategies for implementing changes at health centers. The trainings also began to incorporate peer examples and best practices, a sign of advancing strength from previous participants.

In year 3, Capital Link and CCALAC had some surprising findings. One such finding was health centers were eager to participate and willing to contribute financially, evidence of the strong demand for the program. There was ongoing interest and continued momentum as 52 health centers participated, with some entire teams attending. The content in year 3 demonstrated the industry expertise of Capital Link as they included metrics and benchmarking, effective staffing models, market assessments, cost of care, and board member trainings. Capital Link provided data reports, tools, and tool kits, meeting the desires of the participants for an action-oriented training. From the start of the program to today, participants have indicated a 50% increase in above average satisfaction with data collection and analysis.

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## Moving Forward

While some elements of AFOS have remained the same over time, it has also continued to modify in order to respond to the changing marketplace and needs of health centers. It has always focused on the team-based approach for financial and operational excellence. Capital Link and CCALAC have developed a model that shows how all of the different elements are connected which has supported health centers in understanding, developing action plans, and implementing towards financial and operational success.



Key to the success of AFOS and the health center participants was collaboration and communication, commitment, customization, and comprehension. These elements combined have created a training program that equips health centers for the new opportunities arising and are a model to be considered for anyone embarking on accountable care.



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

For more information contact:

Julie Balter, Specialist, Provider Networks

[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Susan Petrie, MBA, Chief Operating Officer, Capital Link

[spetrie@caplink.org](mailto:spetrie@caplink.org)

Louise McCarthy, MPP, President & CEO, Community Clinic Association of Los Angeles County

[lmccarthy@ccalac.org](mailto:lmccarthy@ccalac.org)

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# Successful Practices in Accountable Care: Change Management and Service Delivery

## Ammonoosuc Community Health Services (ACHS)

### Company Profile

**Name:** Ammonoosuc Community Health Services (ACHS)

**Established:** 1975, Federally Qualified Health Center (FQHC) since 1994

**Locations:** Littleton, Franconia, Warren, Whitefield, and Woodsville, New Hampshire

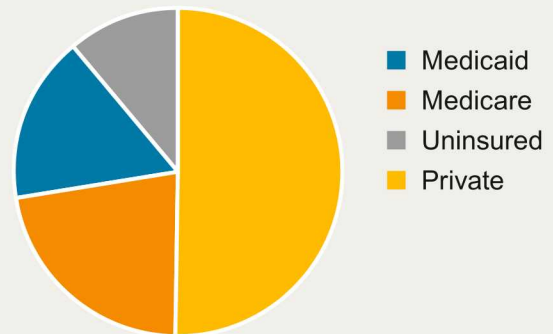
**Patients served:** Over 10,000 (11,209) with a ~7% prevalence of patients with diabetes

**Services:** Medical, Dental, Nutrition and Wellness, Behavioral Health, Vision Care, Substance Use Disorder, Patient Support, Clinical Pharmacy/Pharmacist

Source: Shanshala, Ed (March 29, 2019) In-Person Interview.  
Shanshala, Ed. (2019). Colorectal Cancer Screening: Different Paths to 80% [PowerPoint slides]. Retrieved from <https://bphc.hrsa.gov/qualityimprovement/index.html>.  
2017 Uniform Data System (UDS).



**Payer Mix:** 10% Uninsured, 15% Medicaid, 20% Medicare, 46% Private Healthy People 2020: In 2018, ACHS surpassed the Healthy People 2020 goal of 70.5% of adults receiving colorectal cancer screening based on the most recent guidelines by 11.95 percent.



Ammonoosuc Community Health Services, Inc. (ACHS) has achieved an 81.67% colorectal cancer screening rate (compared to the Uniform Data System screening rate of 42% in 2017) making them one of the top in the nation addressing this critical need consistently. In 2018, they exceeded that rate with 82.45% of adults 50-75 years of age who had appropriate screening for colorectal cancer. ACHS is located in a rural community. The health center serves twenty-six towns with a population of 31,000 residents. Given the area, rural northern New Hampshire, and the population served, ACHS decided to focus on increasing their colorectal cancer screening rates. The entirety of the health center from providers to patients, embarked on a change management process to increase screening rates. ACHS credits their success to (1) an organizational culture of improvement, (2) regular, actionable feedback loop to clinical staff through

Continuous Health Improvement (CHI) Team work, (3) patient engagement strategies, (4) well developed tracking mechanisms to help identify gaps in care, and (5) implementing utilization of the immunological fecal occult blood test (iFOBT).

Key to ACHS efforts was the integration of quality improvement into the culture of the health center. Culture plays a large role in all efforts at ACHS. Ed Shanshala, Chief Executive Officer, describes his role at the health center as co-creator, cultivator, and curator of culture, including clinical culture. In this role, he does not focus on administrating policy, procedure, and the status quo. Rather, he works with all employees of the health center to ensure they have the resources needed to best serve patients and to remove obstacles that prevent the employees from attending to patients' needs. He is

### **Crucial Elements of Success**

- Organizational culture of improvement
- Regular, actionable feedback loop to clinical staff through Continuous Health Improvement (CHI) Team work
- Patient engagement strategies
- Well-developed tracking mechanisms help identify gaps in care
- Change to iFOBT

committed to overcoming technical issues and assisting others in finding solutions that maximize the health center's relationship with their patients.

The senior leadership and board of directors are supportive of the perspective and culture the CEO has developed where the patients are treated as the shareholders, and ACHS works for the patients. This perspective empowers the patients to take ownership of their care and in the health center. ACHS further empowers their patients through engagement in screening. In the bathrooms of ACHS, they have posters to dispel colorectal cancer screening myths. The health center is consistent and persistent in their messaging. It is clear to all patients the message ACHS is sending is the importance of being screened for colorectal cancer. ACHS consistently designs their messages with "readiness to change" in mind and vary their approach depending on their audience, including providing information, scientific research, or personal recommendations.

All employees at ACHS believe in the power of Quality Improvement (QI). Quality Improvement is seen not as a task or committee to be completed in isolation within the organization. QI training is incorporated into employee onboarding. The senior leadership team and board have

created a QI Plan that aims to provide the highest quality care that improves the health of their population. The QI Plan is the foundation for many of their efforts and is supported by regular, open communication pathways. For example, the CEO of ACHS provides his cell phone number to all patients and employees. Improvement is based on honesty and trust, which ACHS has cultivated throughout the organization.

One way in which ACHS approaches QI from the perspective of collaboration is their use of a Continuous Health Improvement (CHI) Team. The CHI Team gathers for monthly, interdisciplinary meetings to discuss systems issues that are barriers to care. Quarterly, screening rates are reviewed at the CHI Team meetings, ensuring timely feedback. The providers collaborate to address different screening rates such as Cervical Cancer, Tobacco Use, and Body Mass Index. The CHI Team also routinely reports to clinical teams that serve as a prompt for the clinical teams to perform patient outreach regarding gaps in care.

As an organization, ACHS is committed to strategically tackling gaps in care, addressing gaps by looking at the data and mapping processes to determine traffic patterns. Determining traffic patterns can show wait and delays or duplication of effort, resulting in more efficient and effective workflows. For example, monthly tracking reports include colonoscopy consults. ACHS also includes in every office visit a preventative care form that states the date of last colorectal cancer screening. This prompts the clinical staff to ask the patient if they are overdue for screening. ACHS designs processes not around the outlier, but rather for the majority of their patients.

ACHS patient access specialists, who are the first to meet and see a patient at each visit to the health center, have a relational role with the patient and are meaningfully engaged in each patient's care. ACHS has also built relationships with other providers outside the health center

to track if patients have been referred for a colonoscopy that was not scheduled or performed. By engaging in change management at the health center, and improving internally, the health center is able to improve externally as well by engaging in relationships to support their patients.

Finally, ACHS was able to increase its colorectal-cancer screening rate by implementing a different type of screening. Since implementing iFOBT, the colorectal cancer-screening rate has increased by 14.75% (from 67.7% in 2014). The iFOBT is an easy-to-use test for identifying blood in stool, which does not require any changes in diet and is completed in the privacy of a patient's home. It also allows patients to return a collection

tube rather than a stool sample. According to ACHS, the iFOBT has been a much better alternative accepted by their patients.

While colorectal cancer screening is one important quality measure, it is not the only one ACHS focuses on. Their approach to improving the measure is what they continue to follow for other measures and used as a model for other health centers. By focusing on quality improvement as an element of culture, working as a team, engaging patients, and having open communication and timely feedback, there is no limit to the improvements seen in the health and lives of patients.

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

For more information contact:

Julie Balter, Specialist, Provider Networks  
[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Edward D Shanshala II, MSHSA, MEd, Chief Executive Officer,  
Ammonoosuc Community Health Services  
[Ed.Shanshala@achs-inc.org](mailto:Ed.Shanshala@achs-inc.org)

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# Successful Practices in Accountable Care: Building Capacity to Support Accountable Care Efforts Washington Association for Community Health

## Organization Profile

**Name:** Washington Association for Community Health

**Year of Incorporation:** 1985

**Number of Health Center Members:** 27

**Number of Health Center Member Sites:** Over 300

**Number of Patients Served By Member Health Centers in 2018:** Over 1 Million

**Key Member Service Demographics:** Member health centers served over 100,000 patients experiencing homelessness, 23,000 veterans, 280,000 patients in a language other than english, 59% of patients covered by medicaid, and over 1 million dental care visits in 2018

**Areas of focus:** The Washington Association for Community Health provides services to their members in three overarching categories (1) policy advocacy and implementation, (2) capacity building, and (3) convening community health centers

**Mission:** To strengthen and advocate for Washington's Community Health Centers as the build healthcare access, innovation, and value



Washington Association for Community Health  
Community Health Centers • Advancing Quality Care for All

## Introduction

Committed to building capacity among Health Centers in Washington State, the Washington Association for Community Health (“The Association”) has supported member health centers in transforming care for the over 1 million patients the health centers served in 2018. The Association’s capacity building efforts and the training and technical assistance through which capacity was built, focused on six key areas: (1) workforce development, (2) Institute for Rethinking Education & Careers in Healthcare (In-REACH) apprenticeships (a workforce development program which trains medical assistants), (3) outreach and enrollment, (4) practice transformation, (5) oral health, and (6) behavioral health. These key areas reflect the highest need of the member health centers and “enable community health centers to deliver effective, evidence-based care to (the) patients.” Through one-on-one coaching, group trainings, connection to industry experts and resources, collaborative process improvement, and facilitated peer discussions (leveraging The Association’s convening power), The Association demonstrates best

practices in ever-changing times. In order to organize the many ways The Association supports health centers engaged in accountable care, this publication focuses on the three domains of NACHC’s Value Transformation Framework (Infrastructure, Care Delivery, and People). In doing so, organizations can consider the capacity needed to support health centers in the transformation from volume to value and have tangible examples of successful strategies plus a conceptual model in which to organize those examples.

The Value Transformation Framework, developed by NACHC’s Quality Center, is a conceptual model designed to help health centers transform from a volume-based, to a value-driven, model of care. It distills research and evidence-based practices into clear pathways for change. The Framework organizes health center systems into three domains – infrastructure, care delivery, and people—and 15 change areas. For more information about the Value Transformation Framework, please see: <http://www.nachc.org/clinical-matters/value-transformation-framework/>

## Infrastructure

The “Infrastructure” domain of NACHC’s Value Transformation Framework features five change areas: improvement strategy, health information technology, policy, payment, and cost. In the past few years, The Association has focused on key quality measures meant to

### Key Quality Measures

1. Comprehensive diabetes care - poor HbA1c control (>9%)
2. Comprehensive diabetes care - blood pressure control (<140/90)
3. Controlling high blood pressure (<140/90)
4. Childhood immunization status - combo 10

impact the overall health of the population served by member health centers which illustrate the importance of the five change areas. The measures reflect Uniform Data System (UDS) and payment methodology priorities, and were ultimately self-selected to focus on by the health center members. The measures are focused on diabetes (comprehensive diabetes care - poor HbA1c control (>9%) and comprehensive diabetes care - blood pressure control (<140/90)), hypertension (controlling high blood pressure (<140/90)); and childhood immunization status (combo 10). By focusing on these measures, among the many different clinical measures and opportunities for quality improvement, The Association is able to “effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience”. For example, in their work on Diabetes, the Association collaborated with the American Diabetes Association which led to 31 community health workers signing up to be Diabetes Ambassadors in their community. According to the American Diabetes Association, Diabetes Ambassadors “implement informational diabetes workshops and other educational initiatives that promote healthy eating, physical activity, and diabetes self-care in their communities and among their peers.” An increase in Diabetes Ambassadors has helped health centers in addressing diabetes care measures.

They also offer supplemental training in change management (practice skills to support effective change), Lean six sigma, motivational interviewing, social determinants of health (SDoH), and trauma – informed care. Additionally, The Association offers data analytics and support for health centers through the development of consistent metrics for quality initiatives allowing the health centers to better track progress. With The Association’s support, health centers have learned about data validation practices and what to look for in choosing health information technology tools. Staff at The Association recognize the value of using data to drive performance improvement as demonstrated by the use of quarterly data submissions by their quality improvement work group. Similarly, through the utilization of health information technology tools and support from the Association, member health centers are able to take a data-driven approach to transformation by tracking, improving, and managing health outcomes and costs. This data-driven approach has demonstrated impact as seen by improvement on key measures by many of the health centers from 2016 to 2018. The Association also utilizes data to drive health center innovation. A recent project described literature on SDoH and diabetes, screening tool uses and pilots and magnitude of risk for diabetes with the hopes of future health center participation in research which could impacts patients at the health center, state, and even national level.

## Care Delivery

The “Care Delivery” domain of NACHC’s Value Transformation Framework features five change areas: population health management, patient-centered medical home, evidence-based care, care coordination and care management, and social determinants of health. The Association relies on practice transformation as the basis for the memberships’ ability to expand access to care and additional services. The Association provides support for population health management through peer learning opportunities and the supplemental quality trainings

such as their work around change management. The Association also offers resources for member health centers seeking Patient-Centered Medical Home (PCMH) status from the National Committee for Quality Assurance (NCQA). Specific to those members seeking PCMH status, The Association provides project management assistance, document review and feedback, NCQA resources and timelines (such as a regularly updated frequently asked question document), and a peer-link with other health centers who have or will be going through the recognition or renewal process. The support provided by The Association is tailored to each health center and recognizes PCMH is just one of the ways in which health centers are approaching care delivery.

Other ways in which health centers are approaching care delivery which The Association supports is through an emphasis on evidence-based care and care coordination and care management. For example, in 2018 and 2019, The Association presented trainings on topics ranging from the [Health Network Program](#) to [blood pressure measurement and management](#). They also presented a webinar series on “Putting PCMH into Practice” which explored not only the process for recognition but also how health centers could implement team-based care, manage their patient population, patient-centered access, care transitions, and performance measurement among other topics. In 2018, The Association designed a Social Determinants of Health screening implementation tool kit and provided data analysis for health centers participating in a national pilot program (PRAPARE). Trainings and resources like the ones highlighted exemplify how The Association seeks to support health centers as each one builds healthcare access, innovation, and value through transforming care delivery.

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## People

The “People” domain of NACHC’s Value Transformation Framework features five change areas: patients, care teams, leadership, workforce, and partnerships. In each of these five change areas, The Association supports health centers take actionable steps. As demonstrated by the reach of their member health centers, their mission, and their actions, patients are at the heart of all of The Association’s work. As many of the staff at The Association are patients at member health centers, they utilize their lived experience to incorporate the patient perspective into their work and, as a result, design processes meant to improve the patient experience. The Association also encourage team-based, coordinated care among doctors, mid-level practitioners, pharmacists, and patient navigators and advocates for policies to support health centers’ ability to provide such care. Through training and technical assistance, The Association is leading the way for health centers to provide quality, comprehensive care which is an essential part of the quadruple aim. Leadership is supportive and encouraging and utilizes the feedback from their members to drive their work and priorities. They also analyze Uniform Data System (UDS) metrics to inform training and technical assistance and are responsive to changing environmental factors. For instance, as health centers were facing transformation challenges, the Association began offering change management training in collaboration with Integrated Work Strategies called the “4D Approach to Change Management”. At the change management training, attendees came with a specific change idea (for example a workflow or process change) they were trying to implement in their health centers. During the in-person training, attendees developed an action plan which demonstrated their ability to put into practice the theories being taught at the training.

**24**

Number of Health Centers  
in Washington with PCMH  
Accreditation in 2018

Workforce is another key area in which The Association supports their members. Not only does the Association assist with recruiting and retaining highly-skilled health professionals, it conducts workforce development events to help health center staff gain skills necessary to address a changing population and shifting needs. When The Association saw the rate of turnover for medical assistants in health centers, they developed a program (In-REACH Apprenticeship Program) to support on-the-job training and certification of Medical Assistants. This program has led to an increase in retention rates, especially as compared to the national average (the two-year retention rate is above the 80th percentile). The In-REACH program also has a unique partnership with local community colleges to allow participants to earn college credits at the same time. The Association assists in addressing changing workforce needs including team structure, hiring, and additional training. Finally, The Association wants to enable expansion of the primary care team through partnerships. As an association, it brings their members together to partner, collaborate, and advance health care

access and outcomes. In the Association's words, "by working together, community health centers exchange ideas, identify shared concerns, and develop solutions that benefit patients." Partnerships are key to the successful outcomes envisioned for health centers in Washington State and the patients.

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## **Conclusion**

Through policy advocacy and implementation, convening, and capacity building, health centers in Washington are supported by The Association in the pursuit of the Quadruple Aim. As exemplified by The Association's work in the domains of infrastructure, care delivery, and people, health centers are able to focus on improving the patient experience, health outcomes, cost of care, and care team well-being. This enables the health centers to better serve over 1 million patients. The work of The Association and their 27 member health centers is a model for strategic goals and actionable steps to advance quality care for all.



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For more information contact:

Julie Balter, Specialist, Provider Networks  
[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Ashley Grant, MPH, LSSGB, PCMH CCE, Director, Training and Technical Assistance,  
Washington Association for Community Health  
[AGrant@wacommunityhealth.org](mailto:AGrant@wacommunityhealth.org)

Hannah Stanfield, Coordinator, Practice Transformation,  
Washington Association for Community Health  
[HStanfield@wacommunityhealth.org](mailto:HStanfield@wacommunityhealth.org)

Ian Randall, PhD, Senior Strategy Advisor,  
Washington Association for Community Health  
[IRandall@wacommunityhealth.org](mailto:IRandall@wacommunityhealth.org)

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# Successful Practices in Accountable Care: Organizational Leadership and Partnership Development Iowa Primary Care Association

## Company Profile

**Name:** Iowa Primary Care Association

**Membership:** 13 Community Health Centers and 1 Migrant Health Program

**Patients served:** More than 203,000 per year

**Total Patient Visits:** 728,000

**Mission:** To provide leadership by promoting, supporting, and developing quality health care for underserved populations in Iowa.

**Vision:** Support a strong system of care so that all people in Iowa have access to a quality health home

**Core Values:** Collaboration, Forward Thinking, Stewardship, Appreciation, Commitment, Integrity. For more information on these values please see: <https://www.iowapca.org/about-us>.



The Iowa Primary Care Association (PCA) believes, “the only way to predict the future is to create it.” Now, more than ever, given the change in healthcare payment and delivery, health centers need to take an active role in creating their own future. Organizational leadership and partnership development are key domains health centers have control over, which allow them to shape their future. Iowa PCA exemplifies this domain in two key inter-related activities. The first, focused on leadership development, is the shift from annual performance reviews to ongoing performance coaching. The second, focused on partnership development, is a multi-year effort to establish an integrated primary care network called IowaHealth+.

## Organizational Leadership and Performance Coaching

The 2016 Iowa PCA Employee Engagement survey demonstrated the existing performance management process was not working. The employees found undertaking annual employee performance reviews was ineffective and onerous, that the goals set, quickly became outdated as priorities and activities shifted, and team leaders were challenged in their ability to apply evaluation criteria consistently (as different team leaders had different ideas of “satisfactory” or “exceptional” performance) to all employees across the organization. The new performance coaching process the Iowa PCA decided to utilize is a research-informed approach developed by Kathryn Oakes and piloted at the Colorado PCA in 2016. In the new approach, employees complete and review a goal setting template with their team lead. They also have the option to complete a quarterly performance form and

discussion guide in preparation for quarterly coaching conversations. By having conversations more than once a year, the goals are able to be agile and adapt as priorities shift, addressing a major concern with the previous annual review process. Team leaders then review the goal setting template, have the option to complete the quarterly performance form and discussion guide, and complete a five question yes/no quarterly snapshot form with their employees, as well as with their supervisor. This snapshot form reduces administrative burden by decreasing the number of questions to answer, paperwork to fill out, and filing to maintain for both the employee and the team lead; addressing the concern that the old process was onerous.

### **Purpose of Performance Coaching Process**

1. Increase organizational effectiveness
2. Develop people
3. Reward fairly

The purpose of Iowa PCA's new coaching process is to increase organizational effectiveness, assist staff with professional growth and development, and reward fairly (considering both compensation and recognition). The new

coaching process helps to further the mission, vision, and values of the Iowa PCA organization. Team leaders often refer to and reference the mission, vision, and values of the organization in the process. It also takes into consideration leadership expectations. Perhaps most importantly, it individualizes the organization's strategic plan to each employee and challenges them to achieve the three purposes of performance coaching. The goal setting process allows individual goals to be connected to team priorities and linked to the strategic plan. Reflecting on the reason behind the change, the goals are employee driven with team leader agreement. The goals are seen as a way to drive great achievement.

Iowa PCA realized this new process required new skills for their leadership staff at all levels, but especially their team leads. They engaged a consultant to enhance their leads'

### **Weekly Huddle Objectives**

- (1) Facilitate communication between staff on important projects
- (2) Provide a broader understanding of the strategy and operations of the different organizations (PCA, HCCN, Integrated Primary Care Network)
- (3) Increase leadership visibility and provide an opportunity for employees to provide direct updates and feedback

ability to effectively coach staff in pursuit of organizational and development goals. The consultant has focused on communication, delegation, accountability, and talent and skill identification. Communication is seen as key to increase employees' sense of purpose, appreciation, and cohesiveness. In order to develop a culture of communication, Iowa PCA has implemented an all staff weekly huddle to start the week, weekly one-on-ones between employees and supervisors, quarterly all staff meetings, quarterly performance coaching conversations, as needed team meetings, and fun reward and recognition events throughout the year. The various opportunities to communicate with one another is key to the culture and leadership development.

As compared to the weekly huddle, the quarterly all staff meetings are more in-depth. The agenda includes progress on strategic priorities, year to date financial performance, broader learning opportunities, employee training opportunities, communication with leadership, an opportunity to recognize employees, and an opportunity to connect with others in the organization. With a focus on the strategic plans for the future, Iowa PCA is creating the future they want to see. Already, they are seeing an improvement in employee response in their employee engagement surveys, employee retention, and overall organizational effectiveness. On their most recent

employee engagement survey, 82% of respondent stated that the quarterly performance process added to their overall satisfaction and 96% said that the employee driven quarterly performance process is effective. As an organization, they are developing strong future leaders who will be able to respond to and manage change, a key to readiness for payment reform. Similarly, they have been able to bring in and further develop staff expertise to better support health centers in both their daily operations as well as preparing for future developments in payment and care delivery.

## Partnership Development

IowaHealth+ is an integrated primary care network that was created in 2011 in response to opportunities with the Medicaid program. The Iowa PCA Board Members came together to address the increasing complexity in the healthcare environment. Specifically, they discussed what does the burgeoning conversation around the desired move to value-based care and payment mean for health centers, what proactive steps could they take to position health centers to navigate the new territory from a position of strength, and what is the role of health centers as it relates to potential hospital system partners. By having these strategic forward-thinking discussions, they realized that developing a network would allow health centers to focus on the high-quality, cost-effective care they are able to provide while delegating health system reform to the network which is better able to manage the complexity through engaging multiple health centers. At its core, IowaHealth+ is a voluntary business association of primary care providers that can demonstrate financial and clinical integration.

IowaHealth+ brings an alignment of organizations together to support the health center. The Iowa PCA provides policy and advocacy leadership, quality and performance improvement, emerging programs, workforce

### ***IowaHealth+: Network Overview***

**Owners:** 11 health centers (AllCare Health Center, Community Health Center of Fort Dodge, Community Health Centers of Southeastern Iowa, Inc., Community Health Centers of Southern Iowa, Crescent Community Health Center, Peoples Community Health Clinic, PHC Primary Health Care, Promise Community Health Center, RiverHills Community Health Center, and Siouxland Community Health) and the Iowa PCA

**Patients Served:** 160,900+

development, outreach and enrollment, health center development and expansion, and communication. Health Centers are further supported by InConcertCare, the Health Center Controlled Network sister company managed by Iowa PCA. InConcertCare provides hosted applications and vendor management, electronic medical record (EMR) implementations and training, practice management and revenue cycle, clinical analytics and data warehouse, performance improvement coaching, interoperability, HIPAA privacy and security services. This allows IowaHealth+ to focus on performance improvement learning collaboratives, value-based purchasing and payment reform, data analytics and reporting, attribution assistance, risk stratification, care coordination, and population health efforts. They are able to partner and contract with Medicaid Managed Care Organizations on behalf of the collaborative health centers as a whole. By working in coordination, these three organizations are able to provide a full range of support to health centers approaching accountable care initiatives and increasing the individual health center's capacity. Already, IowaHealth+ has been able to demonstrate the eleven health centers participating in IowaHealth+'s learning collaborative were able to increase hypertension control by over 10% to 74.4% from 2015 to 2017 for the more than 160,900 patients IowaHealth+ serves. They were also able to increase the percent of patients over the age

of 18 who received tobacco use screening and cessation counseling from 91% in 2014 to 95.1% in 2017. By focusing on accountability, methodology & tools, coaching and mentoring, and building culture they are able to empower, change, and achieve.

In order to continue to make progress, the eleven health center owners of IowaHealth+ and the PCA came together in 2018 to undergo an intensive, six month roadmap planning process to determine the value of the network, the direction, and how they can get to where they desire to be. The planning process included three all-day, in-person workshops, interviews with health center leaders, staff, and key partners, and frequent discussion with the standing committees of the network. This ensured meaningful input and buy-in from all of the participants. It also has been helpful as they are implementing the strategic plan to help addressing the challenge of aligning health center and network goals.

One key in realizing the future state the network desired, was the implementation of leadership and change management training. This allows health centers to enhance the capacity of leadership to manage expectations, which is necessary in the changing environment. Effective communication is crucial. Effective communication includes sharing data openly, choosing vocabulary carefully, and aligning organizations' strategic plans. The Iowa PCA and IowaHealth+ is "increasingly convinced that supporting health center CEOs and other members of the leadership team's ability to apply effective leadership strategies to navigate the demands of the move to value based care and engender engagement and buy-in from staff is key to our success." Much like what the PCA implemented internally, they are developing, and articulating, a leadership support and development strategy externally, with the health center network owners.

By working in partnership, health centers benefit. Rather than allowing themselves to be buffeted by whatever winds are blowing – which they see as exhausting and ineffective for reaching potential – they are proactively planning. Through the coaching of employees to become well-developed leaders, Iowa PCA and IowaHealth+ are creating their own future, which allows them to better achieve their mission in providing high-quality care.

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

For more information contact:

Julie Balter, Specialist, Provider Networks

[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Aaron Todd, Chief Strategy Officer, Iowa Primary Care Association

[atodd@iowapca.org](mailto:atodd@iowapca.org)

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## Successful Practices in Accountable Care: Model for Value Based Care and Contracting

### Organization Profiles



	Michigan Primary Care Association (MPCA)	Michigan Quality Improvement Network	Michigan Community Health Network
<b>Name:</b>	Michigan Primary Care Association (MPCA)	Michigan Quality Improvement Network	Michigan Community Health Network
<b>Year of Incorporation:</b>	1978	2012	2015
<b>Number of Health Center Members:</b>	45	40	44
<b>Number of Patients Served By Member Health Centers in 2018:</b>	Over 700,000 across Michigan with approximately 135,000 covered within the network		
<b>Number of Health Center Sites:</b>	Over 270		
<b>MPCA Mission:</b>	The Voice of Michigan Health Centers		
<b>MPCA Strategic Goals:</b>	Delivery System Transformation, Importance of Data & Analytics, and Payment Reform		

## Introduction

Across the country, more health centers are participating in value-based contracting, specifically through Clinically Integrated Networks (CINs). Primary Care Associations (PCAs) and Health Center Controlled Networks (HCCNs) have played a critical role in the planning and development of CINs in their states. Through the process, both the PCA and HCCN have helped health centers to address challenges and, ultimately enhanced revenue generation for health centers.

Michigan Primary Care Association (MPCA), with their embedded HCCN (Michigan Quality Improvement Network (MQIN)), has served as the incubator and support for a health center led CIN in Michigan, the Michigan Community Health Network (MCHN). MCHN

demonstrates the importance of PCAs and HCCNs collaborating and working together, leveraging the strengths of each organization in a model for value based care and contracting.

### Clinically Integrated Network (CIN)

Defined as a collection of health providers that join together to improve care and reduce costs. There are legal requirements to demonstrate clinical integration. For more information on CINs see: Accountable Care Best Practices: AllianceChicago

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## Addressing Challenges

It is no secret that caring for over 29 million patients in today's complex health care environment comes with challenges for community health centers. Two of the most pressing challenges identified by MPCA include the use of health information technology (HIT) and electronic health record systems (EHR) data and, the transition from fee for service to value-based care and contracting. The state's PCA and HCCN have witnessed the growth of health centers over the past five years; many health centers who had struggled to implement EHRs are now leveraging EHRs for more analytics. Health centers have transitioned from talking about value based care to actively participating in value based payment arrangements. As a result, MPCA wants to ensure its members understand that successfully participating in value based contracting supports not just the individual health center, but contributes to all health centers becoming financially sustainable. Financial sustainability refers to ensuring health centers are compensated for their current work they are already engaged in (ranging from quality improvement programs to team based care) to support the mission of providing accessible quality care for all.

Through the development of the CIN, MPCA and MQIN are able to support data analysis and validation, standardization of workflows, implementation of clinical guidelines, and capacity building efforts. The participating health centers are able to leverage the advocacy and

### **Health Center Challenges\***

- Health Information Technology/EHR Challenges
- Inability to Integrate Clinical, Financial, and Operational Data
- Lack of Process and Workflow Standardization
- Regulatory and Reporting Requirements
- Reimbursement and Payment Issues
- Provider Burnout
- Workforce Shortages
- Emerging Health Care Issues

\*As presented by MPCA at the 2019 NACHC PCA and HCCN Conference

training capabilities of the PCA and the infrastructure and technology of the HCCN to increase quality and outcomes of the network. For example, the PCA and HCCN both had a shared goal of ensuring health centers received Primary Care Medical Home (PCMH) accreditation. The PCA provided training and technical assistance to the centers and the HCCN ensured the centers had the HIT capacity to successfully manage transitions of care and care support (critical elements of PCMH). As a result, 33 health centers, the majority of the health centers in the state, have received PCMH accreditation; the elements required accreditation have been utilized within the CIN.

The organizations also recognize that it is critical to address the challenges by bringing the health centers together. To bring the health centers together they have involved health center staff at all levels, from different backgrounds and roles, representing all types of health centers in the state (from urban to rural and small patient population size to large) from the beginning of any decision making process. The PCA, HCCN, and CIN are aligned through common areas of focus (clinical quality measures and health information exchange and interoperability initiatives) and member representation. These organizations seek to align people, process, and technology to solve many of the challenges health centers face.

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## Lessons Learned

As part of the CIN formation process, MPCA and MQIN met with and learned from their peers – PCAs and HCCNs in other states. Some of the lessons they learned from their peers were potential pitfalls and strategies that had not worked. In learning from their peers, they were able to avoid mistakes. It's important therefore, to consider the lessons MPCA and MQIN learned in the formation of MCHN.

Health center that participate in MCHM must meet certain requirements. MCHN members are expected to adopt standards of care, improve workflows, maintain a care registry, and participate in education, continuous quality improvement activities, and routine communication. Health centers who met these expectations have seen a return on their investments, both in terms of financial success



## Lessons Learned

- Flexibility required as each health center is different
- Need for patient outreach and engagement
- Automated data sharing – single Integrated Data System
- Audit health plan data
- Sustainability (balance costs / need for resources)
- Accountability (performance / participation)
- Payment based upon group performance
- Focus on a defined set of HEDIS Measures to move the needle
- Meet annually with health center executive teams to review performance, to set goals for improved performance, and show the resulting impact on the health centers payments

\*As presented by MPCA at the 2019 NACHC PCA and HCCN Conference

and clinical quality scores. MCHN and the organizations that support it recognize that each health center member is different and requires different levels of support. MCHN approaches the support with a mindset of empathy, seeking to understand how to best help and achieve network-wide success. As a network, the performance of one member impacts the others; therefore, it is important to work together to address challenges identified.

The CIN also recognized the importance of demonstrating return on investment and maximizing savings by approaching endeavors as a collective, rather than as an individual centers. A critical function of the MCHN team is making sure costs are balanced with the need for resources. For example, the network is currently evaluating applications for patient outreach.

One initiative that demonstrated the value of the network was in the need for an integrated data system. The health centers in the network were quickly adopted a system that would allow them to consolidate EHR platforms, aggregate data, and validate data. The ability to share data and utilize the tool to bring in additional data has been a success of MQIN which furthered the sustainability of MCHN and participating health centers.

## Next Steps

Michigan Community Health Network currently has contracts with Meridian Health Plan and Molina Health Plan and 30 health centers participate in those contracts. Going forward, MCHN plans to increase the number of patients covered under those Medicaid plans, the number of health centers participating in those contracts, and secure additional contracts. In 2020, MCHN anticipates having contracts with Aetna Health Plan and McLaren Health Plan, which will allow them to serve an additional 51,000 Medicaid patients, a growth of almost ten percent over one year. The health centers that participate are able to utilize the data and technology to evaluate additional contracts.

The network is also looking to move the needle on quality measures and population health. They are doing this by aligning uniform data system (UDS) measures, Human Resources and Services Administration (HRSA) priorities, and healthy people 2020 goals with HEDIS measures. By focusing on a select number of measures, they expect health centers to be able to make a difference in the overall health of the patients they serve.

## Conclusion

Through shared leadership, staff, and a common strategic vision, MPCA, MQIN, and MCHN are able to serve as a model for value based care and payment. Working together to address challenges and learning along the way has led to their success. The organizations reiterated the importance of their collaboration and collective impact. It is not just one health center, or one PCA, or one HCCN, but a network across the country serving those in need of affordable, high quality care.

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

For more information contact:

Julie Balter, Specialist, Provider Networks  
[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Faiyaz Syed, MD, MPH  
Chief Medical Officer, Michigan Primary Care Association

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# Successful Practices in Accountable Care: Arizona Alliance For Community Health Centers: Oral Health for Whole Person Care

## Organization Profiles

**Name:** Arizona Alliance For Community Health Centers (AACHC)

**Year of Incorporation:** 1985

**Number of Health Center Members:** 23

**Number of Health Center Members Providing Oral Health Services:** 18

**Number of Patients Served By Member Health Centers in 2018:** Over 600,000

**Number of Health Center Sites:** Over 180

**AACHC Mission:** Promoting and facilitating the development and delivery of affordable and accessible community-oriented, high quality, culturally effective primary healthcare for everyone in the state of Arizona through advocacy, education, and technical assistance.

**AACHC Services:** Advocacy/public & media relations, central Arizona Area Health Education Center (CAAHEC), establishing and developing health centers, group purchasing organizations oral health, outreach & enrollment, peer networking committees, population health, quality improvement rural health, workforce development.

This document provides a brief overview of one state's effort to recognize the value of integrated oral health care services in the primary care setting. In highlighting the Arizona Alliance for Community Health Centers (AACHC), Arizona's state-wide primary care association (PCA), this publication examines critical challenges, opportunities to overcome those challenges, and outcomes that others considering service integration should consider in their efforts to improve health outcomes with adequate payment state-wide.

## Introduction

AACHC recognizes the importance of oral health as a key element of overall health and sees how patients benefit from the integration of primary care and oral health. Although there was recognition that dental services were a service that Federally Qualified Health Centers (FQHCs) were providing, there has always been an assumption that FQHCs would provide a broad range of services to address the needs of the patients, without a real recognition that what the FQHCs were doing was integrated care.

However, the formal process of integration, specifically primary care and oral health providers working together using a systematic approach, has demonstrated the importance of oral health as an element of accountable care.

The integration of oral health is a long standing challenge, which AACHC has been seeking to address for over 30 years, making large strides along the way. This integration is in line with the PCA's mission of facilitating the development and delivery of affordable and accessible community-oriented, high quality, culturally effective

## *Arizona 2019-2022 state Oral Health Action Plan*

- Aims to offer a vision, articulate goals, deliver recommendations, and identify strategies to improve oral health of all Arizonians
- Three year collaborative process involving health care stakeholders, state and regional oral health coalitions educational institutions, professional associations, and grassroots organizations

primary healthcare for everyone in the state of Arizona. The Arizona 2019-2022 state Oral Health Action Plan, written with contributions from the Arizona Alliance for Community Health Centers (AACHC), states “Oral health is an essential part of our overall health and well-being.” The state’s Oral Health Action Plan illustrates the complexities of integrating oral health care into medical care. This brief will examine some of the challenges, focusing on the education, quality improvement efforts, and payment advocacy, AACHC has engaged in to address them.

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## Deep Divisions

Integration is the process of combining parts into a whole. When considering the process of combination, it is important to understand the parts and how they differ. The differences between oral health and primary care are distinct and, over time, have formed deep divisions which pose a significant challenge to integration. There are five key differences between oral health and primary care, all of which AACHC has attempted to reduce through education.

### **Key Distinctions Between Oral Health and Primary Care:**

- (1) Language
- (2) Perception
- (3) Point of Access
- (4) Electronic Health Record (EHR) Systems
- (5) Billing

### **Language and Perception**

Language is one of the key distinctions between Oral Health and Primary Care. When discussing oral health, providers use different words to describe conditions, interventions, and treatments. For example, the dental assistant could see a patient with bleeding gums and talk to them about gingivitis, the dentist or oral health provider would discuss periodontitis, and the scheduler could schedule the patient for scaling. Information can be “lost in translation” about both processes and patients. In order to manage a disease and adequately support patients, all levels of staff need to clearly communicate the causes and potential remedies for a health issue. According to AACHC, the language used to describe oral

health also needs consistent from all providers and any other health education source.

The use of different language also impacts the overall perception of oral health and oral health providers. Dentistry is seen as a surgical sub-specialty which leads to the perception that oral health is not a preventative function. One way in which this perception is re-enforced is in the naming of the working space of Oral Health, dentists work in an operator versus a physician who works in an exam room. The perception can also lead to a lack of trust patients and other providers are willing to give dental providers. A recent example was when a health center CEO reached out to the Arizona state board of pharmacy and requested dentists be able to assist in triaging and prescribing medicine for novel coronavirus (Covid-19) patients and the request was denied. Another example is that, despite dentists providing injections as a normal course of business, in many states, dentists are not allowed to provide immunizations. Although Oregon was the first state to allow dentists to provide immunizations, it is not permitted in Arizona. This perceived lack of trust poses another significant challenge to integration. AACHC sees the perception and consideration of dental providers as a larger part of the health care workforce as another key to overcoming barriers to integration.

### **Access to Care**

Oral health is also different in terms of points of access. Oftentimes, patients access oral care only through a dentist and dental services were traditionally provided at the dentist’s office. In the medical model, there are multiple points of entry (community health centers, urgent care, emergency room, etc.) in order to see a doctor or other provider. Due to the imbalance between demand for oral health services and the number of dentists, this difference presents a barrier to access.

### **Records and Data**

Another key difference between Oral Health and Primary Care is the electronic health records (EHR) systems used to capture data in a primary care setting and the electronic dental record (EDR) system or lack thereof. Similar to the difference in language, this difference can lead to a lack of information about patients and the population. By overcoming this difference, health

centers can tell a better story about the care they are providing to patients and the health outcomes of the care provided. Through their health center controlled network, CHC Collaborative Ventures (CCV), AACHC is working to support health centers and oral health providers in maximizing the data they receive to provide quality care with improved outcomes.

Currently, health centers are required to report on their performance using the measures defined in the Uniform Data System (UDS). Some of the UDS measures CCV leverages include utilization, workforce measures, scope of service, quality, and cost measures. Through this data, CCV helps health centers and dental leaders to better understand what percentage of their population receives dental care services, the growth in utilization, and costs and how to redesign their care as a result of the information. The majority of the 18 health centers providing dental services in Arizona report their EHR and EDR systems are completely or somewhat integrated, which according to AACHC means “the dental team can access medical records and vice versa, but it may be time consuming or challenging.” AACHC is actively supporting the centers in that integration and information sharing.

### **Administrative Burden**

Finally, oral health and primary care providers differ in what they can bill for, who they can bill, and how they receive reimbursement. Billing codes for oral health and primary care services vary vastly, which poses a significant challenge for administrative staff and organizations providing these services. This, and all of the above mentioned challenges are concerns shared by AACHC, which they are attempting to solve through education.

### **Education As A Solution For Overcoming Differences**

AACHC sees education as the key for overcoming differences. The education needs to be, and in the PCA's work is, targeted at multiple levels. The multiple levels start with a focus on formal medical education settings: how can dental schools and medical schools communicate more, provide inter-professional education, and consider oral health competencies. AACHC is working with health centers to educate patients on considering oral health a

key component over their overall health and not to treat oral health concerns as separate from concerns they may have about chronic disease.

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## **Quality Measurements**

AACHC has long seen oral health as a component for whole person care and providing oral health care reduces health care costs and improves patient quality outcomes; however, the data has not been available to demonstrate it. In February 2020, AACHC was awarded a grant from DentaQuest in order to build a framework for states to measure oral health quality and integration. AACHC is currently working with CCV to examine what is possible. AACHC is also assessing measurement infrastructure, EHRs and EDRs, and its population health tool (Azarra). With this project the expectation is to move beyond the required UDS measurement of ‘Dental Sealants for Children between 6-9 years’ to examine “data such as the percentage of medical patients who are also dental patients and comparative A1C scores among medical patients who also receive oral health”. This project aims to benefit all health centers considering integrating oral health care (in Arizona and across the country) and demonstrate the value of integration.

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## **Payment Policy**

Beyond the deep divisions and challenges in measuring outcomes, payment is an underlying concern and key to oral health integration. AACHC has been a long-term participant in a coalition advocating for oral health coverage for all adults in Arizona. These efforts have focused primarily on ensuring coverage for those most vulnerable in order to expand coverage more broadly. AACHC recognizes that oral health services that do not prioritize prevention can be expensive.

As a result, AACHC advocacy has focused on incentivizing preventative oral health care and Medicaid adult dental coverage in Arizona has increased incrementally. In 2016, the Arizona Long Term Care System (ALTCS) dental benefit was approved with a \$1,000 cap. In the same year, services provided within an Indian Health Services facility

were also included and were subject to the same \$1,000 limit per contract year. Adult emergency dental services, with a \$1,000 cap and limited billing codes, was approved in 2017. Most recently, AACHC has advocated coverage for pregnant women enrolled in Arizona Health Care Cost Containment System (AHCCCS), the Arizona Medicaid program. Based on the United States Court of Appeals for the Ninth Circuit's 2013 ruling in California Association of Rural Health Clinics v. Douglas, AACHC members filed a lawsuit against the state Medicaid agency. A ruling is still forthcoming. Increasing Medicaid coverage for oral health care has been a long standing challenge, but in line with its efforts to educate, overcome differences, and measure care and outcomes, AACHC is up for the challenge.

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## Conclusion

Oral health integration is reflective of accountable care efforts because it requires bringing together education, data, practice transformation, and payment reform in order to lower costs, improve care and outcomes, and increase patient and provider satisfaction. AACHC's work reflects careful thought and strong support of health centers, which is in line with its mission and the mission of the health center program to provide quality health care for all, regardless of their ability to pay.

### Oral Health During the Novel Coronavirus (COVID-19) Pandemic

Due to COVID-19, dentists are only able to provide emergency dental services in-person. Several Arizona health centers are utilizing teledentistry to triage patients and determine which services are considered essential and qualify as an emergency service. For Arizona Medicaid patients' receiving teledentistry services, the health center is reimbursed at their normal Prospective Payment System (PPS) rate.

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

For more information contact:

Julie Balter, Specialist, Provider Networks  
[jbalter@nachc.com](mailto:jbalter@nachc.com)

Special Thanks to:

Tara Plese

Dan-Nell Pedersen

Jan Grutzius

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