

Colorado Medical Homes

Creating Healthy Connections



THE 2015 COLORADO
Health Report Card



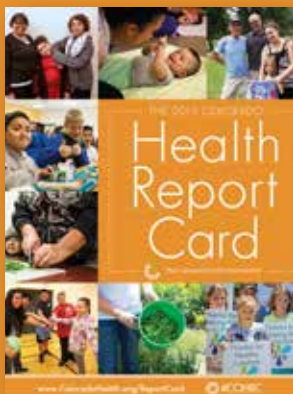
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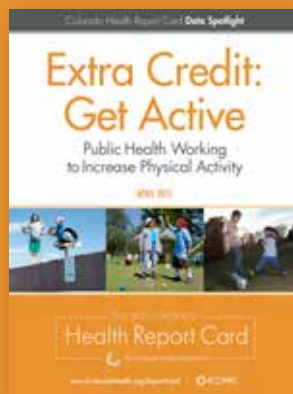
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Colorado Medical Homes

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Custom artwork celebrates the school-based health center at Northside Elementary School in Montrose. BRIAN CLARK/CHI

When it comes to health, a growing number of Coloradans are finding a place to call home.

Practices in Colorado are increasingly adopting the medical home model, which aims to reduce costs and provide better care by focusing on all of a patient's needs.

While every medical home is different, each strives to go far beyond primary care, often by integrating

behavioral health, oral health, and nutrition and lifestyle assistance; providing referrals to specialty care; and making connections to community groups that offer food aid, transportation and other vital non-medical help.

At a practice in Thornton, young patients see a pediatrician, dentist and behavioral health specialist

the same day, all in the same office. In Aurora, teen mothers receive treatment for themselves at the same time they get care for their babies. And in Lamar, teams of doctors, nurses, assistants and health coaches pore over patient data to identify who should get a call about managing blood sugar.

Such approaches position Colorado among the nation's leaders in medical home innovation.

Nearly 200 practices in the state are now officially recognized as patient-centered medical homes by the National Committee for Quality Assurance (NCQA) compared with just 17 practices in 2012. Today, 1,252 Colorado providers work in certified medical homes.¹ And the Colorado Health Institute estimates that more than two million Coloradans — around 40 percent of the population — have a medical home.

But there is much work to be done. Compared with other states, Colorado is in the middle of the pack when it comes to the percentage of residents in a medical home. The 2015 Colorado Health Report Card showed that Colorado ranks 26th of the 50 states for adults and 19th for seniors. And it's just 35th in providing medical homes for children.

Still, the momentum toward medical homes is clear.

Health leaders are betting medical homes will play an important role in ensuring all Coloradans have access to efficient and affordable care.

The state has gone all in on this bet. The Medicaid Accountable Care Collaborative (ACC) puts medical homes at the center of its efforts to improve care for an increasingly large portion of the state's population. And a \$65 million State Innovation Model (SIM) award will build on the medical home concept by extending integrated primary and behavioral health care to the majority of Coloradans, regardless of how they get their insurance.

For all of their benefits, though, medical homes are not a silver bullet for every problem in health care. Research is not yet showing the sweeping improvements in health outcomes and cost savings that proponents had predicted.

Nearly 200 practices in Colorado

are now officially recognized as patient-centered medical homes by the National Committee for Quality Assurance (NCQA) compared with just 17 practices in 2012.

And clinics on the front lines are encountering many challenges in building medical homes and coordinating efforts. Providers must get used to working as a team to support their patients, and patients must take a more active role in their own health. These cultural changes will be hard-won.

Early experiments are suggesting progress in some areas, despite the challenges. This information is allowing health care leaders to hone in on what's working and build from there. For example:

- Patients with chronic health problems benefit the most from medical homes. They show improvements in managing their health concerns — which can yield long-term cost savings.
- Most patients prefer more convenient access to care, often found in a well-run medical home.
- Cost savings have been small, but the return on investment should improve as patients, providers and payers gain more experience with the concept and large upfront investments are recouped.

More importantly, though, medical homes promise to create something that can't be measured. At their best, medical homes can instill in their patients and providers a sense of connection. Of belonging.

Of coming home.



Krystal Palmer, PNP, left, talks with Angel, 19, during the teen's prenatal exam at the Colorado Adolescent Maternity Program. BRIAN CLARK/CHI

The Big Idea

When Angel, a 19-year-old Aurora resident, learned she was pregnant, she knew just where to go – the Colorado Adolescent Maternity Program (CAMP). She had begun seeing providers at the Children's Hospital Colorado clinic five years earlier when she started using birth control.

The staff surrounds her with all sorts of services. In addition to doctors, she talks to a midwife and behavioral health experts. At Angel's 16-week exam, a dietitian asks her about her eating habits and her food supply at home and offers to help her apply for Women, Infants, and Children (WIC) food benefits.

After she gives birth, providers will treat Angel and her baby at the same time at the Young Mothers Clinic. She can get care for herself until she turns 22.

"It makes it way easier for someone who's young," Angel says after her exam. "It's been the same staff here since I was 14."

This is what it looks like when the patient's needs are put first.

The big idea behind medical homes is simple: The patient sits at the center of care. Doctors, who play the starring role in traditional clinics, become supporting actors serving patients, along with a team of professionals who step in as needed.

This patient-centered ideal means care is tailored for each patient. But such custom-made care is difficult to compare and evaluate, let alone to define. Standards have been created by national health care accreditation and quality groups like the Joint Commission and the NCQA. Colorado has its own definition in state law for medical homes serving children enrolled in Medicaid.

While each medical home may differ in details, three foundational building blocks are necessary to create a successful transition from traditional care to a medical home: payment models that provide incentives for practices to coordinate care and increase efficiency while ensuring their long-term financial sustainability; a strategic use of technology; and assembling the key players for the workforce of the future.

Building Block One: Payment

Medical home payments build on such methods of paying for medical care as fee-for-service (FFS) or global payment, which gives providers a single payment to cover all the care their patients may need over a set time.

By Any Other Name

Medical homes have many names.

Primary care medical home. Patient-centered medical home. Health home.

Advanced primary care practice is a newer name being used by many stakeholders.

While the terms may vary, they all refer to primary care practices that adhere to medical home characteristics. This brief uses the terms **patient-centered medical home** and **medical home**.

Most practices receive additional money from insurers to help them coordinate care and perform other functions that make them medical homes.

Two of the most common payment strategies used to support medical homes are:

- **Care coordination payments:**
Providers get monthly payments on top of their usual FFS reimbursement to pay for the staff and technology needed to coordinate patient care.
- **Gainsharing or shared savings:**
Providers receive incentives to meet goals for cost savings and improved quality of care. At the same time, they share in the financial risk if they go over budget or miss the mark on quality.

Building Block Two: Technology

Information must be shared easily, quickly and securely among care coordinators, providers and their patients in medical homes. Most use electronic health records (EHRs) to collect patient data that is shared among the team and used to coordinate care.

Technology can also make care more convenient and accessible – a fundamental goal of medical homes. Patients may communicate with their providers through email or text messages or use online portals to access health information and other resources. A regular examination of EHR data allows care teams

to identify the highest risk patients and focus their efforts. EHRs let providers set up automatic personal appointment reminders.

Telehealth can play a role in connecting providers with one another and to patients, especially in rural areas. It is especially useful for patients with complex health needs. A medical home with telehealth capabilities could allow patients to receive virtual behavioral health visits or let primary care providers consult with specialists about how to manage a chronic condition.

Whatever technology is installed in a medical home, staff members must be trained and willing to use it. Technology upgrades require an upfront commitment of time and financial resources from clinics and an ongoing commitment by clinical staff to using the tools in service of their patients.

Building Block Three: Key Players

Medical homes must have the right teams in place. Often, this means rethinking which providers to hire and how best to deploy them.

Most teams include primary care providers, specialists, referral experts, care coordinators and people to link patients to community resources. Increasingly, medical homes include pharmacists and behavioral health providers.

No matter who is on the team, care in a medical home is patient-centered, so the team's makeup varies depending on a patient's needs. For team-based care to work, all members must be committed to the idea and be open to changing the way they have typically performed their duties. Team members must maintain regular communication about each patient's needs.

The Secret Ingredient

The best medical homes have qualities that can't be expressed on a certificate of accreditation. Building



Patient and provider handprints on a wall in the school-based health center at Northside Elementary School in Montrose. BRIAN CLARK/CHI

Medical Homes Share These Common Characteristics:²

- Patient-centered
- Coordinated
- Comprehensive
- Accessible
- Committed to quality, safety and the patient experience

blocks provide the structure that props up a medical home, but it takes more than floors and walls to make a house a home. It takes heart and soul.

In a truly effective medical home, providers work as a team not because they are trying to meet a national standard, but because it's good for the patient. They don't just install technology, they use it to monitor and improve patient health.

When these ingredients are mixed, the idea of medical homes transforms from an abstract concept to a way of providing care that creates meaningful and healthy connections.

2015 Colorado Health Report Card

While Colorado is on the forefront of many medical home initiatives, data from the 2015 Colorado Health Report Card reveal that a number of other states have more of their residents in medical homes.³

The annual Health Report Card, released in early February by the Colorado Health Foundation and the Colorado Health Institute, tracks 38 health indicators, including medical homes for children and the percentage of adults and seniors with personal doctors or health care providers.

A little more than half (55.3 percent) of Colorado children have a medical home that is accessible, comprehensive, family-centered, coordinated and compassionate. That earns Colorado a ranking of 35 of 50.

Children from low-income families are even less likely to have a medical home, as are black and Hispanic children. The Health Report Card also finds significant disparities in child health, depending on race, ethnicity and income.

The Health Report Card uses a different measure for adults and seniors, tracking the number with at least one person they think of as their care provider, an important component of a medical home.

Nearly three of four adults (72.5 percent) say they have a care provider, moving Colorado's ranking up to 26 from 30 a year earlier. And 94.6 percent of older adults say they have a regular care provider, improving Colorado's ranking to 19 from 28.

Looking to the future as Colorado works to become healthier, improving Colorado's ranking on the medical home indicators has the potential to ripple throughout the Health Report Card.

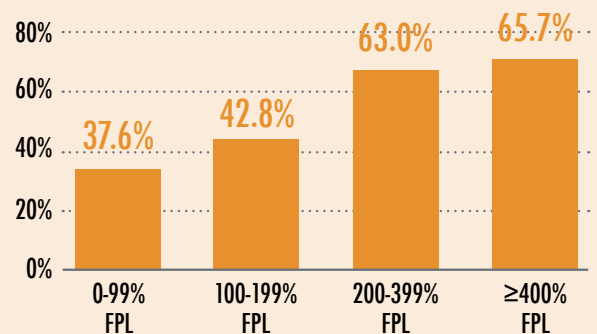
Different areas of health and health care interact

to influence overall well-being, so connecting more Coloradans to patient-centered medical homes will most likely improve Colorado's grades in other areas.

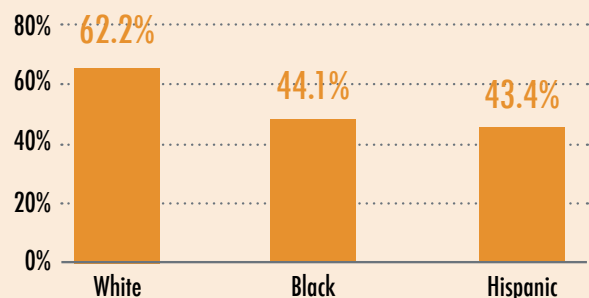
For example, medical homes support patients in healthy living by encouraging good diets and regular exercise. They smooth access to behavioral health specialists. They make sure that patients receive needed immunizations and vaccinations, preventive dental care and counseling to quit smoking.

Percentage of Colorado Children with a Medical Home

BY INCOME



BY RACE/ETHNICITY



Source: 2011-12 National Survey of Children's Health
FPL=Federal Poverty Level

The History of Medical Homes

The idea of medical homes has been around for nearly 50 years. The American Academy of Pediatrics coined the term in 1967. At first, it was applied only to children with complex health needs. In recent years, the model has gained acceptance among clinicians, health plans, consumers and policymakers, increasing medical home access for all Coloradans.

Colorado was an early adopter of the medical home model, partly in response to legal challenges to its managed care model in the Medicaid system. Governor Bill Ritter's administration began seeking innovative alternatives to managed care in 2006, looking for solutions that would control costs and provide better and more efficient care.

Colorado passed legislation in 2007 that established medical homes for children covered by Medicaid. This set the stage for the ACC, the statewide effort that promotes medical homes and coordinated care to manage cost, quality and outcomes in Medicaid.

Thanks to these efforts, other states are looking to Colorado for lessons to advance Triple Aim goals through accountable and coordinated care.

Colorado also was a site for the Multi-Payer Medical Home Pilot – one of the country's first initiatives that involved both public and private payers testing the impact of a medical home model. This pilot and others yielded useful lessons for future initiatives.

Medical Homes in Colorado

The medical home movement in Colorado is accelerating. Ideas and experiments are flowing from every corner of the health care world – public insurance, public and private partnerships and the private sector.

These efforts have already reached more than two million Coloradans, based on estimates by the Colorado Health Institute, and the state is just getting started.

Public Medical Home Initiative

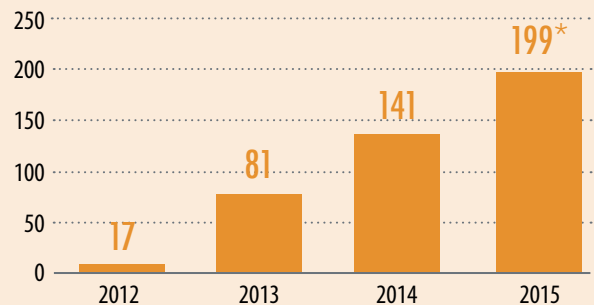
Accountable Care Collaborative (ACC)

The national spotlight is shining on Colorado's largest medical home initiative, Medicaid's ACC, which focuses on regional approaches to coordinating medical and non-medical services in order to improve health.

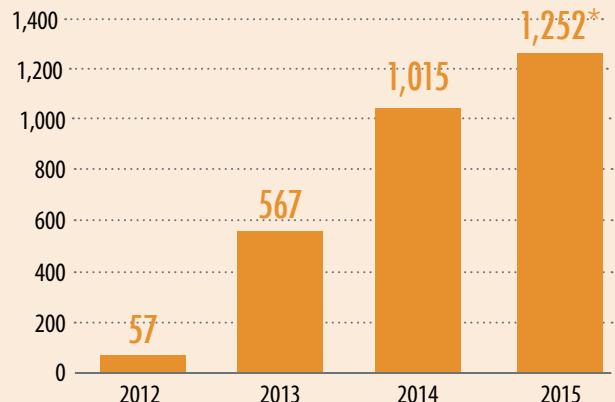
Launched in 2011, ACC enrollment now tops 890,000, and about three-quarters of ACC enrollees have a primary care medical provider.

Altogether, 743,000 Colorado Medicaid enrollees now have medical homes. This number accounts

Colorado Certified Medical Home Practices



Colorado Certified Medical Home Providers



* As of May 28, 2015

Source: National Committee for Quality Assurance

for Medicaid clients inside and outside the ACC.

The Department of Health Care Policy and Financing (HCPF) has organized the ACC into seven regions managed by regional care collaborative organizations (RCCOs). The RCCOs contract with primary care providers who serve as medical homes and work with them to coordinate patient care and measure the results. The RCCOs also connect clients with community services that are not strictly medical in nature but important to health.

The RCCOs and primary care providers receive extra payments for making progress on key performance indicators such as lower emergency department use and increased well-child visits. On the other hand, RCCOs receive lower per member per month payments for enrollees who are not officially connected to a primary care provider for more than six months.

The ACC is making progress in reducing costs. It reported net savings in medical costs of between \$29 million and \$33 million in fiscal year (FY) 2013-14, encouraging but still a small portion of HCPF's \$7 billion budget. Adults without disabilities who were enrolled in the ACC more than six months improved the most on the key indicators, according to the ACC's 2014 annual report.^{4,5}

Interestingly, ACC clients with disabilities did not have fewer emergency department visits or hospital readmissions, despite the seemingly greater potential to coordinate care for those with complex health needs.

The ACC continues to evolve. Medicaid Prime, a payment reform pilot project, has been launched on the Western Slope. Rocky Mountain Health Plans, the area's RCCO, is testing global payments for providing integrated primary and behavioral care.

Apart from Prime, RCCOs will be required to increase the integration of primary and behavioral care when their state contracts are up for renewal in 2017.⁶

Public/Private Medical Home Initiatives

Meaningful expansion of medical homes to more Coloradans will require strong public and private partnerships because most Coloradans have private health insurance.

Coloradans in Medical Homes

A breakdown of the two million-plus Coloradans who are connected to medical homes, according to CHI estimates.

Medicaid enrollees	743,000
Medicare enrollees	121,000
Comprehensive Primary Care (CPC) Initiative – Private	363,000
Other privately insured	795,000
Total	2,022,000

The aging population is increasing Medicare's footprint in Colorado, and Medicaid is expanding rapidly. As a result, the state and federal governments are working in concert with private insurers to test and expand medical homes.

Colorado Multi-Payer Medical Home Pilot

Colorado played host to one of the country's first multi-payer medical home pilots. It was launched to test whether medical homes were an effective strategy for improving care, lowering costs and promoting health as well as whether they could be scaled up to a larger population.

The pilot brought together five private health insurance plans and the state's former high-risk pool insurance carrier to offer enhanced payments to primary care practices serving about 100,000 patients.

Planning began in 2008 and the pilot launched in 2009. Data gathered after the pilot ended in 2012 found positive results on the use of preventive care and screenings, including more tobacco cessation as well as breast cancer and depression screenings.

Preliminary findings also suggest medical homes can be especially useful in reducing emergency department hospitalization admissions among people with chronic diseases.⁷ The current results on cost and patient satisfaction are limited to one payer, Anthem-Wellpoint.⁸

Comprehensive Primary Care (CPC) Initiative

Colorado is one of seven CPC sites across the nation — another public and private initiative focused on strengthening coordinated primary care.

The Center for Medicare & Medicaid Innovation launched the CPC in fall 2012. Clinics in the CPC are referred to as advanced primary care practices, and they feature the core elements of medical homes and more.

Medicare is working with private insurers as well as Medicaid, offering per member per month payments to primary care doctors for coordinating care for their patients and meeting Triple Aim goals.

An estimated 47,000 Medicare and 132,000 non-Medicare patients were connected with participating providers in the program's first year.⁹ It will reach more than 444,000 Coloradans throughout its four-year run.¹⁰

Results on cost and quality are still early and inconclusive. Colorado's payers are scheduled to begin incentive payments in 2015 to practices that improve care quality and save money.



model uses a care coordinator employed by the provider group who works with patients, focusing on those with chronic conditions.¹¹

- **Rocky Mountain Health Plans**

Positive experiences with team-based care over many years have led Rocky to expand its global payment contracts for medical homes that integrate behavioral health into their primary care practices.¹²

- **Anthem Blue Cross Blue Shield's Enhanced Personal Health Care Program**

The company provides financial incentives, actionable data and support for coordinating care, individual patient care planning, patient outreach and quality improvement. Currently Anthem has 60 percent of Colorado primary care doctors contracted under this value-based, pay for performance model.¹³

- **Centura Health**

More than 30 practices with Centura Health Physician Group are NCQA-certified medical homes at the highest level.¹⁴ Centura physicians are also leading the development of Colorado Health Neighborhoods, a clinically integrated network where health teams work with patients to promote wellness, healthy behaviors and prevention.¹⁵

- **New West Physicians**

All 11 practices and five internal medicine offices of New West have received the top-level medical home certification from NCQA.¹⁶

- **Kaiser Permanente Colorado**

Kaiser's system features important components of medical homes, including providing a range of medical services and specialty care, using technology to communicate with patients, and an emphasis on prevention.¹⁷

Private Medical Home Initiatives

The public sector isn't alone in driving the movement toward medical homes. Some of Colorado's biggest private health insurance companies are changing how they pay for care to promote and reward medical home practices.

Private payers are looking to medical homes as a way to control costs by reducing waste and unnecessary care while improving quality. Payers also are attracted to the emphasis that medical homes place on prevention and wellness, which can pay off in long-term savings.

Additional motivation for private payers comes from a desire to get in line with Medicare's move to accountable care organizations and care coordination.

Examples of medical home initiatives from Colorado's private sector insurers include:

- **Cigna's Collaborative Care Program**

Participating providers are rewarded for meeting targets for improved quality and lower costs. Cigna's

The Early Evidence

Studies to date show that medical homes have had only modest effects in boosting quality of care and patient satisfaction while cutting costs. But the studies also provide reasons to expect better results in the future.

By design, truly patient-centered medical homes look different in each practice. This often leads to contradictory study results and findings of limited effectiveness. Evaluators have struggled to identify which components of a medical home have greatest impact.

The medical home model should get easier to study with time and experience. Although the concept dates back to the 1960s, most practices have converted into medical homes recently.

Medical homes may take years to show a return on investment, because they require an upfront investment to install the right technology and it takes time and experimentation to build the right team.

Takeaways on the evidence:

Studies show progress toward the Triple Aim, although the findings vary.

Evaluations have shown both positive and negative results on quality measures, cost control and use by patients. But any gains so far have been modest.¹⁸

Complex patients benefit from coordination.

Medical homes have shown limited impact on improving patient health, but some progress has been made for people with complex conditions such as diabetes or cardiovascular disease.¹⁹ These patients are likely benefiting from the better coordination of care they receive at a medical home.

A Denver Health program that used a medical home framework, 21st Century Care, classified patients in tiers based on their needs. Patients in higher-risk tiers received additional services provided by new care team members focused on coordinating care and addressing social and

behavioral issues. Early results show reductions in inpatient stays and total cost of care for these patients.²⁰ Because complex conditions are expensive to treat, the progress made with these high-risk patients is significant.

Use of emergency departments and hospitals has changed little.

Although some studies have shown patients in medical homes use the emergency department less, others have found no impact. A 2014 analysis of medical home research found that about 60 percent of studies reported a reduction in emergency department use, but only around 30 percent of studies showed a reduction in hospital readmissions.²¹

Patients are still not fully sold on medical homes.

Only about a quarter of the medical homes studied in recent research have shown improved patient satisfaction. And only about a third have increased access to care for their patients.²²

Patients are most satisfied when care is convenient.

The most satisfied patients belong to medical homes with minimal wait times, staff available to consult on the phone or in other non-face-to-face visits, and use of EHRs.²³ Patients seem to like medical homes the most when they make care convenient.

Cost savings are hard to come by.

Some studies are reporting cost savings by medical homes, although early savings tend to be small compared with the initial investment. Delivery system redesign requires an upfront financial investment, and returns on those investments will take time. Medical homes have saved money on elderly patients with the highest health needs. However, most cost studies have yielded significantly different, conflicting results.²⁴

Policy Options

Policy Options to Advance Medical Homes in Colorado

State policymakers play an important role in expanding medical homes in Colorado. So do private health insurers, technology providers and health care workers. Laws and regulations can guide and shape the three building blocks of a medical home.

This study has identified many policy options that can make the model more successful. These ideas come from examining Colorado's early pilot programs, talking with medical home experts, visiting practices on the front lines and looking to the scientific literature.

These policy changes can, over time, build a culture in Colorado in which medical homes become business as usual.

Payment Options

- Providers need resources to support their medical home activities. Public programs such as Medicaid and Medicare and private insurance companies must adequately compensate them for care coordination, home visits and community referrals.
- Providers also want accountability, including opportunities for rewards for meeting care-related measures such as prevention and quality – and penalties for missing the goals.

- But payment should go beyond specific outcomes to include medical home process measures such as extended evening and weekend hours, easy access for patients to their medical information and linkages to community resources.
- Public and private payers must work together to align their expectations and requirements for performance and outcomes to make medical homes a more efficient model for primary care providers. Colorado has already established the groundwork for this unprecedented collaboration through the CPC. Steps could be taken to ensure the lessons learned from the four-year pilot inform other public and private initiatives, including SIM.
- Legislators and regulators could give payers and providers permission to have conversations about collaboration without worrying about running afoul of price-fixing laws.

Technology Options

- Data from public and private payers that details the cost, quality and use of care and that is easy to access and understand can be a valuable resource for providers to improve their work. It can also help practices tailor their care coordination efforts to best meet patients' needs.
- Clear guidance from state regulators on the types of patient information that providers can share

Making the Connection

Improving health does not happen only inside clinic walls. The medical home team approach extends into the community, making connections throughout the health care system and beyond.

Medical homes are ushering in a more connected health care system, one where the links among patients, providers and community resources are strong, meaningful, fast and convenient.

These new connections are happening across Colorado.

Public health agencies are linking their work with clinicians in medical homes to improve population health. Safety net clinics are tapping into behavioral health providers or specialists working at hospitals. Housing groups are on standby to help find homes for patients identified by medical homes. And community volunteers often jump in to help.

with one another, especially behavioral health details, can encourage communication and cooperation among primary care providers and specialists in recognizing and addressing patients' many health needs.

- Financial incentives from public and private payers could offset some of the upfront time and costs needed to adopt and use technology, accelerating the move toward e-communication between primary care providers and specialists, hospitals, nursing homes, public health and community resources. Currently, not all medical home partners use electronic systems, and not all systems connect smoothly with the statewide health information exchange.



Workforce Options

- An effective medical home depends on all team members playing their part in quality patient care. Colorado's lawmakers can examine state health care workforce regulations, considering whether they allow health professionals to provide the full spectrum of services that they are trained to provide.
- Practices may need to seek out technical assistance and coaching to learn how to fully engage each team member to meet their patients' needs.
- Educators from community colleges and universities can develop medical training and curriculum that emphasizes team-based care and provides new professionals with the tools they need to be successful.

CONCLUSION

Colorado has focused its efforts on the coordinated and integrated care that medical homes provide as a way to transform health care delivery, ensure access to quality care for all Coloradans and improve patient outcomes. More than two million Coloradans are now in medical homes, with Medicaid ACC leading the way in the public arena and private payers expanding their own initiatives.

The medical home model is still new, and the evidence so far is not solid enough to declare it a proven winner. But early results show the model can save money while improving the health of the patients who need the most help.

Colorado's early experiences point to the challenges that await. Payers and providers have to agree on

how, and how much, to pay for coordinated care. Computer systems have to be devised to enable easy data sharing. And practices have to do the hard work of changing their culture to work in teams, with patients always at the center.

It will be a long road, but for a state that aspires to be the healthiest in the nation, it's the road home.

Building a Patient-Centered M

More than two million Coloradans have a medical home, the Colorado Health Institute estimates. While definitions differ, one concept is essential — patients are at the center. The goal is the Triple Aim of improved health, lower costs and better care.

Providers

Primary care doctors, nurses, nurse practitioners and physician assistants. They work in a team to serve each patient's needs.

Care Coordinators

As the patient's main point of contact, they schedule appointments with providers, ensuring patients are receiving needed services.

Behavioral Health Providers

Increasingly a member of the medical home team, they provide mental health and substance use disorder care.



Building Blocks

No. 1 Payment

Traditional fee-for-service payments are still the norm in many medical homes, along with a small per member per month care coordination payment. New payment structures will establish financial incentives as well as risks based on their performance.

No. 2 Technology

Medical homes are using technological advances to make care more convenient and accessible. Patients communicate with their providers through email or text messages or use online portals to access health information. Providers use electronic health records to securely track each patient's progress and prioritize high-risk patients.

Medical Home

Specialists

Specialty care providers such as surgeons, pathologists, neurologists, and a vast array of others are brought in as part of a referral process, or through telehealth technology, to meet a patient's needs.

Oral Health Providers

Dentists and dental assistants are on the care team in some medical homes, allowing patients to make one appointment for oral health and primary care.

Community Supports

Supportive services include help with groceries, transportation and housing. Staff at patient-centered medical homes often connect patients with these resources.

Administration

Clinic leaders keep patients in mind by offering convenient hours after work and on weekends. Administrators also hire and train the workforce.

No. 3 Key Players

Primary care providers, specialists, referral experts, care coordinators and others form a care team that maintains close communication. Increasingly, medical homes include oral health and behavioral health providers. The most important player is the patient, who sits at the center of the team.

TIMELINE:

The Medical Home Model in Colorado and the United States

- 1967**
Medical home concept is introduced by the American Academy of Pediatrics. Medical home was initially defined as the keeper of a child's medical records and initially focused on kids with special needs.
- 1990**
National Committee for Quality Assurance is founded.
- 2001**
Colorado's medical home efforts begin with the Colorado Medical Home Initiative for children.
- 2007**
State legislature defines medical home for children.
- 2009-2012**
Colorado Multi-Payer Medical Home Pilot works with 16 primary care practices to establish medical homes.
- 2011**
The Colorado Accountable Care Collaborative (ACC) is launched in Medicaid.
- 2012**
Bipartisan legislation allows state Medicaid contractors to propose alternative payment arrangements to achieve savings.
- 2012**
Comprehensive Primary Care initiative begins its four-year pilot.
- 2013**
First ACC results released, showing \$6 million in cost savings.
- 2014**
Clients dually eligible for Medicaid and Medicare are enrolled into the ACC.
- 2014**
Colorado wins \$65 million State Innovation Model (SIM) award to create a coordinated accountable system of care that integrates primary care and behavioral health.
- 2015**
Colorado begins work on SIM, opening a program office and convening an Advisory Group and stakeholder workgroups that will guide the four-year initiative.



Jennifer Suchon, NP, walks with a patient following an exam at Northside Child Health Center in Montrose. BRIAN CLARK/CHI

Colorado Medical Homes

These innovative clinics are putting the theory of medical homes into practice for patients at every stage of life.



Colorado Adolescent
Maternity Program

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Family
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Colorado Adolescent Maternity Program



Jose Cortes and Raquel Gomez look at ultrasound pictures of their baby at the Colorado Adolescent Maternity Program (CAMP) in Aurora. BRIAN CLARK/CHI

Baby Rebecca is ready for her close-up. She's 26 weeks in utero, and her mom, Raquel Gomez, is getting an ultrasound at the Colorado Adolescent Maternity Program (CAMP) clinic in Aurora.

Dr. Stephen Scott maneuvers the camera.

"There's the baby's lips, the nose and the chin," Dr. Scott said. "Oh, see her mouth open? She's giving you a pretty big smile right now."

Then Dr. Scott says what every parent wants to hear.

"Your baby looks great."

Teenage mothers like Raquel, though, often have more difficult pregnancies than adult women. Teenagers

have more pre-term births and underweight babies – even though teens tend to be in better physical health and usually don't have to worry about gestational diabetes.

"Somehow, the social issues and social stressors play a role in medical outcomes," Dr. Scott said. "We saw that the system didn't address those issues."

CAMP aims to solve this problem.

The clinic serves as a medical home for young mothers and their children, and it offers far more than ultrasounds and prenatal medical exams. The team includes case coordinators, midwives, nurse practitioners, social workers, dietitians, behavioral health providers, visiting dentists and financial counselors to help with Medicaid applications. About 80 percent of CAMP's patients are on Medicaid, Dr. Scott said.

Patients will see all of these team members at some point, starting with case coordinators.

“Both case coordinators and social workers are integral parts of our team, and we all work cohesively to see to the physical and mental health needs of our patients,” said Dr. Scott, the clinic’s co-director.

The whole team comes together to discuss patients every Thursday in a cramped shared office. The room houses a set of small desks and bookcases loaded with papers and stacks of *The Very Hungry Caterpillar* and other kids’ books.

It’s a busy place, with 225 to 275 births a year. Mothers come to the clinic when they become pregnant and they return for appointments with their babies.

The case coordinators introduce each mother to CAMP’s behavioral health providers right away, before the patients are screened for mental health issues. That way, the mothers are familiar with the behavioral specialists if they should need them.

Years ago, before CAMP had behavioral providers on staff, only about five percent of girls would follow through with their referrals. A lack of transportation and the stigma of seeing a mental health provider were big barriers, Dr. Scott said. Now, 50 percent of CAMP’s patients will follow through with their mental health referrals. CAMP has made its providers more convenient to see, and importantly, easier to trust.

“Relationship-building and trust is as big as co-location,” Dr. Scott said. “It was the trust-building and relationships that caused our girls to actually use the services.”

And it’s paying off.

Nationally, 25 percent of teen mothers will get pregnant again within a year of giving birth.²⁵ According to Dr. Scott, it’s 50 percent for teen moms diagnosed with depression. At CAMP, 12 percent get pregnant again within a year, and young moms diagnosed with depression are no more likely than the others to get pregnant.

CAMP also offers long-acting reversible contraception to young moms. Of those who accept, just 4 percent get pregnant in the next year.



Allison Grooms, a registered dietitian at the Young Mothers Clinic at Children’s Hospital, talks to Angel, an expectant mother, during Angel’s appointment at CAMP. BRIAN CLARK/CHI

CAMP is a joint project of Children’s Hospital Colorado and University Hospital. The clinic is attached to the main Children’s building, and mothers deliver their babies down the street at University.

Case coordinators visit new moms in the hospital a day after they give birth, making sure they find their way back to the Young Mothers Clinic — which shares a location with CAMP — for postpartum care and care for their babies.

Dr. Catherine Stevens-Simon founded CAMP in 1991 and served as its director until 2006, the year before she died. Funding from Stevens-Simon’s research grants paid for much of the social work, nutrition counseling and other services that aren’t easily billed to Medicaid, Dr. Scott said.

Children’s Colorado sees patients up to age 21, so young women can go to the CAMP clinic until the day before they turn 22. That will be a big help to patients like an Aurora resident named Angel. At age 19, Angel can look forward to a few more years of care after she gives birth. Angel has met with CAMP’s doctor, therapist, nutritionist and midwife, and she has the confidence to know she’s on the road to a healthy pregnancy and birth.

“I already have a pretty healthy maternal lifestyle,” she said.²⁶

– Joe Hanel

“Relationship-building and trust is as big as co-location. It was the trust-building and relationships that caused our girls to actually use the services.”

Dr. Stephen Scott, CAMP co-director

High Plains Community Health Center



High Plains Community Health Center President and CEO Jay Brooke looks over data reports that track the clinic's progress toward patients' health goals. JOE HANEL/CHI

Big sheets of paper cover the largest wall in the staff break room at High Plains Community Health Center in Lamar, providing pops of bright color.

But they do more than decorate the office. They also offer a point-in-time look at how the clinic is doing. Each sheet highlights one team of care providers and its patients, tracking data on hypertension, obesity, blood sugar and emergency department use. The papers also show how satisfied the patients are with their care.

Placing the data in the break room reminds staffers that it's all about the patient. And at High Plains, it's

also a reminder that teamwork is key.

High Plains uses a team-based approach to deliver care to nearly 9,000 patients from the Eastern Plains counties of Prowers, Baca, Bent and Kiowa. The clinic is one of two medical providers in Lamar.

One provider, either a physician, a physician assistant or a nurse practitioner, three patient facilitators and a health coach form each team. One behavioral health clinician and a billing specialist are assigned to two or three teams. This means that each patient has a team of people working together to make sure they get the best care.

High Plains has been at the forefront of the medical home movement. In fact, it was among the first rural health centers in the nation to be recognized as a patient-centered medical home by the National Council on Quality Assurance (NCQA).

Back in 2001, six years after its founding, President and CEO Jay Brooke knew that business as usual wasn't working any more. Patients were backed up on waiting lists and productivity was down. It was time for a change. He launched a patient visit redesign project.

First, there were the physical changes that did away with the front office and the back office. Now, it's all one office with trained medical assistants answering phones and taking patients into rooms.

Then there were the institutional changes. Brooke and his team came up with a list of guiding principles, including organizing work around the patient rather than organizing the patient around a provider's work, better use of technology and organizing cross-functional teams to meet all patient needs.

The foundation of the medical home was laid. Implementation was next.

Cecilia Bohl's very first day at High Plains was also the first day of implementing the redesigned patient visit model. As Medical Operations Supervisor, she says the system is working, and not just because of the new electronic medical records system and the structural redesign.

Success comes down to the people and the culture at High Plains, she said.

"We hire for attitude and train for skill."

Culture is key to the success of a medical home, according to Brooke. The model sometimes requires staff to put the team ahead of themselves, he said, and he has worked to build a team of people who are willing to do just that.

And staff members tend to stick around. Today, High Plains has a staff of more than 100, including five physicians, three nurse practitioners, one physician assistant, two behavioral health clinicians, two dentists and two dental hygienists.



Tim Bewley, PA, talks with a patient during an exam at High Plains Community Health Center in Lamar, where providers use a team-based approach to provide care to residents of several Eastern Plains communities. JOE HANEL/CHI

Brooke's work has not gone unnoticed. Seen as an innovator in the field, he serves on a number of advisory boards and frequently speaks about the High Plains model.

Annual revenues have reached \$6.8 million, a combination of patient reimbursements, some from Medicaid and some from a sliding fee scale, as well as grants from foundations.

High Plains is closely connected to its rural community, offering fitness and nutrition classes, free transportation to the clinic, weight control groups and more. It has expanded hours and offers evening clinics for migrant farm workers.

Health coaches provide free services, including goal setting, health tips and connections to local resources.

Besides its Lamar campus, High Plains has clinics in Wiley, Holly and at Lamar

Community College. It also has a seasonal migrant health center.

While the staff break room is decorated with patient data, the wall in the lobby wall displays the photos of staff who have been at High Plains for five years or longer. This paints a good picture of the medical home at High Plains – patients at the center, cared for by a team that is seasoned and dedicated.²⁷

– Tamara Keeney

"We hire for attitude and train for skill."

Cecilia Bohl, High Plains Community Health Center
Medical Operations Supervisor

Northside Child Health Center



Jennifer Suchon, NP, examines Ivan Edstrom at Northside Child Health Center in Montrose. BRIAN CLARK/CHI

It's recess time at Northside Elementary School in Montrose. Students swing from the monkey bars while others run around in a giggly game of freeze tag.

While this scene can be found at most elementary schools in the early afternoon, there's something unique about this playground. A walkway from the jungle gym leads straight to Northside's on-site health center.

Before the center opened in 2007, many of Montrose's children had unmet physical, mental and oral health needs. So school and health care leaders created the Northside's school-based health center

(SBHC), a family-centered medical home that serves children up to the age of 21 as well as some parents and guardians in Montrose County.

Northside Child Health Center is one of 56 centers in Colorado providing the preventive, primary and acute care a child would receive in a pediatrician's office. Many SBHCs, including Northside, also offer behavioral and oral health services on-site.

The built-in convenience of a SBHC means that parents don't have to leave work to take their child to the doctor. And a visit doesn't take much time from classes. On average, Northside students spend only about 12 minutes outside of class for a visit to the

clinic. Without a SBHC, a visit can easily eat up a few hours, if not a whole afternoon.

Northside is Montrose's first and only SBHC. The school has the highest proportion of Hispanic students in the district as well as the highest rate of students who receive free or reduced price lunch.

Northside sees more than 800 patients and handles about 1,800 visits a year. Medicaid and Child Health Plan *Plus* (CHP+) reimbursements account for about 20 percent of revenue. The clinic is also supported by grants from foundations, the state health department, the federal government and Connect for Health Colorado.

A small but mighty team of three leads the charge: Violet Saenz, the receptionist; Patty Edstrom, who takes care of family outreach; and the clinic's medical director, nurse practitioner Jennifer Suchon.

Suchon is not your average primary care provider. Since joining Northside seven years ago, soon after it opened, she has developed close relationships with her patients and their families. Some even attended her son's first birthday party last year. Today, she sits across the table with the newest addition to her family, three-week-old Lanie.

She is a master's degree nurse practitioner who is board certified in both pediatrics and family practice so that she can treat parents as well as children. "Chances are, if the kid has strep the adult does too," she said. "And if the adult stays sick, the kids will too."

The clinic is open five days a week, but Suchon often comes in on weekends or makes a home visit. As for the weekday hours, "it just depends on the day," Edstrom said. "If a kid is sick, Jennifer will stay."

Treating the sick is just one part of Northside's work.

The staff organizes an annual summer camp with fun activities focusing on health. The clinic is also a Certified Application Assistance Site as well as a Presumptive Eligible site, which means staff members help with applications for public insurance and can provide immediate medical care even before an applicant is approved for coverage.

The fully bilingual staff breaks down language barriers, which is especially important given that 60 percent of Northside patients are Hispanic and most come from Spanish-speaking families.



Patty Edstrom, right, listens to Montrose school-based health center director Jennifer Suchon (holding her new daughter, Lanie) discuss the mission of the clinic in southwest Colorado. BRIAN CLARK/CHI

Northside has forged partnerships with other providers in the community — an essential step for a small clinic serving as a medical home.

It has a relationship with Pediatric Associates of Montrose that is both personal — Suchon is married to the clinic's managing pediatrician — and professional. The two clinics communicate often and refer patients to one another. Pediatric Associates is available to Northside patients after hours.

Suchon also has strong connections with specialist practices that accept public insurance, such as the Center for Mental Health and the Community Dental Clinic. Northside also partners with the Montrose Department of Human Services, which provides flu shots and tuberculosis tests. If follow-up is needed for a patient without a primary care provider, the health department will refer the patient to Northside to make sure they get the care they need.

This symbiotic relationship works well for the health department, the SBHC, and most importantly, the patient.

Last year, Northside surveyed patients and their families to learn if there was anything they would change about the clinic.

"There is nothing," said one parent. "I like it all. The staff is all fabulous — you can tell they care — and are truly working there for the right reason."²⁸

— Natalie Triedman

Family Medicine Clinic



Care Coordinator Jennifer Mullis talks to a patient about his medical history before he sees a physician at the Family Medicine Clinic in Littleton. JOE HANEL/CHI

It's not the certificates and awards on the waiting room wall that demonstrate that the Family Medicine Clinic in Littleton is a patient-centered medical home. It's the details.

The receptionists at the front desk aren't answering phone calls to this busy family practice – those ring in another room so that front desk staff can focus on greeting and registering patients. A television monitor shows messages about shingles vaccines, wearing sunscreen and getting enough exercise.

Care managers set aside 10 extra minutes for older Medicare patients who may need a little more time than other patients to share how they are doing.

Dr. Steven Singer is a family physician for more than two decades and “quarterback” of the Family Medicine Clinic's patient-centered medical home. He describes a medical home as giving patients a say in their care and being proactive about their health by promoting preventive care, disease self-management and a healthy lifestyle.

Leaders at Physician Health Partners (PHP), a physician management organization that includes the Family Medicine Clinic, recognized through early medical home pilots over a decade ago that the model could achieve high-quality, cost-effective care while improving patient and provider satisfaction.

PHP organized its provider network, which includes over 400 primary care providers and 600 specialists in the Denver metro region, into a health neighborhood with medical homes at its center. It provides tools and resources for the practices to better serve their patients.

These resources include nurses and social workers who meet with patients and families when they are in the hospital, making sure they have supports in place at home to stay there safely and not return to the emergency room.

The nurses and social workers also serve as Dr. Singer's "eyes in the home," making house visits. They update Dr. Singer and the rest of the team daily via email and attend meetings at the clinic, flagging issues that need follow-up, including medication management or support for family members.

All members of the team play a role in putting patient needs first. The daily morning staff huddle gets everyone organized for patients on the schedule. Care managers talk with each patient first, assessing the big picture. Medical assistants pick up from there, tracking vital signs and asking patients about any health concerns. Dr. Singer, or his nurse practitioner or physician assistants, can look at all this new information, which is entered into the patient's electronic medical record, before the exam begins.

Sometimes the game plan hatched at the morning huddle needs to be altered based on what's going on with patients when they show up.

Some of the clinic's 23,000 patients are making themselves at home in this new model of care. On a bustling afternoon in June, clinic manager Jackie Karsten interrupts a meeting to help a man who dropped in unannounced for a blood pressure check. She isn't annoyed. Instead, she's happy that the patient is watching his blood pressure and turning to his medical home when he needs help.

It takes time to be a truly patient-centered practice – something that Karsten and the rest of the Family Medicine Clinic staff recognize and are happy to



Dr. Steven Singer reviews the day's schedule of 25 patients with the rest of the care team. Singer and his team have a "morning huddle" every day to make sure they have enough time to address each patient's specific needs. JOE HANEL/CHI

provide to their patients and families.

PHP has been expanding the support and services it offers to its primary care providers and cites growing excitement among public and private health insurers for investing in the health workforce. Dr. Singer said he appreciates the financial incentives and rewards his medical home team receives for achieving high marks for care quality and outcomes. The additional per member per month payments are helpful but only make a small dent in the resources required to be a patient-centered medical home.

The team's work doesn't end with the patient's office visit, which is typically the only billable service. Team members spend hours in the evening and on weekends coordinating referrals, following up on patient questions, completing notes and reviewing information from other providers.

But the team's journey to becoming a medical home has never been about the money. The real payoff is when patients realize their concerns, needs and well-being come first when they walk into the waiting room.²⁹

– Sara Schmitt

Rocky Mountain Youth Clinics



Marnie Walsh, PA-C, examines a young patient at Rocky Mountain Youth Clinics in Thornton, Colorado's first certified medical home. BRIAN CLARK/CHI



Windows framing mountain vistas sit at child height.

Red wagons dot the hallways, brimming with books destined to go home with young patients.

Twin toddlers with pink ribbons in their shiny hair play beneath a bright sports-themed mural in the waiting room.

And Dr. Lucas Henderson walks down the hall carrying his laptop, heading to command central in the middle of this U-shaped medical office in Thornton.

It's a Monday afternoon at Rocky Mountain Youth Clinics, where kids get care that goes "beyond the stethoscope," in the words of Dr. Larry Wolk, the pediatrician who founded the practice – Colorado's first certified medical home – in 1996. Dr. Wolk now leads the Colorado Department of Public Health and Environment.

Beyond the stethoscope means scheduled well-child visits or same-day appointments for a sick child with a pediatrician, nurse practitioner or physician assistant. It means seeing a dental hygienist or getting behavioral health care in the same office – often during the same visit. It could mean an appointment

with a surgeon at a hospital, coordinated by a referral specialist.

It may also mean a stop in the pantry on the first floor for a week's worth of nutritious food and fresh fruit, all free, along with advice from a registered dietician and recipes printed in English and Spanish. Today it's Turkey Tacos.

Maybe it's an invitation to attend the Get Fit Clinic and join a team that's training for the Colfax Marathon or enroll in a summertime boot camp. Finally, it could mean housing assistance for a family living in its car or a warm jacket from the bank of donated children's clothing.

And it all starts in front of a map of the world, where new patients pinpoint where they came from and let the clinicians know which language they speak. For nearly half of the clients, that language is Spanish, and many of the pediatricians and care providers speak it. Translators help with Vietnamese, French, Russian, Arabic and many others.

The need has been growing. Registered Nurse Carole Saylor, who recently retired as chief operations officer, was around since the beginning, and she counts 12 or 13 moves or expansions. Today, Rocky Mountain Youth Clinics cares for about 22,000 clients – about half of them up to the age of six – at three clinics, four school-based health centers and three mobile units.

Often, these are kids from low-income or homeless families. About 80 percent are covered by Medicaid, the state-federal public insurance program; about 10 percent have private insurance; and the remaining 10 percent are uninsured, according to Executive Director Jessica Dunbar.

Families without insurance are billed on a sliding fee scale, but aren't turned away if they can't afford it. Rocky Mountain Youth Clinics provided more than \$1 million in uncompensated care in 2014.

Patient reimbursements make up about 80 percent of annual revenue. Additional funding comes from philanthropic foundations, including the Colorado Health Foundation and Caring for Colorado Foundation, as well as corporate and private donors.

And Rocky Mountain Youth Clinics has connected with many community partners, including hospitals and behavioral health organizations. Community volunteers, including physicians, round out the support.



Denise Forrest, PNP, listens to a young patient's heartbeat during an exam at the Rocky Mountain Youth Clinics Thornton office. BRIAN CLARK/CHI

The state's Accountable Care Collaborative (ACC) provides an important new funding stream. Under one of its ACC contracts, Rocky Mountain Youth Clinics receives \$3.50 per member per month to provide care navigation services.

Top priority is given to ensuring convenient access to care, including expanded evening and weekend hours. Spots are kept open so most clients can get same-day appointments.

The clinic began integrating behavioral health care in 2008 with a pilot program to hire a psychologist. The integration has widened with the addition of three behavioral health consultants and partnerships with a long list of community mental health organizations. The goal is to have a full-time behavioral health provider in each clinic in two years as well as a behavioral telehealth program.

At Rocky Mountain Youth Clinics, the "home" part of medical home takes on new meanings.

Just ask single dad Jeremiah Birdsall, whose son, Benjamin, was born with fetal alcohol syndrome, eight weeks early and weighing just three pounds. Physician Assistant Denise Vidas has cared for Benjamin since he was three months old, part of a team of specialists, nutritionists, pediatricians, care navigators and social workers.

"Just seeing him, how much he's come since he started coming here, that's what I think about when I think about Denise and Rocky Mountain Youth Clinics," he says.³⁰

– Deborah Goeken

End Notes

- ¹ CHI analysis of the National Committee for Quality Assurance Recognition Directory. Data retrieved May 28, 2015. <http://recognition.ncqa.org/>
- ² Patient-Centered Primary Care Collaborative. (2013). "Why the Medical Home Works: A Framework." <https://www.pcpcc.org/sites/default/files/resources/Why%20Medical%20Home%20Works%20-%20FINAL.pdf>
- ³ Colorado Health Foundation and Colorado Health Institute. (2015). "The 2015 Colorado Health Report Card." www.ColoradoHealth.org/ReportCard
- ⁴ Colorado Department of Health Care Policy and Financing. "Creating a Culture of Change: Accountable Care Collaborative 2014 Annual Report." (2014). <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf>
- ⁵ State of Colorado Joint Budget Committee. "Appropriations Report: Fiscal Year 2014-15." http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/FY14-15apprept.pdf
- ⁶ Colorado Department of Health Care Policy and Financing. (April 2015). "ACC Model Details and Policy Decisions."
- ⁷ Marjje G. Harbrecht and Lisa M. Latts. (2012). "Colorado's Patient-Centered Medical Home Pilot Met Numerous Obstacles, Yet Saw Results Such As Reduced Hospital Admissions." *Health Affairs*. Vol. 31, no. 9. <http://content.healthaffairs.org/content/31/9/2010.full>
- ⁸ Raskas, R.S. et al. (2012). "Early results show WellPoint's patient-centered medical home pilots have met some goals for costs, utilization and quality." *Health Affairs*. Vol. 31, no. 9. <http://content.healthaffairs.org/content/31/9/2002.full>
- ⁹ Erin Fries Taylor, et. al., Evaluation of the Comprehensive Primary Care Initiative: First Annual Report. Mathematica Policy Research (January 2015).
- ¹⁰ Centers for Medicare & Medicaid Services. "Comprehensive Primary Care Initiative: Colorado: Statewide." <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Colorado.html>
- ¹¹ Cigna Health and Life Insurance Company. (2014). "Cigna Collaborative Care." http://newsroom.cigna.com/images/9022/Collaborative_Care_Whitepaper_v10.pdf
- ¹² Personal communication with Patrick Gordon, Rocky Mountain Health Plans. (May 20, 2015).
- ¹³ Anthem. (2012). "Anthem's Blue Priority and Blue Priority PPO Plans." http://www.anthem.com/agent/co/f3/s1/t0/pw_e187623.pdf?refer=ahpagent
- ¹⁴ National Committee for Quality Assurance. Data retrieved April 8, 2015.
- ¹⁵ Colorado Health Neighborhoods. (2015). Email communication with Centura Health. <http://www.coloradohealthneighborhoods.org/chb/home/>
- ¹⁶ New West Physicians. (2013). "Awards & Recognitions." <http://www.nwphysicians.com/about-us/awards-recognition>
- ¹⁷ Kaiser Permanente. (2013). "Kaiser Permanente Colorado Recognized as 'Best Value' for Quality & Affordability." <http://share.kaiserpermanente.org/article/kaiser-permanente-recognized-as-colorados-best-value-health-plan-for-top-quality-and-affordability/>
- ¹⁸ Nielson, M. et al. (2014). "The Patient-Centered Medical Home's Impact on Cost & Quality: An Annual Update of the Evidence, 2012-2013." http://www.milbank.org/uploads/documents/reports/Patient-Centered_Medical_Homes_Impact_on_Cost_and_Quality.pdf
- ¹⁹ Nielson, M. et al. (January 2014).
- ²⁰ Personal communication with Tracy Johnson, Denver Health. (July 8, 2015).
- ²¹ Peikes, D et al. (2012). "Early Evidence on the Patient-Centered Medical Home." <http://pcmh.ahrq.gov/sites/default/files/attachments/Early%20Evidence%20on%20the%20PCMH%202%2028%2012.pdf>
- ²² Nielson, M. et al. (January 2014).
- ²³ *Ibid*
- ²⁴ Cassidy, A. et al. (2010). "Patient Centered Medical homes: A new way to deliver primary care may be more affordable and improve quality. But how widely adopted will the model be?" http://www.healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_25.pdf
- ²⁵ University of Colorado OB/GYN & Family Planning. (2014). "Five Thousand Overwhelmed, Adolescent Mothers Have Received Crucial Help at CAMP." <https://obgyn.coloradowomenshealth.com/press-releases/camp-helps-adolescent-moms/>
- ²⁶ Site visits and interviews with Colorado Adolescent Maternity Program. (May 28, 2015 and June 11, 2015).
- ²⁷ Site visit and interview with High Plains Community Health Center. (May 21, 2015).
- ²⁸ Site visit and interview with Northside Child Health Center. (May 18, 2015).
- ²⁹ Site visits and interviews with Family Medicine Clinic and Physician Health Partners. (June 2, 2015 and June 15, 2015).
- ³⁰ Site visit and interview with Rocky Mountain Youth Clinics. (May 11, 2015).

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