April 2018

Western Colorado Leadership Group

Welcome to The Ascent, an e-resource from the Western Colorado Leadership Group that brings you timely, targeted news each month--news about population health, payment reform and the people working to pursue better care, lower costs and a healthier community.

Leadership

Ken Davis, PA-C, Executive Director, Northwest Colorado Community Health Partnership

Ken Davis, PA-C, is executive director of the Northwest Colorado Community Health Partnership, the network of community and safety net organizations, health care providers and government agencies in Grand, Jackson, Moffat, Rio Blanco and Routt counties. NCCHP is a nonprofit that works with local organizations to ensure residents have access to programs and services they need to be their healthiest self. It supports efforts to identify gaps in service, and then works to create community-wide efficiencies and reduce duplication, collaborating with health and wellness partners, collecting and leveraging regional data to support decision making, and advancing community-driven solutions.

The Ascent: ***You are a community leader in the Accountable Health Community Model. How does that align with NCCHP's goals?***

Davis: First and foremost, after working with underserved populations as a physician assistant and now serving in a community leader role representing the Health Partnership, I'm on the front lines, and I see how broken and fragmented our system is and how that impacts the individual's ability to achieve health and wellness. I'm convinced our greatest hope for improved health happens through partnerships. That's the greatest strength of the AHCM, in my mind. It moves us to work in greater collaboration between all sectors in a community.

The Ascent: ***How does screening for social determinants of health as part of the AHCM align with that vision?***

Davis: We acutely understand that an individual's health outcomes are at most 20 percent attributable to clinical care, and the remaining influences on health outcomes rely on the environment in which we live, genetics and the behaviors that help us to thrive. Screening strengthens the linkage between clinical and community supports. These screenings will also help us collect data and identify the most common social health needs for the various communities we serve so we can tailor our approach.

For example, at our last AHCM Advisory Committee meeting, we talked about food insecurity and how it's been identified as an issue among multiple partners sitting at the table—and that started some juices flowing around addressing it. We've continued to share emails and we've agreed to reach out to Hunger Free Colorado to go after a grant to help us better screen for this. I see great energy and synergy developing around that issue in the near term.

The Ascent: ***What are the next steps regarding screening for social determinants of health?***

Davis: We are identifying clinical champions for piloting the AHCM screening tool for social determinants of health. We are very excited to host the regional AHCM meeting in Craig, Colo. on May 9, and we look forward to the next steps and deeper partnerships that arise from that meeting. Ultimately, I see the Health Partnership helping to support community-wide transformation, using a model that shapes the entire

community fabric in ways that make it easier for all residents to live a healthier and happier life.

Social & Behavioral Health Integration

Providers, payers track impact of screening for social health

Putting reminders in the electronic health record to screen for social factors that affect health, like access to healthy food and transportation, continuously prompts health care providers to gather that data from patients. Providers who are screening and connecting patients to social health resources are seeing sizeable reductions in overall readmission rates as a result. Payer partnerships that include data sharing produce robust tracking capabilities—including whether referrals led to action—as well as cost savings. (*Modern Healthcare*)

Strong correlation between high poverty, pediatric hospitalizations

A five-year study of pediatric hospitalizations was compared to census data in Ohio and found patients in low income areas spent more than twice as many days in the hospital as their high-income counterparts. Since the researchers discovered high-poverty, high-utilization "hot spots" near Cincinnati Children's Hospital Medical Center, the hospital has targeted the community for population health improvement and enhanced community partnerships. (*HealthLeaders Media*; *HealthAffairs*)

Feds call for expanded awareness, availability of overdose drug

United States Surgeon General Jerome Adams called on health care providers to prescribe or dispense the overdose-reversing drug naloxone to patients at elevated risk for opioid overdose—and for their friends and families to have doses available, too. The advisory was seconded by Food and Drug Administration Commissioner Scott Gottlieb, who said the FDA will help manufacturers who want to apply for approval of over-the-counter versions. Cost for doses of naloxone is on the rise as the drug becomes more scarce; some lawmakers are calling on the administration to allow the government to negotiate for lower prices. (Surgeon General's advisory; AMA Wire; *InsideHealthPolicy* [registration required])

Meal delivery programs can lower medical costs

About 13 percent of US households lack consistent, dependable access to enough food, which can impact health. A recent study found home meal delivery for dually eligible Medicare and Medicaid beneficiaries can reduce the overall cost of health care for both payers and participants. Researchers found that participants enrolled in a medically-tailored meal delivery program accessed the emergency department, emergency transportation and inpatient care less frequently than a control group who didn't receive special meal delivery. Even those enrolled in a non-tailored meal program used fewer emergency services. Participants in both meal programs spent less for medical expenses, too. (*American Journal of Managed Care*)

Payment Reform

Putting the "value" into "value-based" payment

Could allowing how appropriate a service is to a patient's health outcome increase the "value" part of value-based payment models? In a new era of precision medicine, building an "appropriateness modifier" into payment incentives could lead to higher-value treatment decisions that take into account a patient's nuanced situation. Similarly, patient cost-sharing could be adjusted to encourage high-value services and discourage less appropriate services. (*American Journal of Managed Care*)

New incentives fund collaborative behavioral health

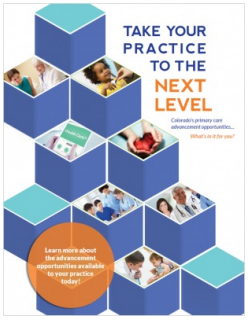
Medicare's 2018 physician fee schedule pays for a collaborative care model enabling physicians to generate revenue when they co-manage patients with a psychiatrist. Supporters say the structure strengthens the connection between physical and mental health, paving the way for better overall health outcomes. Under the collaborative model, physicians must create a care team that includes a behavioral health care manager—often a social worker, physician assistant or nurse practitioner—as well as the psychiatrist. (*Medical Economics*)

RMHP Member Spotlight

Coordinating for care: Kathleen and Gizmo's story

Hope for a shower and shelter connected Kathleen Moore to RMHP Medicaid community health outreach coordinator Jermain Fubler, but she and her dog Gizmo found so much more: Health care coverage and a primary care provider, an eye exam and glasses so she could find a new job, plus dental care—and a new home. Kathleen tells her story here. (Member spotlight)

Practice Transformation



The Primary Care Transformation Resources Catalog, sponsored by the Colorado Health Extension System, features dozens of opportunities to enhance practice efficiency and effectiveness. It will help you assess where you are and where you want to go–and it will allow you to match resources with needs.

For more information, contact
Cynthia Mattingley at cynthia.mattingley@rmhp.org.

About the Community

Western Colorado is creating an accountable community that uses health IT in a meaningful way, adopts value-based payment models, coordinates care and empowers patients to take charge of their health. We aspire to ensure the following:

- High-quality health care is affordable and accessible to all.
- Those who purchase health care are assured that care is effective, safe and appropriate.
- Patient care is a team effort, with roles that are well-defined, connected and collaborative.
- Patients have access to the support and information they need to take charge of their health and make their own decisions.
- Payment reform will foster reimbursement models that support accountability for population health and resource use.
- Information technology supports population health, helping providers predict outcomes, prioritize interventions and prevent disease.
- Health data is a community resource used in a secure way to support coordinated care at the population, practice and personal levels.
- Investments in information technology and health system transformation will improve quality of life and economic well-being across the state.
- Health is a community resource that requires leadership, stewardship, individual responsibility, community support and ongoing maintenance.

About RMHP

Founded in Grand Junction, Colo. in 1974, as a locally-owned organization, Rocky Mountain Health Plans provides access to affordable, quality health care enabling its more than 229,000 members across the Western Slope to live longer, healthier lives.

ROCKY MOUNTAIN HEALTH PLANS®

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