January 2019

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

Leadership: Daniel Darting, CEO, Signal Behavioral Health Network

Daniel Darting is the CEO of Signal Behavioral Health Network, previously serving as its director of information technology. Signal provides substance abuse disorder services in three regions in Colorado, including western Larimer County. Darting serves on the board of the National Council for Behavioral Health, the Colorado Providers Association, and Colorado Behavioral Healthcare Council and numerous stakeholder groups in Colorado.

***Ascent:* Your organization's work is in substance use disorder (SUD) health care interventions. In what way do SUD services have an impact on health care, in terms of outcomes for clients and savings in the system?**

Darting: When you look at the metrics around the cost of SUD to health care, to society, and the broader economic impact, it's substantial. A 2015 study estimated $442 billion in unnecessary health care, economic and criminal justice cost related to SUD. That's 2 percent of GDP—a huge number.

Here in Colorado, the Department of Health Care Policy and Financing estimates there's something on the order of $63 million in potential savings just within Medicaid related to appropriate SUD care. That's a really big number, too.

If you're going to target high health care costs, SUD appears to be the place to intervene with better health care delivery. The way I interpret that number is the cost of care that is not delivered at the time it's needed. When care isn't available when the client needs it, costs can escalate—like ER visits that didn't need to happen had someone received an early intervention.

Early and preventive interventions for SUD are powerful. We see a lot of investment in the treatment system, which is the most acute intervention, but very little for prevention and recovery. Often, when a client completes an inpatient admission intervention, they don't have supports in the community they need, so they may have to return to treatment. That's why the societal and personal costs are so high.

***Ascent:* There has been a lot more attention paid to behavioral health, and SUD in particular, by policymakers, health plans and communities. How has that affected the system and consumer access?**

Darting: There's been a tremendous amount of additional interest and expression of support within the last five years, largely driven by the opioid crisis. We had a substance abuse crisis before that, but the acuity has been higher with opioids.

That's helpful in the sense that some of the barriers or resistance to interventions are less common, there's more support, and we don't have as much stigma. But there are still hurdles to get over and

stigma remains.

There are all manner of ways to address this at local, state and federal levels, but at this time, it feels disconnected. A lot of new funding streams are grant-based. We're grateful for that, but we're missing a level of sophistication that will make funding for SUD look more like funding for health care.

In Colorado's Medicaid program, outpatient SUD benefits are covered, and the state is moving forward on residential care as well. But commercial insurance coverage probably needs to be more uniform. Investments in recovery services—the general emphasis that health plans pay to support long-term wellness—need to be applied to SUD as well. With respect to understanding this as a chronic disease, it's still in its infancy in terms of societal acceptance, and that informs policymakers. We're deeply grateful for what we've seen in the last few years, but it's also just the start.

***Ascent:* What's next?**

Darting: Between 50 to 60 percent of those who receive treatment for SUD enter long-term recovery. That's very much in line with other chronic diseases. But the difference for SUD is that fewer people can access needed services. There is a capacity need for both preventive and intervention services. We're seeing acknowledgement of that, and it's encouraging, but there's a lot of work in front of us.

I think the natural evolution of the system of care is integration of behavioral and SUD services with the rest of health care delivery, in partnership with organizations like Rocky Mountain Health Plans. They have RMHP Prime, which provides full health coverage integrated across all types of need. If you look at potentially avoidable cost, doesn't it make sense to incentivize early treatment and prevention over more acute and expensive health interventions? To do that, you need to link those services. SUD care is specialty care, but having SUD providers integrated with local primary care practices seems like the direction we need to go.

Social & Behavioral Health Integration

High social risk is factor for missed medical visits

Social factors like food insecurity and isolation can affect the ability for consumers to get to health care appointments, but 60 percent of those who self-identified as high-risk for having these factors say they never discussed the issue with a provider or insurance company. The consumer survey on how social determinants of health impact clinical experience found that social health risk is present across every payer class. Those with high social health stress are more likely to have chronic conditions and are more likely to miss medical appointments. (BenefitsPro)

Program for new moms combines fresh food with breastfeeding support

A New Orleans non-profit called Market Mommas Club connects Medicaid- or WIC-eligible new mothers to local breastfeeding support groups. At the meetings, participants can connect with certified lactation consultants and receive peer support. But they also receive access to $80 in Crescent City Farmers Market tokens each month for six months. Outings to the Farmer's Market are family-friendly and offer the opportunity to buy new foods, participants say. (NOLA.com)

Loan repayment incentive aims to boost rural behavioral health

Rural areas have a new tool to recruit behavioral health providers. The Health Services and Resources Administration announced a loan repayment program—worth up to $75,000 over three years—to providers who agree to work full-time in underserved areas. It's designed to put more clinicians in places where the opioid crisis hits hard, but providers are few. A second program is geared to covering gaps in medical, dental and mental health access and could total $50,000 in loan repayment for full-time clinicians over two years. Rural and remote areas tend to have higher levels of social risk factors, such as isolation and poverty, and lower access to detox and other recovery services. (Patient Engagement HIT)

Health plans partner with public agencies for supportive housing

A monthly rent payment costs less than a hospital stay—so insurers are increasingly partnering with public housing authorities to address housing instability as a social factor affecting health. Half the nation's public housing authorities are pursuing health investments in housing along with the nation's largest health insurers. United Health alone has invested $345 million in 3,400 affordable housing units since 2011. The health plan announced a project this fall to build housing for managed Medicaid members, in partnership with the Council of Large Public Housing Authorities, the Robert Wood Johnson Foundation and the Corporation for Supportive Housing. (*Forbes*)

Payment Reform

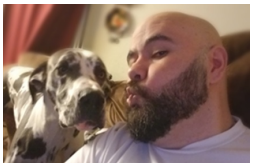
Analysis: Change coming in new managed Medicaid, CHIP rules

The proposed rule to revise the 2016 Medicaid and Children's Health Insurance Program was released in November. Changes include added flexibility to payment rates that states make public, as well as the ability to retain pass-through payments for the first three years after a contract transitions from fee-for-service to managed care. Of concern to consumers and rural providers is a step away from requiring states to use "time and distance" travel standards to determine if an adequate provider network is available. The new rule only requires states to adopt a more general standard, such as provider-to-enrollee ratio, to determine network adequacy, and states can decide not to apply these standards to specialists. That could make it harder for enrollees in remote areas to access care they need. *(The Commonwealth Fund)*

Bill to create public health care option in Colorado General Assembly

A new session of the Colorado General Assembly kicked off with a pair of related bills to create a public option health insurance plan. Democrats introduced the bills, intended to give Coloradans in highest-cost areas an option; One bill would cover a pilot starting in late 2019, and the second would expand the plan in 2020. The public plan is envisioned to offer Medicare reimbursement rate-level coverage, says Rep. Dylan Roberts, D-Avon, who sponsored the bills. *(Denver Post)*

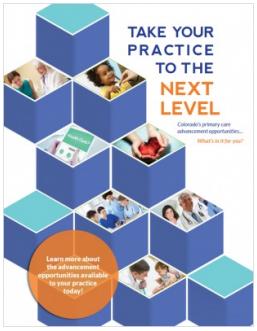
Member Spotlight



Jason Amaya

A 95-mile-an-hour wind lifted Jason Amaya's one-ton pickup and 38-foot trailer trailer off I-80 last February, hurling him and his life in an unforeseen direction. "I died in that accident," Jason says. "They bolted me back together." (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
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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.

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