July 31, 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: Stephanie Monahan
Executive Director
The Health Partnership Serving Northwest Colorado

As executive director of the Health Partnership, Stephanie Monahan is known for her expertise in cross-sector partnership building, program development, and comprehensive health and wellness systems work. Prior to taking her current position in June, she served as the regional health connector for NCCHP, working to improve the efficiency of navigation supports throughout Grant, Jackson, Routt, Moffett and Rio Blanco counties. She spearheaded the regional community health needs assessment on behalf of clinical and community partners to align efforts and strengthen the collective impact on issues like behavioral health and food insecurity.

***Ascent:* You began your service with NCCHP as the regional health connector. That's not a job title that's commonly understood. What does a regional health connector do?**

Monahan: The role of the regional health connector (RHC) was to serve as a critical linkage point between clinical teams and community organizations to support better patient outcomes. RHCs operated in Colorado as a unique workforce; we could take the time to understand community needs—what the priority areas were and the opportunity gaps to fill—via environmental scans and one-on-one conversations with community stakeholders.

Sustainability was important, so we put in place initiatives that will continue to improve the system beyond the regional health connector role and timeline. Read more.

***Ascent:* How does connecting organizations—and their leadership—through the work of NCCHP improve health for the residents in your region?**

Monahan: The predominant work we do as an organization is changing our care environment and system. For example, if your doctor prescribes weight loss for your health, but there's no walking paths, or the only nearby food choices are fast food, the environment needs improvement. We're looking at systemic issues and asking how we can we make healthy choices easier. What factors get in the way of our mental and physical health? What are the barriers to people accessing good nutrition? How can we work to pull those opportunities together to help people live longer, happier, healthier lives? Read more.

***Ascent:* Looking at the big picture, what are three things The Health Partnership is doing to improve access to resources that contribute to health (housing, food, mental health services, etc.)?**

Monahan: We participate in a federally-funded project called the Accountable Health Communities Model, which encourages screening for social determinants of health needs in the clinical setting and

then connecting patients with care navigation and resources at the community level. That's where systemic issues come into the picture. For example, transportation is a huge issue in our region. What are the policy levers we can pull to address transportation? How can we address food insecurity, working together to be innovative above and beyond the supplemental nutrition assistance program? We support the navigation network because there's nothing more important than helping the boots-on-the-ground people who are connecting with people on a daily basis. How can we elevate those experiences to drive change? Read more.

Social & Behavioral Health Integration

CDC: Health declines as income inequality rises

Although the health disparity gap between black and white Americans has closed over the past quarter century, there is a "worrisome" lack of progress in health equity. According to the Centers for Disease Control and Prevention, only 10 to 20 percent of health outcomes are tied to provision of health services, but education, income and other social determinants play a large role in overall health. Self-reported health among those in the lowest income groups is declining over time, while health among those at the highest income levels remains stable. (National Public Radio; *JAMA Network*)

3 success levers advance integrated behavioral and physical health

As more state Medicaid programs require integration of behavioral and physical health, success factors are emerging for better coordinated care. A new issue brief profiles programs in Arizona, New York and Washington and focuses on three levers for advancing integrated care: integrated data sharing and quality metrics for health plans and providers; aligning financial incentives with business practices for integrated care delivery; and adoption of clinical practices such as service redesign, assessments, staffing and care planning. (Center for Health Care Strategies)

Loneliness a risk factor for chronic illness and premature death

Social isolation and lack of community connectedness has been overlooked for too long as social determinants of health, according to former U.S. Surgeon General Dr. Vivek Murthy. The numbers confirm the problem; a 2018 survey found that about half of U.S. adults feel lonely, and 40% reported having no interactions with other people. Health plans are taking steps to mitigate loneliness through a variety of programs. Direct phone calls to patients and partnerships with community organizations are among the solutions. *(Modern Healthcare)*

Stress tied to food insecurity plays a role in diabetes control

Researchers found that low-income patients with diabetes and high levels of food insecurity also produced more stress hormones than those who didn't report food insecurity. They also had higher total cholesterol and insulin resistance. The findings support asking patients about food insecurity and providing resources to mitigate the issue. As one researcher said: "Patients are often referred to a certified diabetes educator or a nutritionist, but they are not referred to a social worker." (Helio)

Payment Reform

APM participation doubles; small practices increase MIPS performance

Participation in Centers for Medicare & Medicaid Services advanced alternative payment models almost doubled between 2017 and 2018, from 99,076 to 183,306 clinicians, and the number of clinicians who received a 5% payment adjustment increased as well. Participants in advanced models don't participate in the Merit-Based Incentive Payment System (MIPS), which represented 98% of other eligible providers in 2018. Based on their performance, 98% of MIPS participants will earn a positive payment adjustment in 2020. Of note, small practices are faring better than they did previously. Nearly 85% of small practices in MIPS scored high enough on measures to earn higher payments in 2020, compared to just 74% the previous year. (Healthcare Dive; CMS announcement)

Key factors that make value-based payment succeed

More health plan payments to providers are based on value-based rather than fee-for-service reimbursement. It's time to focus on what's working in advanced payment models (and what isn't) to accelerate better care, better health, lower costs and greater provider satisfaction. Experts on a recent industry panel highlighted key factors that moved their organizations closer to the quadruple aim: flexible options for provider participation; leadership commitment to engagement and culture change; reasonable benchmarking parameters in risk-based arrangements; and metrics that work across multiple payers. *(RevCycle Intelligence)*

Care Coordinator Spotlight

Lizbeth Cedillo, Loveland, Colorado

After Lizbeth Cedillo earned a degree in psychology, she entered the world of professional purchasing—a far cry from her education roots. But the pendulum swung firmly back in place when she became a care coordinator for North Colorado Health Alliance in 2018.

"I wanted to do something that would benefit the community," she says. "I love this job. In purchasing, I was able to get a good deal on 10,000 bottles of vitamins, but I never saw a change in people's lives." (Spotlight)

Practice Transformation

The Practice Transformation Team at Rocky Mountain Health Plans (RMHP) has partnered with practices located in the Western half of the State of Colorado for over a decade, to develop a community of advanced practices by fostering quality improvement at the practice level between physicians and patients with a focus on team-based, patient-centered primary care. A state-of-the-art practice transformation approach is integrated into the medical neighborhood through the implementation of care management and care coordination processes, and engagement of both primary and specialty practices.

As we find ourselves in an evolving health care environment, RMHP makes it a priority to work with practices to help them continue to provide high-quality health care. RMHP's programs:

- Align with the Colorado Healthcare Policy and Financing Alternative Payment Model (APM)
- Give your practice the building blocks to advanced primary care
- Help participating practices potentially qualify for a higher tier in RMHP's Regional Accountable Entity
- Provide the support and guidance that will help your practice succeed in the APM, including assistance with measure selection and performance

Learn More & Apply
To apply or learn more, please contact
Kristi Hall
Program Manager
RMHP Practice Transformation
Kristi.hall@rmhp.org
970-783-8687

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.

RMHP COMMUNITY

Rocky Mountain Health Plans
2775 Crossroads Blvd, Grand Junction, CO 81506
www.rmhpcommunity.org

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