Aligning in Action:
Rocky Mountain Health Plans

- Lead organization: Rocky Mountain Health Plans
- Lead sector: Health care payer
- Location: Western Colorado
- Year founded: 2017 as the bridge organization for the Accountable Health Community
- Interview with Kathryn Jantz, Accountable Health Communities Model Director

Health is impacted by factors outside of the health care delivery system, including housing, education, poverty, employment, food availability, transportation, and safety. Recognizing that addressing these socioeconomic determinants of health is needed to meaningfully impact health inequities, a national policy shift is taking place.

Government agencies, payers, and providers are all adopting a social determinants perspective. To effectively address these nonclinical needs, partners must work across sectors. Now, the question is how — what are the best practices for effectively aligning systems?

Aligning Systems for Health: Health Care + Public Health + Social Services, sponsored by the Robert Wood Johnson Foundation (RWJF) and managed by the Georgia Health Policy Center (GHPC), is focused on learning from stakeholders across the nation about effective ways to align these three sectors to better meet people's goals and needs.

Given variance in the local context, there is no single model or formula to align systems. However, Aligning Systems for Health seeks to understand commonalities that drive successful efforts to align sectors. This series examines how communities that describe their work as aligning systems are doing it around four core components of a theory of change that RWJF and GHPC are testing: purpose, governance, data, and sustainable financing mechanisms.

Rocky Mountain Health Plans (RMHP) provides a unique example where a payer is facilitating regional efforts to address social determinants of health. RMHP serves as a bridge organization within the Accountable Health Communities Model (AHCM), coordinating efforts in a largely rural area.

Local Context

RMHP is one of seven regional accountable entities (RAE) for the Health First Colorado Accountable Care Collaborative (Colorado's Medicaid program). RMHP connects Health First Colorado members

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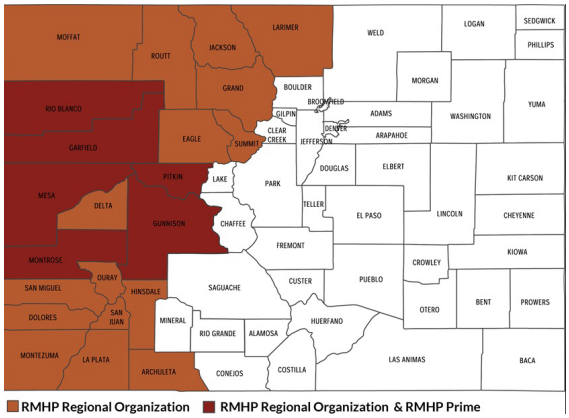
with both primary care and behavioral health services for the large Western Colorado region, which includes 21 counties plus Larimer County. Each RAE serves as a primary care case management program that provides additional services to support whole-person care, including activities to address social determinants of health. RMHP's participation in AHCM closely aligns with the goals and expectations of the RAE. All Region 1 (Western Colorado) RAE counties are included in AHCM, except Larimer County. Expectations of the AHCM grant include partnerships with food, housing, and transportation sectors, as well as other community-based organizations, to engage nonmedical partners.



Given the geographical size of RMHP's RAE region and RMHP's vision to create an accountable community with coordination between provider organizations and human services, there was already an infrastructure in place with community leadership and community partners.

Purpose

Many of RMHP's community partners were independently interested in the Centers for Medicare and Medicaid Services' (CMS') Accountable Health Communities Model, but CMS designed the program with volume in mind (75,000 screenings per year initially). Given the rural and frontier nature of the region, no single community would have had the volume necessary to meet this requirement (e.g., the largest city in the region is Grand Junction, which has a population of about 63,000 people).

RMHP was committed to pursuing a strategy around social determinants of health and felt a responsibility to support the community infrastructures that serve its membership; therefore, RMHP applied to be a bridge organization for the Accountable Health Communities Model.

"Once awarded, we really had to focus our attention on the specific tactical outcomes we were expected to achieve," says Kathryn Jantz, the director of the Accountable Health Communities Model at RMHP. "If we had a blank slate, we may have spent two years refining a collaborative community vision. Instead, we were immediately held to CMS' high standards of social needs screening, care coordination, and community convening."

Jantz reports that the AHCM work includes balancing CMS requirements, priorities of communities, and the incorporation of the strategy and long-term vision of RMHP.

Data

Because screening occurs at a member level, participating clinical sites can view the results of a screening that preceded engagement with them, regardless of where it occurred, including changes over time.

RMHP provides weekly feedback to clinical sites about screening volume and people opting into care coordination. RMHP's partner, the local Health Information Exchange, Quality Health Network,

provides visual monthly data on the prevalence of social needs and member-level detail on screening to clinical sites and to subregions. Analytics examine screening results by income, race/ethnicity, age, gender, and county and look at larger utilization trends (e.g., emergency room use and social needs). These comprehensive reports go to each partner, and they subsequently share data within their community.

Screening is built into Quality Health Network, so the infrastructure can be maintained post-grant.

Financing

As a health plan, RMHP is considering future ways to incorporate social needs screening into broader integration efforts. Data from social needs screening may inform payment adjustment, population stratification, or population-based interventions based on community need.

"We are committed to continuing a social needs screening vision and have been really cautious to build a program that is sustainable," explains Jantz.

Providers are not paid on a per-screening basis (although there are some low-dollar incentive payments paid to the clinic and directly to their staff), and all care coordination is built into RMHP's existing documentation infrastructure. Additionally, all community alignment and community convening relied on pre-existing relationships with organizations.

"We hope we have positioned each of the community partners to be more successful in their continued funding by arming them with data about the needs of their population, fostering skill-building and strengthening their relationships in the community, and giving them an influx of money for five years," Jantz says. "We are hopeful that we will pretty seamlessly move into a sustainable long-term strategy that includes social needs screening and robust community partnerships."

Governance

RMHP has a funded contract with each community organization leading the AHCM in their communities. In three communities, these organizations are local organizations that facilitate health alliances and/or provide care coordination. In two communities, local public health was initially the lead organization, but they ultimately were less comfortable encouraging and supporting screening in clinical sites.

Two people from each lead organization and RMHP meet every two weeks as a group, with an external facilitator. Quarterly, there are large meetings with all of the partners (approximately 180 people). Each of the lead organizations is responsible for engaging their community partners and managing community-level meetings. Many already had an existing community convening infrastructure or governance structure that they adapted for this program.

Most decisions are made by consensus; however, because this effort follows the CMS project structure, many decisions are predefined by the program model.

Insights for Aligning

- RMHP's work in AHCM is another example of cross-sector alignment activities being driven by both a federal grant and policy opportunity.
- RMHP has found a way to share governance across 180 partners and a vast geographic region.
- A key for financial sustainability may be in demonstrating value in connecting patients to social services and resources.

Aligning in Action

In some communities in Western Colorado, the percentage of people eligible for the Supplemental Nutrition Assistance Program who are actually enrolled is as low as 13%.

"What we are trying to accomplish is not that in one month we increased mass enrollment by X%. Although that would be fantastic, what we're trying to do is actually destigmatize and change the culture around accessing social resources. This culture change must come first."

While individual members' issues are being addressed, Jantz says a lot of the cultural change is occurring on the provider side. Previously, providers were concerned about liability, offending members, and not having an immediate solution if a need was identified.

"Having worked with these clinics for years now, they are telling me stories of 'aha moments' by CEOs in small towns who personally knew members but were completely unaware of their financial or social challenges," says Jantz. "It is really about increased awareness. Hopefully, it will change their practice, the way that they approach their patients, the way they engage in their community, and the way that they spend their community benefit dollars. In small communities, clinical site leadership wield clout in their community beyond their official professional role."

COVID-19 and Aligning

Many of the communities in the RMHP region are ski resort communities that are facing unemployment rates of 30%. So, continuing social needs screening has become "tricky" because of the vastly expanded needs that coincide with clinical sites being overwhelmed by COVID-19 and facing capacity challenges of their own.

"We have tried to partner with clinics to really think about how they deliver clinical care and how can we support them," Jantz says. RMHP took some concrete steps like creating functionality to allow screenings to be administered via telehealth. But, more broadly, RMHP is trying to engage in bigger conversations about how clinical sites can prioritize thinking about whole-person health during a significant recession and a public health emergency.