



FUNDERS FORUM
on Accountable Health



Western Colorado AHC Case Study

Western Colorado
2018

THE FUNDERS FORUM ON ACCOUNTABLE HEALTH

The Funders Forum on Accountable Health is a collaborative at George Washington University's Milken Institute School of Public Health that works to advance accountable communities for health (ACH) models by promoting dialogue and catalyzing change among public and private funders of ACH efforts across the country.

The Forum is a common table for funders of ACH efforts to share ideas and experiences, explore potential collaborations, support common assessment approaches, and build a community of practice.

Visit our website at accountablehealth.gwu.edu to learn more!

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FUNDERS FORUM CASE STUDIES

The Funders Forum on Accountable Health conducted ten case studies of different accountable health models to better understand the key implementation challenges and opportunities they face.

Accountable Communities for Health (ACH) are community-based partnerships formed across sectors to focus on a shared vision and responsibility for the health of the community. They pursue an integrated approach to health that focuses not only on the clinical setting, but also on how the broader community can support health care's "Triple Aim"¹ of better care for individuals, better health for populations, and lower health care costs.

The Funders Forum interviewed leadership from ten ACH sites in order to better understand the various approaches to governance structure, portfolio of interventions, investments in technology, funding sustainability strategies, and anticipated short- and long-term outcomes of their ACH efforts.

The purpose of this report is to provide an in-depth overview of the Western Colorado Accountable Health Community. We wish to thank all the participants in this case study.

Reports on all ten case studies are available on our website at accountablehealth@gwu.edu.

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1. Berwick, D. M., T. W. Nolan, and J. Whittington. 2008. "The Triple Aim: Care, Health, and Cost." *Health Affairs* 27(3).

Western Colorado AHC

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What is the Western Colorado Accountable Health Community?

The Western Colorado Accountable Health Community (Western CO AHC) brings together payers, health care providers, public health departments, and social service providers across 20 rural and frontier counties in Western Colorado and one urban county to work together to more holistically address their communities' health and social needs. It is one of 31 community-based initiatives that have been established across the country as part of the federal Accountable Health Communities Model demonstration project, run by the Centers for Medicare and Medicaid Innovation (CMMI).

The Western CO AHC is particularly unique due to the diverse rural communities and large geographic area it serves. The 21 counties included in the Western CO AHC make up almost half of the total land area of Colorado. However, they are home to only about one-tenth of the state's residents, spread out across numerous small mountain towns each with their own resources, infrastructure, and priorities.¹ To this end, the Western CO AHC has established a delegated organizational structure, dividing its total service area into five regions and funding local leaders to convene their community partners to figure out how to partner together to successfully implement the AHC model.

The Western CO AHC is deeply committed to the slow process of culture change in clinical care settings. This includes building the technological infrastructure, workforce, and relationships necessary to systematically screen Medicare and Medicaid patients for social service needs, refer patients to community-based resources to address these needs, and provide high-touch navigation services to the most complex patients with unmet social service needs. This project is particularly focused on identifying and addressing unmet needs related to transportation, food insecurity, utilities, housing, interpersonal violence, physical activity, and substance use.

Origins of the Western Colorado AHC

The Western CO AHC was an out-growth of pre-existing collaborative efforts in the region to improve care coordination and address community health needs. Colorado's Medicaid program has divided the state into seven regions, or Regional Accountable Entities (RAE), tasked with convening community providers to build community-based care teams and coordinating the care needs of the regions' Medicaid patients. In Western Colorado, a small local insurer, Rocky Mountain Health Plan (RMHP), has served as the area's Regional Care Collaboration Organization (RCCO) since 2011. In this role, RMHP had previously built a care coordination model in partnership with medical and behavioral health providers in the community. While this model involved screening patients for social service needs that posed a barrier to care, it was much more focused on addressing health care needs. There was interest among partners to begin taking on social service needs more aggressively, but the RCCO had yet to seriously engage social service partners. Parallel to the work of the RCCO, some clinics in the region were independently working on improving care coordination and trying to address patients' social service needs through a patchwork of initiatives. Provider attention to social service needs continued to grow as many clinics in the area began participating in the federal Comprehensive Primary Care Initiative.

When CMMI announced the AHC model demonstration project, RMHP and their partners saw it as an opportunity to strategically build the infrastructure needed to address patients' health and social needs holistically, and to align fragmented projects already happening in the region. Given the large number of counties within western Colorado, RMHP approached five regional health alliances across the area, each of which already served as an anchor organization and community convener for a smaller subset of counties in the region. Some of these organizations were nonprofits initially founded after passage of the Affordable Care Act to support health coverage enrollment efforts and that had expanded to become broader health coalitions. Others were county health departments that were lead conveners for collaborative community health

1. <https://www.rmhpcommunity.org/sites/default/files/resource/Final%20Western%20CO%20AHCM%20Narrative.pdf>

work. Working together, RMHP and these existing regional health alliances worked to recruit providers and community organizations across their 21 counties to join in their effort to apply to become a CMMI AHC.

Governance Structure

The Western CO AHC has a partially decentralized governance structure in order to ensure that its programs and priorities are tailored to the local needs of the different rural communities it serves. Members include RMHP, the state Medicaid agency, clinical providers, community organizations, the state's health information exchange, the housing division, state and local public health agencies, and clients. The AHC contracts with five "community leads" who steer the program based on input from their communities. These individuals are representatives from a partnering community-based organization, and receive funding from the Western CO AHC to support their work as a community lead. Each of these community leads is responsible for convening a regional advisory board, and leading implementation of Western CO AHC activities within their region.

These community leads and regional advisory boards are the local heart of the Western CO AHC and have a history of working together that pre-dates the Western CO AHC. The regional advisory boards include all partnering clinics, hospitals, behavioral health providers, and social service providers that have signed a Memoranda of Understanding (MOU) with the Western CO AHC. Interviewees noted that the community leads are the most critical partners in recruiting local clinical and social service partners within their region to participate in the program, because they have those local relationships and understand the resources within their communities. The community leads also work one-on-one with partners to assist them in operationalizing the screening, referral, and navigation projects within the Western CO AHC. The regional advisory boards serve a number of roles. They are responsible for conducting an annual gap analysis and quality improvement plan that directs collaborative efforts to resolve health and social service need gaps in the community. These boards also advise RMHP and the consortium on large scale policy and operations decisions, providing an on the ground local perspective. They are also a site for partners to share best-practices and challenges, and to learn from one another.

Across all of this work, RMHP serves as the backbone organization supporting the Western CO AHC. It convenes quarterly community-wide meetings, bringing together partners across all five regions. It manages funds for Western CO AHC activities and is the primary organization in charge of implementing new systems to support the initiative's screening, referral, and navigation activities. In addition, it is a source of technical and state/federal policy assistance for local community partners.

Building a Navigation Model for the Frontier

Western CO AHC is deploying navigators to provide high-touch community resource navigation services to high-risk patients. These services are focused on Medicare and Medicaid patients who screen as having at least one unmet social service need and who have had at least two emergency room admissions in the past year, by their self-report. In building a navigator workforce in each region, the Western CO AHC contracts and trains existing care coordinator organizations to take on this added responsibility. This includes a robust network of care coordinators that serve the regions' Medicaid RAE. Leveraging this existing workforce has allowed the Western CO AHC to capitalize on the expertise and trust that these organizations already hold within the community.

Building a navigator program in this rural area has presented unique challenges. Partners repeatedly emphasized that building trust with clients through face-to-face meetings is critically important. For the most part, navigators are expected to meet patients within their own community, whether it be the client's home or an easy meeting place like the local library. However, building these in-person relationships can be incredibly

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time intensive, particularly when a single navigator serves clients across a huge geographic area, including areas that are remote and not easily accessible. Once navigators have built trusting relationships with a client, virtual check-ins via telehealth could, in theory, help. However, this region still has tele-connectivity challenges that limit telehealth adoption.

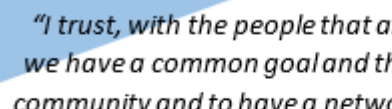
While only in the initial stages of implementation, some partners expressed skepticism that the current volume of navigators will be sufficient to truly meet the needs of clients across all of the AHC's 21 counties. One organization noted that they only have four full-time equivalent navigator staff in charge of serving six counties. In addition, one stakeholder noted that they anticipate a greater share of screened Medicare and Medicaid patients will require more navigator services than the federal government originally estimated. Whether the program will have sufficient capacity to meet local needs is an ongoing question.

Unique Considerations When Building Networks Across Diverse Rural Communities

Interviewees emphasized other unique considerations that the Western CO AHC has had to grapple with because of its rural geography. Multiple interviewees noted that the physician community is made up of predominately small independent practices. Each of these providers is working with different electronic medical records and has different workflow considerations. This has made building a screening and referral system that works for all partnering providers a challenge. To address this, the RMHP has allowed clinics to customize their approach to integrating screening into their existing practices. Some providers have opted to begin by using existing case managers to identify probable high-risk patients, based on clinical data, and to only screen these individuals. RMHP is working with all participating providers to move towards systematic screening. Other providers have decided to use front desk staff to screen all Medicare and Medicaid patients before their appointments. Another site is only screening on days when the navigators are on site as they are not comfortable screening when there is no one immediately available to address any identified needs. While this has created trade-offs in terms of the number of patients screened, providing this flexibility has been important to maximizing clinician participation.

Additionally, a single clinic might serve a large geographic region, distinctly different from the region served by their colleagues in a neighboring town. In order to support patient referrals, these clinics need tailored information about the social service resources within their own catchment areas. To address this, one community lead has built unique guides for different practices that reflect the social service providers only within their service areas.

Because the Western CO AHC includes more populous and affluent ski towns, alongside more depressed and isolated mountain towns, it also has had to be sensitive to disparities across its member regions, in terms of availability of and funding for social services, and the resources of community partners. For example, one interviewee noted that one social service provider in their community was a one-person operation that does not even own a computer to track and report data to the Western CO AHC. In some communities, availability of affordable housing is more of a challenge than in other areas, and the existing care coordination workforce was initially much more limited prior to Western CO AHC implementation. These disparities have forced the Western CO AHC to consider how to accommodate differing capacities.



"I trust, with the people that are engaged, that we have a common goal and that is to unite our community and to have a network that supports our patients in the best way. I truly believe that every person on that committee is committed to doing the right thing for the patient. You do the right thing whether somebody's watching or not and that's the commitment."

Carol Shlageck
Primary Care Partners

All interviewees emphasized the importance of considering their region's local, rural culture and values in building this work. Many of the communities within the Western CO AHC eschew top-down state or federal projects. From the beginning, making this AHC as locally driven as possible was seen as critical to building local buy-in. Partners also emphasized that the close-knit relationships and culture of self-reliance characteristic of this region has helped support the work of the Western CO AHC. It has brought partners to the table based purely on the work aligning with their mission and values. It has also fostered mutual accountability out of desire to maintain good standing and trust with other partners in the region.

Setting a Local Agenda to Improve Social Service Infrastructure

In addition to implementing the screening, referral, and navigator activities, the Western CO AHC hopes to spur regional collaborative efforts to address persistent upstream social service gaps. Once the Western CO AHC is in full implementation, each regional advisory board will be responsible for conducting an annual social needs gap analysis and quality improvement plan. The social needs gap analysis is aimed at identifying persistent unmet social service needs for that region, based on data coming in from Western CO AHC screenings and referrals, other state and federal data sources, community needs assessments conducted by area hospitals and public health departments, and regional surveys of clients and community organizations. Based on this gap analysis, each regional advisory board is expected to outline a process for addressing some of these unmet needs via collaborative efforts to improve service availability and coordination across partners. In keeping with the emphasis on local delegation, each regional advisory board has the autonomy to determine the appropriate structure and processes for carrying out these two projects. Through the gap analysis and improvement plan, the hope is that partners can work together to continuously improve coordination with one another and identify feasible action steps to strengthen the social service infrastructure.

Challenges with Building Infrastructure to Connect Health and Social Services

A major component of the Western CO AHC is implementing a shared system that clinics can use to screen patients for social service needs, share screening results with other providers, and generate referrals to community providers to address those needs. The original vision for this system built upon the region's existing health information exchange, the Quality Health Network, as well as its 2-1-1 system, Community Resource Network.

Having such an automated system in place to assist clinics in referring patients to social service providers was incredibly important for physicians. Interviewees noted that many doctors were only comfortable with the idea of screening their patients if they felt confident that they would have a course of action to help patients address identified unmet needs. In planning such a system's design and recruiting a technology vendor to build out this system, RMHP sought significant input and involvement from clinics. The hope was that this system would create a seamless and efficient way for clinics to complete screening and referrals, and report back data to the larger program.

Unfortunately, the Western CO AHC has experienced major setbacks in the build out of this technology. Because of this, many providers are completing screenings by hand, and they do not yet have the tools to efficiently generate referrals for their patients or share screening results. Community leads have helped support practices by building tailored paper referral guides for clinics in the interim. Long-term, partners stressed the importance of fully developing this technological infrastructure in order for providers to be able to sustain screening and referral activities.

Using Data to Build Momentum for Systematic Change

While the Western CO AHC is in the initial stages of implementation, interviewees shared their hopes regarding how data from this project could also be leveraged to build policymaker support for large-scale systemic change. Multiple interviewees discussed how having robust local data measuring the magnitude of unmet social service needs within their communities could be immensely valuable to broader advocacy efforts. While community partners know that there are inadequate social service resources, particularly in areas like affordable housing, the only available data quantifying these unmet needs has been at the state level up until now. Having local data could be much more valuable in advocating to local policy makers to increase investments in underfunded programs. Interviewees also hoped that having data measuring the health effects of addressing patients' social service needs could help payers appreciate the value of initiatives that require a longer-term time frame to produce meaningful savings and results.

"The biggest concern about screening for services is that there are no solutions...for example, you can't say, "Wow, you're living out of your car? Go to our shelter," because they don't exist. So the clinics are reticent to screen for that because they don't have anything to share with them. So what we are trying to say is we need to have that information so that when we do community health needs assessments or when people are making policy in our local governments, we need to say, "Listen. This many hundreds or thousands of people are experiencing homelessness in our county. What are you going to do about it?"

Lynn Borup, Tri-County Health Network

Broadly, partners hoped that the work of the Western CO AHC could help engage physicians in policy advocacy to address gaps in social service resources. They felt that having clinicians at the table, and not only public health organizations, could bring much more political power to any campaign.

Funding and Sustainability

Generating sufficient funding to support the activities of the Western CO AHC remains a challenge. A large portion of its federal cooperative agreement funding is going towards building technological infrastructure to support a shared online screening system, as well as a referral system through the area's 2-1-1 system. The cooperative agreement funds have also been able to support the work of community leads running the regional advisory boards. For some smaller organizations that employ these community leads, this funding has become a sizeable portion of their overall budget. While the Western CO AHC has predominately leveraged existing care coordination organizations to carry out navigator responsibilities, a portion of the cooperative agreement funds have been used to hire additional navigators in some regions. However, as noted earlier, even with these additional investments partners are concerned that demand for navigator services is likely to outstrip current capacity.

"My hope is that as clinical providers get engaged in the issue, they are politically powerful, they are connected, they have additional voices that our non-profit partners really don't have. My hope is that it creates some of the systemic change that we need to see."

Kathryn Jantz
Rocky Mountain Health

Interviewees noted that lack of funding to support providers in screening their patients remains another significant concern. The Western CO AHC did provide a one-time incentive payment to clinics that participate in the screening and referral program. However, this funding does not come close to compensating providers for the time it takes to operationalize and integrate this new activity into their workflow, and it doesn't create

an ongoing revenue source to support clinics in taking the time to screen patients. Short-term, partners have tried to maintain buy-in and participation among clinics by providing them with as much flexibility and ease of administration as possible as they move into the new system. They also have lifted up stories about the positive impact this new work is having on patients as a way to motivate providers to stick with it.

Long-term, providers hope that they will be able to build this work into value-based contracts with insurers. With this added revenue source, the hope is that they will be able to hire additional care coordinators and begin providing screening and referral services to patients outside of Medicare and Medicaid.

Challenges

Interviewees noted that federal requirements for the AHC demonstration project have created challenges. Because the demonstration is approached as a research project, it has rigid rules that at times are in conflict with optimizing clinician participation. For example, using PRAPARE would have been much easier given that it is already integrated into almost every EHR and many of their providers have already adopted it, but that is not an option under the grant requirements. In addition, stakeholders noted that there is significant duplication in the screening activities being carried out by the Western CO AHC and screening activities required by other federal models, like the Comprehensive Primary Care Plus Initiative. This has led to frustration among some providers participating in both programs.

Multiple interviewees also cited concern that existing social service resources may be inadequate to fully address the needs of patients served by the Western CO AHC, particularly needs related to affordable housing.

Lessons Learned

Interviewees highlighted a number of lessons learned through their planning and early implementation experiences to date. First, integrating screening and referral processes into clinical practices is a significant endeavor that takes time and commitment on the part of providers. Partners emphasized the importance of engaging clinics in this work only once systems are well-planned out in order to be respectful of their time. In addition, garnering buy-in from clinic leadership early on can be critical to securing lasting clinic commitment to incorporate screening into their practice.

Multiple interviewees credited the active engagement of clinical and social service providers in the region as essential to the progress made to date. Key clinics and mental health providers have led the charge in piloting new systems and providing feedback to make the program better. Lead clinics have also created peer pressure for other providers in the community to participate in the Western CO AHC. One partner noted that being transparent early on about the funding constraints of this type of project, and the reality that it won't be a new source of funding for many partners, helped weed out which organizations were truly motivated based on the long-term goals of this work. This helped build a table of partners that was aligned in their commitment to a shared mission.

Despite technological set-backs in implementation, partners emphasized that they are already seeing short-term benefits of building the Western CO AHC. One interviewee noted that the AHC has become its own anchor in communities, spurring greater sharing of information and collaboration outside of the AHC framework. Through regional advisory board convenings, clinical partners have become more familiar with the social service providers in their region, and even identified funding opportunities for smaller non-profits to help bolster the local social service infrastructure. One interviewee framed collaboration as a short-term benefit in its own right.



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