Advancing Accountable Health Communities: Background and Context

Jeffrey Levi, PhD

Professor of Health Management and Policy

Dialogue4Health

January 20, 2016

Milken Institute School of Public Health

THE GEORGE WASHINGTON UNIVERSITY

THE GEORGE WASHINGTON UNIVERSITY

WASHINGTON, DC

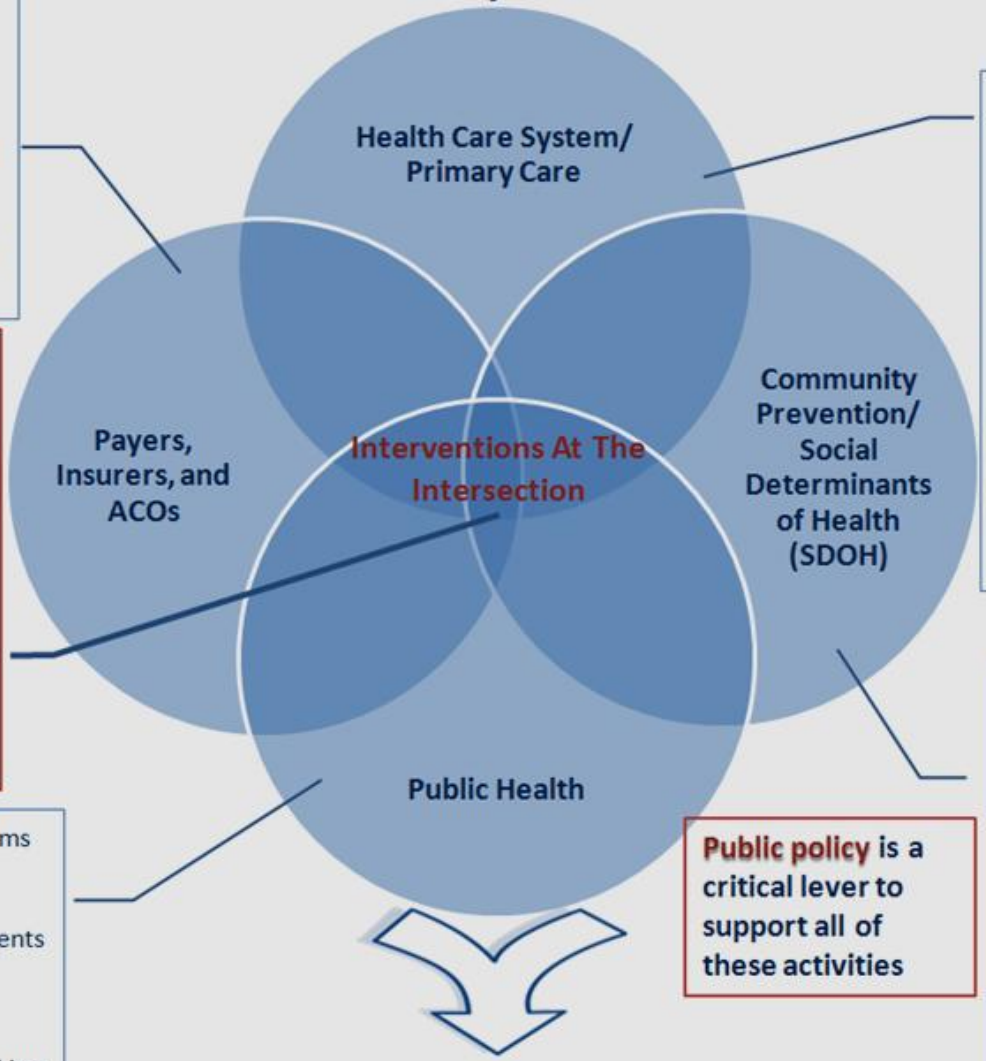
Welcome CMS as a partner in moving healthcare upstream

- AHC FOA is a significant recognition by CMS of the importance of social determinants in achieving improved health outcomes and cost containment
- An incredible opportunity to evaluate how well different systematic approaches achieve these goals
  - Builds on theoretical, practical and policy work of so many on this call today
  - Also builds on research and evidence-based developed to date

Population health in this FOA

- Moving beyond thinking about one patient at a time in a health care setting to addressing beneficiary needs by harnessing a community's assets
- Population health is addressed through a combination of health care services; public health; community policy, systems and environmental change; *and also* individual provision of social services.
  - This FOA brings 2 of the 4 factors to the table and provides the potential, in track 3, of bridging and aligning all 4.

Improving Population Health Outcomes Depends on Transforming the Health System to Coordinate and Integrate Primary Care, Public Health and Community Prevention Efforts



- Incentives for providers to achieve pop. health outcomes and improve quality
- Incentives for plans/ACOs to address population health outcomes
- Funding mechanisms that enable braiding of financing streams

- Primary care & team based care
- Patient assessments include personal data and SDOH regarding patients' homes and communities
- Quality improvement
- Leveraging, linkages and referrals to community resources
- Data collection & EHRs contribute to community health data base
- Coordination with community health outreach workers
- Chronic disease mgmt

- **Interventions at the intersection of primary care, public health and the social determinants of health require:**
- **Common agendas and goals**
- **Shared responsibility**
- **A compelling story**
- **Partnerships and collaboration**
- **Leadership and Integrators**
- **Data**
- **Financing systems**
- **Accountability mechanisms**

- Social and support services
- Disease prevention and management programs
- Outreach and referral to clinicians
- Education, including health education
- School health clinics
- Workplace wellness
- Coalitions and advocacy to address SDOH
- Community capacity building/ engagement

- Policy leadership on programs and policies that improve community health
- Community health assessments
- Educating policymakers, agencies, and stakeholders regarding pop. health
- Population health data tracking and analytic tools
- Aim for health equity

Public policy is a critical lever to support all of these activities

Improved Population Health, Health Outcomes, and Lower Costs (Triple Aim)

Updated 9/28/2012

Builds on prior and on-going related work

- Earlier models: Social Health Maintenance Organizations, Coordinated Care Organizations, Accountable Care Communities, Hennepin Health, Health Leads, Medical-Legal Partnerships
- TFAH Twin Pillars convenings focusing on policy opportunities
  - http://healthyamericans.org/health-issues/wp-content/uploads/2014/09/Twin-Pillars-of-Transformation-Summary-November-2013.pdf
- SIM state efforts around AHC and ACHs
- California Accountable Communities for Health
  - See http://www.communitypartners.org/cachi-reports-resources for relevant related resources from Prevention Institute, UC Berkeley, JSI, and ChangeLab Solutions
- Moving Health Care Upstream

Building partnerships

- Population health is fundamentally about partnerships within health and across sectors
  - We've done it before in linking health and social services: Ryan White Program
    - needs assessment, planning councils as bridge organizations, legal recognition of role of social services
  - We've done it before in the context of community prevention (CPPW, CTG, BUILD)

Learning opportunities from this and related efforts

- Who *must* be at the table for a successful consortium among hospitals, health systems, community, and social services?
- What are the attributes of a successful bridge organization?
- What data/IT needs are critical to success?
- When social service gaps are identified, does setting the right “table” help fill them?
- Even if improved health outcomes and savings are achieved, what is the impact on combined health and social services outcomes and budgets?
- When the AHC operates in the presence of other population health initiatives, does that improve outcomes?

THE GEORGE WASHINGTON UNIVERSITY

WASHINGTON, DC