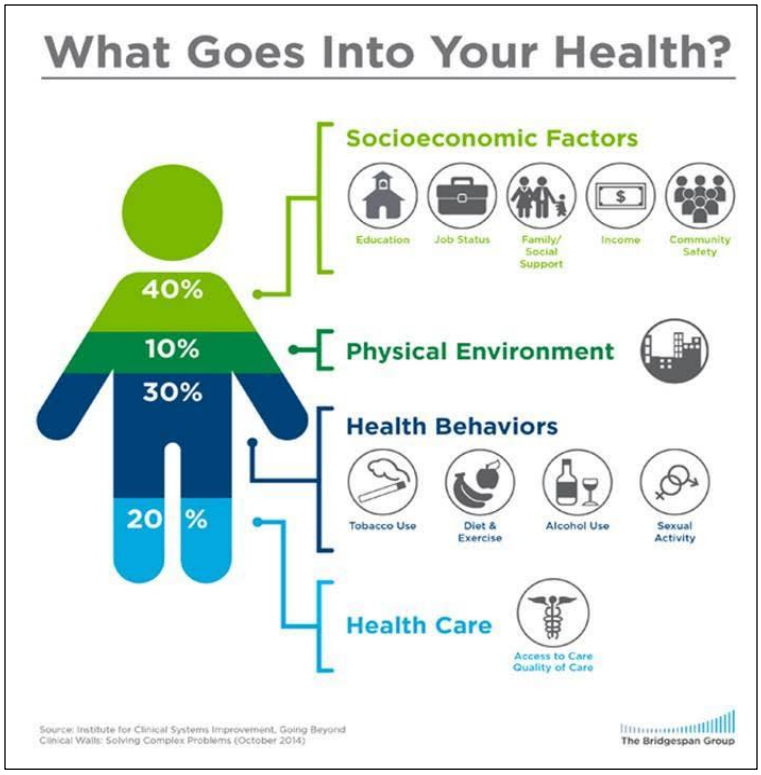
Moving Toward Accountable Communities for Health

Beyond Medical Care

Across the country, new health care models are emerging that attempt to address inefficiencies in the health care system. For instance, Accountable Care Organizations (ACO) are being used to enhance health care by improving quality, controlling costs, and decreasing wasted spending. Essentially, ACOs are an "affiliated group of health care providers held jointly accountable for achieving a set of outcomes and cost performance measures for a defined population over a period of time."[1] Ultimately, ACOs seek to provide more efficient and better quality of care through better collaboration and more accountability.

As ACOs evolve, they are learning that consumers need more than just medical care – they need a whole array of community supports and services to keep people healthy, rather than receiving more expensive hospital services.

Nationally, the Centers for Medicare and Medicaid Services (CMS) is encouraging communities to think about new ways of forming partnerships that go beyond the ACO model. One such model is the Accountable Health Communities Model. According to CMS, the Accountable Health Communities Model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve population health and reduce costs. A number of years ago, frequently-quoted research performed by the University of Wisconsin Health Institute estimated that medical care only determines 20 percent of the health of a population. According to the study, the remaining 80 percent is determined by health behaviors like smoking, exercise and diet (30 percent); socioeconomic factors including income and education (40



percent); and the physical environment (10 percent). [2]

Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individual's ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization.[3]

Accountable Communities for Health (ACH), combine ACO delivery system resources and assets with public health and community improvement resources in order to address the broader social and economic factors that impact population health.

Nationally, health initiatives are increasing their focus on these social determinants of health. For instance, in 2014 the Robert Wood Johnson Foundation (RWJF) funded the Commission to Build a Healthier America to address these social factors that determine health. The group recommended "a seismic shift in funding priorities to improve health." The priorities included increasing access to early childhood development programs, revitalizing low-income neighborhoods, and broadening the mission of health care providers beyond medical treatment.[4]

Although organizations are focusing more of their efforts on the social elements that influence health, the health field still recognizes the weaknesses in current health systems. In the journal of the American Medical Association in November of 2014, Elliott Fisher and Janet Corrigan discussed the lack of coordination among health care, public health, and social services.[5] Similarly, in an Optum Institute/Harris Interactive survey, only 39 percent responded that care was well coordinated within their community.

Donald Berwick, MD, the former Head of CMS wrote in *the Journal of the American Medical Association* that healthcare is a behemoth "faction" that controls one-sixth of the economy and distorts the national economic and political future.[6] He cited a quote from the health economist Victor Fuchs that not a single community in the nation has yet to come close to the scale of improvement in health, healthcare and the per capita cost that ought in theory to be achievable.[7] Steve Shortell, former Dean of the School of Public Health at UC Berkley, has noted that it is unlikely that the delivery system alone can achieve this type of large-scale health improvement.[8]

Although ACOs are effectively improving the way medical care is delivered to communities, they lack a sufficient ability to meet the collective health needs of communities as a whole. In articles by Casalino, Shortell, et al, they state that ACOs have neither the incentives nor the capabilities to address geographic population health. As they point out, the incentives ACO contracts provide are to control costs and improve the quality of care only for their attributed patients, not for the entire population of the geographic area. They also note that

the ACO experience does not lie in addressing the social determinants of health. [9] Fortunately, ACHs are specifically designed to help improve health on a larger scale and through a social lens, providing the potential to truly address the health care triple aim.

In order to begin this shift towards population health, CMS outlined a strategy to begin addressing the move toward ACHs. In January 2016, CMS announced a five year $157 million dollar grant program to test three health models that evaluate the role of social determinants of health.[10] Their quality strategy aims to improve the health of the US population by supporting proven initiatives to address behavioral, social and environmental determinants of health in addition to delivering high quality of care.[11]

How Other States Have Created Accountable Health Communities

Various states are in the process of or have already developed AHC programs, some of which have utilized the CMS grant program. California, Washington, and Minnesota are three states that are leading the way towards accountable health communities. Although these states have used similar strategies, each one has taken a unique path toward establishing their ACH programs.

Washington

Since 2014, Washington has made intentional progress to incorporate ACHs into its health care system. In 2014, state legislation set aside $150,000 in annual funding to create two pilot ACH sites.[12] By 2015, the state received additional ACH funding through the CMS Innovation's State Innovation Model (SIM) Test Award.[13] This funding was used to produce Washington's Health Innovation Plan, known as Healthier Washington, which helped generate seven more ACH design sites across the state. In total, these nine ACH sites, or regions, cover the entire state and will receive $220,000 annually between 2016 and 2019.[14]

In October 2016, Washington received approval for additional funding from the CMS Medicaid 1115 waiver. The waiver will further the states' Healthier Washington initiative by addressing three key areas: Accountable Communities of Health; expanding Long Term Services and Supports options; and supportive housing and employment services.[15] The waiver gives funding to each ACH region in Washington in order to tackle various projects that will transform the Medicaid delivery system and serve the "whole person," through physical and behavioral care.[16]

This five-year support will build upon the previous ACH work started by the state in 2014. In addition to this funding, many of the ACHs in Washington will receive in-kind funding from backbone organizations, partners, or ACH participants.[14]

As part of the CMS Innovation Center, the program will make an important shift from fee for service to value-based care. Each ACH region will be tasked with developing delivery system reforms that focus on the social elements that influence health. In order to encourage effective use of the ACH system, ACH and partner organizations will receive bonuses for hitting certain benchmarks. [15]

Currently, Washington's ACH program is divided into regions that align exactly with the state's Medicaid purchasing boundaries. This unique approach allows Medicaid Managed Care Organizations (MCO) to partner directly with ACHs and their governing agencies. These ACH governing agencies include local and public health agencies, community-based organizations, and nonprofit organizations.[17]

Minnesota

Minnesota was one of the earliest advocates for ACHs. As early as 2012, the Minnesota Department of Health proposed voluntary regional organizations called "accountable health communities" to work with health system stakeholders to review data and improve strategies to meet Triple Aim goals. [14] Five years later, Minnesota has fifteen operational ACHs.

At the heart of Minnesota's ACH program are community care teams, small groups that coordinate between health and social services that serve Medicaid populations. [17] The objective of community care teams is to serve the whole patient through unique service coordination. Minnesota has been using these community care teams to coordinate care since 2011.[18] By serving additional populations and coordinating with new partners, ACHs have the opportunity to expand on the work established by these community care teams. This is precisely what Minnesota has done by developing ACHs out of all three of its original community care teams. [18]

Like Washington, Minnesota created its ACHs through the use of a SIM testing grant that established the Minnesota Accountable Health Model. ACH initiatives were linked to one of the Models five key drivers for success.[19]

Minnesota received its SIM testing grant in 2013, testing the Accountable Health Model led by the Minnesota Department of Health and the Minnesota Department of Human Services. [17] Of the $45 million grant, $5.6 million was set aside to create fifteen ACHs across the state.

In order to evaluate different approaches to improve health and lower costs, each ACH differs in geographic scope, target population, or strategy. Each ACH site operates in a particular region, some of which overlap due to the varying ACH design approaches. [17]

Minnesota's program stresses that these ACHs are community led and community driven. Priority conditions are established by the state and communities set target populations and needs. [18] For instance, one Minnesota ACH serves Medicaid beneficiaries and uninsured, low-income residents, while another ACH serves residents with developmental and intellectual disabilities. [17] The program also requires that each ACH is partnered with an accountable care organization to strengthen its ties with the healthcare delivery system. In order to track specific progress towards enhancing accountable care and the Triple Aim, each ACH is required to complete Minnesota's Continuum of Accountability Assessment Tool. [14]

Besides initial funding, Minnesota offers training, technical assistance, and an ACH learning community that promotes knowledge exchange. At the end of the funding period, ACHs will rely on financial sustainability plans that extract future funding from a diverse source of funds.[17]

The previous funding period ended on December 31, 2016, but recent "no cost extensions" granted by CMMI will allow current grantees additional time through 2017 to complete unfinished work and plan for sustainability. The extension also provides a second round of funding for ACHs to further support patient centered, coordinated, and accountable care through 2017.[20]

California

California's interest in ACHs began when the 2012, California Let's Get Healthy Task Force designated creating healthy communities as one of its six priority goals. [17] The Task Force report would ultimately lead to the development of six ACHs in California.

In 2013, the resulting work from this task force was used to apply for a SIM design grant.[21] That same year, California received initial funding from this grant to develop the State Health Care Innovation Plan.[22] One of the plans four core initiatives was the creation of Accountable Communities for Health pilot sites. [21] In preparation for these pilot programs, California created the ACH Work Group, tasked with designing and implementing the pilot program. [22]

By December of 2014 the state failed to receive SIM test funding to move forward with the ACH programs, but fortunately received a second SIM design grant for $3 million. [22] These

funds, coupled with private funding, were used to create the California Accountable Communities for Health Initiative (CACHI), which would provide the funding for a total of six ACHs in various communities. [14, 23]

The six sites received three year $850,000 awards, funded by both the second SIM design grant and private funds from The California Endowment, Blue Shield Foundation of California, Kaiser Permanente, and Sierra Health Foundation. [23] This private source of funding makes CACHI unique from most state ACH programs, which have relied mostly on federal and state funding to finance their programs. In addition to initial funding, CACHI provides support through grants, technical assistance and research support, a learning community, program evaluation, and a relationship with the federal Accountable Health Communities Initiative. [21]

Each California ACH address one of four priority focus areas that include asthma, violence, obesity, and cardiovascular disease. [14] By specifying a small number of focus areas, the ACHs will be able to better organize and focus their care efforts. ACHs will also direct these efforts through various modes of reinforcing interventions, including: clinical services; community and social service programs; community clinical linkages; environment, and public policy and systems change. [14] Unique from other models, CACHI requires each AHC to create a Wellness Fund that serves to ensure future funding by acquiring and maintaining a pool of funding sources. [20]

More States

- *Vermont*:
  - Currently using SIM funds to use the Peer Learning Lab to research and gauge the readiness of communities to implement ACH programs. [17]
- *Colorado and New Jersey*:
  - Developing statewide Medicaid ACO programs that will set the stage for future Medicaid-based ACH programs.[24] [25]
- *Massachusetts*:
  - Received a CMS grant to develop ACOs that focus on population health management through Medicaid. [26]
- *Oregon*:
  - Currently expanding social services in ACOs to address population health. [27]

What Arizona Has Done

Efforts to create and develop broader communities of care in Arizona are currently under way. One such example is the North Central Arizona Accountable Care organization. The organization currently attends meetings at the County Health Department to meet with community agencies, including mental health providers, to begin building a foundation to work together. To quote Ami Giardina, the Chief Accountable Care Officer, "Our goal is to get more involved with the group. However, we are so focused on the operational aspects right now it is a bit overwhelming." In discussions with most of the ACOs, similar sentiments were found.

Most ACO's (except for Commonwealth and Cigna) have hospital systems as sponsors. It turns out that most hospital systems are supporting different types of collaborations related to population health that might evolve into more sophisticated Accountable Health Communities in the future. These collaborations are listed below.

- Banner Olive Branch Senior Center
    - The Olive Branch has one employee and hundreds of volunteers. In addition, Banner has provided more than 2500 free visits for uninsured and underinsured children through their school based health clinics. Lisa Stevens Andersen, the CEO of the Banner Health Network states, "We are looking at the opportunity as Banner to impact health. If we are all invested in changing the healthcare system we need to meet together to find ways to replicate and not duplicate our successes so we can work towards achieving common goals and leveraging precious resources."
- Arizona Connected Care (ACC)
    - ACC works with many community resources including the Pima Council on Aging, Interfaith Community Services, Jewish Family Services, and Catholic Social Services. They participate in a weekly (open mic) care coordination conference. They are also working with the Tucson Fire Department to triage patients prior to the transporting to emergency departments.
- Abacus
    - A care coordination model that is similar to the Commonwealth model. Ken Adler, the CEO of Abacus reported that 'we created a "living document" that is updated with available Pima County Resources such as domestic violence, supplemental meals, substance abuse in teens, etc. It is on every desk top within the Abacus providers' offices.
- Tucson Medical Center
    - TMC is the hospital partner for Arizona Connected Care and Abacus. The TMC Foundation supports a bike helmet program for all children in Southern

Arizona. The center also has a car seat loaner program for children born in Southern Arizona.

- The Commonwealth ACO
    - Working to build relationships with community resources to connect providers and patients "where they live," according to Lance Donkerbrook, the COO of the ACO. He says the "connection between the ACO, providers and patients can be strengthened."
- Dignity Health
    - Dignity hospitals have a discharge arrangement with the Foundation for Senior Living. Dignity also works closely with Catholic Social Services.
- Honor Health
    - Received a national award from the White House for innovative use of former military medics who are familiar with and trained on accessing community services for patients.
- The District Medical Group (DMG)
    - DMG is a participant in work being done within school districts related to playgrounds, and is tackling issues surrounding childhood obesity. They are working closely with the fire departments in Chandler, Gilbert and Phoenix, employing EMTs to triage patients with the help of a triage nurse. They have had success in preventing admissions to hospitals and emergency departments but a remaining issue is the expense related to the inclusion of the RN.

These examples are the beginnings of ACOs working to address population health. According to Casalino and Shortell, there is more than enough for both ACOs and hospitals to do to improve the health of their patient populations.[28] They add that both entities must establish partnerships with one another to successfully address population health within their communities. By establishing these partnerships, the state can be better equipped to create ACHs in Arizona and improve overall community health.

Arizona ACHs

In Arizona, there are excellent examples of efforts to develop Accountable Health Communities. One example from Tucson is Interfaith Community Services, who received a grant from the Lovell Foundation to train faith-based volunteers to do a 6 week program aimed at preventing readmissions to the hospital for patients with congestive heart failure. The organization has trained volunteers to provide non-medical support to patients with risk for readmission. They provide transportation to the clinics, pharmacies, food banks and prepare patients for their appointments. They are also working with Banner University Medical Center and six partnering faith communities.

In Phoenix, UnitedHealthcare is looking at how they can take the next step into population health. They realize that in low income populations, the social determinants of health impact the quality and cost of services being delivered in the health care system. By partnering with Chicanos Por La Causa, UnitedHealthcare has established myCommunity Connect in Maryvale. The myCommunity Connect site serves to not only address medical, dental, and behavioral health services, but to also take a more longitudinal look at social services for members that walk in the door. The site currently partners with the St. Mary's Food Bank, employment-focused St. Joseph the Worker, Dress for Success, the Women, Infants, and Children program, and a dental provider to provide services to the community.

In addition, behavioral health services are being provided at that location and progress has been made to establish a medical partner for the site. A key aspect to the program is the community health worker who acts as the navigator for the population. MyCommunity Connect is developing relationships with the health workers who have been effective in getting services to the patients. This project is not exclusive to patients of UnitedHealthcare, but sits outside the health plan. Eventually, the goal is to expand this project to Avondale, as well as to Detroit, Michigan.

Another successful Arizona example is the Phoenix Frequent Users Systems Engagement (FUSE) model that is administered by Circle the City. This model aims to break the cycle of homelessness and crisis among individuals with complex behavioral and physical health challenges. These individuals are the highest users of emergency rooms and other crisis service systems.

The YMCA Diabetes Prevention Program is a national and statewide effort to develop an ACH-type system. In 2000, the National Institutes of Health and the Center for Disease Control and Prevention decided to grant the YMCA funds to invest in a program that would identify and help patients with pre-diabetes decrease their risk toward the development of the disease. Their program is one year, and consists of group meetings that organize weekly for the first four months, every two weeks for the second four months, and then once a month for the rest of the year. This program operates in 43 states including Arizona. Nationally they have had 36,625 participants with an average weight loss of 5.5 percent over a year.

Health Leads is another new and innovative national organization worth mentioning. Health Leads' main function is to bring teams of college students to medical clinics to connect patients with social services and resources. They track the thousands of patients needing assistance and then ensure that patients receive it. These students then inform

physicians, residents, and medical students about the social needs of their patients. Both have learned that addressing poverty can make a huge difference in health outcomes.

What Arizona Can Do To Bridge the Gap

Arizona still has work to do to establish accountable health communities as an integral way to improve patient care and enhance population health. Learning from states that have successfully implemented ACH models can certainly help guide Arizona in this process.

Formalizing ACH program efforts has been an important action states have taken to establish ACHs. Typically a guiding framework that serves as the foundation for ACH creation is established through state legislation or policy, and often with the help of federal funding. These models and initiatives can be specific to ACHs or may simply address accountable health care as a whole.

For instance, California created the statewide health initiative in 2012, Let's Get Healthy California, which would help obtain SIM funding and create ACHs. Although the initiative wasn't specifically designed to create ACHs, it eventually helped to do that.[17] Similarly, Minnesota was able to establish the Minnesota Accountable Health Model through SIM grant funding. This model would guide the creation of many health reforms in Minnesota, including ACHs.[19] In the same way, Washington's Healthier Washington initiative is the policy that helped create seven ACH sites in that state.[14] In each of these examples, accountable care models and initiatives were essential to developing ACH programs. By creating some form of accountable care initiative or statewide health model, Arizona could focus its health reform on ACH creation.

Another opportunity for Arizona would be to take advantage of ACH funding sources. Most of the successful state ACH models and programs are tied to some formal funding programs. SIM grants were the most popular source of funding connected to ACH development, and accessing SIM funding could be a potential source of support that Arizona could utilize while developing an ACH program. In fact, in 2016 Arizona submitted a state health care innovation plan it funded by a SIM design grant, although the plan did not include ACHs in its design.[29]

Beyond that, Medicaid funding through the CMS 1115 waiver is a legitimate option to help develop an accountable care model. If CMS continues to offer support through the Medicaid waiver, Arizona could tie future ACH efforts to this funding.

An alternate ACH funding approach Arizona could utilize could be private funding sources. There is no guarantee that CMS grant funding will continue, thus accessing private and local funding sources could be a wise option to secure funding moving forward. Lacking federal funding, California took this approach and relied heavily on private funding sources to create their ACH programs.[22] By establishing private funding, Arizona could create a stable funding source while also garnering key buy-in from influential players in the health field.

Other potential funding sources may include philanthropy, non-profit hospital community benefits, providers and hospitals, payers, private investors, and employers. State funding is also a funding source that has been used to create ACH models, particularly in California and Washington. [21]

ACH program designs can pull from various design strategies. One of the first techniques Arizona could use would be to build upon the current work of ACOs in the state. ACOs are a natural asset that can transform care coordination to include population health and social services.

In fact, many ACOs are already doing this. A study conducted by Health Affairs analyzed the work of ACOs to meet patient non-medical needs such as transportation, housing, and food insecurity. Of the 32 ACOs studied, 16 were currently extending their services to include meeting these non-medical needs.[30] Another study of ACOs conducted by the Robert Wood Johnson Foundation discovered that 95% of ACOs were already working with a social service organization in the community.[31]

Andres Ducas, Program Officer at the Robert Wood Johnson Foundation explains, *"Increasingly, providers understand how important the things that happen outside of the doctor's office or hospital are to improving and managing a person's health...To that end, some leading ACOs are expanding their services to include more upstream, preventive support for patients and are also expanding their work to reach entire communities, rather than just focusing on their assigned beneficiaries."* [31]

ACOs in Vermont, Colorado, and Oregon are proven examples of how ACOs can expand social services to help address population health. Colorado requires its organizations to link members to non-medical, community-based services, while ACOs in Oregon and Vermont are encouraged to use state existing social services to support population health. [24, 27, 17] Allowing ACHs to partner with an ACO or Medicaid ACO are two other approaches states have taken. [17] Instead of focusing on developing every ACO into an ACH model, garnering support from successful ACOs and MCOs in the state can help create and establish effective ACHs.

A different design approach that could help develop Arizona ACH programs includes utilizing community care teams to develop ACHs. This approach was used to produce three ACHs in Minnesota. [18] Maine has taken a similar approach with its own community health teams by helping care managers make connections with social services and supports for patients in health homes and those with complex health issues. [32]

By building on community care teams, Arizona can further develop its accountable health model while beginning the process for ACH creation. Starting with community care teams can allow the state to monitor and study the effectiveness of accountable care delivery techniques, while forming foundational partnerships that create ACHs.

Building on the techniques and approaches from successful states can help Arizona implement its own ACH programs. Whatever the method used, it is evident that accountable health reform is becoming the standard across the nation. New and improved ways of delivering health care are taking shape, and as Arizona continues its shift towards accountable care delivery, accountable communities for health will be a specific reform measure to consider.

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