Community Health: Fulfilling a Vision for Improving the Public’s Health

Claire D. Brindis, Dr. P.H.
Professor and Director
Philip R. Lee Institute for Health Policy Studies
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Overview

• Trends influencing community health
• Social Determinants of Health (SDOH) and intersections with health care redesign efforts
• The Role of Accountable Health Communities (AHCs)
• Promising Models
• Future Directions
ANYONE WHO HAS NEVER MADE A MISTAKE HAS NEVER TRIED ANYTHING NEW.

Albert Einstein
Trend 1. Changes in Disease Profile

- Shift from infectious to non-communicable diseases
- 1 out of 2 Americans lives with chronic condition (cancer, diabetes, respiratory and heart disease)
- Significant increases in health care $$ and economic pressures
- Many of the largest drivers of health care costs fall outside clinical care
The Cost of Health Care
How does it compare?

If other prices had grown as quickly as healthcare costs since 1945...

- A dozen eggs would cost $55
- A gallon of milk would cost $48
- A dozen oranges would cost $134

Trend 2. Changes in Health System Response

- Government, public and private sectors pursuing “bold” approaches for improving health care, while mitigating costs
- Seeking *Triple Aim* –
  - improved care
  - reduced health care $$
  - enhanced population health
Mom would be happier if you got Health Insurance.

You Have Until March 31st to Enroll in Coverage.
Trend 3. ACA Opportunity to Improve Health

- Investments by CMMI (State Innovation Models - SIM) to test Accountable Communities for Health Care (ACHs)
- Improvements in integrated health care delivery, patient-centered care, value and prevention investments
- Address range of clinical and non-clinical factors that influence health through new types of delivery systems and payment reform
Trend 4. Closing Divide between Public Health and Health Care System

- Shift from infectious to non-infectious diseases
- Partnerships aimed at integrating medical and non-medical public health services needed to achieve health equity (health, social service, other sectors within geographic area).
- Leverage public health and private sector to address community-level factors that shape population health
Trend 5. Population Health Improvements

- From individual care, to population health management within a health system, to population health improvement
- Recognition of a wide range of social and environmental determinants shaping health
- Seeks to impact health much further “upstream”
- Requires health care system to work with various sectors — government, non-profits and private industry — to impact physical, social, economic and environmental factors that impact health
Figure. The “3 Curves” of Academic Health Systems

Bottom panel illustrates the potential shift to healthier status for overall population through academic health systems’ augmented focus on the third curve.
Trend 6. Role of Providers/Systems Addressing Social Determinants of Health (SDOH)

- Struggle with what providers can do to address SDOHs
- How to best address health disparities?
- What additional services are needed to address the “whole person’s” needs –
  - dental, vision, nutrition, housing
  - education, legal support, immigration assistance,
  - incarceration, job training, links to technology
  - other
SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.

- Childhood experiences
- Housing
- Education
- Social support
- Family income
- Employment
- Our communities
- Access to health services

Source: NHS Health Scotland
Population Health Drivers

- Physical Environment: 10%
- Genes and Biology: 10%
- Clinical Care: 10%
- Health Behaviors: 30%
- Social and Economic Factors: 40%
### Figure 2

#### Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
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<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
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<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Support systems</td>
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<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Community engagement</td>
<td>Quality of care</td>
<td></td>
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<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td>Provider availability</td>
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</tbody>
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**Health Outcomes**

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
What challenges do you face trying to address social determinants of health and overall population health efforts?

- Lack of data: 25%
- Developing partnerships: 17%
- Patient/community involvement: 24%
- Medical literacy: 7%
- Marketing campaign efforts: 0%
- Other: 27%

*Source: Modern Healthcare research*
What tools have you used for population health?

Electronic health records 72%
Claims data 72%
Smartphone apps 23%
Other data analytics tools 67%
Other 13%

Respondents could choose multiple answers.
Source: Modern Healthcare research
Who are we responsible for?
What are we responsible for?
How will we get there?
Accountable Health Communities Model (AHCs)

Address critical gap between clinical care and community services

A multi-payer, multi-sector alliance of:

- healthcare systems, providers, and health plans
- public health
- key community and social services organizations
- schools, and other partners serving a particular geographic area
Accountable Health Communities Model (AHC)

The goals of an ACH are to:

- improve community-wide health outcomes and reduce disparities with regard to particular chronic diseases
- reduce costs associated with healthcare and potentially, non-health sectors, and
- through a Wellness Fund, develop financing mechanisms to sustain the AHC and provide ongoing investments in prevention and other system-wide efforts to improve population health
Exhibit 1: The 3 Buckets of Prevention

1. Traditional Clinical Prevention
   Increase the use of clinical preventive services

2. Innovative Clinical Prevention
   Provide services that extend care outside the clinical setting

3. Community-Wide Prevention
   Implement interventions that reach whole populations

Critical Components of AHCs

1. Geography
2. Mission and vision
3. Governance
4. Multi-sector partnerships
5. Priority focus areas
6. Data and measurement
7. Financing and sustainability
Figure 1: Components of an ACH
Oregon’s Coordinated Care Organizations

- Medicaid program transformed into CCOs
- Emphasis on elimination of health disparities
- Multi-pronged approach:
  - Strategic planning to eliminate disparities for specific member populations
  - Adoption of National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care – staff training on cultural diversity and equity
  - Hiring of new diverse staff focused on equity, meeting cultural and linguistic needs of members
  - Community Health Workers – Certification program for traditional health workers
Oregon’s Coordinated Care Organizations

- **Multi-pronged approach:**
  - Appropriate workforce diversity and training
  - Cultural competency policies by CCO clinics and providers
  - Encourage the review of data, stratified by race/ethnicity.
  - Regional Health Equity Coalitions as backbone agencies
  - Engagement of underrepresented culturally and linguistically diverse communities (e.g., added health care interpreter services).
  - Complementary legislative, policy, and capacity-building activities
Oregon’s Coordinated Care Organizations - Results

• Reductions in:
  – Emergency Department (ED)
  – Primary care visits
  – Preventable hospital admissions
  – Improved access to well child and adolescent visits
  – Adult preventive ambulatory care, and
  – One measure of appropriateness of care (avoidance of unnecessary head imaging).
Oregon’s Coordinated Care Organizations - Results

- Reductions in disparities in number of primary care visits and access to care (White- Black differences)
- Higher visit rates to Ed remained among Black & AI/AN
- Next steps:
  - Development of quality improvement plans, including incentive measures to reward efforts to reduce disparities
  - Challenging to develop quality metrics for reducing disparities vs. standard quality metrics
Colorado Medicaid Accountable Care Collaborative (7 RCCOs) (2011)

- Convened providers to:
  - Coordinate health transformation activities
  - Implement interventions
  - Connect clinical and community-based organizations, and
  - Track regional health improvement tied to enhanced payment for care coordination and case management
  - No financial risk on providers or RCCOs
Colorado Medicaid Accountable Care Collaborative (7 RCCOs) (2011)

• Developed:
  - High utilizer programs
  - Programs to reduce ED utilization
  - Support for social services, and
  - Centralized data repository to track and report clinic performance
Colorado RCCO Results

- Lower expenditures
- Reductions in inpatient care days
- Reductions in utilization
- Improvement in quality
What will we need to get there?
Conclusions

• Need for multi-sectorial, multi-strategic approaches to better respond to social determinants of health –

• Do we have the right resources? What is the evidence base?

• Medicaid represents an important opportunity to address health disparities

• Scaling – expanding successful models and adopting programs to reflect local context to address persistent disparities

• Need for ongoing monitoring, quality improvement, and measurement development
Future directions

• Build broad-based, multisector community coalitions
• Use data-driven, evidence-based approaches
• Generate locally-driven solutions, striving for consistency in data collection
Future directions

• Advocate for policy changes that promote social justice, economic, and health equity within agencies, as well as across local, state, and federal government
• Utilize new and innovate technologies
• Seek efforts to sustain and leverage each program component beyond funding from any one component
References


