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

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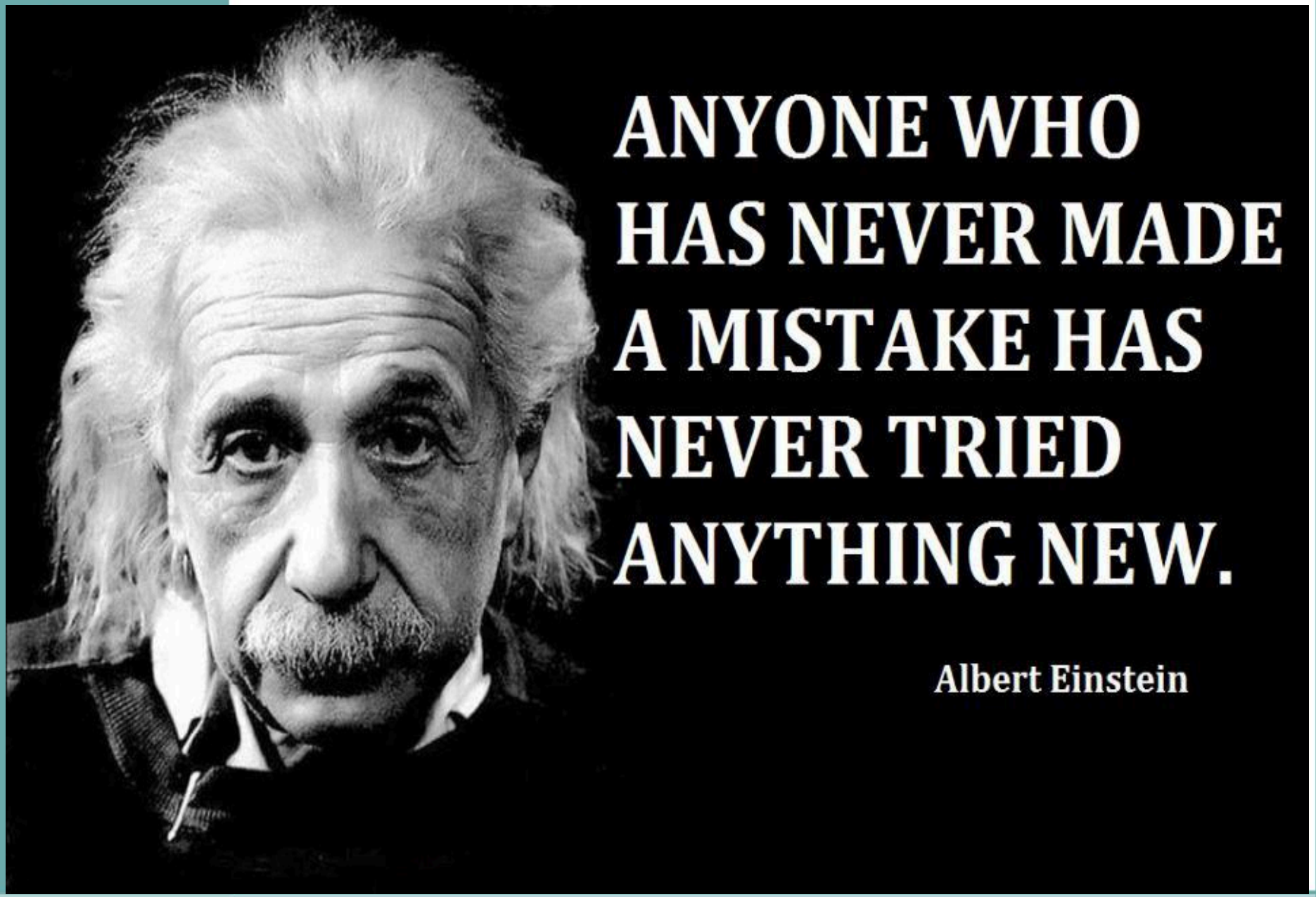
Overview

- 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

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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

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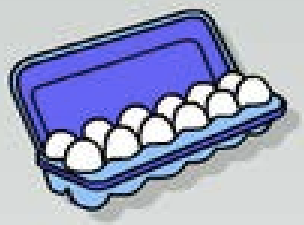
The Cost of Health Care
How does it compare?

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

Source: Statistical Abstract of the U.S.; National Health Expenditures (1945, 2011)

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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
Mom would be happier if you got Health Insurance.
You Have Until March 31ST to Enroll in Coverage.
HealthCare.gov

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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

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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

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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

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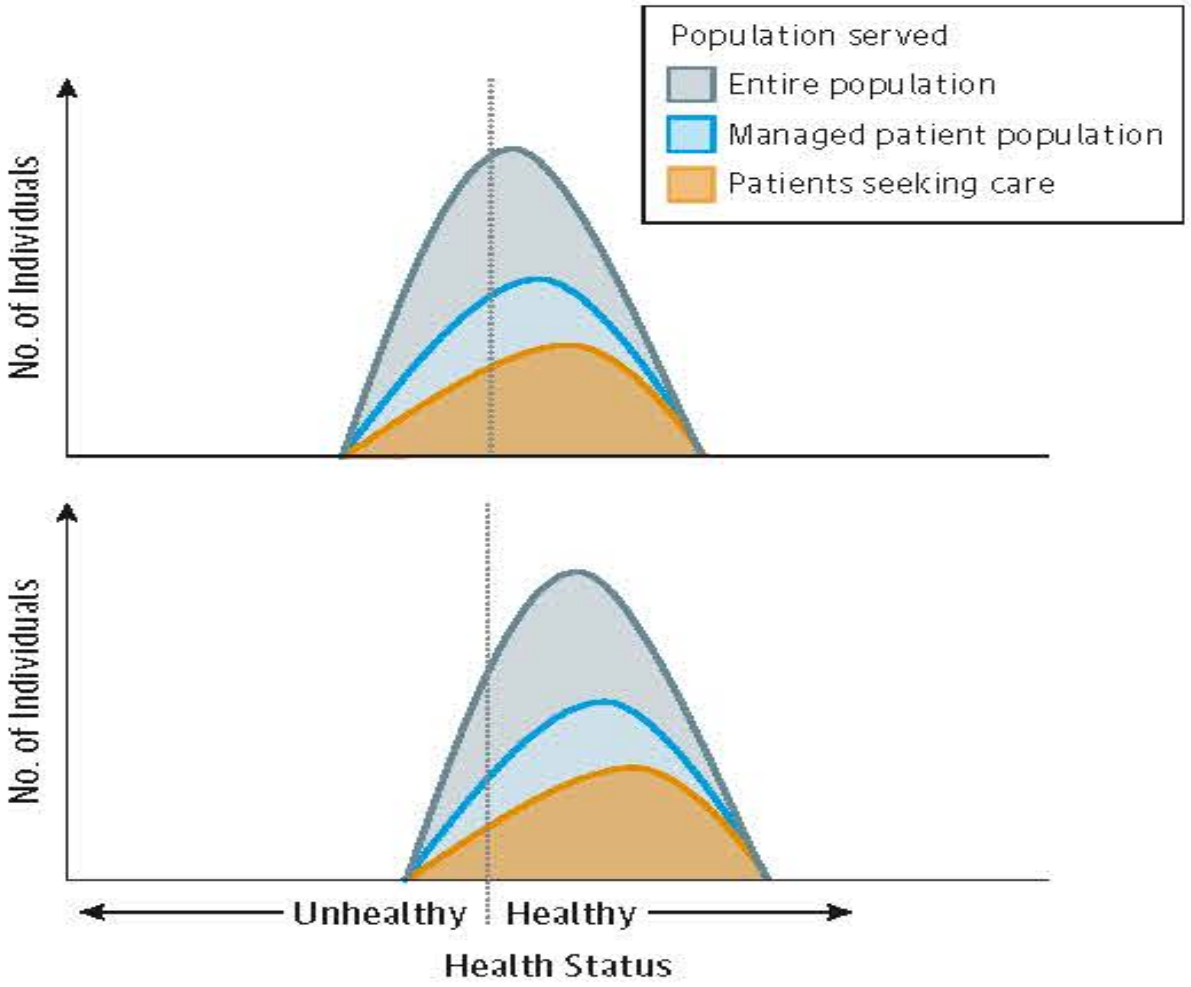
Figure. The "3 Curves" of Academic Health Systems



Bottom panel illustrates the potential shift to healthier status for overall population through academic health systems' augmented focus on the third curve.

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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

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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

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Population Health Drivers

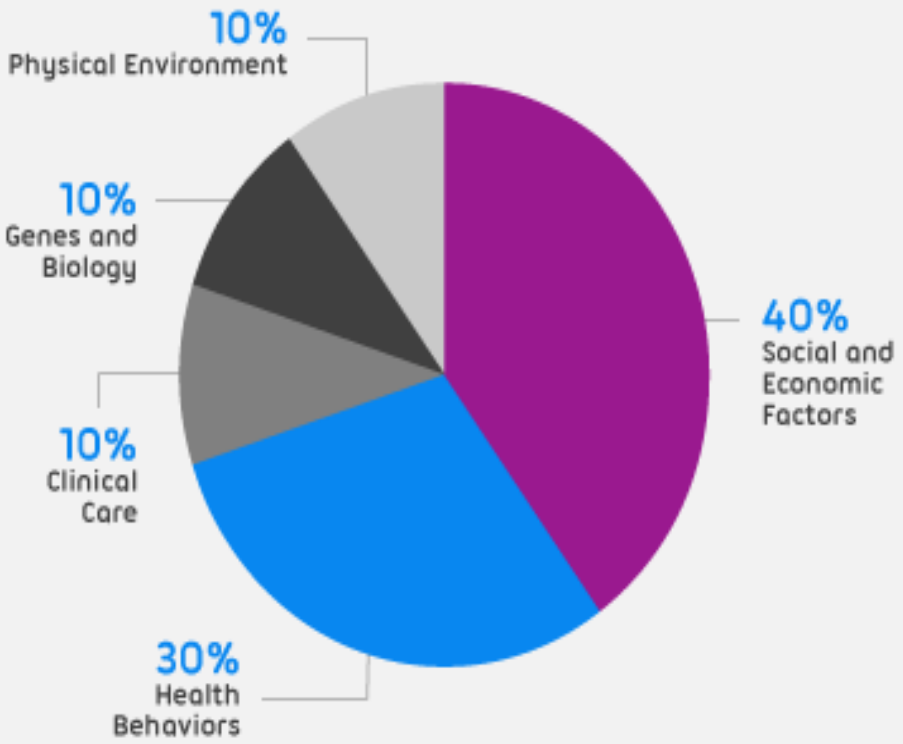

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Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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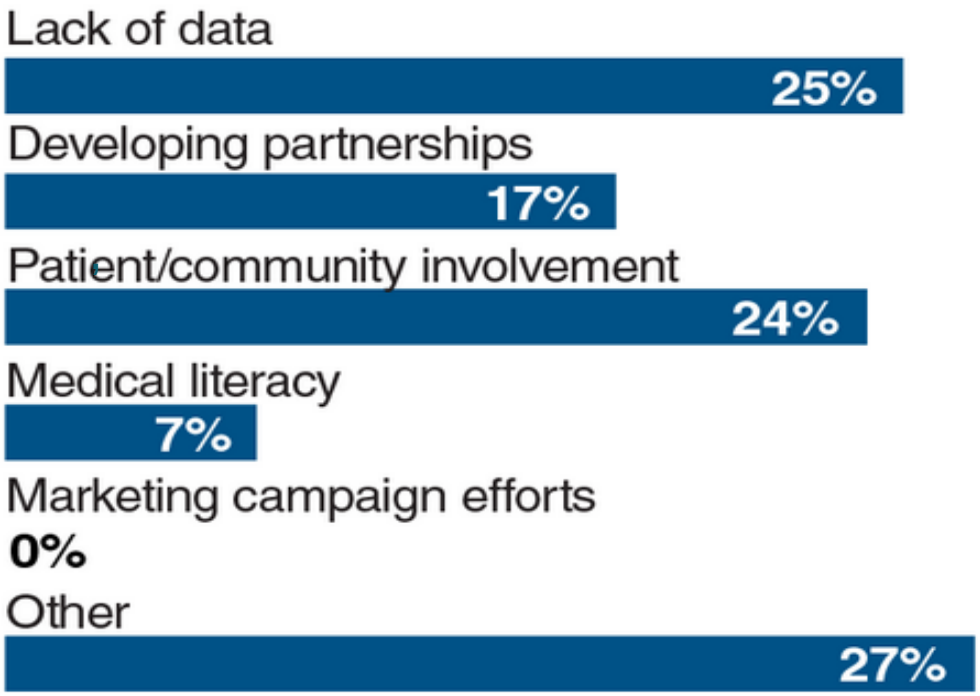
What challenges do you face trying to address social determinants of health and overall population health efforts?



Source: Modern Healthcare research

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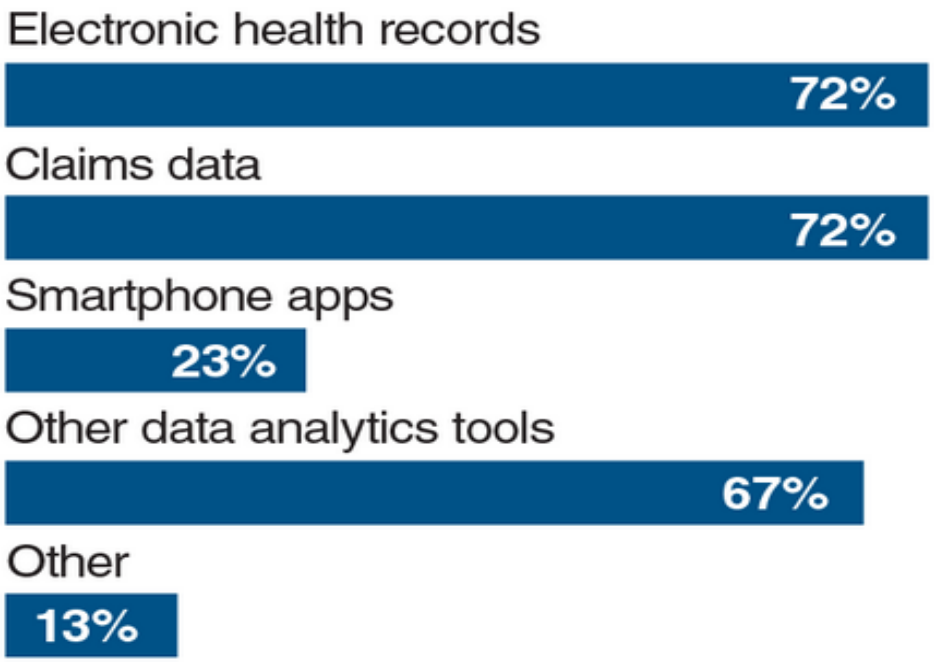
What tools have you used for population health?



Respondents could choose multiple answers.
Source: Modern Healthcare research

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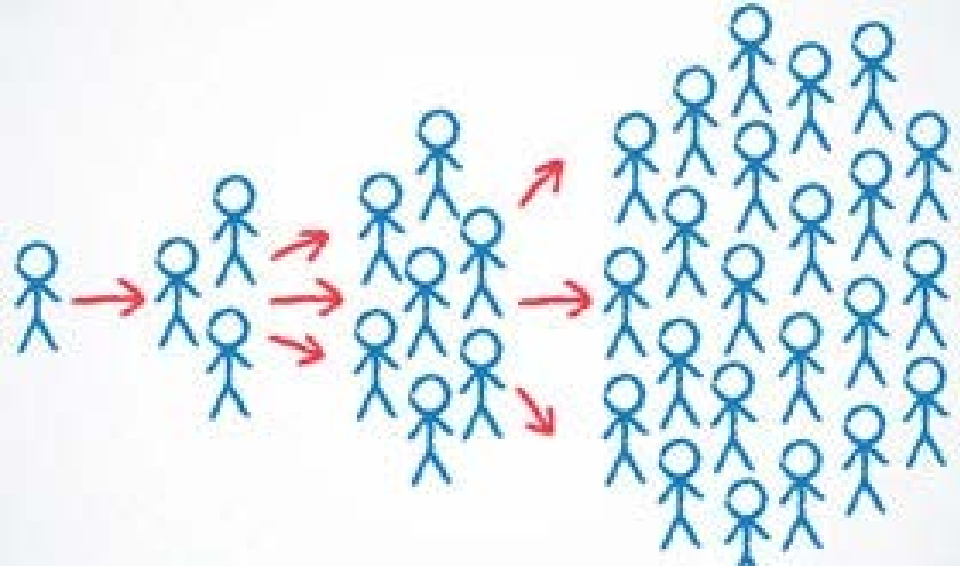
Who are we responsible for?
What are we responsible for?
How will we get there?



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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

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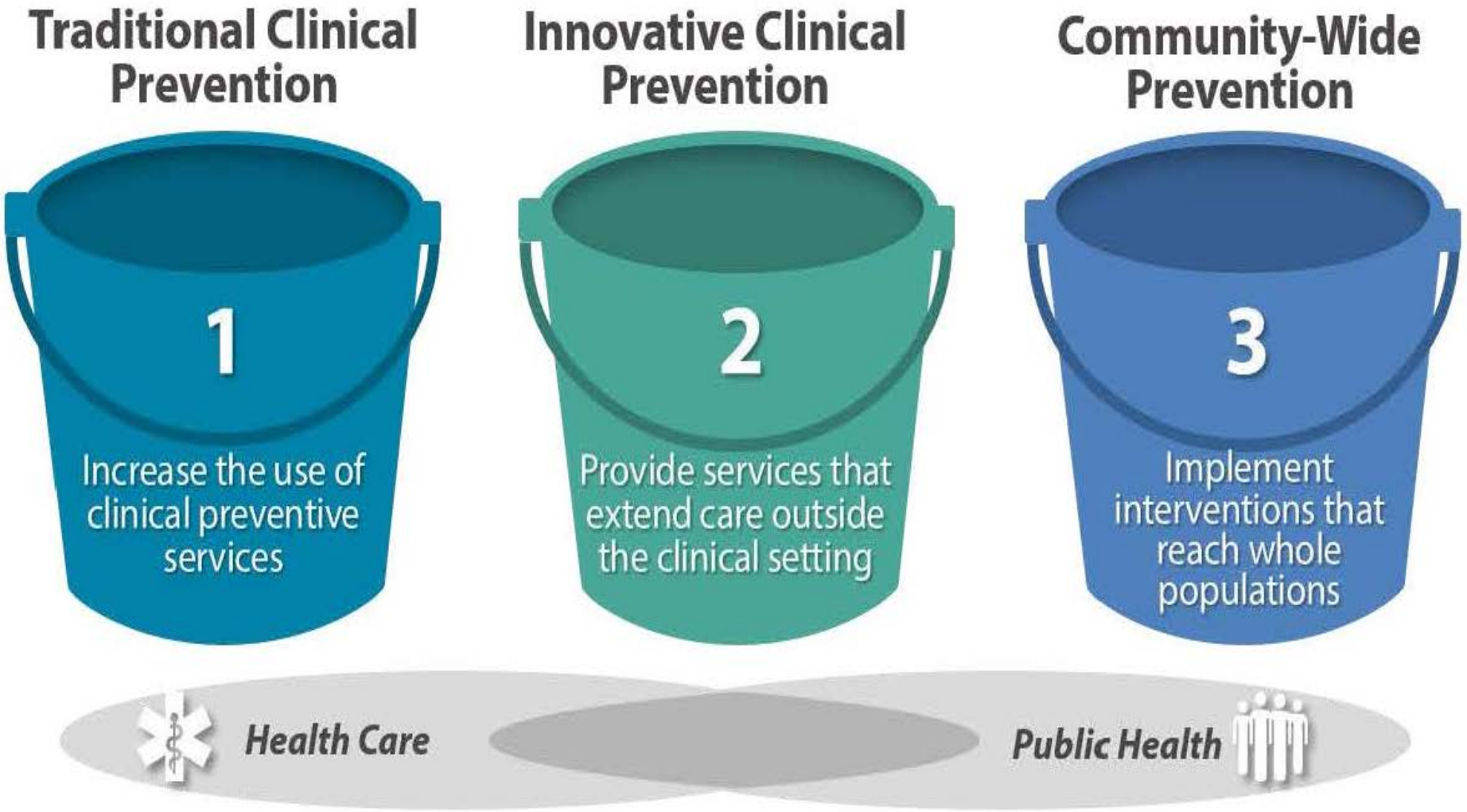
Accountable Health Communities Model (AHC)

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



SOURCE: J. Auerbach. The Three Buckets of Prevention. *Journal of Public Health Management Practice* (2016).

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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

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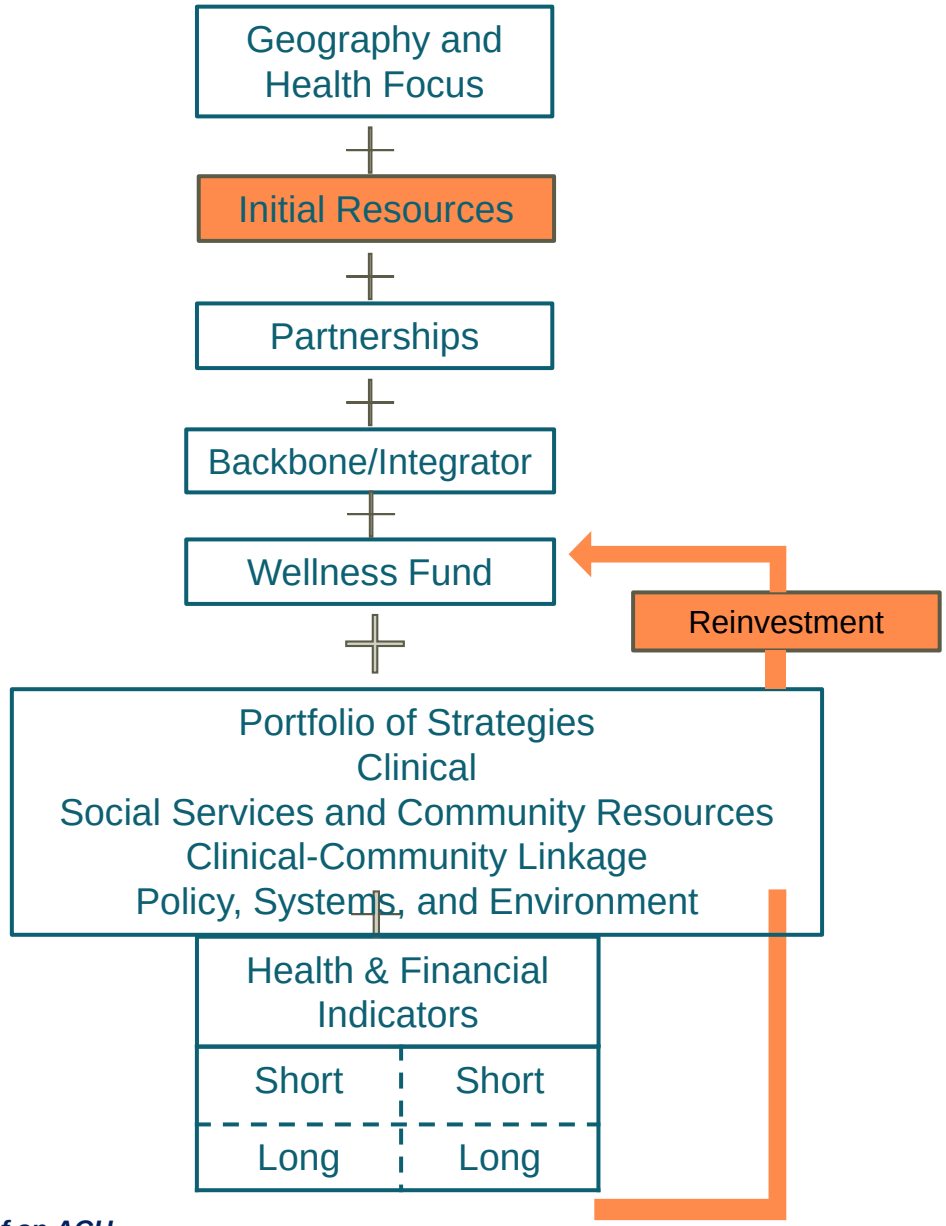

Figure 1: Components of an ACH

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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

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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

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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.

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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

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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

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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

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Colorado RCCO Results

- Lower expenditures
- Reductions in inpatient care days
- Reductions in utilization
- Improvement in quality

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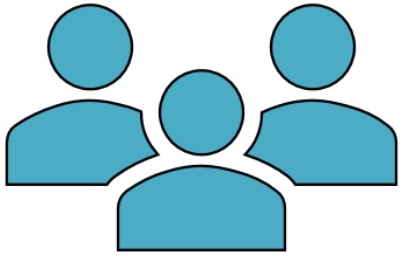
What will we need to get there?



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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

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Future directions

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

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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

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