Twin Pillars of Transformation:

Delivery System Redesign and Paying for Prevention

Meeting Summary

November 13-14, 2013

Washington, DC

This time of intense change in the U.S. health system offers an opportunity to make a concerted effort to improve the health of the population, reduce health disparities and reverse the escalating epidemic of chronic diseases, such as obesity, diabetes and cardiovascular disease, which are among the main drivers of health care costs. The U.S. spends more per capita on health care than other high-income countries, yet Americans live shorter lives and experience more illness and injury.\(^1\) Total U.S. spending on health and social services, however, is roughly the same as other high-income countries. What differs is the balance. The U.S. spends more on health care and less on social services\(^2\), and yet we know that clinical care accounts for less than 20 of the variance in health over time\(^3\). Population health models that address the complex social needs of individuals and invest in community-based prevention therefore have the potential to improve the health of all Americans. Trust for America’s Health (TFAH), with support from the Robert Wood Johnson Foundation, The California Endowment, and the Kresge Foundation, has been convening experts over the past couple years to identify policies and practices to advance population health models in the reformed health system.\(^4\)

In November 2013, TFAH convened national experts and local innovators in Washington, DC to define practical steps to build a system that improves population health and reduces health disparities. For our purposes, we defined a “population health” initiative as one that:\(^5\)

1. Is organized to improve the health of a population.
2. Partners with multiple sectors.
3. Is redesigning processes and systems to transform care and, in particular, to link clinical care with community prevention and social services.
4. Demonstrates results, both improved outcomes and evidence of utilization reductions and/or cost savings in the health care system.
5. Invests in prevention, including addressing causal factors in community health through policy and environmental change.
6. Is supported by an “integrator” that convenes and coordinates.
Participants at this convening, *Twin Pillars of Transformation: Delivery System Redesign and Paying for Prevention*, identified **key elements that are critical to the initial launch of a population health initiative**:

1. A major, easily identifiable health problem or initiative (could be a catalytic event, a threat or a disparity);
2. Clear, consensus-based goals;
3. A coalition or integrator⁶ that leverages partner commitment of time, resources and to a way of doing business (changing the way business is done to align with the goal was as important as a partner dedicating resources); and
4. Funding and/or dedication of in-kind resources. Funding itself can be the event that brings stakeholders to the table to develop a population health initiative. And, while funding is certainly helpful, it was noted that it does not necessarily need to be a large amount initially.

The following elements were identified as **key to sustaining a population health initiative**:

1. A dedicated integrator that is resourced and has a governance structure;
2. A broad coalition that can exert influence from both the top down (via key community leaders) and the bottom up (pressure from local neighborhoods);
3. A sustained commitment and willingness from the partners to have some give and take among the partners over the process;
4. An ability to listen and respond to the community’s needs;
5. Adaptability to create the workforce required (such as community health workers, for example) even if the competencies and curricula are not yet defined;
6. Bi-directional referral linkages among clinical, community and social systems;
7. A business model that includes cost transparency, reinvests in the integrator, and rewards improved health outcomes and reduced health care utilization/costs;
8. The ability to braid various funding streams together; and
9. Hard work.

Three case studies (attached) were explored in-depth to identify pathways, both policy and practice, to spread and scale successful population health innovations and to develop action steps to pursue these pathways. In particular, convening participants delved into five specific issue areas: health system delivery reform, data and information technology, measurement, workforce and financing.

**Building a Reformed System: Five Core Issues**

1. **Cultural Change and Delivery System Reform**

The case studies provided real-life examples of initiatives that go beyond traditional health care programs and services to address the social determinants of health and prevent chronic disease. Each of these case studies highlights the fact that improving population health requires a major, systemic cultural shift.⁷ The case studies also
demonstrate the importance of bridging the cultural divides between sectors to create a common language to enable communication and collaboration.

Broad-based partnerships across the clinical, community, social service, and consumer realms are integral to addressing the proximal and root causes of chronic disease that contribute to differential health outcomes. Beginning with one specific health issue can help those operating in separate systems to see how linkages would improve their work. When working on asthma in the community, for example, clinical providers are introduced to the social conditions and community experience of their patients, such as poor housing conditions. Those insights often lead providers to a new awareness of the need to address social conditions in order to improve health. Over the long-term, changing expectations and new approaches to training the clinical and public health workforces will support the cultural shift necessary to spread and scale population health initiatives.

Participants discussed a vision of unification and alignment across clinical systems, community prevention initiatives and efforts to address the social determinants. In many cases, an integrator exists or is created to facilitate the vision of alignment. Participants noted that that delivery reform and financing are inextricably tied and thus true alignment will occur when the financing incentives reward population level outcomes. The shift toward value-based payment (such as global payment and other financing mechanisms that shift risk to providers) and the subsequent focus on outcomes is a critical change that will incentivize investments in population-based prevention, as discussed in the Financing section below.

An area that needs further exploration is how to effectively engage consumers when starting and implementing population health initiatives.

2. Data/Information Technology

Population health initiatives require timely, hyper-local data to identify the health needs and issues in the community, to develop a plan to address them and to measure progress. Both quantitative and qualitative data are important. From traditional epidemiology to stories, a myriad of data sources and types are required.

Since population health initiatives link clinical, community and social systems to address the needs of patients and communities, data from systems in multiple sectors are needed. Data sharing between sectors, however, can be complicated and difficult, in part due to safeguards to protect patient privacy. Convening participants shared many experiences that highlighted the barriers to accessing and sharing data. The Institute of Medicine’s Committee on Recommended Social and Behavioral Domains and Measures for Electronic Health Records (EHRs) is exploring the possibilities for linking EHRs to public health departments, social service agencies, or other relevant non-healthcare organizations. Case studies will be considered of where this has been done and how issues of privacy have been addressed.
Hennepin Health and the Akron Accountable Care Community each have data warehouses that gather information from multiple, competing health care providers. The data are analyzed at multiple levels – individual, neighborhood, community and population-wide. Hennepin Health has also had success linking to county social services data and has built their own “lifestyle survey” in the electronic health record, to identify social needs and assess social risk. One of the barriers to linking is lack of a standardized patient identifier.

Information technology capacity is a core function of an integrator, such as ABIA in Akron. While privacy regulations can be a barrier, it is not an insurmountable challenge. With persistence, data sharing agreements can be established to protect privacy and adhere to related regulations in the various sectors (health, social services, education, etc.). Privacy policy may need to be updated to reflect integrated delivery structures, such as Accountable Care Organizations. For example, ACOs need to share consents but are currently prohibited under HIPAA.

Analytic skills and tools are necessary to implement population health initiatives. The integrator often takes on these functions. Analyzing the geographic variation in health and social conditions can lead to more efficient program design. For example, if one apartment building has conditions that are triggering asthmatic episodes, working with the housing authority and owners to remediate the allergens can impact a large group of patients who would need to access health care services in the event of an episode. Risk assessment and predictive risk models are also important analytic tools for this work, since interventions can be targeted to those most at risk. At Hennepin Health, they are considering social factors when assessing risk.

Lack of investment in community-based health research at the National Institutes of Health (NIH) was raised as a barrier to data collection and analysis. NIH research grants could build the evidence base and they would provide important infrastructure for community-level data efforts.

3. Measurement

There is not yet national consensus on how to measure success in population health initiatives, though many esteemed national organizations are focused on population health measurement, including the Institute of Medicine\textsuperscript{10}, the National Quality Forum\textsuperscript{11}, Institute for Healthcare Improvement and the Centers for Medicare and Medicaid Services at HHS. The National Quality Forum has endorsed five population health performance measures. At the same time, health care providers and community-based organizations feel overwhelmed with measures. There is a clear need to prioritize and harmonize measures in health care.

Convening participants envisioned a standardized set of population health metrics at the national level, from which communities could select the metrics that make the most sense for their work and which can be derived from locally available data. This set of metrics would be cross-sectoral, simple, aligned and customizable to the community. It would include measures of public and community health, individual
health, health care systems and community services and outcomes, as well as social and cost measures. This set could be used by governments, funders, payers and researchers. It would allow comparisons across communities and would document disparities. It could be used as a basis for an outcomes-based payment system or for measurable grant deliverables.

The greatest barrier to measuring success in population health is the timeframe. Most federal grant programs require progress to be shown in three years, which is a very short timeframe to demonstrate a return on investment in community-based prevention initiatives. The Congressional Budget Office (CBO) scores proposals with a five-year window, which is also a shorter timeframe than is desirable for investments in community prevention. As the case examples demonstrate, while early progress can be measured (especially if projects are strategic in choosing their targets), the partnerships required in population health initiatives take time to develop and the most significant health impacts may occur well after the intervention, as is the case with interventions in early childhood.

Population health measurement is complicated due to the multiple sectors involved. From identifying the right metrics and defining them correctly, to accessing and analyzing the data, cross-sector measurements are complex and time-consuming. More research needs to be done on the measurement of costs and benefits across sectors.

Another challenge in measurement is risk assessment for social factors, such as socioeconomic status (SES). Performance measures are not currently risk adjusted for social factors, including SES, based on the theory that risk adjustments based on SES might mask disparities in care, and thus standard practice has been to stratify performance measures based on SES to identify disparities in care. Given the move to pay-for-performance and the shifting of risk to providers, the National Quality Forum has assembled an expert panel to reconsider whether performance measures should be risk adjusted for socioeconomic status to allow for fair performance comparisons among providers when factors beyond their control influence patient outcomes. The Institute of Medicine’s Committee on Recommended Social and Behavioral Domains and Measures for Electronic Health Records is working to identify domains and measures that capture the social determinants of health to inform the development of recommendations for Stage 3 meaningful use of electronic health records (EHRs).

An important tool for community-level assessment is the Community Health Needs Assessment that non-profit hospitals are required to complete every three years in partial fulfillment of their Internal Revenue Service (IRS) community benefit requirements. Public health departments and federally-qualified health centers also routinely analyze the health status, assets and gaps in their communities. These existing tools and methods can provide the foundation for measuring improvement in population health and can be used to identify the health priorities for the community, particularly if they assessments are conducted collaboratively. One challenge is to ensure coverage of an entire geographic region when defining the areas to be included in a community-wide needs assessment. Since each hospital typically measures its
own market area, gaps sometimes exists when the plans are viewed from a community-wide perspective.

4. Workforce

Convening participants expressed concerns about the ability of the current workforce to meet the needs of many more millions of Americans who will become insured starting in 2014. One strategy for maximizing our current workforce is to ensure that all licensed health care professionals are operating “at the top of their license”, which entails delegation of some duties to other providers on the team. At the same time, creating partnerships and linkages between clinical and community systems requires skills and competencies that may not exist in traditional systems.

As the case studies demonstrate, workforce innovations are central components of population health initiatives. Population health initiatives employ care coordinators, community health workers, health educators and many other new providers. These workers fill important roles at both the individual patient level and the systems level. In the REACH Charleston and Georgetown Diabetes Coalition and in the Akron Accountable Care Community, community health workers educate and support patients, connecting them to needed services in the community, and helping them to manage their disease and change their behaviors. Similarly, new skills and competencies may be required to support the integrator, such as working across various sectors, aggregating data and identifying systemic issues and policy and environmental solutions.

As noted above, changes in education are required to achieve the cultural shifts necessary for different disciplines to work together in a population health improvement initiative. This training is needed for the clinical and public health workforce.

5. Financing

There was a lengthy, in-depth conversation on financing population health initiatives at the convening. The participants recognize the current transition from volume-based to value-based and global payments will provide the right incentives for investment in prevention both within and beyond the health care system, particularly as integrated care models and ACOs accept risk for larger populations, and as multi-payer ACOs develop. As providers take on more risk, attention to outcomes increases. One health system executive noted that once providers take on risk with some populations, they favor moving more of their market onto risk-based contracts. Prospective capitation, global payment and other full risk payment arrangements incentivize investments in care coordination and community prevention. During this transition period there is a need for several types of financing, including start-up funding, funding to operate the population health initiative, funding to spread and scale successful initiatives, and research funding.
Participants outlined a business model that begins with cost transparency throughout the system, which is currently lacking. Cost transparency for health care services, public health and other interventions is needed to be able to quantify savings and/or avoided costs. Prevention investments are expected to reduce health care utilization and, thus costs over time. Without cost transparency, however, identifying, capturing and allocating those savings is challenging. The first step is linking clinical and community systems in order to monetize savings, determine how to share them among partners and reinvest a portion of the savings to support the integrator and initiatives beyond the initial start-up period.

In the Akron ACC, financing is provided by up-front investments from multiple stakeholders, including government, health care providers, employers, a national park, the public library system, insurance providers and payers, the metropolitan planning and public transportation, etc. Revenues and savings are shared according to agreements negotiated with individual entities. A small percentage of the savings is redistributed as grants to spur innovation.

Once costs are transparent and savings are being generated and identified, a mechanism must be established to share the savings among the partners. Population health initiatives often target the highest cost users and design programs to better manage their care, reducing any unnecessary utilization. Over time, the rate of saving could go down, unless the up-front investments in prevention are increased and new innovations are implemented.

As the case examples show, local population health initiatives are nearly always funded by a myriad of sources, both public and private, from various sectors (e.g., health, social services). Current sources of funding include federal grants such as CTGs; Health Care Innovation Awards, State Innovation Models and other awards from CMMI; private foundation funding; state funding; and some service delivery revenue. Health care providers are increasingly leveraging their community benefit programs to invest in programs that link their clinical systems to the community. Managing the complexity of braiding and blending so many funding sources together, with different goals and expectations and multiple timeframes for applications and reporting, is an enormous administrative burden. States and communities are considering “wellness trusts” as mechanisms to coordinate these various funding streams and invest in community-based prevention programs.16

In recognition of the fact that investments in one sector can accrue benefits in another, the convening participants discussed how a financing agent from one sector can be rewarded when better outcomes and/or savings are achieved in another sector.

The Robert Wood Johnson Foundation and the Federal Reserve Bank of San Francisco have sponsored a series of discussions about how health might be better incorporated in community development efforts and investments. The Community Reinvestment Act encourages banks and other financial institutions to provide
investments and access to financial services for residents of low- and moderate-income neighborhoods. The Akron ACC has leveraged resources and investments from diverse partners, including banks, nonprofits, and foundations, and returns funding to institutes based on results, a model that shares features with pay for success contracts and social impact bonds. There is potential for new models in which hospitals and banks blend community benefit and community reinvestment dollars to address some of the upstream causes of bad health such as poverty and poor housing.

Recommendations for Federal and State Action

Federal Government Options for Incentivizing Investments in Population Health

It is clear from the convening discussions that catalyzing and supporting these types of partnerships requires incentives (both policy and financial) and the removal of programmatic and bureaucratic barriers to collaboration. The federal government has many tools that can create a new dynamic for community health funding.

Provide Flexibility in Federal Funding

1. **Fund the integrator.** Having an “integrator” is central to successful long-term partnerships. Existing federal health funding streams should be targeted to support developing locally designed and appropriate integrator functions. This includes initial start-up funding for the integrator as well as long-term infrastructure needs. Examples of current federal health funding streams that could be used for this purpose include: Community Transformation Grants (Centers for Disease Control and Prevention (CDC)), REACH grants (CDC) State Innovation Models (Centers for Medicare and Medicaid Innovation (CMMI)), and Health Care Innovation Awards (HCIA at CMMI).

2. **Encourage and support local blending and braiding of various funding streams.** Successful community-based models braid or blend existing funding streams from third party payments, categorical funding by various federal agencies, and other (e.g., foundation) funders. The federal government should actively encourage this kind of braiding by creating incentives in these programs and removing regulatory and reporting barriers. Among the tools that can be used are competitive grant preferences; streamlined grant requirements and performance metrics; technical assistance aligned across programs; and sharing of best practices among grantees. One direct way to incentivize this would be through issuance of common funding opportunity announcements (FOAs). The federal government should also support the infrastructure to manage complex financing, including information technology and administrative support.

3. **Clarify the ability of non-profit hospitals to use community benefit dollars for population health.** Leadership from non-profit hospitals has been
central to a number of community level efforts. The federal government should incentivize this engagement by clarifying that, under the new ACA-driven requirements for non-profit hospital community benefit activities, hospitals may indeed dedicate community benefit dollars to such population health initiatives (including support for an integrator).

**Integrate Health into Place-Based Initiatives**

4. **Federal place-based programs should have explicit requirements to link with population health initiatives in their communities.** Many population health initiatives are place-based. Indeed, true improvements in population health, especially the elimination of health disparities, require a broad-based approach that addresses a full range of social determinants of health -- from health to employment to housing. The federal government has a number of place-based initiatives (e.g., the Neighborhood Revitalization Initiative which includes Choice Neighborhoods and Promise Neighborhoods, Sustainable Communities, and Regional Innovation Clusters), but these are only tangentially explicit about how they address health and require no linkage to the evolving health care delivery and public health systems.

**Establish Supportive Requirements within Health Programs and Grants**

5. **Reporting Requirements.** Population-level outcomes should be required as part of the grant goals for appropriate federal health programs. The federal government should develop an agreed upon set of population health metrics and recommend appropriate timelines to demonstrate population-level outcomes and return-on-investment from community-based prevention and integration investments. Three to five year reporting timeframes (as with CMMI HCIA and CBO scoring) are often not long enough to achieve significant progress in many community-based prevention programs.

6. **Partnership Requirements.** Successful population health initiatives engage multiple sectors to address the needs of individual patients and the social factors that impact health. The federal government should require multi-sector community partnerships in appropriate federal health programs, including engagement of non-traditional partners. The federal government should also fund related supports, including multi-sector measurement and data sharing and bi-directional e-referral systems, such as the one under development in Massachusetts. The federal government could also encourage population health approaches in federal grant programs by encouraging or requiring partnership with multiple entities to ensure broad geographic coverage. The State Innovation Model awards, for example, required all-payer approaches that maximized the portion of the state population that would be impacted, leading logically to a population health approach.

7. **Financial Incentives.** Population health initiatives can save money, as the case examples demonstrate. Population health programs that reduce health care utilization and thus health care costs should be rewarded with a portion of
the savings. Sharing these savings ensures continued partner engagement. Furthermore, a portion of the savings should be reinvested in population-based prevention programs, thereby creating a sustainable funding stream for programs that improve health and result in future savings. Allowing shared risk can also promote population health initiatives, since sharing risk changes provider behavior, motivating providers to invest in prevention. The federal government should encourage and/or require shared risk and savings models, including global payments.

8. **Payment Policy.** As a major payer, the federal government should set policies that encourage population health investments (including linkages between the health care system and the community) and that reward improved population health outcomes. For example, the Medicare Readmissions Reduction Program, which is reducing payment for inpatient readmissions within 30 days of discharge, has been an incentive for hospitals to connect patients to what they need, at home and in the community, to manage their health at home. The Medicare Hospital Value-based Purchasing Program makes value-based incentive payments to hospitals based on quality measures that could include population health metrics. CMMI’s Pioneer ACOs represent similar opportunities. CMS recently changed Medicaid statute to allow reimbursement for preventive services delivered by non-licensed providers upon referral. This change supports the workforce innovations that connect patients to the community supports they need. The federal government should change payment policy from our current predominantly fee-for-service system to new payment methods that reward investments in prevention and population health outcomes. There are numerous demonstrations currently underway, both within the Medicare program and at CMMI, which once proven successful, should be spread.

9. **Workforce Innovation.** Population health initiatives that link the health care system and the community are innovating with new types of workers. Appropriate federal health programs should encourage this type of innovation by permitting grant funds to support new types of workers and establishing payment policies to ensure sustainability of successful innovations.

10. **Technical Assistance.** The federal government should support the development of tools and the provision of technical assistance to communities to further the spread of population health initiatives. For example, communities need:
   a. Models of governance structures for integrators;
   b. Learning collaboratives, such as the one focused on Community Health Workers at the Centers for Medicare and Medicaid Innovation at CMS/HHS; and
   c. Financing options and models for sustainability, particularly for federal grant programs that encourage clinical-community collaboration and investment in prevention, such as CTGs, SIMs and HCIAs.
11. The federal government should build population health measures into Meaningful Use (of Health Information Technology) requirements, including requirements for data sharing between public health and health care systems.

**Clarify Legal Constraints**

12. The federal government should clarify federal regulations to designate safe harbors for antitrust law. When health care providers and payers work together to improve health in their community, they need to ensure compliance with antitrust laws that guard consumers from anticompetitive behavior. In particular, coordination of payment approaches among organizations that otherwise compete might be considered an illegal restraint of trade. The federal government can develop regulations that create specific exemptions and states can also create exemptions if they determine that consumers are better served by collaboration among competitors.\(^\text{21}\)

**Invest in More Research**

13. The federal government should invest in more research, particularly community-based participatory research, to build the population health evidence base.\(^\text{22}\) Multi-disciplinary research is needed to continue building the evidence base for population health and, importantly, to link population health science and practice. Since population health initiatives by definition involve the community, the research methods and practices should be community-based, with researchers working side by side with community members to define the questions and methods, implement the research, disseminate the findings and apply them.

**State Government Options for Incentivizing Investments in Population Health**

1. Incorporate community prevention into new and existing federal grant programs to promote the health of their residents. For example, several states are working to incorporate population health goals, community prevention programs and supportive structures, such as Wellness Trusts, within their State Innovation Models.

2. Create Wellness Trusts, such as Massachusetts did recently.\(^\text{23}\) Wellness Trusts differ from traditional public health funding in that they are not annual appropriations, but rather long-term commitments (four years in Massachusetts). The Massachusetts Trust is funded by a one-time assessment on the state’s large insurers and hospitals. The focus of the funds is linking public health activities and clinical care.
3. Include requirements that promote population health in managed care contracts, such as requiring Medicaid managed care companies to invest in community prevention or report on population health outcome measures.

4. Pursue Medicaid waivers to gain flexibility in delivering and paying for Medicaid services. Oregon, for example, received an 1115 waiver to establish Coordinated Care Organizations. This waiver gives Oregon the flexibility to provide more preventive care and disease management than was possible under traditional Medicaid guidelines, in part due to the global payment structure. New York is pursuing a Medicaid waiver to fund its investment in affordable/supportive housing.

5. Include requirements for providers to report on population health measurements in relevant legislation, such as legislation to establish and regulate Accountable Care Organizations or exchanges.

6. Submit a Medicaid state plan amendment to leverage the recent Medicaid change allowing reimbursement for preventive services delivered by non-licensed providers upon referral from a licensed Medicaid provider. States can encourage workforce innovation by creating a sustainable funding mechanism for providers who work to bridge clinical and community systems to meet the health needs of patients and communities.
How a Social Accountable Care Organization Improves Health and Saves Money and Lives

By, Nancy Garrett, Ph.D., Chief Analytics Officer, Hennepin County Medical Center

When Minnesota decided to expand Medicaid to a poor, childless adult population in Hennepin County, the interested parties decided to take an innovative approach to ensure patients were receiving the kind of care they needed to be healthy. In essence, we built a Social Accountable Care Organization (ACO), a model wherein a group of healthcare partners (Hennepin Health) took on more risk and partnered with social services to care for this vulnerable population.

Hennepin Health was formed as a capitated Medicaid demonstration project by four organizations: Hennepin County Medical Center, NorthPoint Health and Wellness (a Federally Qualified Health Center), Metropolitan Health Plan and the county’s Human Services and Public Health Department (including Health Care for the Homeless, the county’s Mental Health Center and other social services). The providers bill the plan on a fee for service basis and split the gain (or loss) at the end of the year.

Together, we serve over 6,000 enrollees who face some stark health realities: 45 percent have chemical dependencies, 42 percent have mental health needs, 32 percent have unstable housing and 30 percent suffer from at least two chronic diseases. In total, the top 5 percent of the population’s healthcare utilizers demand 64 percent of the available healthcare dollars.

Clearly, the old system wasn’t working for these individuals. So, we built our model on the concepts of a primary care medical home with a strong continuum of care coordination paired with addressing the social determinants of health (housing, substance abuse, joblessness, etc.).

For this population, before you can even address the traditional health problems of a patient, you have to look at the social and behavioral issues present, which makes the partnership with the county’s social services so vital. For every patient, we try to meet them where they are and we’ve found that when we can get someone to a stable housing situation they are then able to start working on the prevailing health issues. Quickly, we decided to move mental health specialists directly into the clinic to provide easy access to care for the patient and consultation for primary care providers.

This approach has paid dividends to our bottom line and the health and wellbeing of all our patients. For one patient, who was a frequent utilizer of the emergency department, our model has improved his life dramatically. When we looked at his admission rates, we realized someone needed to coordinate the vast array of care he needed: he had many chronic conditions and the coordinator found the patient was also homeless.

So, the care coordinator called her partner social worker and together they found stable healthy housing. In that process, the coordinator discovered that the patient was...
interested in getting a job. We realized this was not unique to this individual so we used some of our savings to bring an employment counselor to the clinic to help people with behavioral problems learn how to get and keep a job. The counselor works to place them at a job and helps the patient for a year afterward, so they can retain their job.

Without the relationship with the care coordinator, we never would have had this patient applying for jobs and working on managing his chronic conditions. He has accessed primary care consistently and is much better health-wise. Even when this patient slipped and ended up in detox, his first call was to the care coordinator for help. This example demonstrates that there’s no easy fix with socially complex patients. There will be ups and downs, but if relationships exist and you can connect people with the appropriate social services, patients’ lives and health will improve. What could have been a complete substance abuse spiral ending in an emergency department visit became a simple call to a care coordinator who connected the patient with the appropriate services.

For our model to work this seamlessly all of the partners have to buy in. It was relatively easy for us since every partner is governed by the county and we serve the same populations. While we weren’t used to working with one another, through trial and error, we have found effective ways to collaborate.

It also doesn’t hurt that there are dollars at the table. If, collectively, we can treat the population for less, the money can be dispersed back to the partners and invested outside the conventional government boundaries into innovative ideas that better help those who we have spent our entire careers trying to help. We will finally focus on prevention.

Our early results are positive. We have seen an increase in primary care visits and non-billable phone and email visits as well as reduced medication costs. There have been increased connections of patients to social services (food assistance, transportation and financial assistance) and substance abuse and mental health services.

In our first year, Hennepin Health reduced emergency department visits by more than 20 percent. In fact, spending for some of the program’s top 200 users of medical services dropped. In total, the county has been able to reinvest more than $1 million in savings toward filling service gaps and providing even better, cost-saving, care.

We have used excess funds to pay for on-site behavioral health counselors and licensed alcohol and drug counselors, the employment counselor and expanding our complex care clinic. We plan on using future dollars to provide interim housing for people who are ready to leave the hospital but don’t have a stable housing situation.

We’ll also be building a sobering center. Looking at our data, a lot of the emergency department capacity has been used by people who are simply intoxicated. They didn’t need medical care, they needed somewhere to sober up. So, instead of using these valuable resources, we’ll build a separate center that can be minimally staffed and a lot less expensive than an emergency room visit.
Another beneficial aspect of this diverse, but dependent group of partners was the ability to share data. While it was time consuming and difficult to plan out the technical and legal aspects, we’ve built a data warehouse that includes claims from the plan, Epic information (one of the best, most integrated electronic health systems (EHR)), and some social services data.

Bringing in the social services data and combining it with medical history provides as full a picture as possible of a current individual’s health and wellness. We have installed EHRs in a lot of social service agencies so they know what’s going on with medical care and medical providers will know what kind of social services a patient needs when they are treating them.

We can also use the warehouse as a sort of drug monitoring program. When we created the plan we really wanted to include dental. With the analytics, we can tell who is having a dental emergency versus who has been to the emergency room frequently for painkillers for various ailments. We can then track these individuals and get them into counseling.

There is always more we can do. Right now, we’re conducting a lifestyle survey to get information on health risk behaviors (smoking, exercise, access to healthy foods, etc.) to understand the determinants of health. We have only completed surveys of about 10 percent of our population, but, for those 10 percent, the data is coming into the warehouse and will be added to the record and accessed by social services and healthcare.

A successful health system must meet an individual’s basic needs before it can improve health. Experience has shown that social disparities often result in poor health management and costly revolving door care. Quite simply, by coordinating systems and services, Hennepin Health has improved health outcomes and reduced costs.

Success requires innovation, collaboration with non-traditional healthcare, adaptive and decisive leadership to force major systems changes and lean processing to streamline systems and reduce waste. By intentionally linking social services with healthcare, Hennepin Health is saving money and improving the health of individuals who are traditionally among the most costly and difficult to treat.

For more information on Hennepin Health, see:

Hennepin Health: the County’s Health Care

Hennepin Health: People. Care. Respect. Presented at Trust for America’s Health

Twin Pillars of Transforming a Sick Care System to a Health System: Delivery System Redesign and Payment for Prevention, July 17, 2013

Hennepin Health Summary

Hennepin Health: Our Clients and Our Solutions
Akron, Ohio — The First Accountable Care Community in Action

By, Janine E. Janosky, Ph.D., Vice President, Head, Center for Community Health Improvement, Austen BioInnovation Institute in Akron

In 2011, Austen BioInnovation Institute (ABIA) in Akron, Ohio brought together a wide range of more than 70 different groups to launch the first-of-its-kind Accountable Care Community (ACC).

The ACC is focused on improving the health of the community and incentivizing the health system to reward improved health while delivering cost effective care. Success is measured by factors such as the improved health of the whole community, cost effectiveness and cost savings in the healthcare system, improved patient experience for those using the healthcare system, job creation in Akron, and more.

The effort began by zeroing in one of the most widespread, high cost preventable health problems in their community: type 2 diabetes. Approximately 11 percent of adults in Akron have diabetes, and 2.1 percent more are considered pre-diabetic and are at risk for developing full blown diabetes. People with diabetes have 2.3 times higher average medical costs per year than non-diabetics. If current trends continue, one-third of the Akron population could have diabetes by 2050.

Of the individuals with type 2 diabetes involved in Akron’s ACC, around 38 percent have private health insurance, 31 percent have public health insurance (Medicare or Medicaid) and 31 percent have no health insurance. Combined, around 80 percent of the county’s population are represented.

Effective approaches to prevent and control diabetes require a comprehensive approach of primary, secondary and tertiary prevention. The ACC leverages the resources and expertise of a wide range of organizations, including the major health systems and healthcare providers, local public health district, employers, the Chamber of Commerce, universities, housing groups, public parks and city planners, transportation groups, economic developers and planners, a range of faith-based organizations and many others.

Strong, consistent medical care that is affordable and/or covered is vital to managing or preventing diabetes. In addition, daily self-management and maintaining a healthy diet and higher levels of physical activity are necessary to help those with diabetes improve their health and prevent others from developing diabetes in the first place. Some of the activities and initiatives promoted by the ACC, in addition to those directly related to education and care for disease, have included community gardens, fresh food preparation, exercise and others.

Specifically, the ACC has worked on the following initiatives: (1) expansion of the concept of “public lands for public health” with the Cuyahoga Valley National Park; (2) a regional health impact assessment of the Akron Marathon; (3) partnerships with the faith-based community and the University of Akron for health education and increasing screenings for individuals who are underserved including refugees, Native-
Americans, the homeless, and those in low-income housing; and (4) work with the Akron Metropolitan Transportation System to transform some of the local roadways into “Complete Streets”27.

In addition, the collaborative recognized that knowledge and information management is essential to understanding and analyzing health and cost patterns. This led the ACC to develop systems for confidential sharing of patient data using an integrated data platform, which allows healthcare entities to track health trends and cost savings. Participating hospitals and providers receive a share of the healthcare cost savings achieved by the program, and other funds are reinvested in the ACC or other community efforts.

The initiative also received a Community Transformation Grant (CTG), which was created by the Affordable Care Act, from the Centers for Disease Control and Prevention (CDC) to help support their activities. CTGs are awarded to communities that are taking integrated, evidence-based approaches to preventing disease.

In just over two years, the initiative has already seen positive results:

- The average cost per month of care for individuals with diabetes was reduced by more than 10 percent per month;
- After one year of involvement, consistent reductions in healthcare costs are in excess of 25 percent with estimated program savings of $3,185 per person per year;
- Decline in emergency department visits because of diabetes: a drop from nine to six emergency room visits for people in the higher glycated hemoglobin ranges (HbA1c>8%); and a drop from six to three visits for people in the lower glycated hemoglobin ranges (HbA1c<8%);
- More than half of participants lost weight and reduced waist size;
- Lowered cost per person per contact hour with healthcare providers ($25 vs. $37.50 for other leading diabetes prevention programs);
- Better management leading to decrease in glycated hemoglobin (A1C) (a measure of diabetes) and LCL cholesterol (often known as “bad” cholesterol) levels;
- No amputations because of diabetes;
- Increase in reported exercise and flexibility;
- Significantly fewer days in which reported mental and physical health was not good;
- Improved self-rated health; and
- Improvement in knowledge surrounding healthier dietary choices, health behaviors and diabetes self-management.

The ACC has been successful in improving quality of care, lowering the cost of care, delaying the progression of disease, expanding the population receiving
comprehensive care, reducing the overall burden of disease in the community, and increasing productivity. The initiative is planning to expand to focus on additional health problems, such as obesity, hypertension and asthma. Akron is a healthier place with lower healthcare costs because of the ACC, and it is more attractive to businesses and other groups because of its more vibrant and productive workforce.

For more information on the Akron Accountable Care Community, see:

Austen BioInnovation Institute in Akron

Healthier by Design: Creating Accountable Care Communities

Transforming Health by Developing an Accountable Care Community
Saving a Leg: a Community Focused on Improving Diabetes

By, Carolyn Jenkins, DrPH, APRN-BC-ADM, RD, LD, FAAN, Professor and Ann Darlington Edwards Endowed Chair, Director, SCTR Community Engagement Core, Medical University of South Carolina

Nearly 20 years ago, the Medical University of South Carolina was charged by the state legislature to investigate diabetes and ascertain the related problems and challenges.

Not surprisingly, we found that diabetes cases were rising and disproportionately affecting underserved and minority populations. In addition, we quickly realized that the number of diabetes-related amputations far exceeded what we thought would be occurring.

The result of that initial work was a study focused on addressing the prevalence of diabetes by improving professional education of providers, fostering better community relations and increasing surveillance and data.

I inherited the community piece and it quickly became my lifelong work. A year or two after we started to address diabetes at the community level by creating a coalition, the Centers for Disease Control and Prevention (CDC) began collecting proposals for the Racial and Ethnic Approaches to Community Health (REACH) grants. Suddenly, my work, which was largely without dedicated funding, had the opportunity to receive additional resources to specifically focus on reducing the disparities faced by Blacks at risk for or living with diabetes.

So, the University applied for the grant on behalf of the Diabetes Initiative of South Carolina, with a deep focus in Charleston and Georgetown Counties. Georgetown was actually a late addition to the proposal, as they didn’t announce their intention until about 24 hours before the grant was due. However, in short order, we received 50 letters of support.

This was one of the first indications that there was great interest in addressing diabetes at the community level. In fact, when we started the work, community groups kept coming and saying diabetes was a huge problem in their community, but they didn’t have the resources or expertise to design a successful grant to CDC.

For there to be good work, you have to have a good plan. Early on, I made the administrative decision that the University wasn’t going to go into communities and say “look at these statistics, they’re just terrible.” Instead, we asked the communities what challenges they faced in relation to diabetes and what they wanted to do about it and then identified what we could do together. I didn’t want to start with the University as a driver of community-based solutions.
This approach didn’t exactly allow us to hit the ground running. However, after several months of community members asking me what the University was going to do and my answer being “we’re going to do whatever you think will solve the problem,” they finally got the picture. It was as if the light bulb turned on and everyone realized this wasn’t going to be the typical University grant exercise, wherein the University comes in, experiments with communities and disappears when the money goes away. It was important to show that the University was in this for the long haul and we were building a true academic-community partnership.

From then on, community organizations began providing ideas for how to address diabetes. And, what’s even better, the issues they identified were the same as what the epidemiological data indicated – this was very empowering for the community.

Together, we looked at diabetes and all the negative health outcomes as well as the community assets to figure out what to focus on in the three to five years we had to document outcomes. Everyone, from local podiatrists to the traditional health system to the community, told us that people with diabetes had two great fears: losing their legs and having to go on “the kidney machine” (dialysis). But, ultimately, they decided that their legs were most important.

Unfortunately, amputations were a big problem at that time, as patients were showing up to hospitals and primary care providers with extensive sores and even gangrene. It appeared that a lot of the problems were in the health system and in the way the health system was dealing with the people in the community.

At first, the healthcare providers were a bit resistant as they saw the problem as belonging to the patient who often “did not take care of their diabetes.” However, I and the University helped the community recognize that providers and their patients needed support and weren’t to blame.

When we started saying “the problem belongs to all of us,” the entire continuum of care could come together. For instance, a certified medical assistant can look at someone’s feet and check whether someone is in danger of losing a leg. So, we taught anyone who would listen how to conduct foot exams. We even developed a foot care course for nurses.

Eventually, the community bonds were so tight that podiatrists made an agreement with community health workers that if a patient couldn’t afford care and the community health worker called the podiatrist, they would see the patient for just a $5 co-pay and, if there was a lesion, they would see the person for free if the person had no money or insurance.

We also built basic principles for working together as a coalition that involved listening to each other and the community, clearly putting health issues on the table and being open minded about the issue. Slowly, community, patient, doctor, nurse, and pharmacist learned to speak the same language.
It was also important for community health workers to educate patients on how to communicate with providers by encouraging patients to ask doctors and nurses “what the numbers mean.” We responded to provider concerns about how they would get paid to provide the quality of diabetes care we were seeking, and worked with the state legislature to establish insurance coverage for diabetes education and supplies. We also responded to concerns about the multiple standards for diabetes care, and synthesized all the diabetes guidelines into a two-page document. We’ve incorporated these guidelines into the health professions curriculum and continuing education programs.

As a result, we’ve made significant progress in improving the delivery of diabetes care, including lower A1Cs and blood pressure in people with diabetes and we’ve narrowed the gap between the amputation rates for Blacks and whites in Georgetown and Charleston Counties. Community-wide, our statistics are looking better and we estimate that we save between $1.6 to $2 million a year in prevented amputations.

With this academic-community-provider partnership forged, we began to look at health systems quality improvement teams around community health workers, which we call community health advocates. We trained and employed the advocates to help patients navigate the health system and coordinate a continuum of care. At the same time, the advocates trained us how to work more effectively with the community.

The advocates went into the community and learned what was and wasn’t happening to improve health. Initially, they found that men were not showing up for treatment. To address this, they created numerous community-based solutions. One example was an all-male play that was a take-off of Steel Magnolias. In essence, it was a womanless wedding, during which they served diabetes-appropriate food, one actor had to have an amputation and others acted out the dangers of not monitoring blood sugar levels.

In short order, the advocates had built trust between the traditional health systems and patients, who had little to no interaction previously. To expand their work, before there were electronic health records, the partners worked together to build a diabetes registry to identify which patients had come into health centers and were in danger of developing diabetes or not controlling their condition. They helped patients navigate the center and traditional healthcare and offered education programs on how to control diabetes to patients, families, and friends in the community, at churches, beauty parlors and other community gathering places. In addition, they provided referrals to Federally Qualified Health Centers (FQHCs) to increase access to primary care and connected patients with social services to link them with the resources needed to manage diabetes and avoid amputations and hospitalizations.

While this was happening, the traditional health system moved more and more into the community. As one health provider worked in the community, he became an advocate to his colleagues and, often, providers were “hooked” on doing more community work than they had originally intended.
In short, community ownership made all the difference. The University, instead of being a traditional academic institute at arm’s length, served the necessary role of the catalyst for change. The University team being out there in the community was vital to success: every time we hit a snag, someone had to be positive and get the right community leaders to look at the problem and see what the community could do about it.

For any health intervention to work, the emphasis needs to be on a broad based ownership of health. There is no one or two groups that can truly and fully benefit and improve a community’s health. While there will be one or two groups that lead, they must bring in the entire community support structure, including nontraditional support from outside the health world (schools, sororities/fraternities, churches, clubs, business, foundations, and others).

For more information on the Georgetown and Charleston County REACH Coalition, see:

REACH US SEA-CEED

REACH Charleston and Georgetown Diabetes Coalition, South Carolina: Case Study of a Place-Based Approach

An Academic-Community Partnership: The Medical University of South Carolina College of Nursing and REACH Charleston and Georgetown Diabetes Coalition as Integrators

REACH Charleston and Georgetown Diabetes Coalition’s Efforts to Decrease Diabetes-Related Amputations in African Americans

Beyond the Medical Model: Interdisciplinary Programs of Community-based Health Research
Endnotes


4 Summary of TFAH's July 2013 Twin Pillars Convening, Background Paper for TFAH's July 2013 Twin Pillars Convening, Summary of TFAH's August 2013 Community Prevention Convening

5 The challenge of defining population health is discussed in Adler, N. Bachrach, C., Daley, D. and Frisco, M., *Building the science for a population health movement.* Discussion Paper, Institute of Medicine, Washington, DC.


7 Sox, H. Resolving the tension between population health and individual health care. JAMA. 2013;310(18):1933-1934.


9 Institute of Medicine Consensus Study on Recommended Social and Behavioral Domains and Measures for Electronic Health Records


11 See National Quality Forum's Project -- Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities and Endorsement Summary: Population Health Phase II Measures

12 For discussion of an analytic software program that assesses both clinical and social factors in patients’ records, see Amarasingham, R. Applying data analytics and information exchange to improve care for patients. *Health Affairs,* 31, no. 12 (2012):2785-2786.

13 National Quality Forum Risk Adjustment and Socio-Economic Status Project

14 Institute of Medicine Consensus Study on Recommended Social and Behavioral Domains and Measures for Electronic Health Records

15 IRS Regulations for Non-Profit Hospitals under the Affordable Care Act

16 The Massachusetts Prevention and Wellness Fund Fact Sheet, In South Los Angeles, A Bold Plan to Address Health Disparities and California State Health Care Innovation Plan


18 Place Matters: A Q&A With David J. Erickson, Federal Reserve Bank of San Francisco

19 White House Neighborhood Revitalization Initiative Presentation, UNCA Neighborhood Revitalization Conference, August 2, 2012


21 Navigating Antitrust Concerns in Multi-Payer Initiatives. Academy Health, September 2010

22 Adler, N. Bachrach, C., Daley, D. and Frisco, M., Building the science for a population health movement. Discussion Paper, Institute of Medicine, Washington, DC.


24 Oregon Health Authority Transformation Center

25 New York's 1115 Waiver

26 ABIA is a unique biomedical innovation institute, founded in 2008 by Akron Children’s Hospital, Akron General Health System, Northeast Ohio Medical University, Summa Health System, The University of Akron and the John S. and James L. Knight Foundation. The City of Akron and the County of Summit are key participants in the initiative.

27 See Smart Growth America for a definition of “Complete Streets.”