Accountable Health Communities Models

Grantmakers In Health Webinar

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Milken Institute School of Public Health
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What is “accountable health”?

- Accountable health approaches integrate (in varying degrees) the health care and social needs of individuals in the hope of improving health outcomes, reducing costs, and resolving upstream factors that affect health.

Growing evidence base

- What happens outside the clinic has a direct effect on success of clinical interventions
- The physical and social environment in which we live can improve or worsen our health
- Social determinants affect outcomes (though with varying time horizons and delivery systems)
  - Housing vs. education

Value-based purchasing drives move to accountable health

- If we are rewarding outcomes over volume, then mobilizing all factors that affect health will have rewards
- Unknowns: which approaches are the most effective, who should lead, and what is a sustainable financial model

A spectrum of approaches

- Upstream approaches with long time horizon vs. services/changes that have quick impact
- Emphasis on meeting individual (social) service needs vs. policy, systems, and environmental change
- Leadership from health system vs. public health vs. community

Many experiments…few answers yet

- Support from government (using traditional funding/financing mechanisms to special funding through CMMI)
- Support from philanthropy
  - AHC and CACHI are just two examples

Part Two

Forum on Accountable Health

- Create a "learning community" of public and private funders supporting accountable health
- Initial guidance and support from:
  - Robert Wood Johnson Foundation
  - W.K. Kellogg Foundation
  - Kresge Foundation
  - The California Endowment (California Accountable Communities for Health Initiative)
  - Department of Health and Human Services
    - Center for Medicare and Medicaid Services
    - Centers for Disease Control and Prevention
    - Office of the National Coordinator for Health IT

Goals of the Forum

- Track investments, learning communities and evaluation approaches
- Rapid cycle learning for funders
- Coordinated approaches to evaluation, identification of policy challenges

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Accountable Health Communities

Prevention & Population Health Group

The CMS Innovation Center

Alexander Billioux, MD DPhil

Acting Director, Division of Population Health Incentives and Infrastructure

CMS Aims

Better Care: We have an opportunity to realign the practice of medicine with the ideals of the profession—keeping the focus on patient health and the best care possible.

Smarter Spending: Health care costs consume a significant portion of state, federal, family, and business budgets, and we can find ways to spend those dollars more wisely.

Healthier People: Giving providers the opportunity to focus on patient-centered care and to be accountable for quality and cost means keeping people healthier for longer.

CMS Strategic Goal 2

Prevention and Population Health

All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services.

http://intranet.cms.gov/Component/CSP/documents/CMS-Strategy.pdf

Accountable Health Communities Model Overview & Structure

Why the Accountable Health Communities Model?

- Many of the largest drivers of health care costs fall outside the clinical care environment.
- Social and economic determinants, health behaviors and the physical environment significantly drive utilization and costs.
- There is emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and impact costs.
- The AHC model seeks to address current gaps between health care delivery and community services.

The Vision for Enhanced Clinical and Community Linkages

Care Process	Today's Care	Future Care
Identification of health-related social need	Ad hoc, depending on whether patient raises concern in clinical encounter	Systematic screening of all Medicare and Medicaid beneficiaries
Provider response to health-related social need	Ad hoc, depending on whether provider is aware of resources in the community	Systematic connection to community services through referral or community service navigation
Availability of support to help patient resolve health-related social need	Ad hoc, depending on whether case manager is available and has capacity given case load and care coordination responsibilities	Community service navigation designed to help high-risk beneficiaries overcome barriers to accessing services
Availability of community services to address health-related social needs	Dependent on fragmented community service system not aligned with beneficiary needs, often resulting in wait lists or difficulty accessing services	Aligned community services, data-driven continuous quality improvement and community collaborations to assess and build service capacity

What Does the Accountable Health Communities Model Test?

The Accountable Health Communities Model is a 5-year model that tests whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts health care quality, utilization
and costs.

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Testing the **effectiveness of referrals** to increase beneficiary awareness of community services using a rigorous mixed method evaluative approach
- Testing **the effectiveness of community services navigation** to provide assistance to beneficiaries in accessing services using a rigorous mixed-method evaluative approach
- **Partner alignment** at the community level and implementation of a quality improvement approach to address beneficiary needs

Health-Related Social Needs

Core Needs	*Supplemental Needs
Housing Instability	Family & Social Supports
Utility Needs	Education
Food Insecurity	Employment & Income
Interpersonal Violence	Health Behaviors
Transportation	

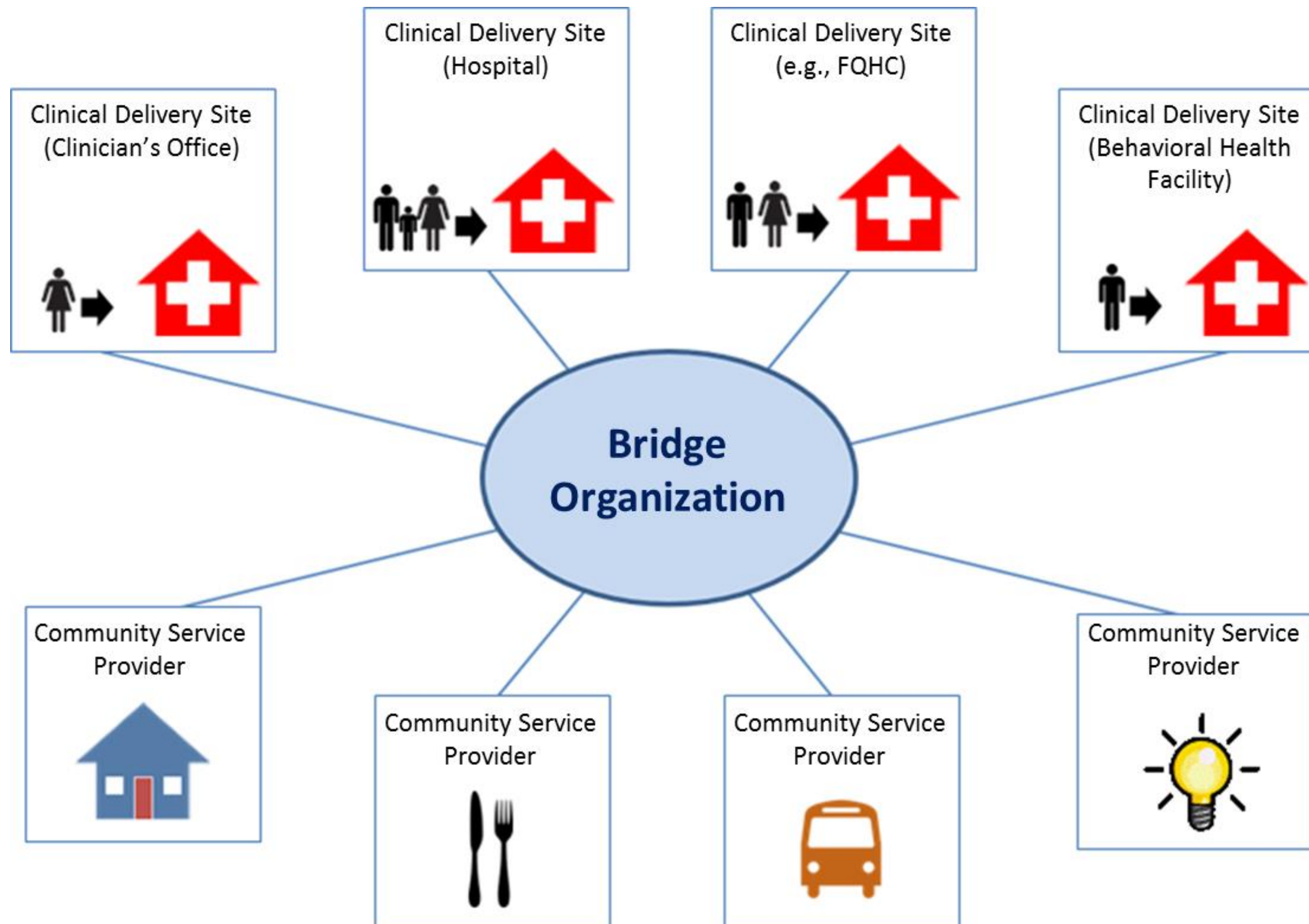
* This list is not inclusive

Model Structure

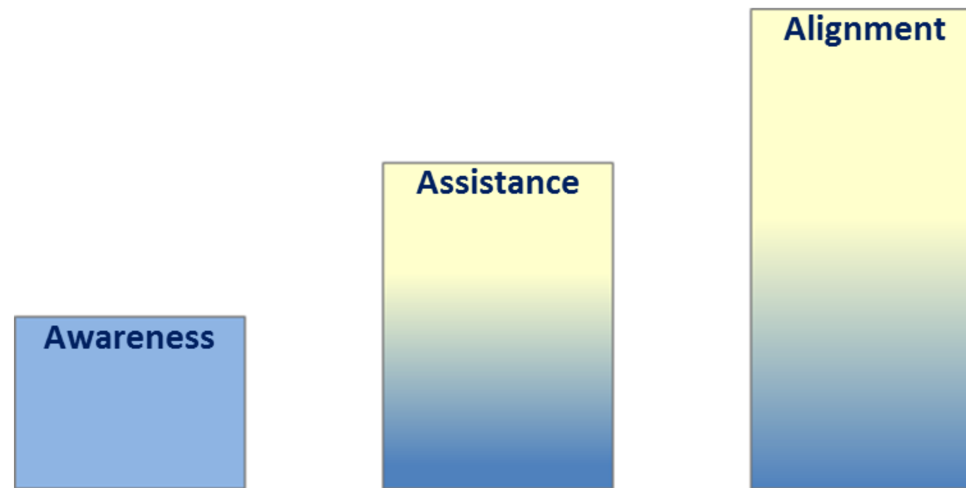
Model Structure

- The AHC model will fund awardees, called bridge organizations, to serve as "hubs"
- These bridge organizations will be responsible for coordinating AHC efforts to:
  - Identify and partner with clinical delivery sites
  - Conduct systematic health-related social needs screenings and make referrals
  - Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers that might be able to address those needs
  - Align model partners to optimize community capacity to address health-related social needs

Accountable Health Communities Model Structure



Accountable Health Communities Model Intervention Approaches: Summary of the Three Tracks



- **Track 1: Awareness –** Increase beneficiary ***awareness*** of available community services through information dissemination and referral
- **Track 2: Assistance –** Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services
- **Track 3: Alignment –** Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

Model Performance Metrics

- Healthcare utilization: emergency department visits, inpatient admissions, readmissions and utilization of outpatient services
- Total cost of care
- Provider and beneficiary experience

Accountable Health Communities: Funding Opportunities Update

Track 2 & 3 Updates

- The initial application period for Tracks 1, 2, and 3 closed in May 2016
- Applications for Tracks 2 & 3 are currently under review
- CMS anticipates awards will be announced in Spring 2017
- All applicants, including those who applied to Tracks 1, 2 or 3 in the previous Funding Opportunity Announcement (FOA), are eligible to apply to this FOA
- Successful applicants will be selected to participate in a single track only

Track 1 Changes

- CMS modified Track 1 application requirements and released a new funding opportunity. The modifications include:
  - Reducing the annual number of beneficiaries applicants are required to screen from 75,000 to **53,000**; and
  - Increasing the maximum funding amount per award recipient from $1 million to **$1.17 million** over 5 years.
- CMS believes these two key modifications to Track 1 will make the program more accessible to a broader set of applicants
- Applicants that previously applied to Track 1 of the AHC Model under the original FOA must **re-apply** using this FOA to be considered for the Model
- CMS anticipates announcing Track 1 cooperative agreement awards in the Summer of 2017

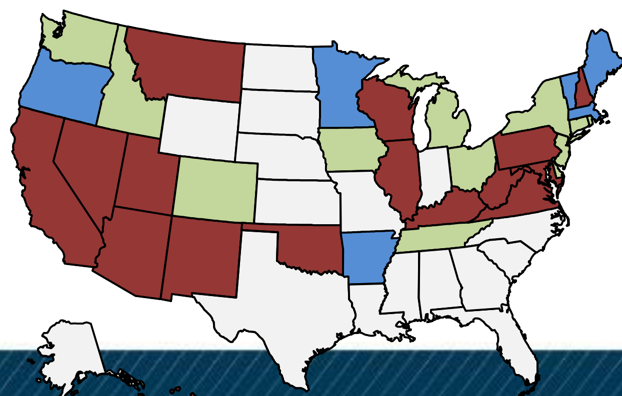
Application Process, Review, and Award

- Go to **Grants.gov** to view the full funding opportunity announcement and application kit.
- Submit application at Grants.gov no later than **3pm EST, November 3, 2016**.
- Applications downloaded from Grants.gov into GrantSolutions.
- Applicant review process begins.
- Program produces decision memo recommending selected applicants.
- CMS begins budget negotiations with selected applicants based on the submitted SF 424A, budget tables, and narratives.

State Innovation Model grants have been awarded in two rounds

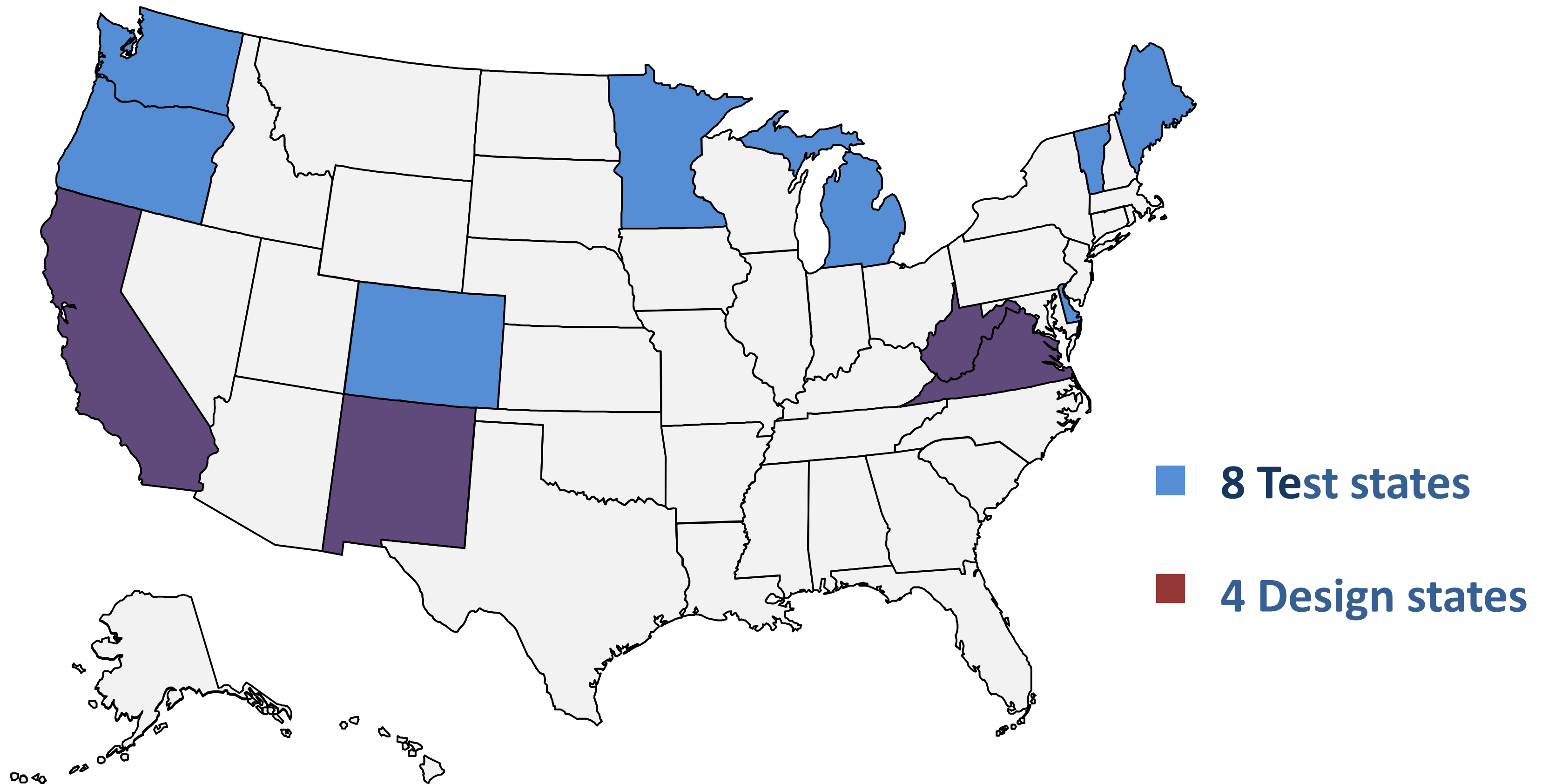
- CMS is testing the ability of **state governments to utilize policy and regulatory levers** to accelerate health care transformation

- Primary objectives include
  - Improving the **quality of care** delivered
  - Improving **population health**
  - Increasing **cost efficiency** and expand **value-based payment**



- Six round 1 model **test states**
- Eleven round 2 model **test states**
- Twenty one round 2 model **design states**

SIM States Engaging in Accountable Health Communities-like Programs



Important Accountable Health Community Model Web Links

For important updates and more information on the Accountable Health Communities Model visit:

https://innovation.cms.gov/initiatives/ahcm

For assistance with www.grants.gov,

contact support@grants.gov or 1-800-518-4726

Community PARTNERS®

Accelerating ideas into action
to advance the public good.

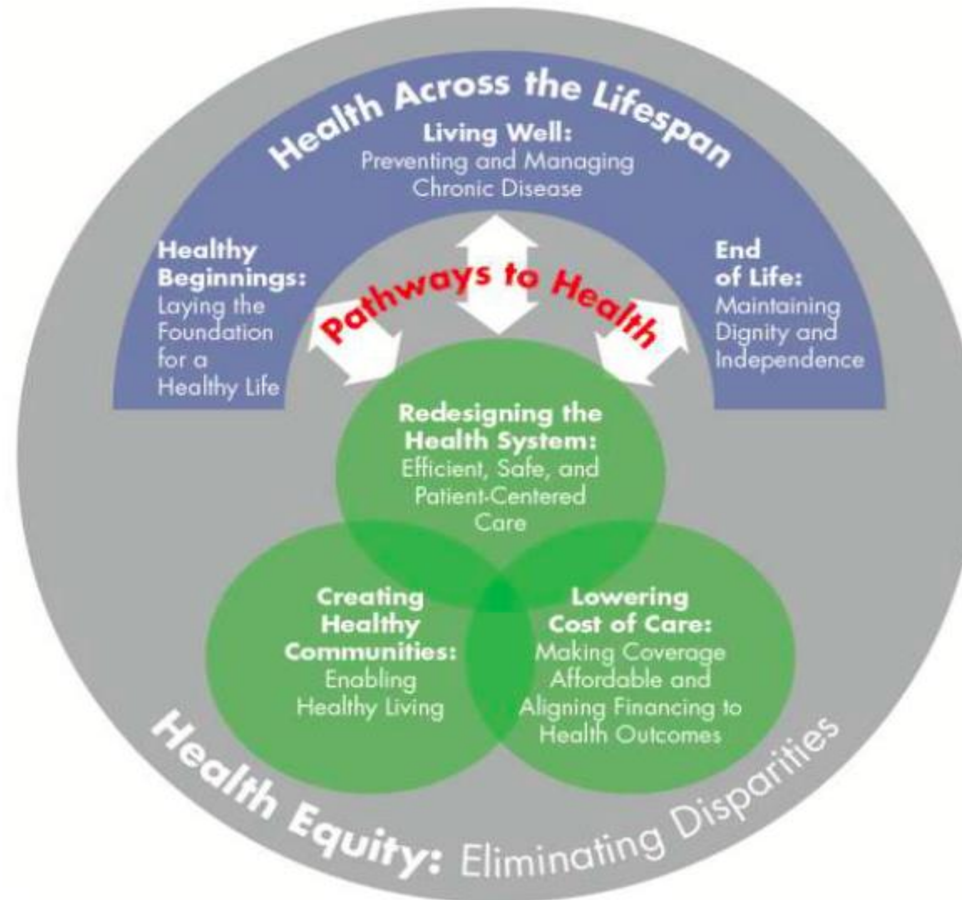
California Accountable Communities for Health Initiative

GIH Webinar

September 30, 2016

Barbara Masters
Project Director

Let's Get Healthy California Task Force December 2012



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California State Health Care Innovation Plan

The California Innovation Plan includes four initiatives and six building blocks, which are collectively designed to achieve savings within three years, as well as to catalyze longer term transformations of the health care delivery system. The Innovation Plan brings together leadership from California's public and private sectors to work together to implement these initiatives and building blocks.

The Innovation Plan has three overarching goals designed to advance the Triple Aim:

1. Reduce health care expenditures regionally and statewide.
2. Increase value-based contracts that reward performance and reduce pure fee-for-service reimbursement.
3. Demonstrate significant progress on the Let's Get Healthy California dashboard.

TRIPLE AIM

Lower Costs	Better Health Care	Better Health

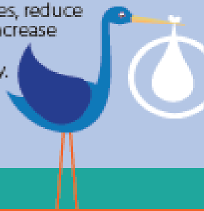
Let's Get Healthy California (LGHC) is the foundation for the Innovation Plan. LGHC identifies six goals to create health and achieve greater health equity: Healthy Beginnings, Living Well, End of Life, Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care.

INITIATIVES

MATERNITY CARE

ISSUE C-sections are more costly than vaginal deliveries and can lead to adverse maternal outcomes. C-sections have increased from 22% to 33% from 1998-2008.

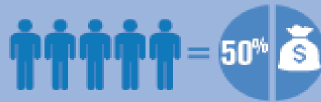
GOAL Reduce elective early deliveries, reduce C-sections, increase Vaginal Birth After Delivery.



HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS (HHPCN)

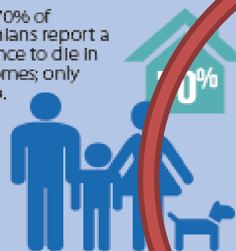
ISSUE 14 million CA adults have 1 or more chronic conditions. 5% of CA population accounts for over 50% of health care expenditures.

GOAL Expand HHCP model to provide high-risk patients with better coordinated care.



PALLIATIVE CARE

ISSUE 70% of Californians report a preference to die in their homes; only 32% do.



GOAL Better align care with patient preferences with new benefits and payment approaches.

ACCOUNTABLE COMMUNITIES FOR HEALTH (ACH)

ISSUE More than 75% of health care costs are due to chronic diseases, which are highly preventable, and in which significant racial and ethnic disparities exist.

GOAL Pilot ACCs to improve the health of the entire community by linking community prevention activities with health care.

California Accountable Communities for Health Initiative

Blue Shield of California Foundation is an independent licensee of the Blue Shield Association

Accelerating ideas into action to advance the public good.

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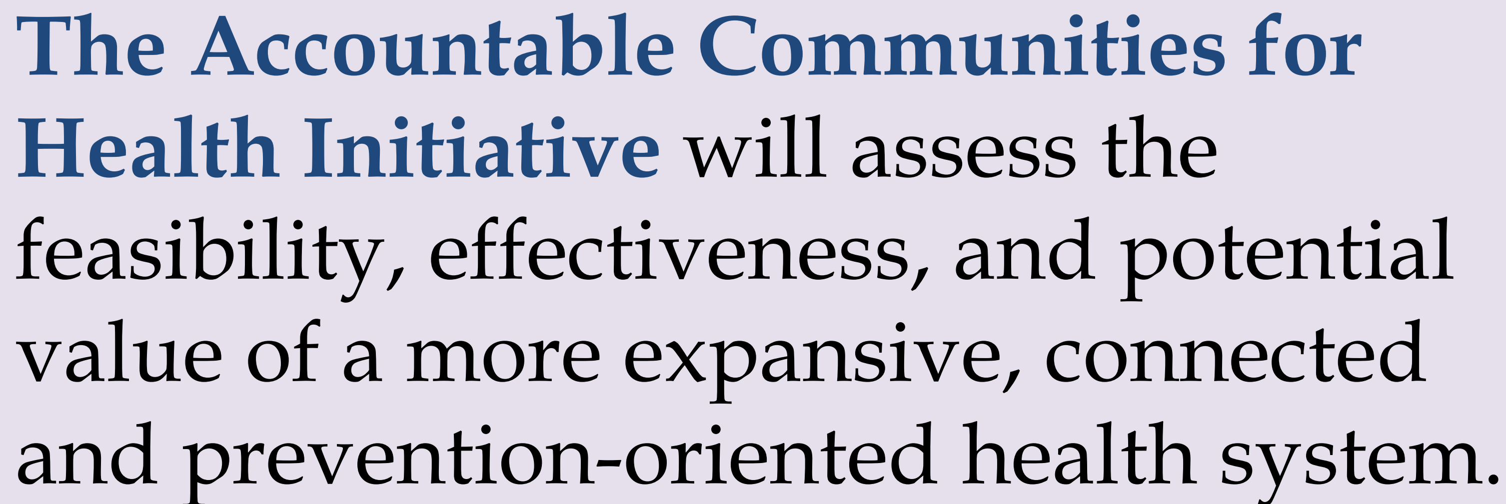
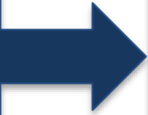
California Accountable Communities for Health Initiative



- What is the impact of implementing a portfolio of interventions?
- What are structural and programmatic elements of successful models?
- What strategies can help sustain and spread the model?

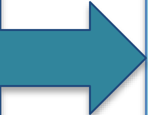
Initiative OVERVIEW

Initiative



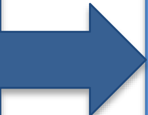
- Grants
- Research
- TA & Peer Learning
- Evaluation

Funding



- Six grantees
- $250,000 for first year, up to $300,000 years two & three

RFP



- Balance definitional elements with local flexibility
- High level of readiness and geographic diversity

Link

- Other national efforts to accelerate learning about what works

Definitional Elements of an ACH

Shared vision and goals

Partner-ships

Leadership

Backbone organi-zation

Data analytics and sharing capacity

Wellness Fund

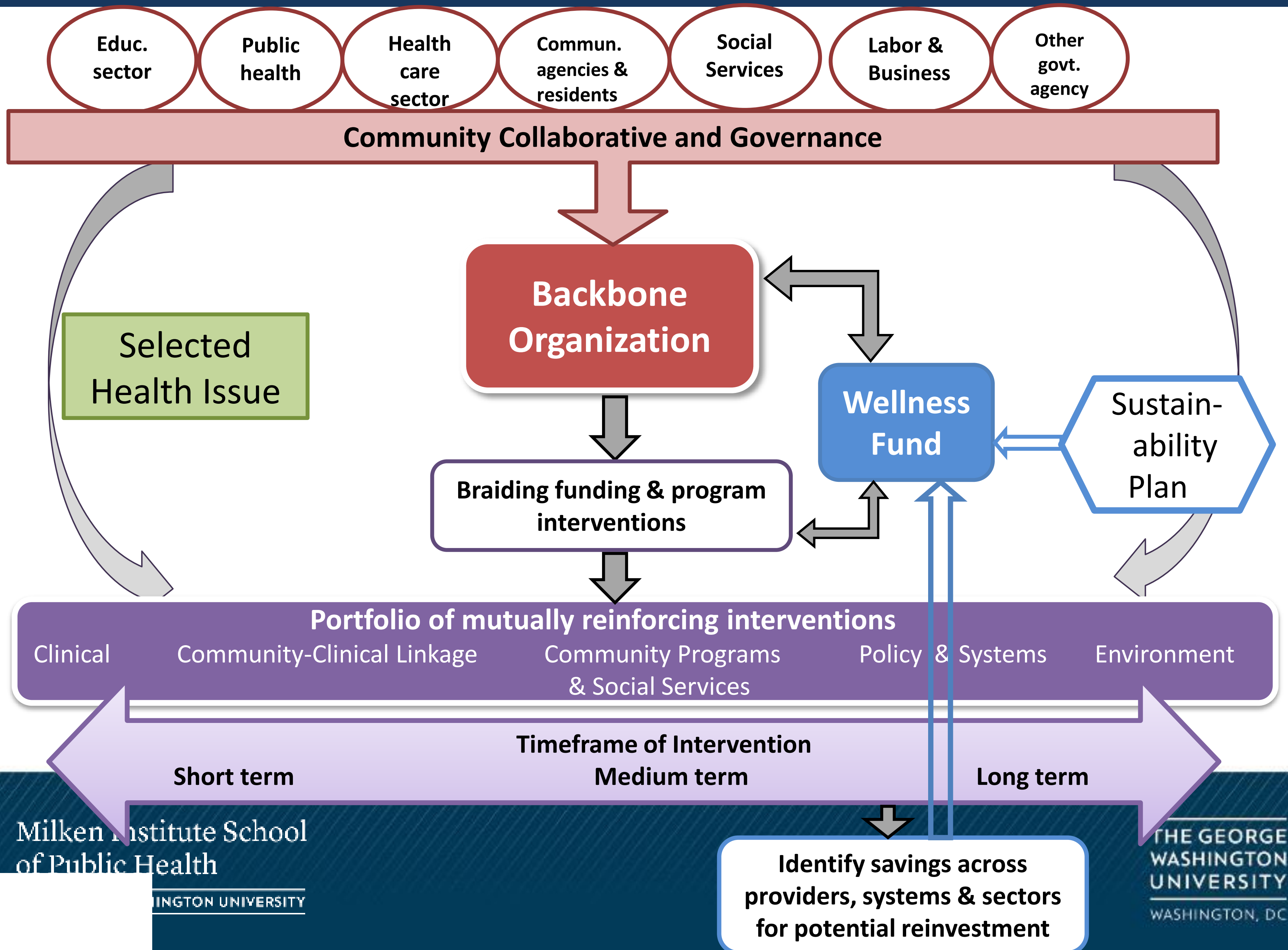
Portfolio of inter-ventions

Definitional Elements

Portfolio of interventions

	Intervention/Program	Time Frame (e.g. short, med, long)
Clinical services		
Community programs & resources		
Clinical-Community Linkages		
Public Policy & Systems Changes		
Environmental Changes		

Accountable Communities for Health



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Selected Health Issue *Examples*

Health Need	Chronic Condition	Community Condition	Set of Conditions
• Tobacco Use • Obesity	• Diabetes • Asthma • Depression	• Community and Family Violence • Lead	• Cardiovascular disease + diabetes • Air quality + asthma • Diabetes + depression

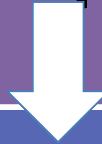
CRITERIA for Issue selection:

- Amenable to having interventions, which are evidence-based to the greatest extent possible, across the five domains, and
- Inclusive of a variety of populations within a community, not just high need, high cost populations

CACHI RFP and Review Process

Process

44 Proposals



10 Finalists
for Site Visits

6 Grantees

Selection Process: Cohort Approach

- No single ACH model
- Each community's ACH is structured in response to its history of collaboration, the health care structure and market, and other dynamics
- Cohort reflects a range of variables to test different approaches in different circumstances

County*	Backbone	Issue	Type of Community
Imperial County	Public Health Department	Asthma	Rural
Merced County	Public Health Department	Cardiovascular disease, diabetes & related depression	Rural/Small City
San Diego County	Non Profit/University	Cardiovascular disease	Large Urban
San Joaquin County	Hospital	Trauma	Small-Med City
Santa Clara County	Public Health Department	Violence prevention	Large Urban
Sonoma County	Health Department	Cardiovascular disease	Small City

*Each ACH will focus on a particular community of between 100,000 and 200,000 residents

Preliminary Observations from RFP Process

Vision

- Strong vision for health equity and population health that predated the ACH RFP
- CACHI represents a path to achieving the vision, rather than a funding opportunity

Collabora-tive Process

- Developed the proposal through a collaborative process, rather than solely by the applicant

Community/Resident Engagement

- Site visits included grassroots organizations and residents in a visible role
- Recognition of importance of and commitment to community engagement to achieve their goals

Preliminary Observations—Cont.

Portfolio of Interventions	• Many interventions already underway but they are not connected • More intentionality about identifying and promoting linkages and interrelationships between them.
Governance arrangements	• Bringing together various collaborations adds a level complexity to the emerging governance arrangements; for most grantees, identification and/or governance of Wellness Fund remains to be determined.
Data Analytics & Capacity	• An area of significant needs, although several grantees have sound foundational capacities.
Level of Engagement from Health Care Sector	• Health care sector (hospitals, clinics and/or health plans) present in all ACHs, but deeper engagement will be needed going forward.