# THE ACCOUNTABLE HEALTH COMMUNITIES OPPORTUNITY: JUMPSTART YOUR SOCIAL NEEDS STRATEGY

FOLEY
FOLEY & LARDNER LLP

Health Leads



## Today's Agenda

- Introduction—Michael L. Blau, Esq.
- Accountable Health Communities: What it is, why it matters, and how we got here
- What it takes to do this work well & case studies
  - Key elements of successful social needs strategies
  - Technology considerations
- Q&A

# What Determines Health?

(adapted from McGinnis et al., 2002)

| Genetics | Healthcare | Social, Environmental, Behavioral Factors |
|---|---|---|
| 20% | 20% | 60% |

CHA CONNECTICUT HOSPITAL ASSOCIATION



# Health Leads

**Health Leads**

envisions a healthcare system that

**addresses all patients' basic resource needs**

as a standard part of quality care


## Today's Speakers

**Rocco Perla, Health Leads President,** former senior official at the Centers for Medicare & Medicaid Services (CMS)

**Lea Tompsett, Health Leads Principal of Learning Networks,** leads the organization's work to empower providers through learning networks

**Zach Goldstein, Health Leads Principal of Innovation,** led design of Health Leads' REACH technology platform



## CMS Innovation Center

The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles.

*- The Affordable Care Act*

# Innovation Center Models
## *Over 40!*

- **Accountable Care Organizations**
  - Pioneer
  - Medicare shared savings
  - Advanced payment
  - Next generation ACO
- **Primary Care Transformation**
  - Comprehensive primary care initiative
  - Multi-payer advanced primary care demo
  - Independence at home
  - Home health value-based purchasing
- **Bundled Payments**
  - Episode-based
  - Oncology care model
  - Joint replacement
- **Medicaid-focused models**
  - Strong start
  - Medicaid innovation accelerator program



# CMS Accountable Health Communities (AHC)

"The AHC model addresses a critical gap between clinical care & community services . . . by testing whether systematically identifying & addressing the health-related social needs of beneficiaries **impacts total health care costs, improves health, & quality of care."**

CMS.gov
Centers for Medicare & Medicaid Services

- AHC: $157 million/5 years; up to 44 awardees
- Risks: relatively small $$, implementation restrictions, reinventing wheel, adverse selection among providers
- CMS leadership: an "historical" model

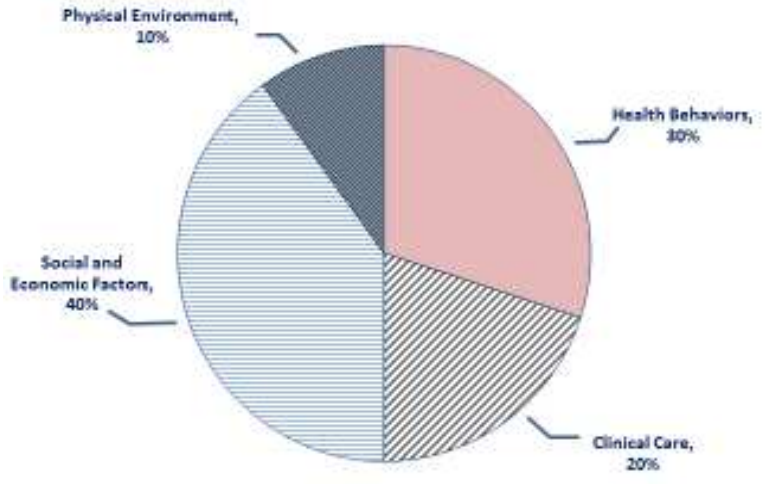
# Why Is This Historic?

The Accountable Health Communities (AHC) Model is the….

- First attempt **EVER** to test social needs as an explicit part of healthcare delivery on a national scale.
- First attempt **EVER** to test a payment model for addressing unmet social needs in healthcare.
- First attempt **EVER** to redefine what counts as healthcare by a major U.S. payer of healthcare services.



# Modifiable Factors That Influence Health




Source: U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services Center for Medicare & Medicaid Innovation – Affordable Care Act Funding Opportunity Announcement: Accountable Health Communities

# Unmet Resource Needs Yield Poor Health, Inefficient Utilization

BMJ Quality & Safety
The international journal of healthcare improvement

| | Patients who report an unmet need % (n=416) | Patients who do not report a need % (n=2750) |
|---|---|---|
| Chronic conditions | | |
| Depression | 17.8 | 9.5 |
| Hypertension | 54.3 | 46.3 |
| Cerebrovascular disease | 7.7 | 6.8 |
| Chronic kidney disease | 7.9 | 6.0 |
| Coronary artery disease | 16.4 | 14.6 |
| Diabetes | 32.7 | 20.4 |
| Health service use | | |
| High emergency department use (>2 in calendar year 2013) | 11.3 | 5.4 |
| High 'no-shows' to clinic appointments (>1 in calendar year 2013) | 21.6 | 11.9 |
| Chronic disease management | | |
| LDL cholesterol >100 mg/dL* | 41.8 | 27.5 |
| Haemoglobin A1c >8.0%† | 37.7 | 27.3 |
| Haemoglobin A1c >9.0%† | 22.4 | 12.1 |

Source: Berkowitz, S.A. et al. 30 November 2015 British Medical Journal Quality and Safety: "Addressing Basic Resource Needs to Improve Primary Care Quality: A Community Collaboration Programme."



# The Challenge

- Incentives alone will not work
- Delivery systems need to develop capability and infrastructure to effectively incorporate a social need program…

## Case Study: CMS Chronic Care Management Fee

"The CMS reported that about 35 million Medicare beneficiaries are eligible to receive these billable care-management services. But the agency has received reimbursement requests for only about 100,000."

Modern Healthcare, Oct 17, 2015

# Leadership and Change

**Reframe organizational definitions of health & care** → **Develop capabilities & infrastructure**

*Systematically acknowledge & surface social co-morbidities*

*Clinically-integrated programs that address social co-morbidities*



# Critical Program Elements

**Patient Identification & Screening**
Identify your target patient population and surface their most critical needs

**Workforce**
Create an approach to workforce development, including planning, training and management

**Resource Directory**
Compile and maintain high quality resources that best meet your patients' needs

**Workflow**
Outline roles, processes, and systems to seamlessly integrate into clinic workflow

**Impact Measurement**
Define the results you want to see and how to collect and analyze data to track progress

**Leadership & Change**
Understand and address stakeholder needs to drive adoption and enable success

Prepare → Implement → Improve & Expand

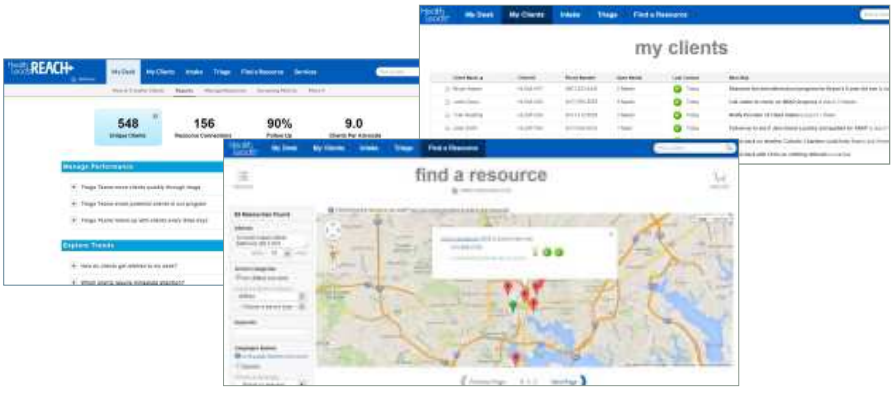
## Case Study: The Dimock Center

- Federally Qualified Health Center in Boston, MA
- Critical goals for social needs program:
  - Improve impact of limited resources
  - Track impact to maintain & expand funding

THE DIMOCK CENTER
Healing and caring for the community for over 150 years.



## Case Study: The Dimock Center




How to track impact to (eventually) enable reimbursement?

How to maximize impact of limited resources?

## Tech: Critical Enabler of Success

Reduce Data Entry

Scale Your Program

Quality Improvement

Care Coordination

Better Outcomes at Lower Cost



## Required Features

To successfully address social needs, your
**Social Needs tech solution should have these features:**

Screening Forms

Community Referral Tracking

Care Plan for Social Needs

Social Need Analytics

Common standards for *storing* and *exchanging* social need data

# Required Features

**Screening Forms**
- Screening questionnaires
- Multi-language support
- Demographic elements
- Intervention status tracking

**Community Referral**
- Resource directory
- Resource referral tracking
- CBO tracking of utilization

**Care Plan for Social Needs**
- Social needs on problem list
- Action plan
- Recent communications
- Outcomes tracking

**Social Need Analytics**
- Program performance
- Workforce management

**Store & Exchange Data**
- Between CMS, bridge organizations, clinical site, community at large



# Case Study: Kaiser Community Resource Hub

KAISER PERMANENTE® + Health Leads

Launched **first social needs call center** in the country

Proactive screening for **top 1% of predicted high utilizers**

# For Additional Detail

For more insight into the resources, approach and technology to design a successful social needs strategy, Health Leads is hosting three new online educational workshops:

**Design a Strong Program and Funding Application – Accountable Health Communities Workshop**

**Select Your Social Needs Tech Platform – REACH Webinar**

**Build a Sustainable Social Needs Strategy – Prepare Workshop**

More information available at:
www.healthleadsusa.org