ACO
ACCOUNTABLE CARE ORGANIZATION
LEARNING NETWORK

Fifth Annual National ACO Summit

June 18-20, 2014

Follow us on Twitter at @ACO_LN and use #ACOsummit

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute

THE FIFTH NATIONAL

Accountable Care Organization Summit

The Leading Forum on Accountable Care Organizations and Related Delivery System and Payment Reform

Track Twelve: Community-Based Accountable Care Arrangements

Keynote

Janet Corrigan, PhD, MBA
Distinguished Fellow, Dartmouth Institute for Health Policy and Clinical Practice

ACCOUNTABLE HEALTH COMMUNITIES: TAKING SHAPE

Janet M. Corrigan, PhD
Distinguished Fellow
The Dartmouth Institute

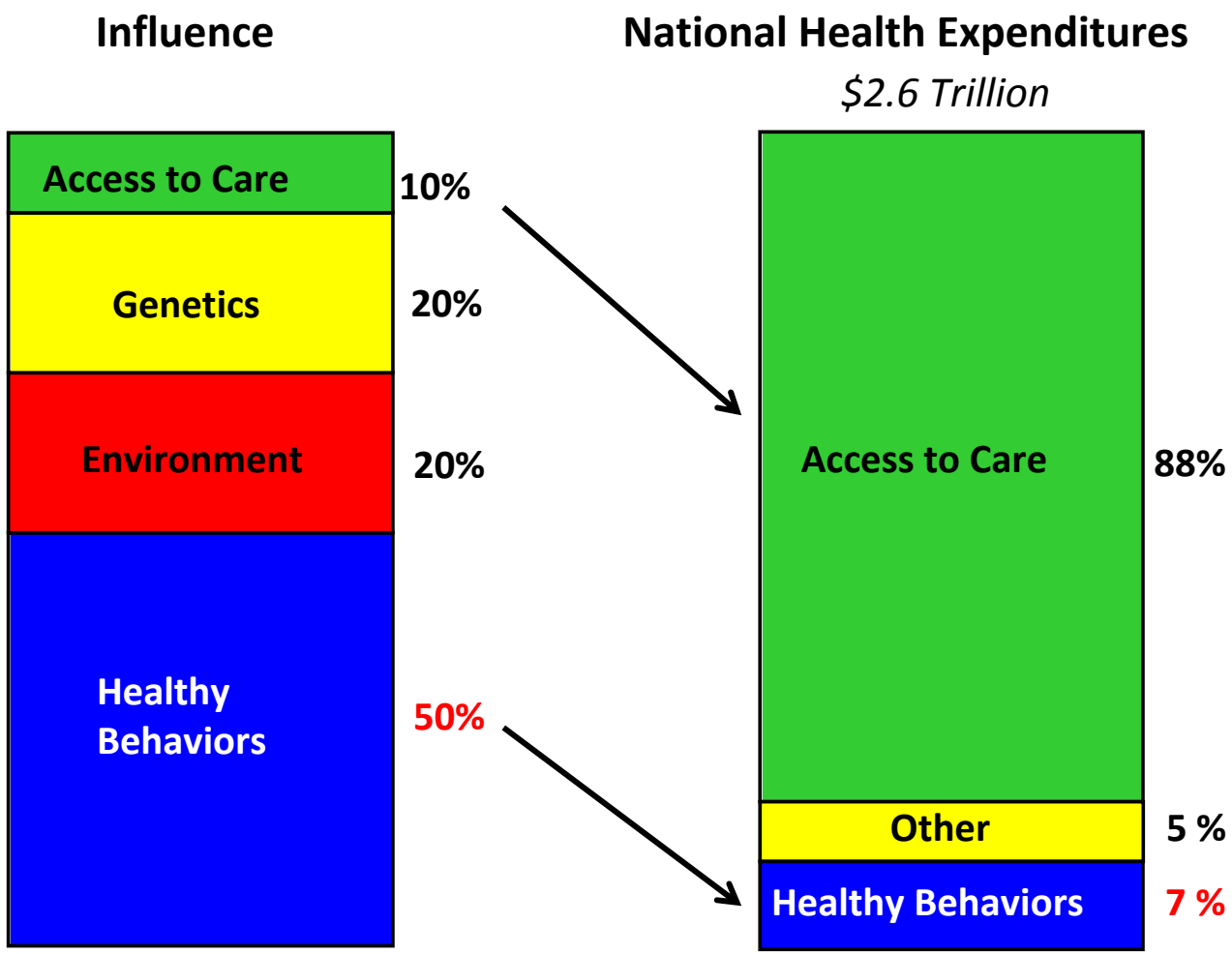
Session Objectives

- Rationale for establishing Accountable Health Communities (AHC)
- Key characteristics of an AHC
- Examples of how states and regions are operationalizing the AHC concept

Information sources:

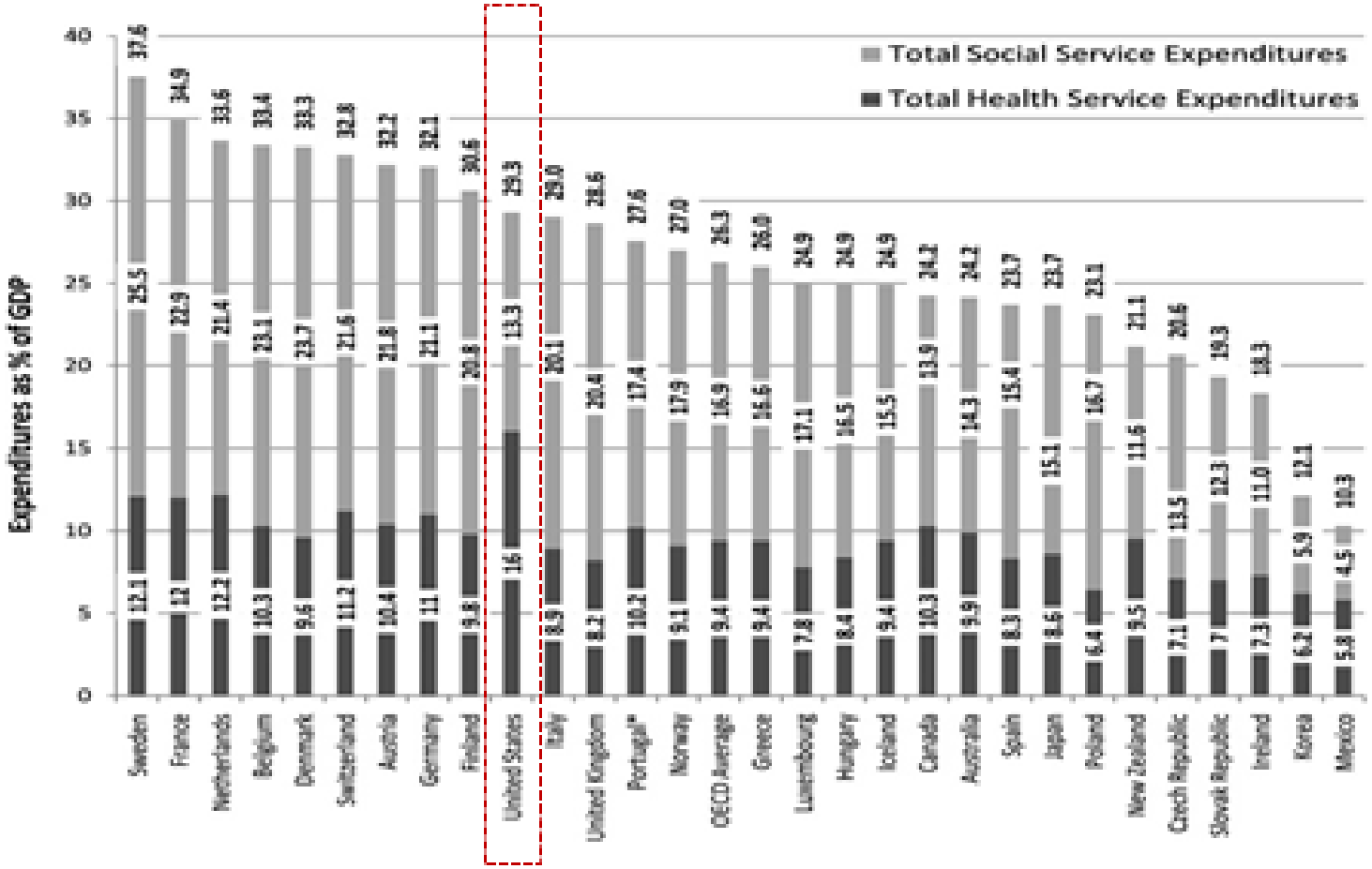
- 3-state review (questionnaire and interviews) conducted by Corrigan and Fisher
- Profiles of 8 states developed by NASHP

Health Status and National Health Expenditures



Source: NEHI and UCSF

Health-service and social-services expenditures for OECD countries, 2005, as % GDP



BMJ Qual Saf 2011;20:826e851.

Underinvestment in Social Services

- Ratio of social service spending to medical care spending
  - European countries 2.0
  - U.S. 0.9

(Bradley, 2011)

- 25% of hospital admissions and 60% of ED visits avoidable if there were adequate community-based services

(MedPAC, 2012)

Underinvestment in Social & Environmental Determinants

- Currently spend $238B per year to treat 4 largely preventable chronic conditions (Type 2 diabetes, hypertension, heart dx, stroke)
- $1 invested in community-based public health saves $5.60 within 5 years.....
  - early childhood education and school health saves $13
  - biking/walking paths saves $11.80
  - food and nutrition programs saves $10
  - tobacco cessation programs saves $1.26
  - fluorinated water saves $40

Source: RWJF Policy Highlight Brief, Dec 2013; Trust for America's Health

Potential Investment Opportunity

- Health Dividend -- $750 – 765 B (IOM,2009)

- Investment Strategy will vary by State and county (adapted from Kindig, 2014):

States		Kentucky	Utah
Smokers	28.3%		10.6%

Maryland	Baltimore	Howard
Smokers	24%	8%
Alcohol-impaired driving	29%	37%

Accountable Health Community

- Kindig (1998) -- Health Outcomes Trust
- Rippel Foundation (2008) -- ReThink Health
- Austin BioInnovation Institute (2012) -- Accountable Care Community
- Magnan and Fisher (2012) -- Accountable Health Community
- Shortell (2013) -- Community Health Management System Board

Key Characteristics of AHCs

- Multi-stakeholder, backbone organization

- Wide-angle vision and mission grounded in local needs

- Collective Impact (Kania and Kramer, FSG, 2011)
  - Common agenda
  - Shared measurement
  - Mutually reinforcing activities
  - Communication mechanisms

- Balanced Investment Strategy
  - Maximizes contributions of full set of health determinants
  - Balances near- and long-term health returns
  - Strives for equitable distribution of both health and cost burden

SIM States: Hotbeds of AHC Innovation

- CMMI State Innovations Model (SIM) -- $300M to 25 states to implement models for multi-payer payment and health care delivery system transformation
- 3 Stages – design, pre-testing and testing
- Complex plans; works in progress
- Examples of states that have reform strategies with roles for communities: California, Colorado, Minnesota, Oregon, Vermont

Converging Pathways to AHCs

- Community Benefit
- Wellness Trusts
- Coordinated Networks of Community-based Services
- Health Systems/ACOs with Community Partnerships
- Geographically-Defined Global Budgets
- Cross-Sector *Collective Impact* Strategies

Community Benefit

- 10% of hospital operating revenues; small proportion for community health improvement, but may increase

- Shift from institutional model to geographic model

- Examples:

– Atlanta, GA (ARCHI): coordinated approach to needs assessment and improvement plan
– Akron, OH (Austin BioInnovation): coordinated approach to investing CB resources in social supports including reinvestment of hospital savings
– Dignity Health: provide low interest rate loans to non-profits focused on social determinants (e.g., day care, job training)

- Considerations:

- Advantages of pooling CB resources.
- Approaches to leveraging CB dollars
- Scaling promising innovations; is there a role for fed'l or state regulations?

Wellness Trust

- Resources for population health improvement
- Numerous state-level trusts with resources derived from tobacco tax, non-profit conversion funds, special assessments
- Example:
  - California (2014): state provides AHCs with seed money for local wellness trust; LT funding to come from investment of health care savings
- Considerations:
  - Sources of state funding (Medicaid dollars- 1115 waivers; assessment on insurers)
  - Should there be required matching funds from communities?

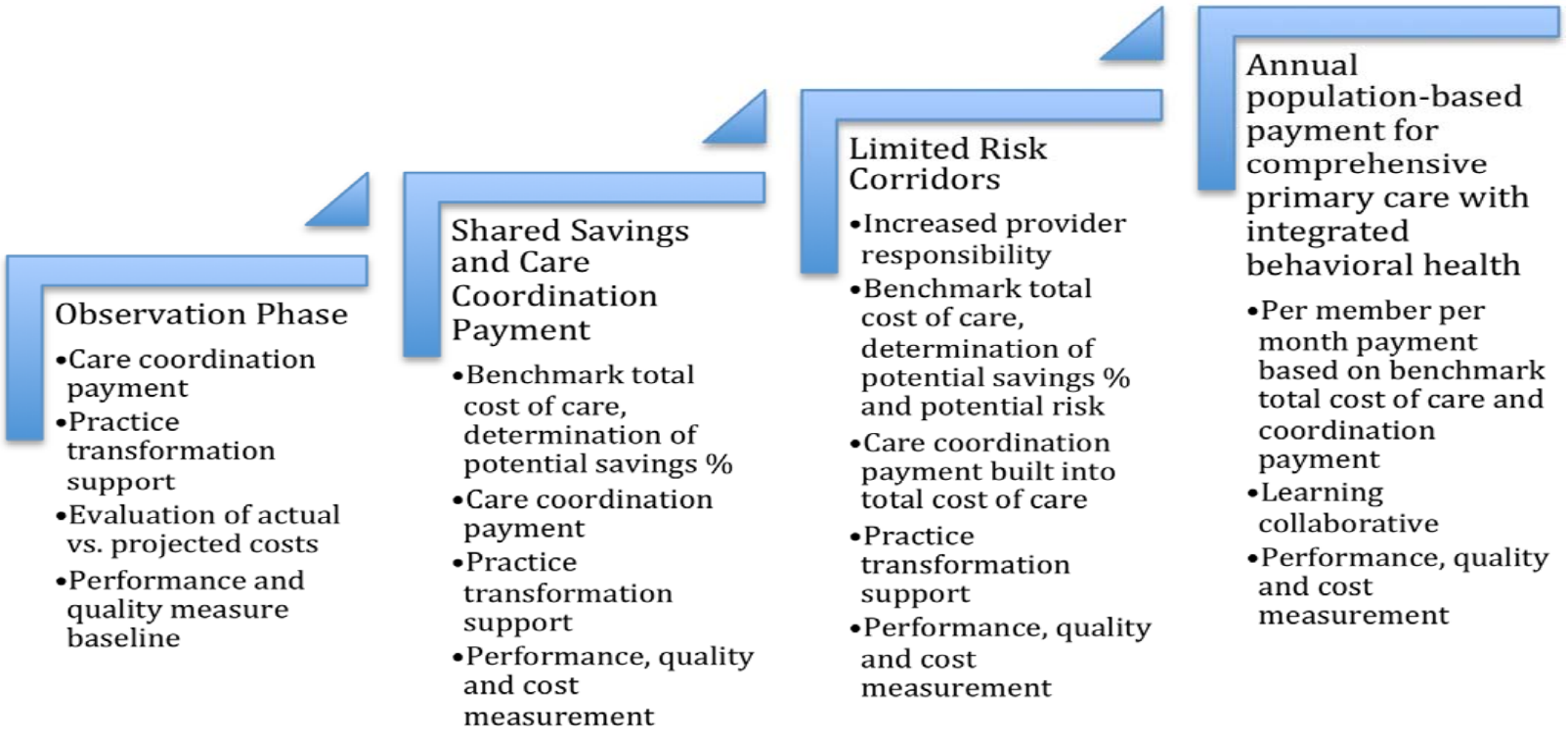
Network of Community-based Services

- Necessary organizational capabilities:
  - Organized systems: primary care, behavioral health and social supports
  - Team-based care focused on the frail and cognitively impaired, complex chronic conditions and behavioral health issues

- Examples:
  - North Carolina -- 14 regional community care networks
  - Vermont – Medical Homes; Community Health Teams; Support and Services at Home (SASH)
  - Colorado -- 7 Regional Collaborative Care Organizations, Medical Homes

- Considerations:
  - Requires significant infrastructure (HIT, performance measurement)
  - Access to capital
  - May over time assume financial risk

Colorado: Payment Glide Path for Medical Homes



Source: Draft SHIP, 2013

Health Systems/ACOs with Community Partnerships

- Health systems/ACOs with population-based payments or shared savings tied to health outcomes and cost

- Examples:
  - Minnesota: RFP to designate 15 Accountable Communities for Health; must include ACO(s) and shared savings/risk with community partners
  - Maryland: all-payer, global budget for hospitals/health systems; partnerships with Local Health Improvement Coalitions

Considerations:

- Migration to integrated health systems with population-based payments is slow and uneven
- Should future federal ACO regs include community partnership requirements?
- Could this approach be pursue through voluntary negotiations and agreements?

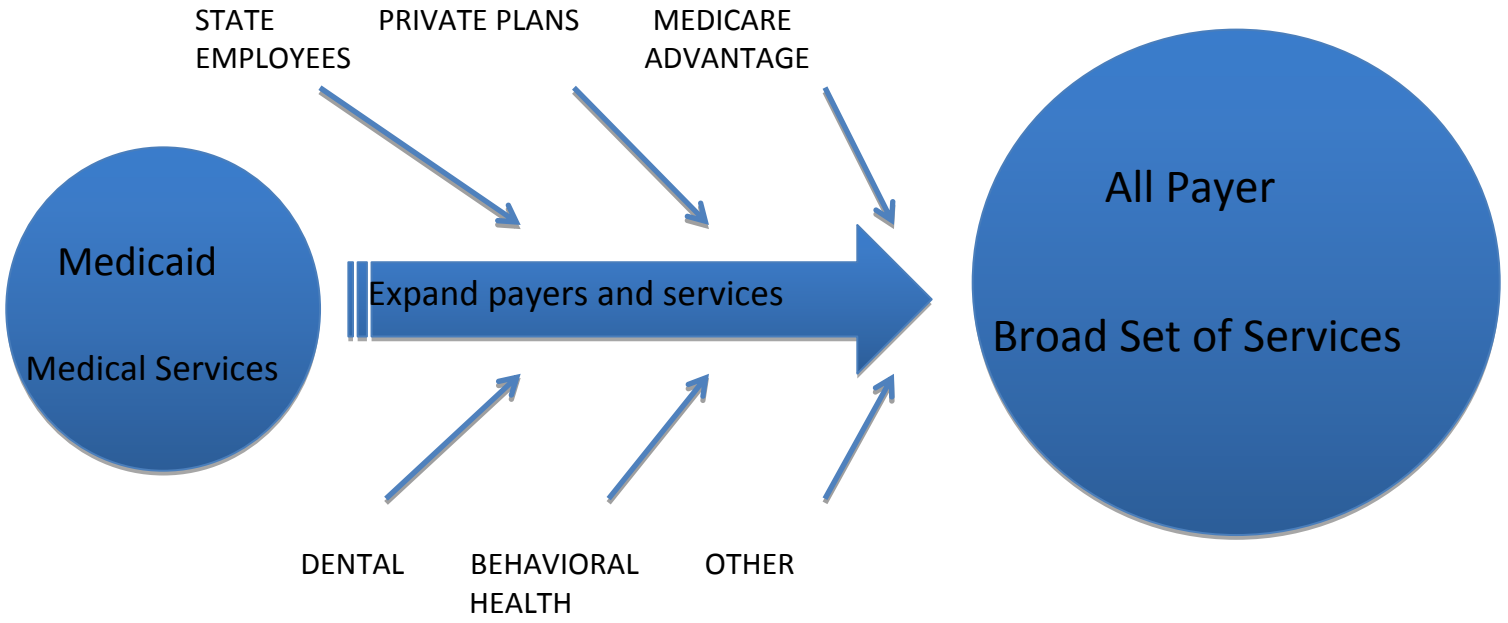
Geographically-Defined Global Budget

- Global health budget for a geographic region with local flexibility to pursue a balanced investment strategy

- Example:
  - Oregon: 16 regionally-defined Coordinated Care Organizations; moving toward global budget tied to sustainable rate of growth

- Considerations:
  - Market power and consumer choice
  - If set global budgets at current health care spending levels, hardwire waste into the system
  - Still need to reform underlying provider payment programs to align incentives
  - Must build community infrastructure to manage financial risk

Oregon: Glide Path To Broad Global Budget



Cross-Sector Collective Impact Strategies

- Collective Impact: (Kania and Kramer, FSG)
  - Multi-sector backbone organization with common agenda
  - Shared measurement
  - Mutually reinforcing activities
  - Communication

- Health in All Policies and Programs

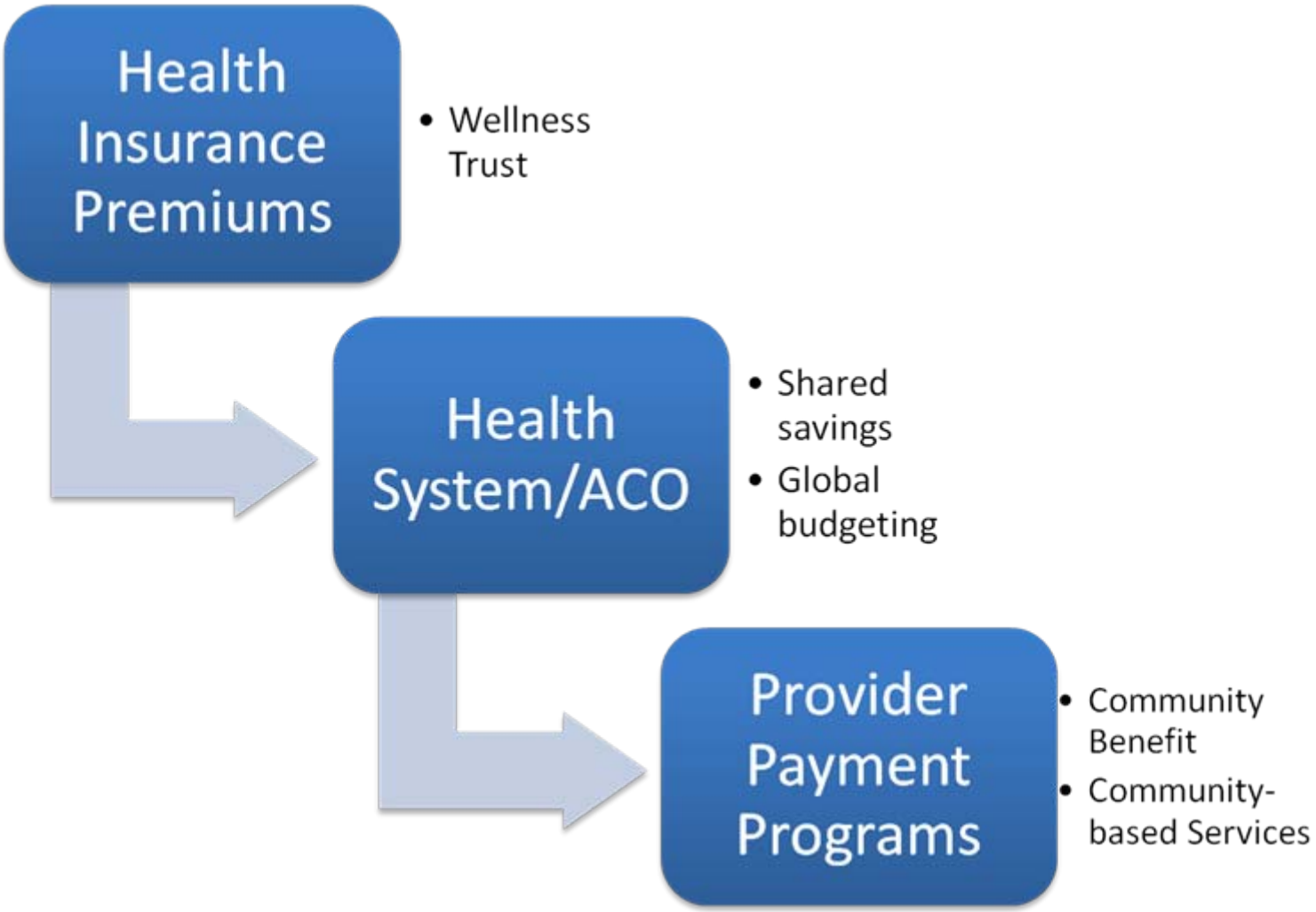
- Leverage Financial Investments
  - Other Sectors- housing, transportation, parks and recreation ….
  - Community Development Financial Institutions
  - Philanthropy

- Well-positioned to negotiate social impact bond agreements

Summary & Policy Considerations

- Care delivery is local, financing is not. Federal and state governments must create enabling environment.
- New organizational structures at community- level or build on existing?
- Different strategies for tapping into health care dollars.
- Logical ordering of activities, but regions pursuing different pathways.
- Integration of health care and social supports: health system- driven versus independent community networks.
- Upstream investments in a “healthy community” may or may not be tied to health care savings.

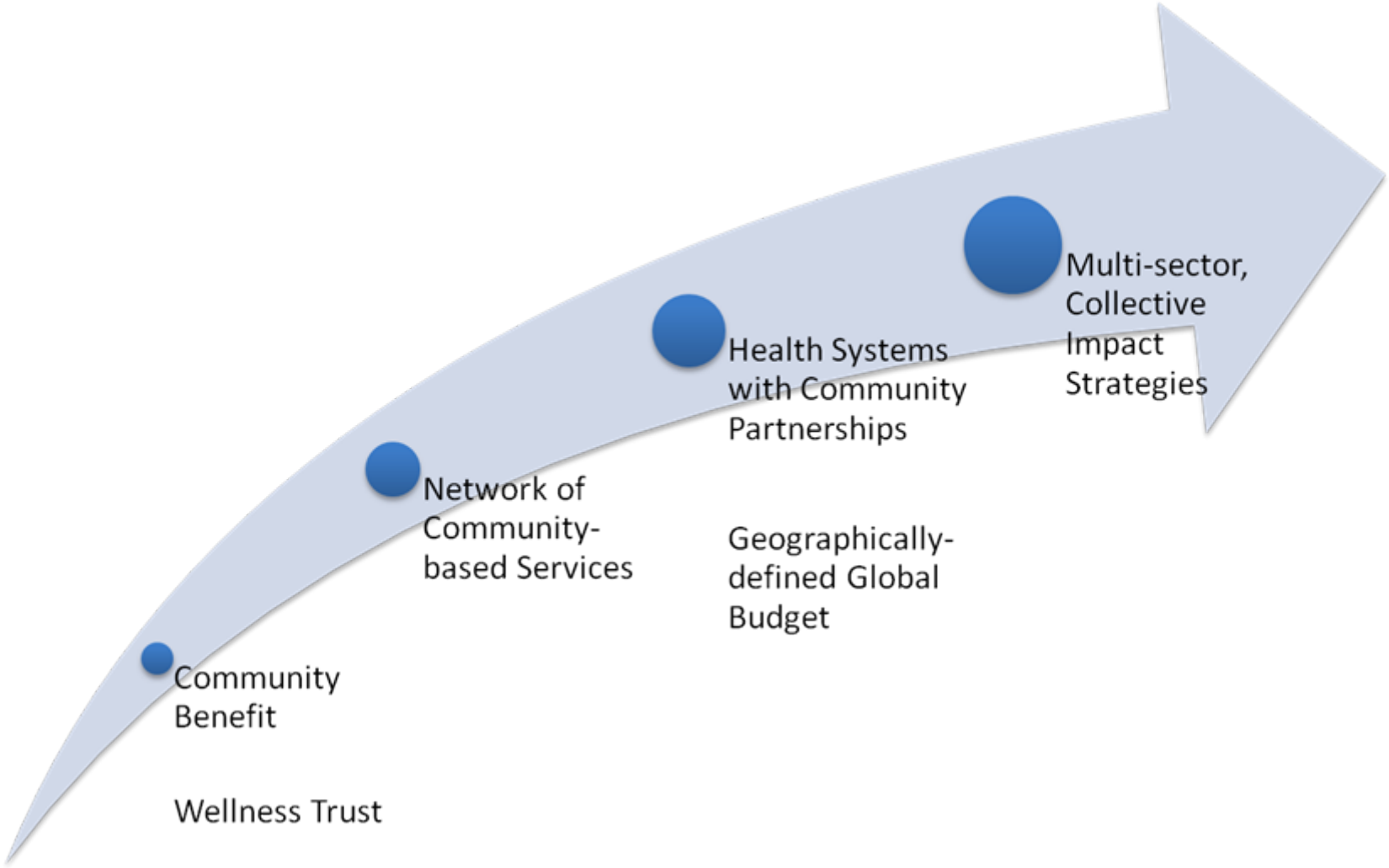
Leverage Points for Tapping into the Health Care Pipeline



Summary & Policy Considerations

- Care delivery is local, financing is not. Federal and state governments must create enabling environment.
- New organizational structures at community- level or build on existing?
- Different strategies for tapping into health care dollars.
- Logical ordering of activities, but regions pursuing different pathways.
- Integration of health care and social supports: health system- driven versus independent community networks.
- Upstream investments in a “healthy community” may or may not be tied to health care savings.

Logical Ordering, but Non-Linear Paths



Summary & Policy Considerations

- Care delivery is local, financing is not. Federal and state governments must create enabling environment.
- New organizational structures at community- level or build on existing?
- Different strategies for tapping into health care dollars.
- Logical ordering of activities, but regions pursuing different pathways.
- Integration of health care and social supports: health system- driven versus independent community networks.
- Upstream investments in a “healthy community” may or may not be tied to health care savings.

Acknowledgment:

Supported in part by the Frontiers in Sustainable Financing and Stewardship Project of the Fannie E. Rippel Foundation and The Robert Wood Johnson Foundation

THE FIFTH NATIONAL Accountable Care Organization Summit

The Leading Forum on Accountable Care Organizations and Related Delivery System and Payment Reform

Track Twelve: Community-Based Accountable Care Arrangements

Susan E. Birch MBA, BSN, RN
Executive Director, Colorado Department of Health Care Policy & Financing

Jennifer DeCubellis, LPC
Assistant County Administrator for Health, Hennepin Health

George Kerwin
President and Chief Executive Officer, Bellin Health

Elliott S. Fisher, MD, MPH
Director, The Dartmouth Institute for Health Policy and Clinical Practice

ACO
ACCOUNTABLE CARE ORGANIZATION
LEARNING NETWORK

Fifth Annual National ACO Summit

June 18-20, 2014

Follow us on Twitter at @ACO_LN and use #ACOsummit

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute