IssueBrief

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Connected, accountable and coordinated: Whole-person, whole-community care

It *sounds* so basic: In a true accountable community, individuals have access to affordable high-quality health care and to the support, resources and information they need to take charge of their health. An accountable community fosters collaboration and cooperation across the community and connects existing resources; it doesn't build new platforms and silos.

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Easy to say, but getting to there from here is a challenge. So is accurately describing an accountable community. In fact, Kathryn Jantz, senior consultant with The Steadman Group, has serious misgivings about the commonly used term "accountable care community." Focusing on "care" can be misguided. "We need to start changing the question and the dialogue—the question we should be asking is not about 'care,' it's about 'health'—accountable health communities. When we start with a question about 'care,' we usually end with an answer that involves health care. However, when we start with a question about 'health,' we end with an answer related to community and community services."

When Jantz—who previously served as Accountable Care Collaborative strategy lead at the Colorado Department of Health Care Policy & Financing—talks about an accountable community or accountable health community, she means a model where clinical sites and the broader community partner to improve the overall health of all residents of an area. Similar terms are used for models in which care is the focus but for her, health needs to be the focus. "This seemingly minor shift results in fundamentally different values, priorities and activities."

An accountable community encompasses the broader community, says Kavita Patel, MD, fellow and managing director at the Brookings Institution, and a practicing primary care physician at Johns Hopkins Medicine. It includes public and private entities, community and clinical services. And, both she and Jantz stress, it focuses on the recipients of those services.

But beyond breaking down—or at least bridging—those silos, what else

constitutes an accountable community? Patel and Jantz offered the following five characteristics. An accountable community

1. **Acknowledges all sectors of the community.** Health, education, employment must all get similar consideration, Patel explains. Both she and Jantz emphasize that.

2. **Has a strong infrastructure, including governance.** The partners must include people who have autonomy and the capacity to engage: those who are decision-makers or who are empowered by the decision-makers in their respective communities. This involves clear roles and responsibilities, Jantz says. "We need to clearly delineate who is responsible for what activities, and support the old and still-much-needed activities as much as the new."

3. **Engages major stakeholders.** A community effort doesn't work if one clinic is highly motivated and no one else is, Patel says. All participants, including the clinicians, need to buy in. Jantz emphasizes that stakeholders without the same level of funding as clinical providers must have equal footing.

4. **Ensures sustainability.** Funding is essential, but a truly accountable community has a feasibility plan that goes beyond initial funding. People make plans and hope they can get a grant for them, says Patel. Not everyone gets the grant, and even if they do, it won't last forever. There are, she says, too many examples of organizations that received a one-time infusion of funds, but lacked alignment with payers. They didn't last.

The future in Western Colorado

As evidenced by the RCCOs, the community is making progress. And Rocky Mountain Health Plans also intends to take part in a national five-year test of accountable health communities. For the first time, Centers for Medicare & Medicaid Services Innovation Center has created a program—the Accountable Health Communities Model—to address social determinants of health. The goal: Make beneficiaries struggling with unmet health-related social needs aware of the community-based services available to them and receive assistance in accessing those services. Slated for a fall 2016 launch, it will focus on the health-related social needs of Medicare and Medicaid beneficiaries, including building alignment between clinical and community-based services at the local level.

Moving forward

Continued success in the Western Slope, in Colorado—everywhere, actually—requires imagination, says Jantz. "We need to return to a state of prior innocence where we can imagine systems and communities that are different and better, and we can believe that we are the people who help our communities realize that vision." There is no single challenge, so there is no single remedy. "We face a sea of challenges. In the scramble for limited dollars, the anxiety around change, and general fatigue, Western Colorado will have to focus on the big picture—the 50-year vision—without getting drowned in the minutiae of today."

5. **Has a robust IT infrastructure.** Technology is a tool to facilitate established relationships, improve access, lower costs and allow for objective measurement. "You need a strong IT structure to support the sharing of information and rapid communication, and the development of reliable and comprehensive measures of success," says Jantz.

Those five characteristics are just the basics, the foundation of accountable health communities. Here's a look at some of what they do.

Accountable communities take social determinants seriously

Where and how people live and how they think affects their health. An accountable health community supports people where they are so they can thrive emotionally, mentally and spiritually, as well as physically.

It's all connected. Efforts to address those issues, especially those related to poverty, are often framed in terms of caring for the needy without considering how it will improve the community, Jantz says. But the economic security of the individuals in the community affects the health of the community. She points to a body of literature showing the association between population health and income inequality levels.[1,2] An even larger body of literature supports the idea that environmental and social factors are root causes of a host of health problems.[3,4]

"We might find that our existing delivery systems could more effectively and efficiently address social needs if more focus were placed on developing connected communities and less on coordinating among clinical care sites, or attempting to coordinate with social services that aren't there." She adds, you *can't* coordinate people among care sites that aren't there. "If the fundamental problem is inadequate housing, you can't coordinate your way to better housing."

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Accountable communities meet patients where they live

Meeting patients where they are means first understanding the patients' lives, says Patel. An accountable community looks at what gives rise to admissions, readmissions, illness, emergency department visits, etc. It takes into account the social determinants—housing, transportation, domestic violence, access to healthy food and other non-medical issues.

Providers often have limited insight into the lives of the patients most at risk. What's the *specific* reason they are in the hospital? What's a typical day like for them? "We need to understand their lives in a more detailed way," she says. It can't be done for everyone, which is why risk stratification is so important. That can involve sophisticated algorithms, but there's also a simple way to stratify, she adds. Ask yourself: Who's likely to be in the ED in the next year, and why?

Ideally, Patel says, stratification would be data-driven. But it's often difficult to extract the data needed from the EHR. That information doesn't come from the administrative and clinical data commonly available within most health systems. Instead, it comes from having a complete picture of the patient, created with information from multiple sources. What is each patient's current physical/social/emotional/financial status? Where

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[1] Wilkinson RG, Pickett KE."Income inequality and population health: a review and explanation of the evidence." *Soc Sci Med* 2006 Apr;62(7):1768-84. Epub 2005 Oct 13

[2] Kawachi I, Kennedy BP. "Health and social cohesion: why care about income inequality?" *BMJ.* 1997 Apr 5;314(7086):1037-40.

[3] Bachrach D, Pfister H, Wallis K, et al., "Addressing patients' social needs: an emerging business case for provider investment," Commonwealth Fund report, May 2014

[4] van Walraven C, "The Utility of Unplanned Early Hospital Readmissions as a Health Care Quality Indicator," *JAMA Intern Med.* 2015;175(11):1812-1814.

do they live? Where do they eat? Do they have transportation? What are their goals and what are the barriers to meeting them?

For Jantz, meeting patients where they are begins with *not* thinking of them as patients at all. "They are people." It gets back to her distinction between health and care. "Care" focuses on the entity providing the care, on fixes. "We need to recognize that diet, exercise, social network, all of these factors will have far greater impact than a pill." So meeting patients—people—where they are means involving them in their own health. "How do we support individuals in managing health? I'm not sure health *care* is the place for that."

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As an example of this happening outside the health care delivery system, she points to Denver's Re-vision; its mission is to work with people in economically marginalized neighborhoods to develop resident leaders, cultivate community food systems and create an economy owned by the community. That includes food co-ops and food gardens; and community workers, called "promotoras," teach nutrition courses, help families cultivate gardens and monitor the general well-being and health of the community.

Creating these systems requires the creation of new organizational relationships as well as new ways to share information and coordinate resources. The wide variety of non-clinical health care supports and services must be networked with each other and connected to the patient. That's a challenge, given the current fragmentation in health care and human services delivery.

Accountable communities are high-tech and high-touch

Technology can help address this challenge. High-tech and high-touch are not mutually exclusive, and some individuals prefer more of one than the other. For example, deployed correctly, virtual access allows organizations to realign and make best use of limited physical and human resources, helping control costs. Patel sees this in various incarnations around the country, with organizations deploying Skype, chats, texts—"every medium," she says. Some use community health workers to meet with the patient and, when necessary, connect remotely with a clinician.

Accountable communities blur the lines between health and care

For accountable communities to succeed, care payment models must change. Some are evolving in ways that promote integration, accountability and coordination. Patel notes that new care and payment models are beginning to support such efforts, from the Comprehensive Primary Care model at CMS to the Regional Care Collaborative Organizations in Colorado. The RCCOs bring everyone to the table.

The clinician's experience with payer programs offers a microcosm of the challenges to building an accountable community. From the provider perspective, it can be difficult, given that each payer has its own program, its own set of resources and its own targets. That's the biggest problem—competing, sometimes conflicting, efforts that do more harm than good. "I haven't found the solution," Patel says. But she does have a strategy.

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What's she's done—and has seen other physicians doing—is to pick a path and stick to it, rather than try to meet each different set of expectations. And that lesson can carry over into trying to coordinate disparate community efforts: "Talk to the other services, the organizations you are working with. Say 'We're doing this. Can you fold this into what you are doing?'"

Accountable communities share the burden and share the bundle

Both Patel and Jantz point out that, although there is plenty of money in the health care sector, there is very little for housing or transportation or other areas that have a direct impact on health.

Flexibility in funding—for instance, bundled payments—allows providers to remove barriers to care and meet patients where they are. A flexible, global budget allows the accountable health community to fund housing, to fund transportation, to ensure access to fresh healthy food.

Patel describes one of her patients with diabetes. She was taking her medication but, at the end of each month, her blood glucose dropped precipitously. Patel and her nurse eventually figured out the patient ran out of money for food at the end of the month, and were able to connect her with a food bank. Once she was eating regularly, her numbers stabilized.

Meeting patients where they are, says Jantz, means having the flexibility to use the money where they and their needs are, from nurse health lines and classes to funding for housing and transportation. "We know that health care doesn't drive outcomes," she says. "Behavior does. Environmental factors do."

"For accountable communities to really work, we're going to have to recognize what the other sectors

3 tips *you can use in building an accountable health community*

Organizations across the country are undertaking efforts to build truly accountable communities. Patel offers the following counsel:

1. **Figure out how much time you think you will need—and triple it.** It takes time to sort through these issues—it can take months just to get the stakeholders in one room, on the same page. "Be patient. Give yourself plenty of time—even if you don't feel like you have the luxury of time—to do gathering, organizing, engaging."

2. **Think about financial sustainability early. While you're trying to get people in that room, while you're considering workflow, think about building a sustainable model.** For those working with a nonprofit hospital, the community health needs assessment is a good place to start. "Nonprofit hospitals need to have a plan to address those needs, and you can be part of that plan. It's a natural place for sustainability."

3. **Be realistic about integrating changes into workflows.** "Once you think about ways to become more accountable, look for ways to integrate that don't upset the apple cart. Be practical about integrating those changes into the existing workflows." This doesn't just apply to the physician's office. Each organization that's part of the community has its own workflow, its own processes. Changes can't simply be imposed; they must be integrated.

face—especially food and housing," says Patel. "We complain that we don't have enough money. But everyone perceives health care as rich and fat and having all the money." And in many ways, it does. Still, she says, "I have homeless patients who can't find housing. We don't have affordable housing solutions." She relates a comment from a food bank she coordinates with: "Kavita, you have millions of dollars. We have nothing."

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And yet, those services—as well as transportation, job placement and others—are essential to a community's health. "We need to approach this with a note of humility," she says, humility about the limited power the health care system has to improve health, and the disproportionate share of the resources it has. "Deal with the fact that health care takes up time, money, people. Other hugely important areas lack those resources."

Ideally, Patel would like to see funds shared with food banks and similar community-based organizations where it can make a real difference in health and prevent costly medical interventions. "Accountable communities share resources when possible." She adds that sharing resources doesn't always apply to funding. Some clinics turn into multiuse community centers after hours, hosting a variety of programs including job training.

Such thinking needs to go beyond health care and into the larger state budgeting process. Funding is siloed, without considering how so many areas are interrelated, says Jantz. People are touching every state system, from corrections to schools to human services. "To have this dialogue, we need to step outside the silos of our organizations, our professions and discuss how we reconcile the gap between where we are investing our community resources and where we will have the greatest return on our investment. We will likely find that spending 30 percent of our state budget on health care does not correlate with better health outcomes."

Accountable communities measure results

Neither is advocating simply tossing money willy-nilly and letting everyone go wild. Flexibility and accountability go hand in hand. "To have a payment model that supports accountability, you need to measure outcomes," says Jantz. One way to do that, she says, is through population health measures. The drawback is they don't produce the immediate, short-term wins that so many stakeholders (including payers like the state) crave. "They can be frustrating, take a long time to collect and publish."

Patel is unimpressed with the current array of tools used to measure success vis-à-vis social determinants of health. Many of them are based on resource utilization, she says. "I think that's flawed. We need people-centered measures. Cost is important, of course, but we should be looking at other issues. How many days did a person work last month? How many nights did they go to bed hungry?" Those are far better measures, she says.

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Changing the conversation

For Jantz, it comes back to changing the locus from health care to health. Policy and data alone won't drive transformation, she argues. On the other hand, sustainable transformation is unlikely without changes in policy and access to robust data.

We must disabuse ourselves of the notion that there is only one way to address the health of a community, one way to build accountable communities, Jantz says. "We must readjust our thinking: There is no magic pill that will deliver whole-person health—health that is not just a lack of physical disease but true emotional, social and physical well-being," she says. "In fact, the pill we do have—the current health care system—has side effects that are so catastrophic that we may be undermining the health of our communities."

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KAVITA PATEL is a fellow and managing director at the Brookings Institution. She is also a practicing primary care physician at Johns Hopkins Medicine and clinical instructor at UCLA's Geffen School of Medicine. Previously, she was managing director of clinical transformation at the Center for Health Policy and led research on delivery system reform, healthcare financing, physician payment reform, and healthcare workforce development. She served as a director of policy for The White House under President Obama and as a senior advisor to the late Senator Edward Kennedy. Her prior research in health care quality and community approaches to mental illness has earned national recognition and she has published numerous papers and book chapters on health care reform and health policy. She has testified before Congress several times and is a frequent guest expert on CBS, NBC and MSNBC as well as serving on the editorial board of *Health Affairs.*

KATHRYN JANTZ has more than 10 years of experience in health care and health care policy. She has worked extensively at supporting efforts that further health care delivery system reform. She has interest and expertise in behavioral health integration and the nexus between health care and the social determination of health. She supports organizations in policy analysis, strategic planning, project management, proposal drafting and stakeholder engagement. Prior to joining the Steadman Group, Kathryn worked at the Colorado Department of Health Care Policy and Financing on the implementation of the Accountable Care Collaborative and the next phase of that vision. Kathryn also has experience in clinical social work at Massachusetts General Hospital and the Asperger's Association of New England. She also conducted health policy research at the Health and Disability Working Group.

About Rocky Mountain Health Plans

Founded in Grand Junction, Colo. in 1974, as a locally owned, not-for-profit organization, Rocky Mountain Health Plans provides access to affordable, quality health care enabling its more than 229,000 members across the Western Slope to live longer, healthier lives.

About the Community

Western Colorado is creating an accountable community that uses health IT in a meaningful way, adopts value-based payment models, coordinates care and empowers patients to take charge of their health.

We aspire to ensure the following:

- High-quality health care is affordable and accessible to all.
- Those who purchase health care are assured that care is effective, safe and appropriate.
- Patient care is a team effort, with roles that are well-defined, connected and collaborative.
- Patients have access to the support and information they need to take charge of their health and make their own decisions.
- Payment reform will foster reimbursement models that support accountability for population health and resource use.
- Information technology supports population health, helping providers predict outcomes, prioritize interventions and prevent disease.
- Health data is a community resource used in a secure way to support coordinated care at the population, practice and personal levels.
- Investments in information technology and health system transformation will improve quality of life and economic well-being across the state.
- Health is a community resource that requires leadership, stewardship, individual responsibility, community support and ongoing maintenance.

For more information:

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