Partnering With Accountable Care Organizations for Population Health Improvement

Acknowledgments

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Introduction

This issue brief describes accountable care organizations (ACOs), and how public health agencies and community organizations (e.g., faith-based organizations, academic institutions, agencies on aging, community wellness and prevention organizations) can work with ACOs to improve community health outcomes, specifically for older adults. This brief also includes information about the ACO model of coordinated care, opportunities for partnering with ACOs, and recommendations from public health agencies and community organizations on how to facilitate effective collaboration with ACOs.

> *"Only 10% of health outcomes are a result of the medical care system, whereas … 50-60% are because of health behaviors. To change health behaviors, it will be necessary to engage in activities that reach beyond the clinical setting and incorporate community and public health systems."*[1]

Accountable Care Organizations

The Affordable Care Act called for the establishment of ACOs to help improve patient care while controlling rising health care costs. Typically, ACOs are networks of hospitals, physicians, and other health care providers that share responsibility for providing care to patients. ACOs create financial incentives to cooperate, share information, and save money, while providing coordinated, high-quality care to their Medicare patients[2]—primarily adults age 65 and older. Coordinated care means providers exchange important clinical information about their patients with clear, shared expectations about their roles.[3] This helps to ensure that chronically ill patients "get the right care at the right time, while avoiding … duplication of services."[2] Essentially, ACOs organize the different elements of the health care system (e.g., hospitals, primary care, specialists, home health care) to ensure the parts work well together for the patient.

Community prevention efforts to improve population health are also important elements of ACO partnership models. Such partnerships between ACOs and community prevention efforts are sometimes called "accountable care communities (ACCs)" or "accountable communities for health."

ACOs focus on improving individual health and also improving the health of the entire population for which they are accountable. This is known as population health management.[4] ACOs improve population health by focusing on prevention and carefully managing patients with chronic diseases. Incentives (such as tying reimbursement of providers to quality care metrics or fining hospitals for unplanned hospital readmissions) encourage ACO members to provide high-quality care to improve their patients' health and to maintain their patients' health status. While there are numerous implementation models for ACOs designed to meet the needs

of diverse providers and populations, this issue brief will address the application of the ACO model to Medicare populations.

Research shows that a "small percent of Medicare beneficiaries with multiple chronic conditions account for the vast majority of Medicare spending, all too often due to inadequate care, poor communications, and weak adherence by patients."[5] As ACOs proliferate, with an estimated 250 to 500 ACOs nationwide in 2013,[5,6] the positive impact of coordinating care for chronically ill older adults is becoming clear, as evidenced by the following quotes:

- According to an article on eldercare and care coordination, "A decade of research and demonstrations has developed evidence regarding 'care coordination' interventions that are effective in achieving both improved beneficiary outcomes and reduced Medicare expenditures."[5]
- According to Eldercare Workforce Alliance and the National Coalition on Care Coordination, "Evidence in support of these programs [care coordination] for older adults includes lower mortality, lower costs, lower hospital admissions, and less frequent use of expensive services."[7]
- According to the National Coalition on Care Coordination, "Coordinated care can improve quality of care and life for older adults by improving communication among providers, older adults and families; streamlining services; eliminating duplication … and connecting older people with appropriate care."[8]

Opportunities for Partnering With ACOs

ACOs foster *internal* coordination and partnership with payers. However, according to a 2013 survey of 115 health care executives conducted by the health care improvement company Premier, Inc., over half of all ACOs in the United States also partner with *external* organizations (e.g., health departments, large employers, other providers). According to this survey, partnership with local public health departments is common, particularly among small, rural, or stand-alone hospitals.[6] As ACOs focus increasingly on improving population health, they must consider how to adopt population-based strategies, which are often under the purview of local health departments.

> *"No single segment of health care can manage the health of a population on its own; consequently, success will be easier to achieve with partnerships that span the care continuum. As more care is delivered in the community, these partnerships must expand beyond traditional care settings to include community groups, employers and payers."[6]*

Valuable opportunities exist for ACOs to collaborate with external partners (e.g., public health agencies, community organizations) to improve the health of older adults. Physicians and hospitals cannot alone meet the standards and requirements for the preventive health, care coordination, and at-risk population quality measures. As the Association of State and Territorial Health Officials notes, "For ACOs to be successful and for any health system to be truly integrated, public health must be at the table."[9] Public health departments bring not only expertise in the core functions of public health—assessment,

policy development, and assurance—but also experience and expertise in preventing disease rather than treating it.

ACOs and health departments can play complementary roles in improving population health.[1] Some examples of the role health departments can play in helping ACOs meet their health improvement, quality, and cost saving goals include the following:

- Collecting or providing data on access to health care, as well as disease risk factors, incidence, and prevalence by population.[9]
- Coordinating across closely aligned state and local health efforts.
- Providing information on or offering evidence-based prevention strategies geared toward older adults (e.g., fall prevention, healthy behaviors).
- Addressing health disparities through culturally tailored approaches.
- Leading campaigns and supporting policy changes that promote healthy behaviors.[1]
- Providing care and coordinating with other safety net providers.
- Providing evaluation support and monitoring of population health.
- Serving as a neutral convener.
- Connecting to state and national health networks to provide leadership and guidance.

Depending on the focus population, other key collaborators may include payers, mental health providers, long-term care organizations, agencies on aging, faith-based organizations, philanthropists, academic institutions, and community wellness and prevention organizations. (Kerry Kernen, MPA, MSN, RN, Summit County Public Health, oral communication, July 23, 2014).

Examples of Promising ACO Partnerships

As ACOs partner with community organizations and health departments to meet the complex needs of older adults, a number of promising models have emerged. One model involves ACOs that have established or are working through Community Care Teams (CCTs). CCTs are multidisciplinary, community teams often linked to patient-centered medical homes. CCTs, in states such as Maine, Iowa, Vermont, New York, Minnesota, and North Carolina, include mental health providers, long-term care, local health departments, faith-based organizations, and community programs.[10] CCTs can serve in many capacities, including providing guidance on coordinating work across local, state, and federal initiatives; coordinating hospital and health departments' community needs assessments; identifying local priorities for interventions; and implementing interventions and evaluating their impact.

Another example of how ACOs partner with community and health departments to improve population health is through shared health information technology (HIT). For example, Southern Prairie Community Care, an ACO partnership in Minnesota, is working across 16 hospitals, health and social service agencies in 12 counties, and numerous clinics and community providers to establish shared HIT systems. Their health information exchange will support coordination of care delivery across community services, primary care, behavioral health, and public sector services.[11] Data provided through this shared HIT system enables ACO partners to measure and improve health outcomes.

Several Centers for Disease Control and Prevention (CDC) Division of Community Health (DCH) awardees are implementing ACCs.

> ### *Spotlight on Live Well San Diego*
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> *Live Well San Diego (LWSD) is a 10-year comprehensive initiative that was launched in 2010 to create a healthy, safe, and thriving San Diego County. A key vehicle for implementing LWSD is an accountable care community (ACC) that extends beyond the current ACO model to include the broader community and entire population. Through ACCs, multiple competing health care systems can collaborate to change the culture of practice, share best practices, and improve quality while working to reduce costs and provide optimal care. The County of San Diego has established successful collaborations with all major regional health care systems, San Diego's extensive network of Federally Qualified Health Centers, many social service organizations, and a broad array of public- and private-sector partners. The organizations are working collectively toward improving community health.*
>
> *An example of the ACC in action is the San Diego Care Transitions Partnership, which has brought together the County of San Diego and four large health systems, including 13 hospitals, to provide comprehensive hospital- and community-based care transition support to medically and socially complex patients. The program is successfully reducing the 30-day, all-case hospital-readmission rate by delivering patient-centered interventions (including coaching by transition nurses, medication support by pharmacists, and short-term intense post discharge care coordination by social workers) and targeting almost 21,000 high-risk, fee-for-service Medicare patients per year.*

Another example of a DCH awardee implementing an ACC model is Summit PACCT, a coalition of more than 70 local organizations spanning public schools, academic institutions, faith-based organizations, public health agencies, social services agencies, housing authorities, transportation, and hospital systems. Major organizations in this partnership include Austen BioInnovation Institute in Akron, Summit County Public Health, and Community Legal Aid. No one organization is leading or directing activities in this ACC model; efforts toward population health improvement are a collective and collaborative process. While the partnership grew out of necessity in response to decreasing funds, these agencies and organizations came together to not only save costs by avoiding duplication of efforts but also address areas of need in the community.

To create healthier communities, Summit PACCT focuses on the impact of social determinants of health (income, education level, and race/ethnicity) through policy, systems, and environmental changes. For example, through their partnership with Akron Metropolitan Housing Authority (AMHA), the coalition conducted an investigation to determine why there had not been compliance to the smoke-free housing policies in designated AMHA buildings. Findings suggest that many residents were not aware of the smoke-free policy. Working in conjunction with Community Legal Aid, Inc., the coalition members communicated the details of the policy to residents (many of whom are older adults) while ensuring that residents were aware of their individual rights. The coalition anticipates that compliance with the smoke-free policy will increase and improve the health of AMHA residents.

Recommendations for Partnering With ACOs

This section is a compilation of recommendations from the awardees highlighted in this document, as well as other experts, agencies, and organizations that have partnered with ACOs. Lessons learned to create effective collaborations include the following:

- Use a neutral convener to bring partners together. Public health agencies have "a history of bringing partners to the table to implement solutions on a regional basis [that] aids in ongoing productive collaborations" (Dean Sidelinger, MD, MSEd, County of San Diego Health and Human Services Agency, oral communication, July 15, 2014).
- Encourage stakeholders to set aside their personal or organizational goals. "Bringing together partners, particularly those who compete in the marketplace, requires … that participants leave some of their institutional goals back in their offices" (Sidelinger, oral communication, July 15, 2014).
- Consider conducting a joint (hospital and public health agency) needs assessment to identify shared priorities.[1] Setting shared priorities based on data ensures community needs are being addressed and encourages support from all partners.
- Collaboratively select desired health outcomes and which population health indicators should be tracked.[1] Agreed-upon measures and a common evaluation framework will help the partnership demonstrate success and identify opportunities for improvement.
- Focus on the highest-risk people, especially those at risk for hospitalization, to yield the greatest success in terms of improved quality of care and reduced cost.[8] Focusing efforts enables the partnership to demonstrate effect on health outcomes and cost.
- Promote care coordination models that integrate different disciplines and settings of care, including long-term care and other nonmedical settings. A primary strength of collaboration between health care, health departments, and other partners is the opportunity to coordinate services to better meet the complex needs of chronically ill older adults.
- Ensure the interdisciplinary team has access to timely data on care delivery.[8] A formal agreement with the ACO and other partners to share data and monitor progress toward goals in clinical and community settings leads to increased communication and reduced fragmentation of services (Kernen, oral communication, July 23, 2014).
- Determine where ACO patients live and what organizations are already providing services to those areas. This effort, sometimes called "hot spotting," can help the partnership better direct community strategies and reduce duplication of work.
- Use local leaders and policy makers to promote efforts. Identifying the right spokespeople to champion the efforts will help inform the broader community about the importance of the work and the progress made.
- Encourage the ACO to use a portion of cost savings to support community health activities (Sidelinger, oral communication, July 15, 2014). External partners can ask ACOs to consider reinvesting their cost savings into community efforts to ensure sustainability.

The Path Ahead

"What produces health is not the health care delivery system, but the communities in which we live and how we invest in our own health."[12] Hospitals and medical providers alone cannot meet the growing needs and increasing costs of the aging population in the United States. There are numerous benefits for ACOs that partner with health departments and other community organizations to improve population health—especially for chronically ill older adults. In particular, health departments bring significant skills and expertise to the table and can offer assessment, facilitation, evaluation, coordination, and public awareness support. While the most effective partnership models are still being identified, the experiences, examples, and insights shared in this document help light the path ahead for those seeking to work with ACOs.

Additional Resources

- **Quality Matters:** The Commonwealth Fund provides *Quality Matters*, a bimonthly newsletter with reports on emerging models and trends in health care quality improvement and interviews with leaders in the field. The February/March 2012 article, "Improving Population Health Through Communitywide Partnerships," offers support for health care and public health partnering to improve community health.

- **A Bold Proposal for Advancing Population Health:** To strengthen the focus on creating a culture of health, the United States needs partnerships that cross sector boundaries and cultures, beginning with health care delivery, public health, and community and social services. Dr. Stephen Shortell identifies the four components—strategic, structural, cultural, and technical— to address in paying for population health improvement through cross-sectoral partnerships.

- **National Academy for State Health Policy:** The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers dedicated to helping states achieve excellence in health policy and practice. A nonprofit and nonpartisan organization, NASHP provides a forum for constructive work across branches and agencies of state government on critical health issues.

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