Maximizing the Success of Population Health: Building Community Partnerships

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With the passing and implementation of the Patient Protection and Affordable Care Act (ACA), the healthcare industry has experienced a resurgence in the drive to reduce healthcare spending via Accountable Care Organizations (ACOs), Patient Center Medical Homes (PCMH), and the overarching concept of population health management.

For payers and providers, the convergence of these models refocuses the discussion on how to manage patient outcomes and costs through population health management programs. Population health relies on risk stratification via health profiles and cost considerations, and thus different care strategies for each risk strata. This means the pool of healthcare resources that payers and providers need will vary. Gaps in this resource pool are common for non-clinical care needs, especially those that reside in the patient's community and are related to social, economic, and environmental factors that impact health. This paper will highlight those gaps and discuss key partnerships that can begin to address them.

The Impact of Gaps in the Continuum of Care

Not addressing the non-clinical care needs of patients can have a negative impact on healthcare costs and outcomes. Highly vulnerable patients have disproportionate emergency department (ED) visits, hospitalizations,

readmissions, and increased utilization of medical services overall. These patients, often referred to as "super users," represent just 1 percent of the population, yet account for nearly 25% of healthcare expenditures.1 They are more likely to need community and social services such as home care, day health programs, shelters, chemical dependency programs, transportation services, reduced cost medication programs, and meal delivery services.

Examples of this include:

- patients who could be successfully treated on an outpatient basis but cannot make appointments due to transportation issues and may arrive at the ED via ambulance to address a routine health event;
- homeless patients who could be discharged from the hospital, but whose lack of adequate shelter necessitates a longer stay, increasing costs and the risk of secondary infection

Coordinating care and providing necessary social services would contribute greatly to the estimated $25 billion that can be saved in preventable hospital readmissions2 and $14 billion in unnecessary emergency room visits.2

How to Identify and Build the Community Landscape

Payers and providers need to keep focus on the patients' communities and available resources and may need to establish a network of community partners. Developing this network, however, can be challenging. Identifying the available community resources alone may be daunting and then establishing partnerships with these entities, which often have competing priorities and limited resources, creates additional barriers to a full continuum of care for the population. Below are some recommendations for tackling this effort.

Identify Resources

One starting point for organizations to identify resources is the Community Health Needs Assessment (CHNA), a requirement of the ACA that started in 2012. With the goal of creating healthier communities, the ACA states that non-profit hospitals must complete the CHNA for their area once every three years. A CNHA includes data and information on a broad spectrum of issues that provide an aggregate profile of the health status, quality of life, and barriers to care among residents of the community. This includes high prevalence or acuity for particular health conditions, the numbers and types of health professionals who are available and willing to serve specific populations in the community, and existing community healthcare and social service resources.3

Some states required CHNAs long before the ACA. California, for example, mandated CHNAs in 1994.3 Based on the assessment's results, the hospital must develop an implementation strategy to address the identified gaps.

As the ACA requires that non-profit hospitals include "input representing the broad interests of the community" in their reports and identify "all organizations with which the facility collaborated in preparing the CHNA,"6 a comprehensive group of providers will need to be involved in the assessment. This includes primary care

physicians, other ambulatory services, providers, and public health agencies. The assessment process provides an ideal opportunity to identify the scope of resources available in the community and gaps in care or services.

For communities that may not be able to take advantage of the CHNA, working with local and state public health entities may be the best starting point to identify the scope of available resources.

Build Partnerships

Once resources are identified, the next challenge is to establish partnerships. One of the most common challenges, and likely the biggest, is engaging the needed community entities as partners. Community organizations may be competing for limited resources and are constrained in the ability to provide additional services. The current healthcare model, which focuses on the delivery of services versus the prevention of negative health events, may further hamper the ability to provide community resources with the needed funding to take on these programs.

As a result of the ACA's recognition of this challenge, there are now more opportunities for communities to obtain funding from healthcare foundations to develop programs to improve patient outcomes.

Additional sources of funding have been identified by Cantor, Mikkelsen, Simons, and Waters in the paper "*How Can We Pay for a Health Population? Innovative New Ways to Redirect Funds To Community Prevention"* 2:

- Wellness Trusts. These are types of funding pools created specifically to support prevention and wellness interventions to improve health outcomes of targeted populations. The Massachusetts Legislature created a trust to support prevention efforts, with the Massachusetts Department of Public Health leading the distribution of the funds to local communities, regional agencies, and healthcare providers. North Carolina also has a wellness fund.
- Social/Health Impact Bonds. This is a market-based approach to pay for "evidence-based interventions that reduce healthcare costs by improving social, environmental, and economic conditions essential to health." The first-ever health impact bond in the U.S. is in Fresno, California. The goal is to reduce the incidence and severity of asthma, specifically in the lower socio-economic sectors of Fresno that have a higher prevalence of the disease.
- Community Benefits from Non-Profit Hospitals. Per legislation passed in the 1990s, non-profit hospitals must provide community benefit in the public interest as a condition of their tax-exempt status. Several hospitals in both northern and southern California have community benefit programs, which range from providing new service lines to address needs of their population to improving access via mobile clinics to outreach programs and community health screenings.
- Some ACOs are using the reductions in the total cost of care for their population of patients to invest in preventative initiatives aimed at improving the community's health. Akron, Ohio, is demonstrating this concept by creating an "Accountable Care Community," which is being defined as encompassing medical

care delivery and public health systems, community stakeholders, and community organizations whose work often covers the entire spectrum of the determinants of health.

Healthcare entities that wish to engage community organizations will need to creatively partner to find the additional resources that make partnerships feasible. Initially focusing on those most in need – the highly vulnerable population – may be the optimal place to begin, as this provides a mission-driven incentive for most healthcare providers and community service organizations.

Developing community partnerships to implement a community health strategy may not show significant results in the short-term. Signs of progress may be slow to appear, and engaging the community to complete the continuum of care may be challenging. And at the same time, it is essential to the success and sustainability of population health management to invest in these community partnerships for long-term optimal outcomes.

Resources:

1. Cohen S, Yu, W: The concentration and persistence in the level of health expenditures over time: Estimates for the U.S. population, 2008–2009. Agency for Healthcare Research and Quality. January 2012.
2. PriceWaterhouse Coopers' Health Research Institute: The Price of Excess: Identifying Waste in Healthcare, 2008. http://www.pwc.com/cz/en/verejna-sprava-zdravotnictvi/prices-of-excess-healthcare-spending.pdf
3. Barnett K: Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential. Report of Proceedings from a Public Forum and Interviews of Experts. February 2012. http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf
4. Stoto MA: Population Health in the Affordable Care Act Era. February 21, 2013 academyhealth.org
5. Cantor J, Mikkelsen L, Simons B, and Waters R: How Can We Pay for a Health Population? Innovative New Ways to Redirect Funds To Community Prevention. January 2013. preventioninstitute.org
6. Casey M, Prentice B, Williamson J, Boyle K, Hsu C, and Beery B: Strategies for Building Community-Public Health Partnerships: Lessons Learned from the Program Office of the Partnership for the Public's Health Initiative. December 2007, partnershipph.org
7. Research briefing by The Advisory Board Company (Health Care Advisory Board Care Transformation Center): Three Key Elements for Successful Population Health Management. 2013 advisory.com
8. Rowley R: Health Care Is Shifting Toward Population Management. February 9, 2012 practicefusion.com
9. Kaiser Permanente: Community Health Needs Assessment Toolkit – Part I Pre-Assessment & Data Collection. Kaiser Permanente Community Benefit Programs. August 2012 http://assessment.communitycommons.org/kp/Toolkit/