Achieving Accountability for Health and Health Care

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There is no well-established mechanism at the local level to discuss or manage the balance of investments in health care and the other social determinants of health. We propose the development of voluntary regional organizations and/or use of current organizations to work with stakeholders of the health system to 1) review local data on health, experience and quality of care, and costs of care (Triple Aim); 2) create shared goals, actions and investments to meet the Triple Aim; and 3) involve citizens in local delivery system reform and stewardship of financial resources. These accountable health communities (AHCos) would contribute to co-creating a sustainable health system.

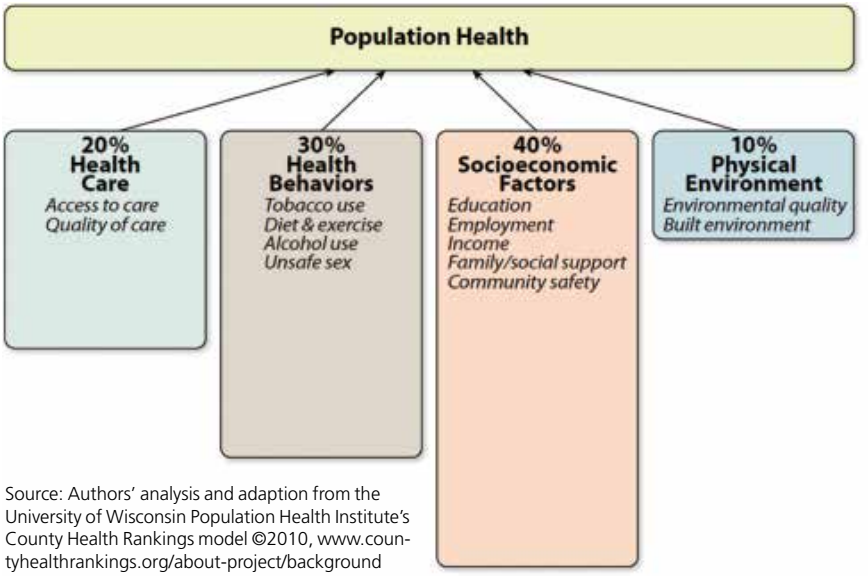
Health reform is occurring locally and nationally with an almost dizzying array of opportunities. At the federal level, the Affordable Care Act (ACA) has set in motion numerous policy reforms intended to improve health and health care including accountable care organizations (ACOs), medical homes, bundled payments, prevention strategies and hospital community benefit requirements.[1] The Center for Medicare and Medicaid Innovation is exploring and implementing many such reforms, with plans to also focus on community and population health models.[2] The National Quality Strategy calls for simultaneously improving population health, improving the experience of care and improving affordability by reducing the cost of quality health care.[3]

This three-part aim, known as the Triple Aim,[4] is well-justified: As a nation, we have successfully built the most expensive health care system in the world without achieving the best outcomes. To improve population health, there is a growing recognition that we must invest more in the other modifiable social determinants of health (eg, healthy behaviors, education, job development, housing and the environment) that collectively have a greater impact on the health of a community than access to and quality of care (Figure 1).

There is, however, no well-established mechanism at the local level to even engage in a discussion about the balance of investments in health care and the social determinants of health. Furthermore, the leaders of health care system redesigns, such as ACOs or medical homes, are often not directly linked to other stakeholders who have influence on the social determinants of health. In addition, citizens often believe that investments in more health care—and more expensive health care—must result in better health, not recognizing that rising health care costs are jeopardizing the

FIGURE 1

Social Determinants of Health



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's County Health Rankings model ©2010, www.countyhealthrankings.org/about-project/background

other factors that make the population healthy.

The Institute of Medicine (IOM) report "For the Public's Health—The Role of Measurement in Action and Accountability" describes a health system composed of public health agencies, the clinical care delivery system, the community, employers, educators, the media and other government agencies. The report develops a framework and recommendations for measurement that will provide communities and decision makers at the local and national level with relevant information on the determinants of health.[5] Similarly, a performance evaluation framework for ACOs is being discussed that includes not only "for what, to whom and how"[6] but also a process for evaluating the health needs of the population an ACO serves. And, importantly, tax-exempt community hospitals must now comply with the ACA's requirement for a community health needs assessment.[7,8]

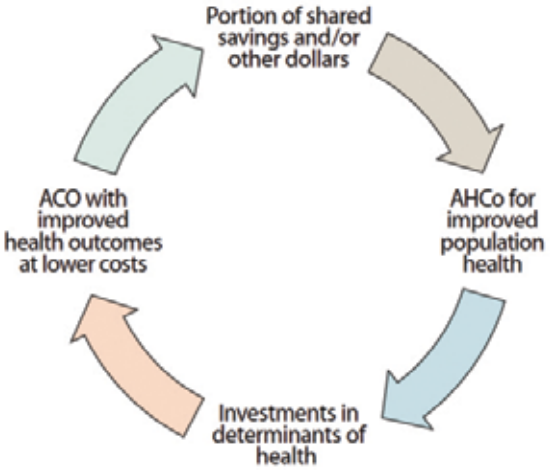
Co-creation to Achieve the Triple Aim

To bring these important pieces of the puzzle together, we propose the creation of voluntary regional organizations that would work with local and regional stakeholders toward attaining a community-focused Triple Aim. These new organizations could be called "health outcomes trusts"[9] and could build on existing community or regional multi-stakeholder organizations and/or initiatives. They would need to have not only the charge of the Triple Aim but also a carefully defined geographic focus, a portfolio of projects that address both population health and health care reform, and sustainable funding. Their purpose would be to build understanding of the problems and create interventions to move the focus from health care to health based on a community's vision and goals.

Each would have the IOM-proposed stakeholders including one or more participating hospitals, local clinical care systems including ACOs, and citizens from the community. The trust would be responsible for developing plans to work across multiple stakeholder groups to invest upstream in the social determinants of health. Hospital community benefit dollars would be available for investment purposes, but other financial resources could also be used to meet community needs, including state and federal grants, refocused local philanthropy, better-aligned community benefit investments, allocation of a small share of insurance premiums, or commitment of a portion of value-based payments to demonstrated progress in population health improvement. In addition, savings generated from improved practice and performance could also be reinvested in the community, creating a reinforcing loop (Figure 2). The ReThink Health Dynamics simulation modeling from the Fannie E. Rippel Foundation illustrates the importance and feasibility of this reinforcement.[10]

FIGURE 2

Community Reinvestment: A Reinforcing Loop



Source: authors' analysis
ACO = accountable care organization
AHCo = accountable health community

The allocation of hospital community-benefit dollars in this systematic way could be significant. For example, McGinnis has argued that a "small, dedicated set-aside from medical care spending" could solidify partnerships between medicine and public health.[11]

How might this work in a community? We envision three closely aligned areas of activity for the trusts. First, they would work collaboratively with local health departments and/or state health departments to evaluate measures of health and health care, such as the rankings of local communities on the social determinants of health (www.countyhealthrankings.org). Under public health accreditation processes, both local and state health departments are already responsible for using measures to make assessments. Under the ACA, there would be a synergistic opportunity for non-profit hospitals to complete these community assessments.

In fact, in North Carolina, public health and hospitals have formed the NC Public Health–Hospital Collaborative, which is exploring how public health and hospitals could collaboratively conduct community health needs assessments.[12,13] A trust would facilitate such collaboration but also expand it to include measures on quality of care such as those provided by members of the Network for Regional Healthcare Improvement (eg, MN Community Measurement and the Wisconsin Collaborative for Healthcare Quality), and on costs and affordability of health care, such as Minnesota's initiative to create publicly reported peer-grouped measurements of clinics' and hospitals' risk-adjusted quality and costs[14] and Massachusetts' measures of costs of hospitals.[15] Therefore, each community would have measures to review on access, quality and costs of health care; healthy behaviors; socioeconomic measures such as education, housing and job development; and the environment.

Drawing on these, the trust's second activity would be to develop shared goals based on the Triple Aim. These goals would focus work with community stakeholders to align community policies and clinical practices as well as interventions and investments such as community-benefit dollars. For example, community

stakeholders in Mower County, Minnesota, including public health, employers and Austin Medical Center–Mayo Health System, are using original research[16] and data such as the county health rankings to prioritize and identify potential interventions.

Community goal-setting could also be augmented by provider incentives to move toward "pay-for-population health,"[9] such as Minnesota nonprofit health plans' including measures of tobacco and obesity in their pay-for-performance or ACO contracts. This systematic approach that aligns clinical, payment and community policies as well as investments toward shared goals will be critical to directly and indirectly slowing spending growth and balancing the Triple Aim.

A third broad area of activity for the trusts would be convening conversations with citizens focused more directly on local delivery system reform, such as community involvement in the implementation of ACOs and the stewardship of financial resources. Whether or not ACOs achieve their promise will depend in large part on whether a wise balance can be struck between competition and collaboration. If local hospitals continue to compete primarily for high-margin services, the medical arms race could lead to mutually assured destruction for the populations they serve. The trusts could foster a more constructive discussion around shared aims focused on local populations' needs.

Previous attempts to slow rising health care costs through managed care led to the perception by consumers that they were being denied needed care. With ACOs and payment reform, it will be important that we build in a much greater degree of engagement with patients and citizens that leads not just to input and feedback on services but also to a true "co-creation"[17,18] of the future to address all parts of the Triple Aim.

Change Is Needed

The redesign of our health system is underway, with many moving parts. Because both health and health care are locally produced, we believe a key piece that's missing is a local structure focused on the critical goal of achieving accountable health communities. A change in focus is needed—a change from more health care to more health. But it will not be easy to decrease investments in clinical care, hospitals, medical technology, etc. in order to increase investments in the social determinants of health. Local leadership and efforts will be needed to promote transparency and accountability, to bring the citizens' and patients' voices to the table, and to bring discipline to a medical industry that consumes more than one-sixth of our economy. Nothing less than accountability for our children's future is at stake. **MM**

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This article was originally published at www.icsi.org/health_care_resdesign_/accountable_health_communities as a white paper. It was developed through the State Quality Improvement Institute 2008-2010, when several authors were on the staff of the Minnesota Department of Health. The work was sponsored by Academy Health and the Commonwealth Fund. No one from Academy Health or the Commonwealth Fund participated in the writing or editing of the white paper.

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