North Carolina Institute of Medicine
NCIOM
shaping policy for a healthier state

Task Force on
Accountable Care Communities

TASK FORCE ON ACCOUNTABLE CARE COMMUNITIES

MEETING SUMMARY

January 24, 2018

10:00 am – 3:00 pm

North Carolina Institute of Medicine

630 Davis Drive

Morrisville, NA 27560

Attendees:

- *Co-Chairs:* Miles Atkins, Reuben Blackwell, Sec. Mandy Cohen, Ronald Paulus
- *Steering Committee:* Jason Baisden, Chris Collins, Jeff Spade, Shelisa Howard-Martinez, Allison Owen
- *Task Force Members*: Donna Albertone, Paula Swepson Avery, Blair Barton-Percival, Rep. MaryAnn Black, Tristan Bruner, Brett Byerly, Laura Caldwell, Heidi Carter, Debra Collins, Kathleen Colville, Satana Deberry, Al Delia, Howard Eisenson, Robert Feikema, Margaret Feldman, Peter Freeman, Kim Green, Shauna Guthrie, Robby Hall, Nicole Johnson, Dee Jones, Ruth Krystopolski, Lisa Macon Harrison, Ann Meletzke, Nicolle Miller, Kevin Moore, Barbara Morales Burke, Kristin O'Connor, Abbey Piner, Maggie Sauer, Kim Schwartz, Linda Shaw, Pam Silberman, Tish Singletary, Steven Smith, Anne Thomas, Sheree Vodicka, Mary Warren, Charles Willson, Ciara Zachary

Introductions and Welcome to the Task Force:
Co-Chairs: Miles Atkins, Reuben Blackwell, Sec. Mandy Cohen, Ronald Paulus

The meeting began with brief introductions by the Task Force co-chairs, steering committee members, and Task Force members including their position and organization they represent. Each co-chair spoke for a few minutes about their reasons for participating in the Task Force.

Introduction to the NCIOM & Accountable Care Communities
Adam Zolotor, President & CEO, NCIOM

Dr. Zolotor gave a brief overview of the NCIOM and its work. He then talked more specifically about what this task force will cover. There was a brief introduction to social determinants of health and the idea that "all health is not healthcare." The choice of the name "Accountable Care Communities" is meant to be less-restrictive than "Accountable Health Communities", acknowledging that there will not be a single model for success; communities are in different places in their ability to address social

determinants and invest in partnerships. Related to recommendations from the Task Force, there will be voting, potentially at each meeting, on various measures. (Task Force members vote, while steering committee members, co-chairs, and interested persons do not. Voting members of the Task Force may send a designee in his/her place, who will vote on the Task Force member's behalf.) Meetings are open to the public and guests are allowed. E-mails to NCIOM staff are always welcome- for questions contact Dr. Zolotor, Brieanne Lyda-McDonald (project director), or Maggie Bailey (research assistant).

Zolotor presentation here.

Moving Towards Fee for Value
Steve Neorr, Chief Administrative Officer, Triad HealthCare Network

Mr. Neorr began his talk by reiterating the theme of high healthcare costs compared to poor health outcomes and discussing the impact of system design on outcomes. He argues that the healthcare system is working as intended because it is designed to give high-cost care without regard for cost or quality. We have two separate systems within healthcare – delivery and payment – with the delivery system being very fragmented and reactive and the payment system operating as fee-for-service. An illustrative example of how the system drives outcomes is that New Zealand and the United States are the only countries that allow direct-to-consumer advertising of medications, and therefore people in the US and New Zealand take more prescriptions regularly than in other countries. He discussed Triad HealthCare's founding principles, mission, and the main intent of the organization: to lower the cost of care and improve quality and outcomes. Triad's initial steps toward population health included deploying advanced IT resources, care management, team-based care, and addressing design problems to improve care transitions, reduce readmissions, and manage chronic diseases. Compared to results of other 2016 Next Generation ACO Results, Triad ranked second for total shared savings. He introduced the concept of the "nest" vs. the "wild," where the nest is when patients are in the office/clinic or in the hospital (1-2% of their time) and the rest of their time is in the "wild" outside of the healthcare setting. 80+% of costs are due to chronic conditions due to lifestyle. While 5% of patients may account for 50% of costs, focusing only on addressing the needs of that small population won't move the needle in terms of population health. Moving from the "nest" to the "wild" involves moving from outlets of care (hospitals, office, clinic) to interactions (on demand access to healthcare, care management, kind of taking the care to them). He concluded by describing several of Triad's pilot projects, including: a partnership with Guilford EMS for paramedicine within individual's homes, in-home palliative care, making calls to individuals as transition of care outreach, and automated prescription dispensers.

Questions/Discussion:

Question: Who has access to a patient's healthcare data for the telemedicine program?
Response: That is something Triad is trying to work out and is a challenge.

Question: Triad is doing great work to bring care to individuals in their home, but what community partnerships (with social services, public health, community organizations) are there to address social determinants of health?

Response: When you look at the populations we are serving, we are just now starting to do that. The past 18 months we have really come to the realization that there are a lot of great resources out there and we need to figure out how to integrate them better.

Question: How are you reinvesting those dollars saved?
Response: Reinvestment is in infrastructure – paying EMS, paying for the prescription dispensaries, etc.

Question: Have the home visits to patients with chronic disease been effective? Also what happens in the office – complicated patients are a high cause of burnout, how do you balance those needs?
Response: About half of care management visits are home visits from EMS. Those high touch visits are the best, but we are trying to figure out how to do that better and faster. Capacity of the care managers on staff to meet the needs of all those high-need patients is always a concern. Can we start monitoring them on an every-day basis without having to be in their homes. Regarding the second question – again stressing team-based care, freeing up physicians' time by having the patients deal with a care manager or a pharmacist instead of the physician.

Question: In the case of home visiting, maybe you have a COPD patient, and the care manager sees mold, how are care managers equipped to deal with conditions they may see?
Response: Triad will pay for those things that they need (mold removal, AC, ramps). Going back to reinvesting question, paying for those things is how we reinvest.

Neorr presentation here.

Discussion: Determinants of Health and Partnerships in Your Community
Facilitators: Shelisa Howard-Martinez, Brieanne Lyda-McDonald, Berkeley Yorkery, Adam Zolotor

The four clusters of tables in the room were asked to discuss as small groups how they have seen determinants of health addressed in their communities. Specifically, what kind of successful partnerships have happened within and between agencies and organizations; what were core principles that made partnerships successful; and what were some barriers to success? The facilitator from each table reported out on themes from the discussion. From Group 1, themes were alignment locally and regionally, standardizing data collection, taking on new roles as individuals and organizations, new workforce development, and understanding what workforce skills are needed. From Group 2, themes were payment is a big issue in getting people around the table and keeping initiatives going (and funding for community-based initiatives, partnerships), finding dedicated leaders to get things off the ground and plan for sustainability, having a business model that supports ongoing programs, having funding to plan programs that are evidence-based. From Group 3, themes included bringing non-traditional partners into discussion around policy changes that might not otherwise be involved in those discussions. From Group 4, themes were similar to some of those from Group 2, as well as barriers – notion of misaligned incentives for a common goal, information sharing, technology solutions to info sharing what is the role of a health information exchange, including a broader set of stakeholders.

Addressing Determinants of Health – Spectrum Health
Ken Fawcett, Vice President, Healthier Communities, Spectrum Health

Dr. Fawcett began by discussing the origins of Spectrum Health as a merger of two community hospitals. As part of the merger they allocated $6 million to spend for the medically underserved and economically disadvantaged. This funding essentially functions like a private foundation. Spectrum engages in targeted interventions to address social determinants of health. Dr. Fawcett described their work with three populations of focus: maternal and infant health, school health, and chronic disease. Spectrum's maternal and infant health program, Strong Beginnings, has worked to address the high rates of infant mortality among families of color in the Grand Rapids area. Community health workers go into homes to help educate women, and some of these workers are women who have been part of the program in the past. Dr. Fawcett described Social Impact Bonds, used as part of the funding mechanism for Spectrum's programming. The state benefits from the program because there is reduced Medicaid spending (reducing NICU utilization, special education). The state keeps half the savings and pay the other half to an intermediary. The intermediary then pays back investors and Spectrum so that they can continue the program. Savings are enough to be able to pay initial investors a market-based rate of return. For their school health program, Spectrum partners with local schools around technology to create a portal of entry for a workforce that is more reflective of communities they are serving. The school-based health clinics provide medical, behavioral health, and dental care for students in the school districts that are served free of charge. This reduces stigma for behavioral health and transportation barriers for medical care. Nurses can help take care of 98% of what a child would go to the health clinic for (cost of $84,000 per year per nurse). Spectrum's chronic disease management program is called Core Health and involves community health workers (CHW) visiting patients in their homes. CHW's screen patients for social determinants of health every 3 months and the results of the screening prompt referrals to community partners. Much of Spectrum's work is driven by the Community Health Needs Assessments. He concluded by giving examples of community partnerships, including Partner-2-Partner, to help community partners get the equipment they need from the hospital's group purchasing. A community food club offers individuals at 200% Federal Poverty Level or lower an opportunity to shop for food in a grocery-style setting.

Questions/Discussion:
Question: You said you started with $6 million and now $11, where is that additional funding coming from?
Response: Spectrum gets around $7.3 million annually and then they augment with other grants

Question: For the food club program, how does food purchasing work? Do you use group purchasing?
Response: Yes, but we also use Community Supported Agriculture (CSAs) from local farmers. Bulk of food comes from Feeding America, they charge a minimal handling fee. The program has only about 4 paid employees, the rest are volunteers. Augment food supply with buying wholesale, try to use the organizations that have more of a philanthropic mission.

Question: If someone begins to earn more than 200% FPL, are you looking at stratifying people so people who start to earn more still have access to the community food club but maybe pay more?
Response: We haven't really been tracking eligibility over time once people are initially eligible, but this is a good point to consider.

Question: Have outcomes from projects created the opportunity for other parts of state government to be involved?
Response: Local banking industry has been very involved/interested in our work in underserved communities. Trying to tighten relationships with the city, haven't reached out to department of commerce yet.

Question: Seems like for most services, you all are the provider of the services, are there examples where you partner with community organizations that are not part of Spectrum?
Response: Public school districts – Spectrum puts in money for school nurse salaries, so they are employed by the school districts.

Question: Are you advocating for more funding from the government?
Response: Haven't done that, in the process of having individual conversations with payers.

Question: Who is managing the Social Impact Bonds?
Response: When merger occurred, Spectrum set aside dollars on an annual basis. Michigan healthcare endowment trust, Spectrum health was a sponsor for social impact bonds, PNC has funded a chunk, Frye Foundation, Kellogg. Most of these funders have told us to keep the money we make back and create equity in the program. For the intermediary, we used an organization called IFF out of Illinois to create early social impact bonds and worked with the Kennedy School at Harvard to create the SIB model. We have a CDFI intermediary for the bonds.

Question: Since you have a variety of funders, your funders probably want to see reports and metrics. Do your funders want to see them separated out by funding stream?
Response: We do a single financial report and bring everyone to the table every 6 months.

Question: Would you say your source of innovation is more the local or the national partnerships?
Response: Both, I'd say it's about 2/3 and 1/3. We are starting to tap into national work to showcase what we are doing and learn from others.
Question from Maggie Sauer: The state is looking right now at what are the measures around social determinants of health. Can you talk a little about the standardized lists the ACOs have been given.
Response: Starting June 1 is when they will have to start reporting. None of the dollars can be used to create services. How can you work just on social determinants of health without getting into EMRs, we are just starting to figure that out.

Fawcett presentation here.

Panel: How Can Payers Support Accountable Care Communities?

Beverly Hamilton, Director, Government Contracts, Molina Healthcare of South Carolina

Ms. Hamilton gave an overview of Molina Healthcare and the organization's background. Molina works with government-sponsored programming, but primarily works with Medicaid. They adhere to a high-touch level and utilize "community connectors" (community health workers) whose presence makes people more accepting and trusting. She described managed care organizations (MCOs) as "people pleasers," trying to work in partnership with multiple stakeholders, but said that there must be expectations of the MCOs. The organization takes community partnerships seriously and pays employees for 16 hours a year of active volunteering in local communities. If care management systems are already in place, Molina will contract with those groups and infuse the community health workers already in place. Within the communities that Molina serves, they invest in "food, health, housing, and hope." She concluded by providing some examples of their work, including Ohio's community development for all peoples partnership, Healthy Moms & Babies, workforce development and job readiness (when those needs can be identified) by connecting people to organizations already offering these services in their community, Furniture Bank of Central Ohio, Food Share in South Carolina, and housing and community services in Texas.

Kevin Moore, Vice President of Policy, Health, and Human Services, UnitedHealth Group

Mr. Moore provided a background of UnitedHealth, a provider of commercial insurance, military, Medicare advantage program. He described the problem of members feeling lost in the service systems, where fragmentation makes systems difficult to navigate. He described UnitedHealth's global investment strategy, clinical interventions that are finding ways to realign the clinical model to get better outcomes, and, finally, looking at what are people doing that doesn't have to do with health care directly, but really has a huge impact on health outcomes. He provided examples of UnitedHealth's efforts in Maricopa County, Arizona with chronic homelessness and their Accountable Health Communities grant in Hawaii. In Maricopa County, they provide wraparound services with housing as the foundation. Challenges include rents going up and having to "double down" or find new property, as well as difficulty of finding people who are homeless – used a Z code for Medicaid, which is not commonly used by physicians. They have developed local partnerships to maximize housing and currently have 500 units with 50 filled. In Hawaii, UnitedHealth will be addressing social determinants through Federally Qualified Health Centers (FQHCs) and providers, essentially screening 75,000 individuals. They are building a network of state and local providers to address the issues they screen for and navigators help patients navigate the service system. The kick-off date for this initiative has been delayed.

Gloria Wilder, Vice President, Innovation and Preventive Health, Centene Corporation

Dr. Wilder provided some background on Centene, which has locally-controlled health plans in 29 markets across the United States. They are willing to work with communities on social determinants of health. She emphasized the importance of starting on something and failing fast – especially in healthcare, which doesn't have good evaluation built in for claims paid, and evaluations are based so

much on outputs (tests and treatments) rather than outcomes (did it matter to the patient, did it make a difference). She talked about challenging community organizations to become outcomes-focused and finding sustainable funding is the first key. Centene works with communities to identify their individual needs and is focused on housing, transportation, food insecurity, and job readiness.

Questions/Discussion:
Question: We've heard a lot about housing, food, education, but haven't heard much about what you are doing about transportation, for people who don't have Medicaid, people who don't have non-emergency medical transportation?
Response from Dr. Wilder: Centene is helping to fund local transportation networks. Providing Uber, Lyft. Encouraging markets to look at solutions that are very local – like church shuttle services to take people to the grocery or doctor.
Response from Mr. Moore: United has a partnership with an EMT service out of New York, interested to have a conversation about other funding streams for that vehicle to be used to serve other populations. Bus passes in urban areas – again difficult with regulations.

Question: Informal caregivers play a huge role, there are some publicly-funded programs to reimburse informal caregivers, but are any payers looking at doing this?
Response from Ms. Hamilton: South Carolina has a dual eligible program, where a family member can be reimbursed to provide different services, they have to be assessed but once it is in place, Molina does reimburse those caregivers.

Question: What should North Carolina do to hold MCOs accountable so that rural communities don't get left out?
Response from Dr. Wilder: Strong collaboration within the state is important. Make a cohesive ask.
Response from Ms. Hamilton: There's definitely an awareness of the rural/urban divide. Some of the requirements that the bidders must address show that there is a gap for rural communities.

Hamilton presentation here.

Moore presentation here.

Discussion: Task Force Charter
Adam Zolotor, President & CEO, NCIOM

Dr. Zolotor described the charter as a way to talk about how we are going to do our work together. The draft is a way to give everyone something to respond to. There will be a final draft for review at the next meeting based on people's comments. He described an additional product of the Task Force, along with a written report, which is a Technical Assistance manual, as we think a lot of the work will happen at the level of state recommendation, but a lot will also happen at the community level. The TA manual will

include information tools, legal tools, financial tools to support partnerships. Dr. Zolotor also talked through what would be in and out of scope for the Task Force discussions.

Questions/Discussion:
Comment: I think we should be approaching this task force from the perspective of focusing on social determinants of health and not value-based purchasing. With clinical care and social determinants of health, there's a fuzzy line but we are really focusing on social determinants of health.
Response: Yes, and we should understand the importance of screening and referrals in clinical setting as well.

Question: What is in scope and out of scope in terms of eradication of poverty? I do hope we have some opportunity in how to engage with sectors to move people out of poverty, as financial security is really a cornerstone of health.
Response – Agreed, this is a draft, so push back if there is disagreement. Not sure that health systems and insurers are totally involved in the same way. Importance of keeping a health lens on that will help us understand what is in and out of scope. Don't want to limit the discussion in a way that's not constructive

Comment: Want to emphasize the importance of keeping in mind the distinction of what we are talking about in terms of social determinants of health and population health.

Comment: For our recommendations, we should make clear that it is important to meaningfully engage other sectors so that responsibility and expectations aren't always falling back on hospitals and insurers, and understanding that all sectors do have a role to play and that addressing social determinants of health doesn't mean that health systems have to take all of this on.

Question: Can you clarify our aim about recommendations related to Medicaid transformation?
Response: Medicaid managed care- those recommendations are well-received, we have a conduit to communicate with DHHS to see if a recommendation we are thinking about is something that is in scope for DHHS.

Next Steps
Brieanne Lyda-McDonald, Project Director, NCIOM

Ms. Lyda-McDonald gave a brief presentation on the upcoming meeting dates, topics we will cover, methods for communication, and the Task Force website.

Lyda-McDonald presentation here.