

NCIOM 2017 Annual Meeting
Accountable Care Communities for a Healthier Nation
September 25, 2017

Morning Breakout Session 2
Payment Reform: Incentivizing Health Care
Toward Accountable Health Communities

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Duke Health

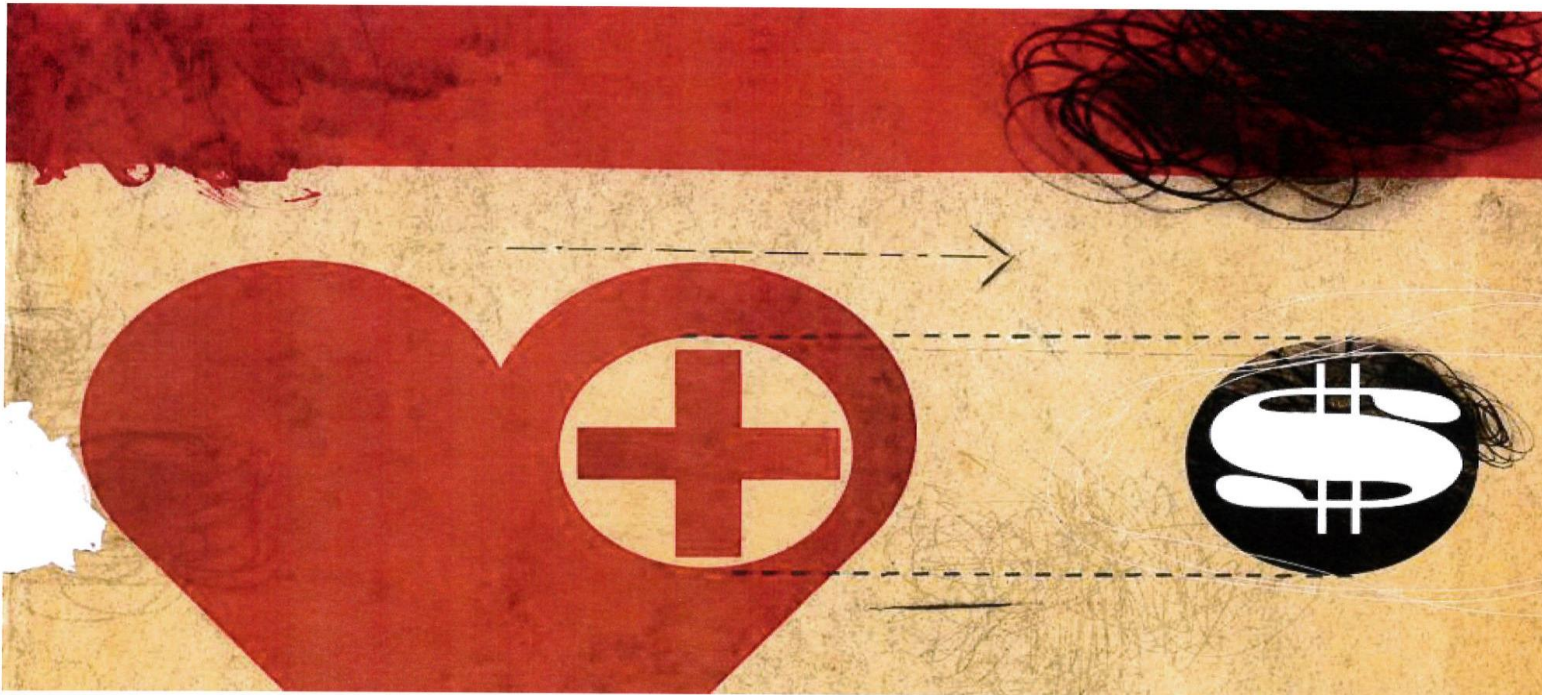
Accountable Care Communities

A working definition for this session:

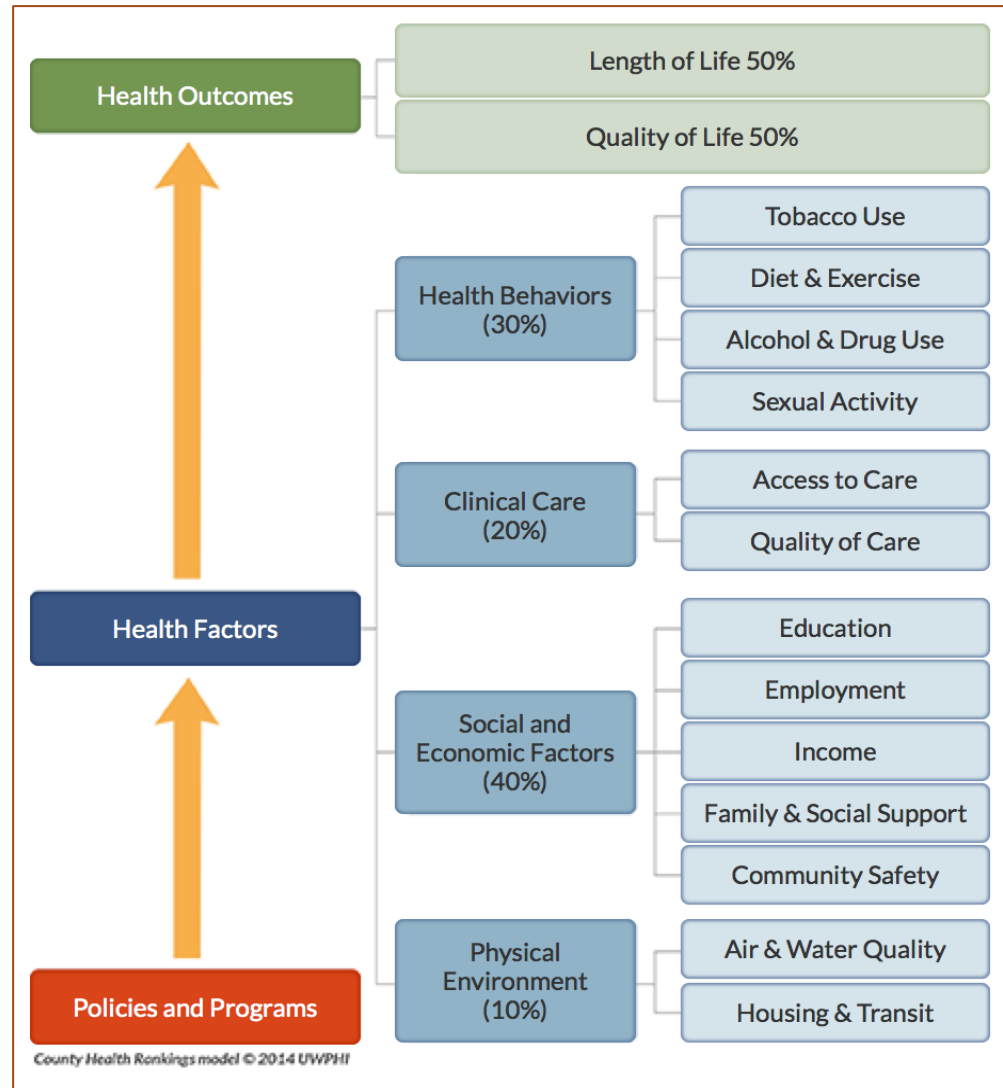
“The development of partnerships between healthcare and community-based organizations which involve shared risk and shared reward to move health systems further upstream in addressing the social determinants of health.”

Value-Based Care Alone Won't Reduce Health Spending and Improve Patient Outcomes by David J.

Bailey June 16, 2017



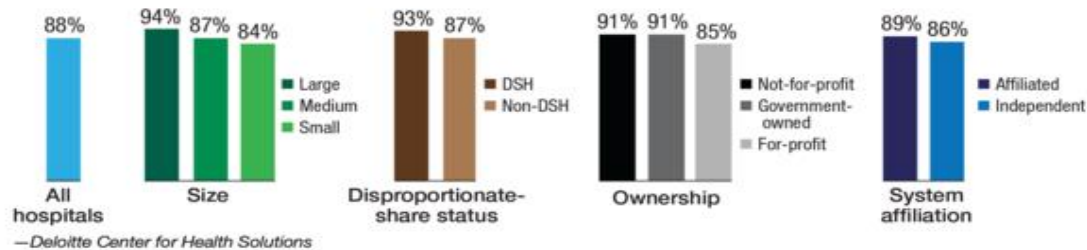
What We Know: Determinants of Health



Source: countyhealthrankings.org

Hospitals Screening for Social Determinants of Health

Screen for social needs



What hospitals screen for



More illness

83% of people who lose their job are more likely to have a stress-related health condition

25-year-olds

with a bachelor's degree or higher live eight to nine years longer than peers without a high-school diploma

—Commonwealth Fund

Data Points: Social Responsibility
Modern Healthcare,
Sept 23, 2017

Struggles and Disconnects

What social determinants of health are of most concern to your organization?

Education/job security

15%

Food insecurity

12%

Shelter

16%

Violence

8%

Transportation

8%

Other

41%

Source: Modern Healthcare research

What kind of partnerships are you involved in that aim to address population health issues?

Other local health organizations

23%

Insurers

15%

Local municipal or public health offices

5%

Federal agencies

0%

Not-for-profit organizations (United Way, YMCA, etc.)

10%

Retail stores or clinics

2%

Transportation services

2%

Local employers

2%

Other

43%

Note: Does not add up to 100 because of rounding.

Source: Modern Healthcare research

Source: Modern Healthcare CEO Power Panel 3rd Quarter Survey. Population Health: Providers Still Struggling to Build Community Connections. Vol. 47/No. 38. September 18, 2017. Pages 14-16

Multi-Sector, Multi-Stakeholder Partnerships



Four Core Competencies

- **Be Goal Oriented**
 - Root Cause
- **Conduct Research, Evaluation, and Education**
 - Plan, do, teach, and disseminate
 - Pursue multi-sectoral, evidence-based interventions
 - Evaluate as you go along
- **Understand Your Community Context and Construct**
- **Embrace Paradoxes and Complex System Thinking**

Polarity Management

A Multi-Sectoral Collaborative that seeks to address Social Determinants of Health is continuously and simultaneously balancing the particular **with the whole.**

- | | | |
|-------------------------------|---|------------------------|
| ▪ Specific population program | ↔ | ▪ The whole population |
| ▪ Tactical | ↔ | ▪ Strategic |
| ▪ Resource Focused | ↔ | ▪ Contextual |
| ▪ Intensive | ↔ | ▪ Integrated |
| ▪ Individual Impact | ↔ | ▪ Collective Impact |
| ▪ Uniqueness | ↔ | ▪ Connectedness |

From Chaos to Patterns to Particular to the Whole

The Value Proposition Continuum

Enlightened Self-Interest

Mutual Self-Interest

Benign Self-Interest

Pure Self-Interest (Machiavellian)

Top 25 Cost Impact

Estimated 2012 Cost to:	
Mental Health *	\$540,000
Durham County Jail	\$232,750
EMS	\$74,869
Fire	\$89,010
Law Enforcement	\$93,603
TOTAL	\$1,030,232

**similar 12-month period*

Serving Durham, Wake, Cumberland and Johnston Counties

Source: Durham County Familiar Faces Forum, 2014. Alliance Behavioral Health Presentation

LATCH: Local Access to Coordinated Healthcare

For Uninsured:

- Decreases in Hospitalizations
- Decreases in Emergency Department Visits
- Increases in Primary Care Utilization
- Increases in Specialty Care Utilization
- Provides Care Management for Project Access of Durham County
- Outreach and Education About Health Insurance Exchange

Through:

- Core LATCH
- LATCH-PADC
- LATCH-Respite
- LATCH-BEC
- LATCH SOAR



LATCH Interventions

<u>LATCH Interventions; Serves Uninsured people</u>	<u>Fiscal Year 2015-2016</u>
Total Unique Enrollees/patients*	6562**
Total Direct Contacts	11,520
Medical Appointments	Number of contacts
Pre-appointment reminders	3,435
Referrals to PCP	1,783
Specialty scheduling and post Appt. follow up	1,259
Enrollee Encounters	
Chronic Conditions , follow-ups with patients/providers under HEDIS care guideline	
Asthma	16
Cancer	14
Diabetes	143
Hypertension	6
Pain	31
Chronic Conditions Risk Factors	
Alcohol cessation referrals	29
Smoking cessation referrals	28
Mental Health & Substance Abuse	
Mental health referrals	226
Interpersonal violence referrals	15

Social Determinants of Health

Basic needs (money, clothes)	188
Bills assistance (medical & nonmedical)	34
Employment assistance and referrals	25
Food access	61
Foreign language interpretation arranged	42
Foreign language interpretation provided	46
Housing (quality, affordability and access)	181
Legal aid referrals	23
Medicaid application assistance	1,280
Medication assistance	583
Nutrition counseling	19
Supportive counseling	13
Transportation (medical & non-medical)	355

Specialty Care Coordination

Dental care referrals	261
DME referrals and purchases	293
Eye care appointments	119
Eyeglasses referrals and purchases	147
OB referral and follow-up	22
Physical therapy referrals	9

* A person has to enroll in LATCH and sign a consent before receiving any care management/coordination services

** 54% Latino

The Duke Outpatient Clinic - Community Connected Health /Advanced Medical Home

Just for Us

DUH

Transportation

Care Management

Affordable Housing

DRH

HCFH Clinic

Acupuncture

Physical Therapy

Alliance Behavioral Health

Durham Diabetes Coalition

Medical Respite

Neighborhood base
Community Health Worker

Community Housing Specialists

LATCH

Crisis Intervention Teams

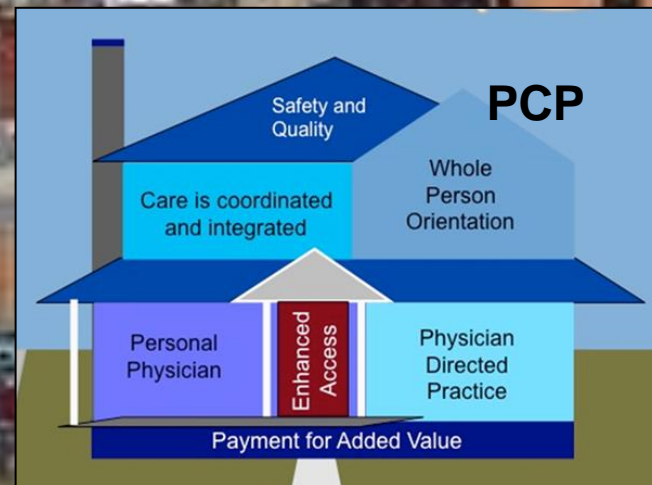
Partnership for Healthy Durham

Wellness City Peer Support

Center for Living

Adult Protective Services

Occupational Therapy



Healthy Durham 20/20

A New Vision...Join the Movement!

Contact Information

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Q & A