CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

CACHI

...The Next Generation of Health System Transformation

Leveraging Accountable Communities for Health to Meet CalAIM Goals

INTRODUCTION

"Issues such as housing, exposure to trauma, food insecurity and economic instability are powerful determinants of health outcomes..."

There is broad agreement among all stakeholders that California's current health care system is costly, unnecessarily complex, and falls short of producing desired health outcomes. California has been a leader in expanding coverage through the Affordable Care Act and implementing managed care. However, health care services delivered in clinical settings are not going to be sufficient to improve health, moderate costs and increase health equity across the state. There is growing recognition that issues such as housing, exposure to trauma, food insecurity, and economic instability are powerful determinants of health outcomes. Health care can respond to mitigate the impact those factors have on individuals' health, but it takes a coordinated effort across sectors, with managed-care plans as a critical partner, to implement the range of strategies (from services to policy change) that are necessary to see significant change.

The Department of Health Care Services recently launched the CalAIM initiative, which stands for California Advancing and Innovating Medi-Cal. CalAIM proposes a framework to guide upcoming Medicaid transformation initiatives, including waiver renewals, as the state's current 1115 waiver (Medi-Cal 2020) and 1915(b) waiver come to a close in 2020. CalAIM provides an opportunity for policymakers and stakeholders to build on progress to date to make the health care delivery system more efficient and effective for people who rely on Medi-Cal.

INSIDE THIS BRIEF

TRANSFORMING COMMUNITY HEALTH THROUGH PARTNERSHIP

CACHI

CACHI is a public-private partnership between private funders and state government. This initiative was developed in 2016 in response to recommendations from the State Health Care Innovation Plan and the Let's Get Healthy California Task Force advocating for a new model of health system transformation. CACHI's key partners include The California Endowment, Blue Shield of California Foundation, Social Impact Exchange, Kaiser Permanente, The California Wellness Foundation, Sierra Health Foundation and the Well Being Trust, in collaboration with the California Department of Public Health. CACHI is supported by Community Partners.

Learn more at www.CACHI.org.

To successfully achieve CalAIM's goals, Managed Care Plans (MCPs) will need to expand the services they provide and the strategies they employ. Those new services and strategies will require different relationships with the communities MCPs serve, specifically new infrastructure and partnerships within the health care sector as well as across other sectors, such as public health, housing and human services.

Spawned by the state of California's *Let's Get Healthy California Task Force* and *State Health Care Innovation Plan*, the **California Accountable Communities for Health Initiative (CACHI)** is a public-private partnership created to support the implementation of accountable communities for health (ACHs) in communities across the state. ACHs work to **improve the health of individuals and the community as a whole in order to change the ultimate trajectory of health outcomes and costs.*** The 13 ACHs provide venues for partners to collectively set priorities, pool and align resources, implement effective interventions and create an enduring infrastructure that supports shared accountability. ACHs have fostered needed relationships and could provide an infrastructure to help deliver on many of CalAIM's goals.

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* The George Washington University Funders Forum on Accountable Health provides this working definition of accountable health: "Accountable health approaches (often called Accountable Communities for Health or Accountable Health Communities) offer, in varying degrees, an integrated approach to the health (prevention and public health), health care and social needs of individuals and communities in order to improve health outcomes, reduce costs and resolve upstream factors that affect health. In a value-based purchasing environment, accountable care holds providers responsible for better management of clinical conditions in a patient population; accountable health holds multiple sectors (including health and health care) responsible for the health of a community." More information at: accountablehealth.gwu.edu/funders-forum/principles-accountable-health.

SHARED OPPORTUNITIES

Through the ACH model, communities are addressing a variety of health and wellness issues including chronic disease (e.g., cardiovascular disease, asthma, diabetes), community-level trauma and violence, substance use disorder and children's well-being. In terms of population, ACHs focus on communities where there are significant opportunities to improve health and social outcomes; most residents of these communities are enrolled in Medi-Cal. Key elements and core competencies of an ACH include:[i]

- A formal infrastructure, including an identified backbone entity, to support partnerships and facilitate a collective action approach;
- Resident engagement, participation and leadership;
- A portfolio of interventions that spans clinical interventions; community-based services; linkage activities; and policy, systems and environment changes. The portfolio brings together these many interventions into a cohesive framework with a set of short, medium and long-term outcomes agreed to by local leaders; and
- A locally governed wellness fund to support the ACH's work and infrastructure, and align funding across sectors to achieve shared outcomes.

The CalAIM proposal presents three programmatic and strategic goals:

- Identify and manage member risk and need through Whole Person Care approaches and addressing social determinants of health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery initiatives, modernization of systems and payment reform.

It is clear that there is significant alignment between CACHI and CalAIM in terms of high-level objectives. Moreover, the ACH model could make four critical contributions toward achieving CalAIM goals:

A. Provide neutral, trusted coordinating entities

B. Ensure a prevention-oriented focus on social determinants of health

C. Integrate and coordinate care and services for physical and behavioral health and health-related social needs

D. Genuinely engage community members

A CLOSER LOOK AT ACHs' POTENTIAL CONTRIBUTIONS

Each of the four potential contributions on the previous page are evident in ACH activity in California and are also reflected in Medicaid reform efforts in other states. The sections below describe further the potential contributions of CACHI and the ACH model more broadly, provide examples of relevant California ACH activity to date and share examples of promising work from other states. While California has a unique Medicaid history and structure, there are valuable lessons from other states that are testing innovative strategies to improve the health of populations, reduce the per capita cost of health care and advance health equity.*

A. PROVIDE NEUTRAL, TRUSTED COORDINATING ENTITIES

Backbone organizations convene stakeholders and create conditions for shared responsibility for progress in meeting health improvement goals. They align disparate interventions and resources across sectors to achieve mutually agreed upon outcomes. Evidence is growing, indicating that health collaboratives lead by a coordinating entity are associated with improvements in health outcomes, shared vision and goals, and engagement of community organizations.[ii,iii,iv] Numerous types of organizations can fulfill the backbone role, including nonprofit organizations, public health departments, health systems or hospitals.[v] Achieving CalAIM proposal goals listed above, and improving health and equity in California will realistically require the guidance and support of a strong local coordinating entity.

California Example: Sonoma backbone builds trust to improve HEDIS scores.

Health Action of Sonoma County convenes multisector partners and promotes cardiovascular disease prevention across the community through a portfolio of interventions (POI). Over several years, Health Action, supported by the Sonoma County Department of Health Services, has fostered trusted relationships among local health systems that have in turn supported data sharing for quality improvement efforts. One focus of Sonoma County's effort is improving HEDIS scores related to controlling high blood pressure. Health Action and partners developed a robust set of countywide strategies to control blood pressure.

* Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care. More information at: https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.

On an annual basis from 2014 - 2017, four participating provider organizations agreed to report and share data for the blood pressure HEDIS measure. In other environments, these provider organizations may view one another as competitors; in this case the backbone organization generated trust and collaboration, allowing for collaborative planning, interventions and data sharing. Overall, participating provider organizations reported a 19% and 20% improvement on the two blood pressure control HEDIS measures.

National Example: Washington State ACHs have an expanding leadership role.

Nine regional ACHs work across Washington State to build infrastructure, which provide the foundation for regional, multi-sector collaboration. The ACHs also produce regional health improvement plans, implement health initiatives and advise state agencies about their geographic region.[vi] ACHs were featured prominently as a key part of Washington's State Innovation Model (SIM) and then through the state's 1115 Delivery System Reform Incentive Payment (DSRIP) waiver.

Among other responsibilities in program planning and implementation, ACHs are also responsible for distributing earned incentives to partners for meeting certain milestones related to planning, reporting and outcomes.[vii] In 2018, the nine ACHs earned almost $296 million in incentives.[viii] A recent evaluation of the ACH model in Washington reports that key strengths of the ACHs include building trust and collaboration through their role as neutral conveners and creating infrastructure for large-scale system change.[ix]

The evaluation also notes that "over time, backbone staff assumed more of a leadership role, often becoming the voice of their ACH in statewide conversations."[x] The funding allocated across ACHs and their backbone organizations has also increased from $7.3 million under the SIM to up to $1.1 billion for the DSRIP waiver.[xi]

FIGURE 1.
CONTINUUM OF STRATEGIES TO ADDRESS HEALTH ISSUES

B. ENSURE A PREVENTION-ORIENTED FOCUS ON SOCIAL DETERMINANTS OF HEALTH

The CalAIM proposal emphasizes the importance of investing time and resources in response to social determinants of health. The social determinants of health are "the conditions in which people are born, grow, work, live and age."[xii] and are distinct from an individual's health-related social needs (HRSNs).[xiii]

What CalAIM describes is primarily, if not exclusively, focused on individual social needs. While addressing the health-related social needs of individuals is undoubtedly crucial to improving their health, these efforts are not sufficient to create significant change in population health status or have an impact on health equity.

First, HRSNs are identified after the fact, so the response is always going to be mitigating harm and effects on health, not prevention. That means that patterns (by socio-economic status, race, gender, ethnicity, sexual identity, etc.) of who gets sick and injured will remain largely the same. Second, responses to HRSNs focus on the needs of individuals but do not reflect the broader policy and systems issues that determine the needs and/or availability of resources to respond and prevent illness and injury. For example, homelessness and housing instability among patient populations are unlikely to be addressed through identification of the issue and navigation services.

The underlying problems often include the lack of affordable housing and substance use disorders caused by adverse childhood experiences. Childhood adversity and trauma require a comprehensive strategy that builds off the state's investment in clinician training and screening but goes well beyond these initial steps. ACHs have an explicit focus on bringing together individual and community-based focused strategies that address these root causes.

California Example: Imperial County supports cross-sector efforts to address root causes of asthma.

Through an agreement reached as part of Medi-Cal rural expansion, California Health and Wellness (a subsidiary of Centene) makes regular contributions to a Wellness Fund to address priority health concerns across Imperial County. The funds are overseen by a cross-sector commission, with the majority of funding allocated to support systems change work.

Specific new initiatives have been launched, such as the Asthma Community Linkages Project, which connects asthma patients in the emergency department to appropriate follow-up and preventive home-based care, including home remediation strategies to eliminate asthma triggers. Moreover, in line with the ACH concept of a Portfolio of Interventions, this ACH is addressing root causes of asthma through partnerships with environmental protection, education and housing, and work on county policy related to improving air quality.

National Example: North Carolina creates flexibility to address risk factors.

One example of state activity in this realm is North Carolina's current 1115 waiver, known as the "Healthy Opportunities Pilot." Under this pilot, the state is allowed to cover non-medical evidence-based services that address social needs known to impact health.[xiv] This waiver takes the furthest step yet in targeting interventions to social needs of Medicaid enrollees and allowing Medicaid to pay directly for such services with up to $650 million in funding.[xv] In addition to funding services, the pilot also supports infrastructure to share information across organizations.

To be eligible for the pilot, enrollees must have at least one specified physical or behavioral health condition and at least one "social risk factor" related to housing, food insecurity, transportation, and/or be at risk of witnessing or experiencing interpersonal violence.[xvi]

Among 1115 waivers, the North Carolina waiver pushes the envelope in terms of the types of services the state can reimburse, including payments for improvement to the safety and quality of housing, one-time payments for housing (e.g., first month's rent), legal services for interpersonal violence issues and evidence-based parenting support services.[xvii, xviii]

C. INTEGRATE AND COORDINATE CARE AND SERVICES FOR PHYSICAL AND BEHAVIORAL HEALTH AND HEALTH-RELATED SOCIAL NEEDS

Complex patients and health conditions are often interrelated with a host of behavioral, social and economic issues. It is rare that a single provider will have all of the skills and resources necessary to respond to the range of issues. California initiatives, including Whole Person Care and the Health Homes Program, focus on improving coordination and a comprehensive response for complex, high-utilizing populations, with an emphasis on homelessness. The need, however, stretches far beyond a narrow population and set of services. Issues such as housing insecurity, opioid misuse and childhood adversity affect many individuals who may not yet be in the top 5% of utilization. As clinical institutions screen for social needs and social determinants more systematically, the issues are going to become more evident, and patients and providers are going to expect a commensurate response. Furthermore, clinical organizations often lack connections with community providers and resources, and in turn community organizations tend to lack the capacity and know-how to manage partnerships with clinical entities.

Because of the nature of ACHs, which take a holistic approach to producing health improvements, including health and social needs,[xix] the ACH model can enhance efforts to meet CalAIM objectives related to better care integration and coordination at a community scale. ACHs facilitate the development of partnerships, data sharing and other strategies, such as training and incorporating Community Health Workers to support coordination of care across clinical and community providers. ACHs serve as brokers among various partners who have historically not worked together directly but often serve the same people.

California Example: San Diego backbone convenes multisector partners for a navigator program.

Be There San Diego (BTSD) serves as the backbone organization for San Diego's ACH. A well-respected and neutral convener, BTSD has been able to bring together cross-sector partners, including multiple Medi-Cal managed care health plans, to launch Neighborhood Networks, designed to connect health care and community-based organizations to address health-related social needs. BTSD partners recognized that a skilled Neighborhood Navigator can provide a crucial service to health plans and providers by filling the gap between identifying social needs and managing relationships and referrals with a set of community service providers.

National Example: Colorado integrates physical, behavioral and other health-related services.

The Colorado Medicaid program recently reorganized into seven Regional Accountable Entities (RAEs) responsible for physical and behavioral health and other health-related services. In addition to administration and financing, RAEs are responsible for coordination of services in physical and behavioral health, and other providers in their "health neighborhood." A capitated managed care rate is paid to the RAEs for each enrolled member.[xx]

D. GENUINELY ENGAGE COMMUNITY MEMBERS

Community engagement and participation will be important factors in determining the success of the CalAIM initiative. Effective community engagement and participation lead to strategies that actually meet the needs of enrolled members and their families, and greater participation by those members in managing and improving their health. Additionally, NCQA certification for plans (a CalAIM objective) specifically requires community engagement.

ACHs emphasize authentic community partnerships and are developing a range of strategies to make that happen. Engaging residents as true partners in health improvement efforts necessitates setting up inclusive accountability and equitable decision-making practices. That means that community residents in particular are not only asked for their input but also have power in decisions about priorities, interventions and resources.

California Example: The East San Jose PEACE (Prevention Efforts Advance Community Equity) Partnership is developing a comprehensive racial and health equity effort to prevent and reduce violence and trauma.

An inclusive leadership team that includes representatives from health care, public health, governmental agencies, community organizations and community residents guides the Partnership. Full community participation, with an emphasis on youth, and equity implications are considered in all aspects of development from strategy selection to financial management to measurement and evaluation.

National Example: Oregon requires community oversight and input.

Currently, 16 CCOs serve nearly 9 out of 10 Oregon Medicaid enrollees.[xxi, xxii] CCOs require local governance including community member participation, and each CCO is required to convene a Community Advisory Council (CAC).[xxiii] The CAC must include mostly consumers and is required to include representatives from all county governments included in the regional service area.[xxiv]

RECOMMENDATIONS

In order to advance the four strategies described above, a number of specific steps could be taken through the CalAIM process, managed care procurement, subsequent waivers or a legislative process. Regardless of the policy vehicle, the important result is increased accountability for health locally. The entities involved will look different in each context and community, and a spirit of innovation should foster piloted ideas and learning shared across the state. These recommendations are intended to outline bold steps the state could take to build accountability and long-term capacity to address underlying causes of illness and injury.

» Require investment in community health through a coordinating entity

A number of states have required health plans to make community investments a part of contracting (e.g., Arizona and Oregon).[xxv] Others have put requirements in place for hospitals and health systems to invest in local communities through regulatory policy and/or as a requirement attached to major capital expenditures.[xxvi] A small (from the health care sector's perspective), but mandatory, investment could provide the certainty and continuity to build significant capacity over time in community-based coordinating entities entrusted with pursuing shared objectives.

» Institute robust community oversight of Medi-Cal Managed Care Plans

The CalAIM proposal emphasizes and expands the role of managed care plans as the primary agents of health system reform. Those plans have a mixed record of performance according to state auditors and other observers.[xxvii] In order to ensure that public resources are expended in line with local priorities, managed care plans should have oversight by a board with a majority of members who are Medi-Cal clients or representatives from community-based organizations.

» Designate funding to support "Social IPAs"

There is such a pressing need for coordination and linkage between clinical institutions and a range of community organizations that work on social needs related to health that specific funding and contracting agreements are warranted. In the same way that an independent physician association functions to reduce complexity, establish contracts and manage risk for providers, a "social IPA" could do the same for non-clinical community organizations that provide services related to social needs and social determinants of health.

» Establish community health quality metrics

The majority of value-based incentives remain focused on services and individuals. Tying value-based incentive dollars to a set of population-level measures focused on outcomes (e.g., rates of chronic disease in an entire geographic area) or determinants of health (e.g., community level body-mass index, opioid use or kindergarten readiness) could serve to break down concerns among health care payers about churn and focus collective efforts on measures with meaning. A number of other states are experimenting with such population-level quality metrics. These sorts of metrics, even if connected to modest incentives, drive interest and attention to the role health care can play in improving health at a community or population level. Additionally, managed care plans should be encouraged to align related pay-for-performance incentives for providers.

CONCLUSION

In order for California to meet the goals laid out in the CalAIM proposal (better management of risk, addressing social determinants of health, reducing complexity, increasing flexibility, improving quality outcomes, system transformation),[xxviii] the state, managed care plans and key stakeholders must expand efforts to address health beyond the delivery of medical care.

Notably, there is a clear need for multisector collaboration that bridges public health, social services, education and other sectors that affect health, with a strong emphasis on resident participation. To date, managed care plans and the delivery system have made progress in addressing the health-related social needs of individuals and have provided opportunities to work on social determinants of health. The CalAIM proposal builds on this progress. However, while this is important and necessary, such efforts alone are insufficient to create accountability for improving health and increasing health equity.

Other states are responding to the imperative to operate differently by providing more flexibility to focus on social needs and underlying social determinants of health, putting resources and funding into infrastructure and coordinating entities, requiring meaningful community participation and establishing incentives tied to community health.

This brief shares examples of such efforts. California has a strong starting point through ACH work in 13 sites across the state to date, supported by millions of dollars of investment from philanthropy. Bold action could leverage that capacity, create better alignment between the interests of health care entities and community stakeholders, and lead to improved fiscal, health and social outcomes.

ENDNOTES

i. California Accountable Communities for Health Initiative. Uniting Leaders to Improve Health. https://cachi.org/uploads/resources/CACHI_One-pager_Overview_v14-FINAL.pdf.

ii. Mongeon M, Levi J, Heinrich J. Elements of Accountable Communities for Health: A Review of the Literature. National Academy of Medicine. https://nam.edu/elements-of-accountable-communities-for-health-a-review-of-the-literature/. Published June 18, 2019.

iii. Mays GP, Mamaril CB, Timsina LR. Preventable Death Rates Fell Where Communities Expanded Population Health Activities Through Multisector Networks. Health Affairs. 2016;35(11):2005-2013. doi:10.1377/hlthaff.2016.0848.

iv. ORS Impact. When Collective Impact Has Impact: A Cross-Site Study of 25 Collective Impact Initiatives. HultCenterArts. https://www.orsimpact.com/blog/When-Collective-Impact-Has-Impact-A-Cross-Site-Study-of-25-Collective-Impact-initiatives.htm. Published February 28, 2018.

v. Heider F, Kniffin T, Rosenthal J. State Levers to Advance Accountable Communities for Health. National Academy for State Health Policy. May 2016. https://nashp.org/wp-content/uploads/2016/05/ACH-Brief-with-Appendix.pdf.

vi. Center for Community Health and Evaluation. Regional collaboration for health system transformation: An evaluation of Washington's Accountable Communities of Health. January 2019. https://www.hca.wa.gov/assets/program/cche-evaluation-report-for-ACHs.pdf.

vii. Healthier Washington. Accountable Communities of Health 101. https://www.hca.wa.gov/assets/program/ACH-101.pdf.

viii. Washington State Medicaid Transformation Project Demonstration. Washington State Medicaid Transformation Project (MTP) demonstration Section 1115 Waiver Annual Report (DY 2) / Quarterly Report (DY 2 Q4) Demonstration Year: 2. May 2019. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wa/medicaid-transformation/wa-medicaid-transformation-qtrly-annl-rpt-dy2-20190519.pdf

ix. Center for Community Health and Evaluation. Regional collaboration for health system transformation: An evaluation of Washington's Accountable Communities of Health. Published January 2019. https://www.hca.wa.gov/assets/program/cche-evaluation-report-for-ACHs.pdf.

x. Ibid.

xi. Ibid.

xii. About Social Determinants of Health. World Health Organization. https://www.who.int/social_determinants/sdh_definition/en. Published September 25, 2017.

xiii. National Academy of Sciences. Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health. http://nationalacademies.org/hmd/Reports/2019/integrating-social-care-into-the-delivery-of-health-care. Published September 25, 2019.

xiv. Hinton E, Artiga S, Musumeci MB, Rudowitz R. A First Look at North Carolina's Section 1115 Medicaid Waiver's Healthy Opportunities Pilots. The Henry J. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots/. Published July 1, 2019.

xv. North Carolina Department of Health and Human Services. North Carolina's Healthy Opportunities Pilots: A Review of Proposed Design for Interested Stakeholders. February 2019. https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf.

xvi. Ibid.

xvii. Ibid.

xviii. Ibid.

xix. Principles of Accountable Health. GWSPH Centers and Institutes. https://accountablehealth.gwu.edu/funders-forum/principles-accountable-health.

xx. Bontrager J. The Ways of the RAEs. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/ways-raes.

xxi. Coordinated Care: the Oregon Difference. Oregon Health Authority: Health Policy and Analytics. https://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx.

xxii. Raths D. Oregon Prepares to Launch 'CCO 2.0' Era. Hea!thcare Innovation. https://www.hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/news/21088094/oregon-prepares-to-launch-cco-20-era. Published July 11, 2019.

xxiii. Smith J. Transforming the Oregon Health Plan: Coordinated Care Organizations. Office for Oregon Health Policy and Research. June 2012. https://www.shvs.org/wp-content/uploads/2014/02/State-Network-AM-Jeanene-Smith.pdf.

xxiv. Ibid.

xxv. Bachrach D. Sustainable Investment Social Interventions in Medicaid. https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review. Published January 31, 2018.

xxvi. Institute on Urban Health Research and Practice. An Innovative Approach to Prevention as a Component of Health Care Reform. https://www.northeastern.edu/iuhrp/wp-content/uploads/2013/12/PreventionTrustFinalReport.pdf

xxvii. California State Auditor – 2018-2019 Reports on the Department of Health Care Services. https://www.auditor.ca.gov/reports/agency/137.

xxviii. The IHI Triple Aim. Institute for Healthcare Improvement. http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx.