VBPmonitor

Adding Social Needs to the Value-Based Care Equation

By Carole Black, MD and Dorothy Berry, RN

The Centers for Medicare & Medicaid Services' (CMS) first major announcement of 2016 addresses the need to bridge the gap between clinical care and health-related social needs. A new initiative called the Accountable Health Communities Model (AHCM) will help the agency assess if connecting patients in a clinical setting to community resources, providing assistance with adequate housing, food, transportation, and other critical support, will increase care quality and reduce the cost of care for Medicare and Medicaid beneficiaries.

Numerous studies and first-hand experience show that patients lacking support for health-related social needs are at greater risk for developing one or more chronic conditions, such as diabetes, obesity, and/or heart disease. That, coupled with the inability to effectively manage these conditions, leads to higher utilization of the healthcare system through repeated emergency department admissions, the use of costly prescription medications, and other potentially avoidable events. It's well-documented that vulnerable populations account for a significant portion of healthcare-related costs in the U.S., and the hope is that implementation of the AHCM will support CMS's "better care, smarter spending, and healthier people" approach to improving care delivery.

Under the AHCM, participating provider organizations will be responsible for conducting screenings, making referrals, and connecting Medicare and Medicaid patients to other organizations or services in the community that can support an individual's unmet social needs across five core areas:

- Housing instability and quality
- Food insecurity
- Utility needs
- Interpersonal violence
- Transportation needs

Over a five-year period, the new model will implement and test a three-pronged approach: increase awareness of available resources, assist patients in accessing resources, and align resources to ensure that patient needs are met. While the AHCM is new, many provider organizations participating in value-

based arrangements already have implemented their own tactics to help meet the growing social needs of their patient populations.

In fact, one of the strategies hospitals and health systems have adopted to address patient barriers to care is incorporating a social or community health worker as part of an established clinical team to improve coordination and quality. In this standard staffing model, individuals who fill these roles serve as patient liaisons, taking on a multitude of tasks such as monitoring patients in unstable housing situations, ensuring their contact information is current, and visiting patients in their homes to see first-hand the implications their social situations have on their physical health.

These are just a few examples that organizations across the country have established that already support the AHCM's desired outcomes. CMS's announcement facilitates integration of currently fragmented efforts to deconstruct clinical and social silos in healthcare. The AHCM keys on an emerging trend – viewing individuals holistically and considering physical, mental, and social factors of health – and creates a way to test approaches and develop best practices.

So, how does an organization evaluate enacting measures to support the AHCM?

Know Your Patients

Understanding the patient demographic is key in implementing any population health initiative. Organizations evaluating participation in the AHCM should:

- First look at the Medicaid and Medicare beneficiaries served. According to the U.S. Government Accountability Office (GAO), 5 percent of Medicaid beneficiaries account for nearly 50 percent of all healthcare-related costs. Focusing on bettering outcomes for the sickest segment of the population will result in significant savings and improvements in health outcomes.

- To stratify the population further, an organization also can drill down to patients with the greatest number of medical complexities and chronic conditions. The Centers for Disease Control and Prevention (CDC) reports that treating people with chronic diseases accounts for 86 percent of the nation's healthcare costs.

- Lastly, conducting a comprehensive assessment of existing health-related local resources will build both a strong database of community connections and uncover gaps where ties need to be established to ensure that patients receive needed support.

Understand Your Value Proposition

Hospitals and health systems maintaining organizational self-sufficiency through value-based care arrangements and those operating a provider-sponsored health plan (PSHP) are well-positioned to address social determinants as barriers to care. PSHPs can be designed and customized with a provider organization's patient population in mind, setting the stage for better alignment of incentives, increased clinical coordination, and the ability to effectively target pools of at-risk patients.

Pending the success of the AHCM at the end of the current five-year test period, it's fair to assume that the model will be widely established. For this reason, healthcare leaders should weigh the benefits of taking on increased risk for their organizations in the form of a PSHP or other value-based care model to accelerate the development of more complex and coordinated care systems that stretch well beyond traditional hospital and doctors' office walls.

Build Your Network

Provider organizations also can help provide assessments of existing social determinants, offer recommendations for effective solutions, and serve as the connection point to community services. For example, understanding that a patient doesn't own a cell phone and could experience difficulty making appointments or speaking with their physicians will provide the much-needed context to fix the issue that causes them to forego receiving care.

Holistic Care: Looking Ahead

Amid the continued push toward coordinated, high-quality care, the healthcare industry faces growing pains and challenges in providing the best possible patient care at the lowest possible cost. However, the AHCM is a significant step toward optimal care coordination, better outcomes, and lower healthcare costs, and is the much-needed beginning to a larger conversation encompassing social determinants of health. Aggregate data resulting from the model's trial period could serve as a vital tool in continued progress toward achieving a healthier nation with lower healthcare spending rates.

About the Author

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