MEDICAID ADVISORY COMMITTEE
July 26, 2017
9:00am-12:00pm

Webinar registration: https://attendee.gotowebinar.com/register/4662689441953504004
Public listen-in only conference line: 1-888-398-2342
Participant 3732275

Meeting Objectives

- Regular business (e.g. approve minutes)
- Review results of legislative session relevant to the MAC's work
- Increase understanding OHA and DHS integrated eligibility project
- Discuss and potentially finalize Guiding Principles for Oregon Medicaid in the event of federal changes to the program
- Understand the concept of Social Determinants of Health and increase understanding of how these determinants can be addressed in the health care system, particularly at a clinical level

Time	Item	Presenter	Purpose
9:00	Welcome and Introductions • Adopt minutes	Co-chairs	Action
9:15	Legislative session report	Brian Nieubuurt, OHA	Informational
9:30	DHS/OHA Integrated Eligibility/Medicaid Eligibility Project	Wayne Haddad, OHA; Eric Smith & Kim Fredlund, DHS	Informational & Discussion
10:00	Guiding Principles for Oregon Medicaid (in response to federal Medicaid proposals)	MAC Guiding Principles Workgroup & All	Discussion & Possible Action
10:50	Break		
11:00	Primary Care and the Social Determinants of Health	Carly Hood, OPCA	Informational & Discussion
11:45	Public comment		
11:55	Closing	Co-chairs	

Next Meeting:
Sept 27, 2017
Oregon State Library
Salem

DRAFT Guiding Principles for Oregon Medicaid

A set of principles to guide the state in the event of federal changes to program financing or structure

The Oregon Medicaid Advisory Committee (MAC) is a public advisory group established in accordance with 42 CFR § 431.12 and ORS 414.211 to advise the Oregon Health Authority and Department of Human Services regarding Oregon Medicaid policy and planning using a member and community lens. The MAC developed a set of six guiding principles to assist the state as it considers possible federal changes to Medicaid financing and structure and increased programmatic flexibility. These principles are meant to begin a conversation; the MAC invites Oregon policymakers to engage with the Committee in future policy development work in the specifics of Medicaid reform.

The MAC would like to emphasize that the following principles were created in the context of possible financing and structural changes to Medicaid that would result in a cost shift from federal to state funding sources. As such, these principles are not meant to present an ideal or improvement framework for Oregon's Medicaid program. Instead, the MAC principles are meant to identify core, foundational elements of Oregon Medicaid that should be protected even in the face of possible cuts or increased flexibilities for state programs.

While the following principles are specific to the Medicaid program, the MAC recognizes Medicaid as integrally linked to the broader health care system. Indeed, Medicaid members frequently move between Medicaid and other types of coverage, including qualified health plans and employer-based coverage, and into Medicare as they age. Other bodies have developed principles for the health care system as a whole, including the Oregon Health Policy Board's guiding principles for its Action Plan for Health, and Oregon's principles for federal reform.[1] The MAC endorses these broader principles and has sought alignment in developing its own principles for Medicaid.

[1] See American Health Care Act: Impact on Oregonians. March 16, 2017. Oregon Department of Consumer and Business Services and Oregon Health Authority. Available at: http://www.95percentoregon.com/uploads/9/9/2/6/99265876/ahca-report.pdf

Six Guiding Principles for Oregon Medicaid

1. Maintain Medicaid's capacity as a critical support program for diverse subpopulations of low-income and categorically eligible Oregonians.

Oregon should maintain Medicaid's capacity as a critical support program for diverse subpopulations of low-income and categorically eligible Oregonians, including but not limited to parents, women, children, seniors, persons with disabilities, communities experiencing health inequities,[2] and residents in rural and frontier areas. Furthermore, Oregon should strive to maintain the significant coverage gains the state has achieved since the implementation of the Affordable Care Act. In particular, the state should maintain coverage for vulnerable populations, such as children, without allowing the number of uninsured individuals to increase. The MAC supports the growing consensus that health care is a human right.

2. Continue improving and streamlining enrollment processes and avoid barriers to enrollment.

Oregon should continue to improve administration of outreach, initial eligibility determination, enrollment, and redetermination of eligibility, and avoid creating barriers to enrollment, especially for those experiencing health inequities. Programmatic changes to Medicaid should be designed with attention to health equity and ensuring adequate, culturally responsive outreach to all populations eligible for Medicaid. The State should continue to invest in technology that will improve administration and support care coordination.

3. Continue to prioritize a patient-centered care model with a focus on all aspects of health and primary care at its core.

Oregon should continue to prioritize a patient-centered care model that focuses on primary care and delivering the right care at the right time in the right place. The State should leverage and support the capacity of public health agencies, patient-centered primary care homes, and rural health, tribal health and community health centers and other front-line workers in this model. Changes to payment or procedures should not compromise Oregon's most dedicated Medicaid providers or undermine ongoing efforts to build a culturally competent workforce that reflects local community characteristics and needs. It is essential to maintain a provider network adequate to ensure access to covered services for all members, including linguistically diverse populations and people with disabilities. Wherever possible, the State should minimize administrative burdens on providers and avoid unnecessary barriers to Medicaid participation.

4. Engage consumers, providers, and plans in solutions.

Oregon should meaningfully engage consumers, providers, and health plan administrators in developing solutions to improve efficiency and manage costs, while maintaining quality. Members should be engaged from both the managed care and FFS delivery system. Targeted investment of resources and continued efforts to engage diverse populations, community-

[2] Communities experiencing health inequities include but are not limited to culturally and linguistically diverse populations, immigrants and refugees, migrant and seasonal farmworkers, homeless populations, LGBTQ individuals, and people with disabilities.

based organizations, and leaders in the private sector will be needed to achieve sustainable solutions.

5. Maintain Oregon's commitment to integrated health services.

Oregon should maintain its commitment to an integrated health system that coordinates physical, behavioral and oral health care services along with a robust and coordinated long term care system. As it considers changes to benefits, services, or financing, Oregon should ensure that changes don't undermine efforts to improve health or address health equity. Further, changes should not shift the financial burden to members in ways that reduce access to care or increase costs downstream in the health care system. Oregon should consider increased cost-sharing as a last resort, as research has shown that prior increases to OHP cost-sharing negatively impacted access, coverage and health.[3]

6. Continue to shift the focus upstream.

Oregon should emphasize prevention and promote healthy development and healthy behaviors where people live, work, and play. Oregon's health system transformation should continue to be a model for achieving cost-savings through changing health care delivery, not rolling back eligibility, benefits or funding levels. Oregon should continue its leadership in addressing the social determinants of health through providing health-related services and prioritizing long term care services in home and community-based settings to support full integration of individuals into their communities. Improving health equity and addressing root causes of health issues can drive savings not only for Oregon's Medicaid program but for the State overall.

[3] *See e.g.* Wright BJ, Carlson MJ, Allen H, Holmgren AL & Rustvold DL. (2010). Raising premiums and other costs for Oregon Health Plan enrollees drove many to drop out. *Health Affairs, 29(12):*2311-2316

OPCA
Oregon Primary Care Association

Primary Care and the Social Determinants of Health

Oregon Medicaid Advisory Council

July 26, 2017

Carly Hood MPA, MPH – Social Determinants of Health Manager & Policy Associate

Oregon Primary Care Association

Today's Agenda

- OPCA introduction
- Definitions and framework
- Social determinant of health work at OPCA
- What clinicians can do
- What health & CCO systems can do
- Why does it matter
- Q & A

Oregon Primary Care Association

Our Mission is to lead the transformation of primary care to achieve health equity for all.

- **Why**

We believe that all people, in Oregon and beyond, have the right to good health and equitable health care.

- **How**:

OPCA supports health center sustainability while working to inspire and spread innovative approaches to providing better primary care to more people at less cost.

- **What:**

We connect, build the capacity of, and advocate for community health centers across Oregon.

What are the social determinants of health?

OPCA Oregon Primary Care Association

Definitions

Health disparity

Differences in health outcomes between groups of people.

Health inequity

Differences in health outcomes between groups of people that are considered preventable, unjust or unfair.

Health equity

Fairness in the distribution of resources and the freedom to achieve healthy outcomes between groups with differing levels of social disadvantage.

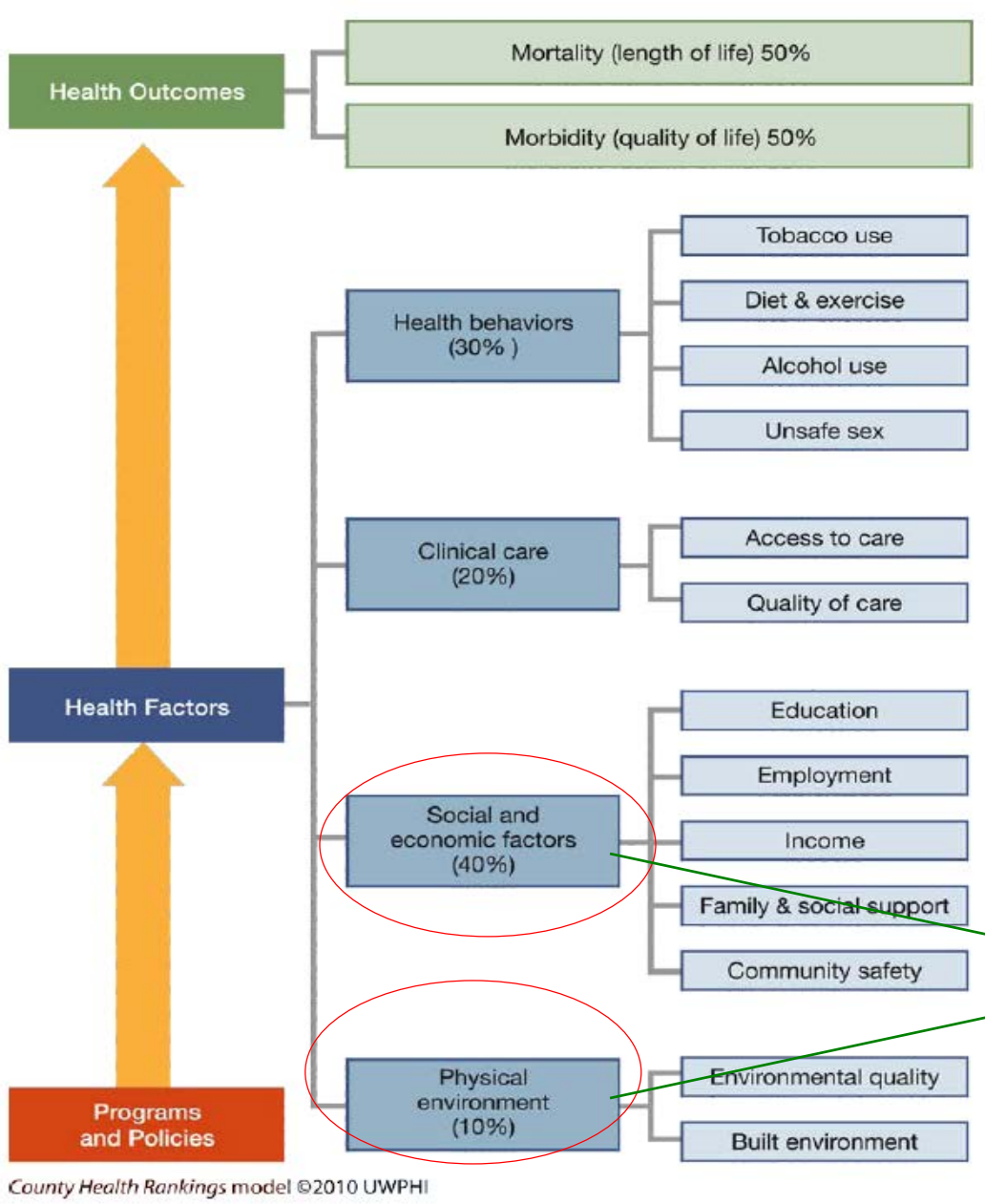
Social Determinants of Health

The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Sources: ASTHO 2000, HW2020, WHO

OPCA
Oregon Primary Care Association

What Impacts Health?

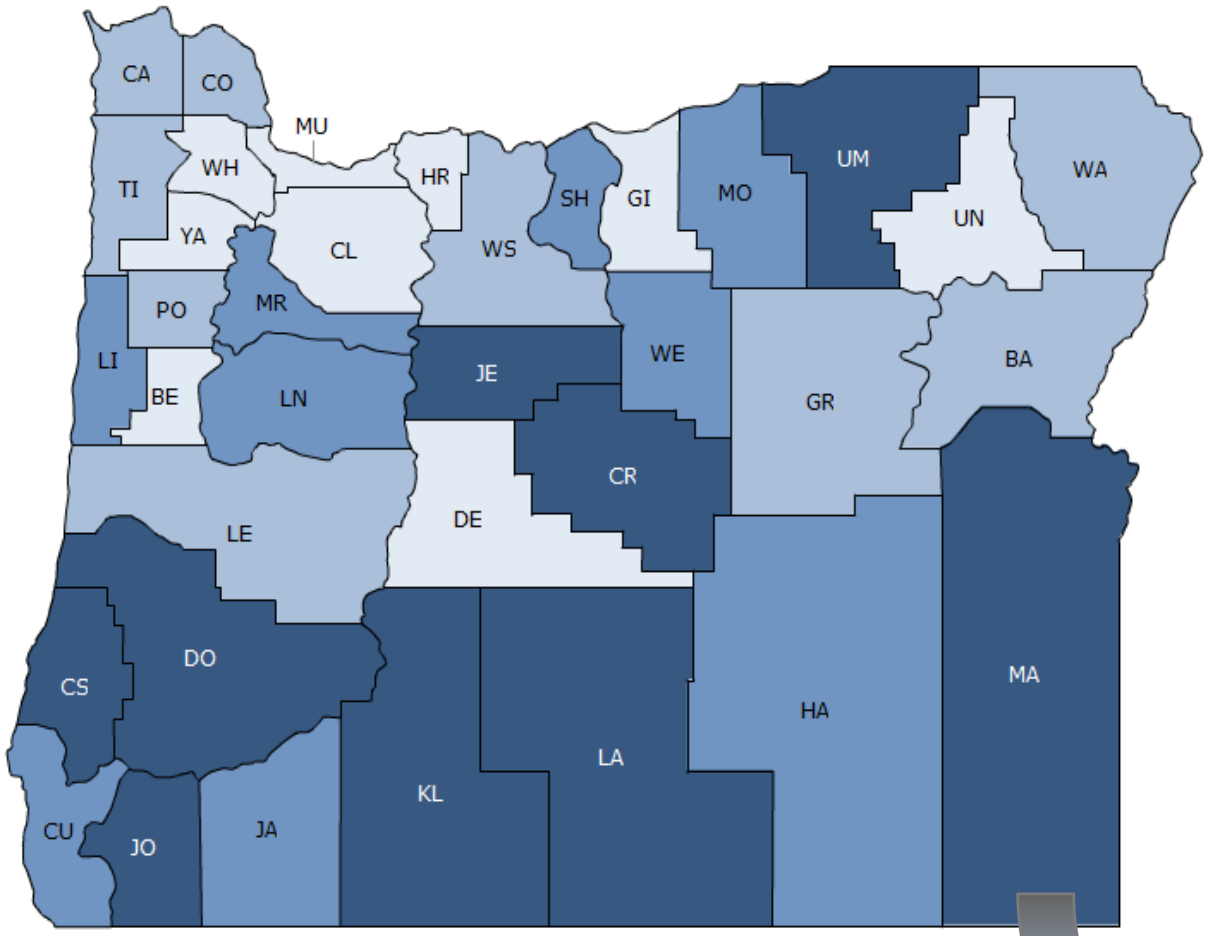


Social Determinants of Health (SDoH)

OPCA
Oregon Primary Care Association

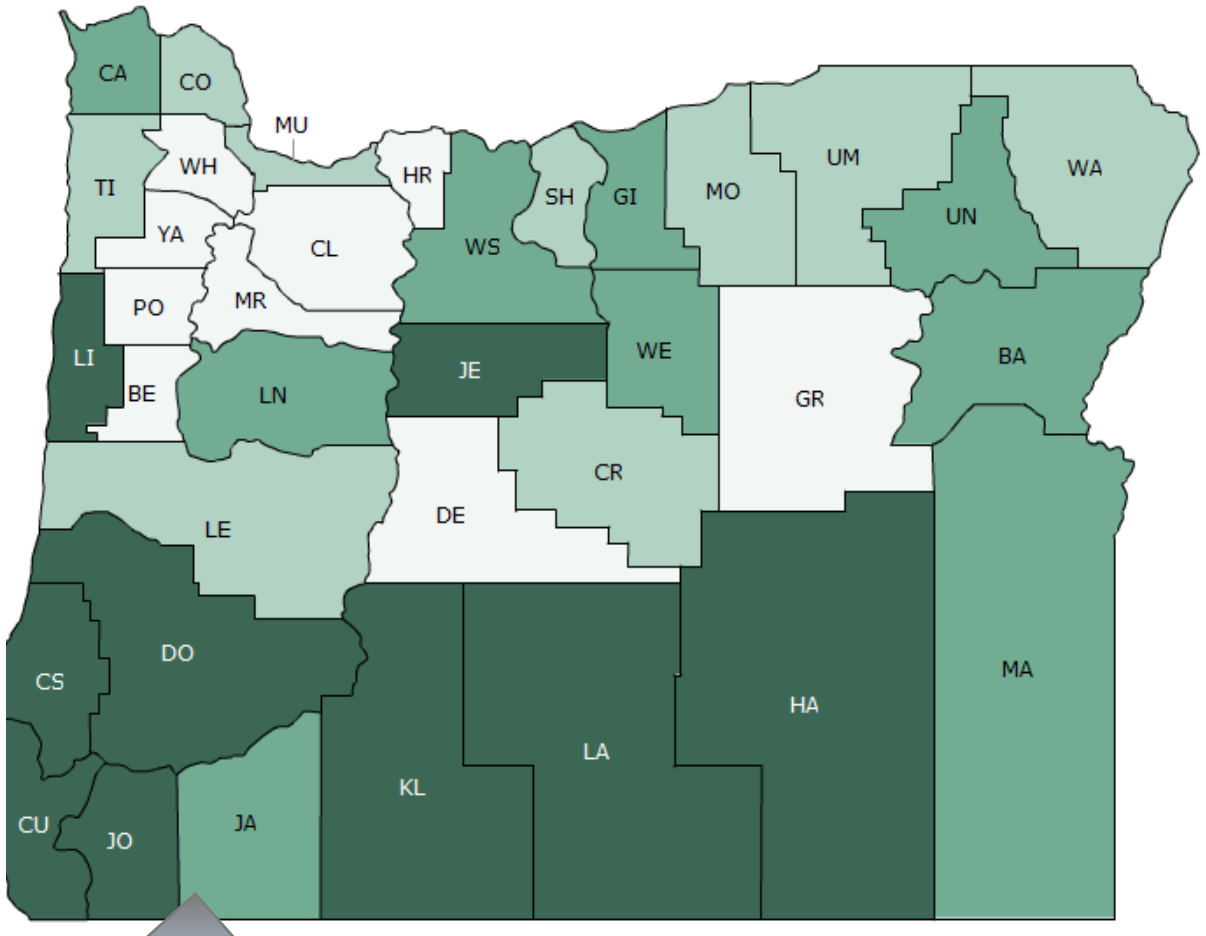
Oregon by county…

2017 Health Factors



Rank 1-9 | Rank 10-18 | Rank 19-27 | Rank 28-36

2017 Health Outcomes



Rank 1-9 | Rank 10-18 | Rank 19-27 | Rank 28-36

Source: http://www.countyhealthrankings.org/app/oregon/2017/overview

Employment

A STABLE JOB WITH FAIR PAY LEADS TO BETTER HEALTH

For most Americans, employment is the sole or primary source of income, which enables individuals to provide their families with[2]:

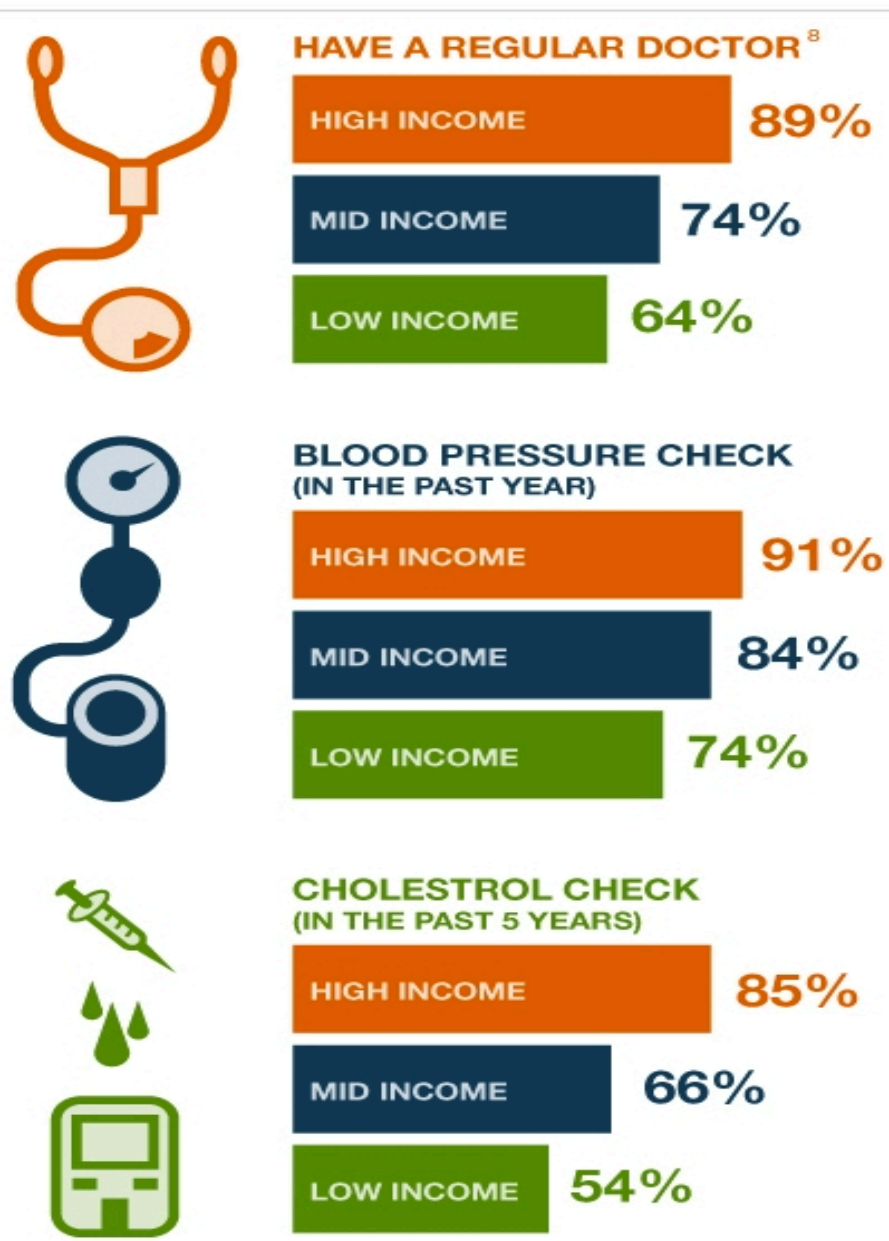
- Nutritious Foods
- Quality Childcare
- Educational Opportunities
- Healthier Homes & Neighborhoods

Unemployment has also been linked to[6]:

Sources: RWJF-Stable Jobs http://www.rwjf.org/en/blogs/new-public-health/2013/01/stable_jobs_health.html

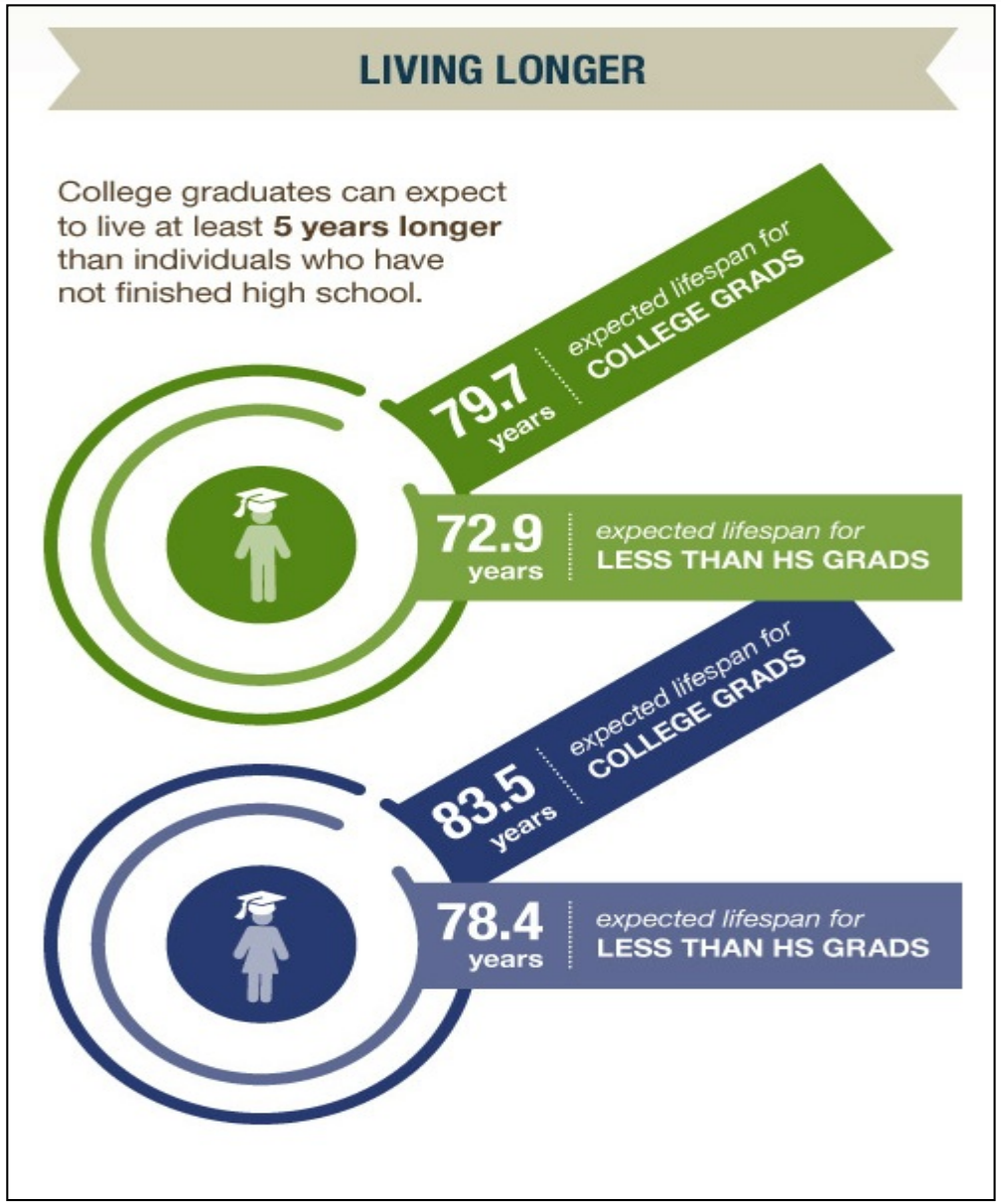
Income

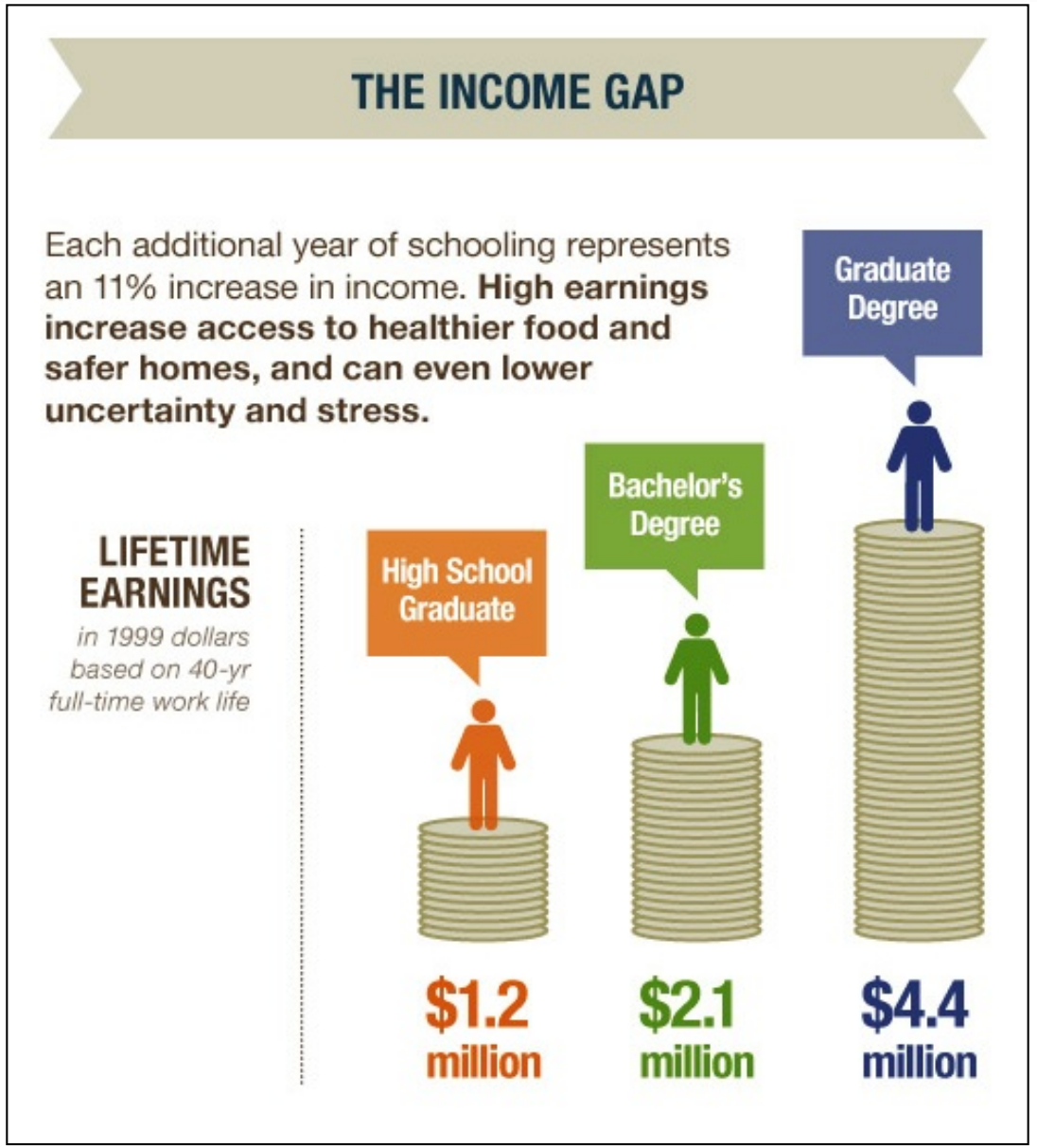
- Access to health promoting goods and services
- Psychosocial effects linked with economic resources
- Cumulative effects over time and at critical periods.



Sources: RWJF 2008, Obstacles to Health Report, Szanton 2005,
RWJF-Stable Jobs http://www.rwjf.org/en/blogs/new-public-health/2013/01/stable_jobs_health.html
Braveman, Paula. Income Wealth and Health. RWJF Special Issue Brief http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70448

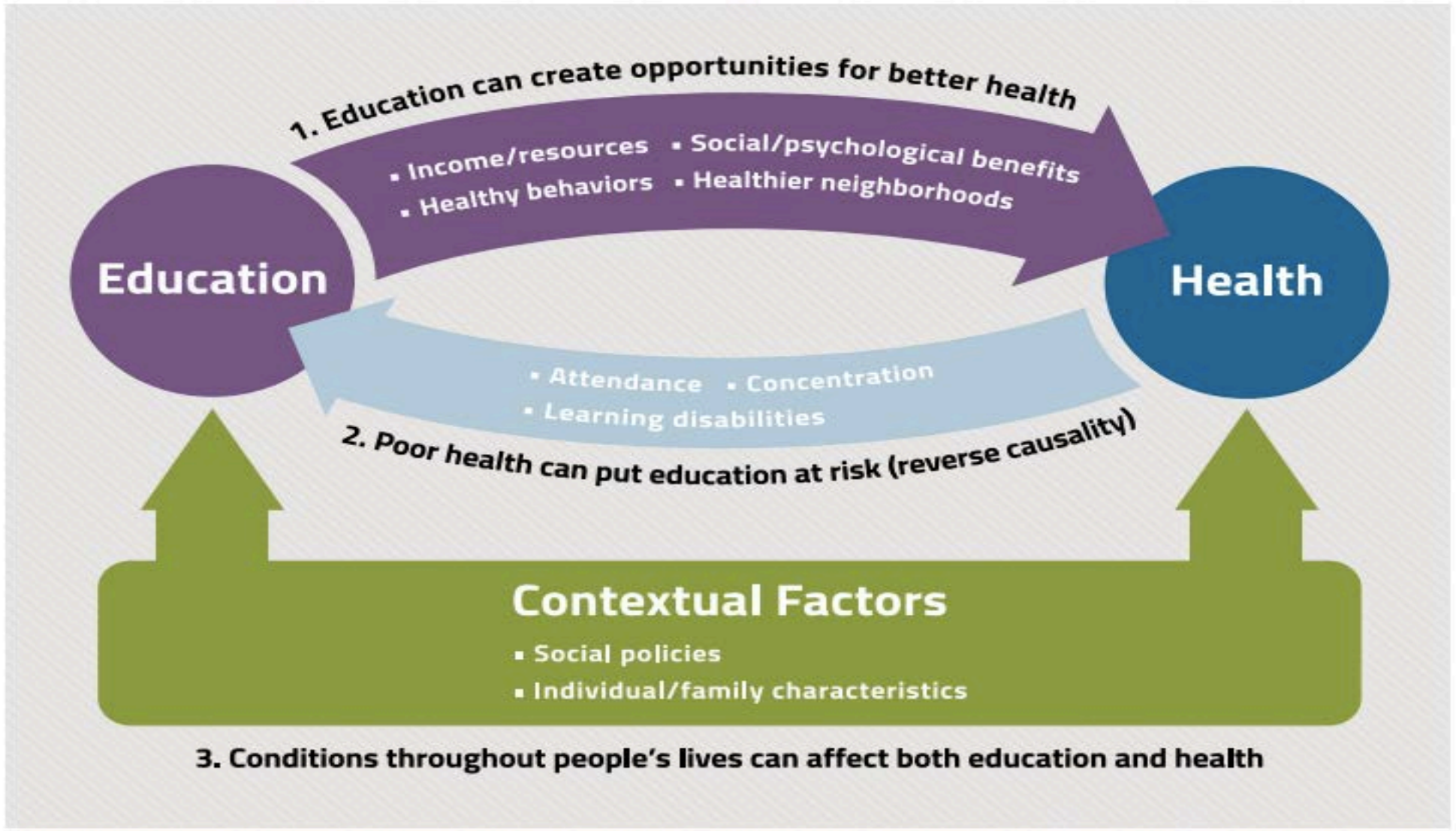
Education





Source: RWJF 2012 http://www.rwjf.org/en/blogs/new-public-health/2012/08/better_educationhea.html.html

Main connections between health and education



Source: Robert Wood Johnson Foundation http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412692

Housing

- Affordable.
- Meet other basic needs.

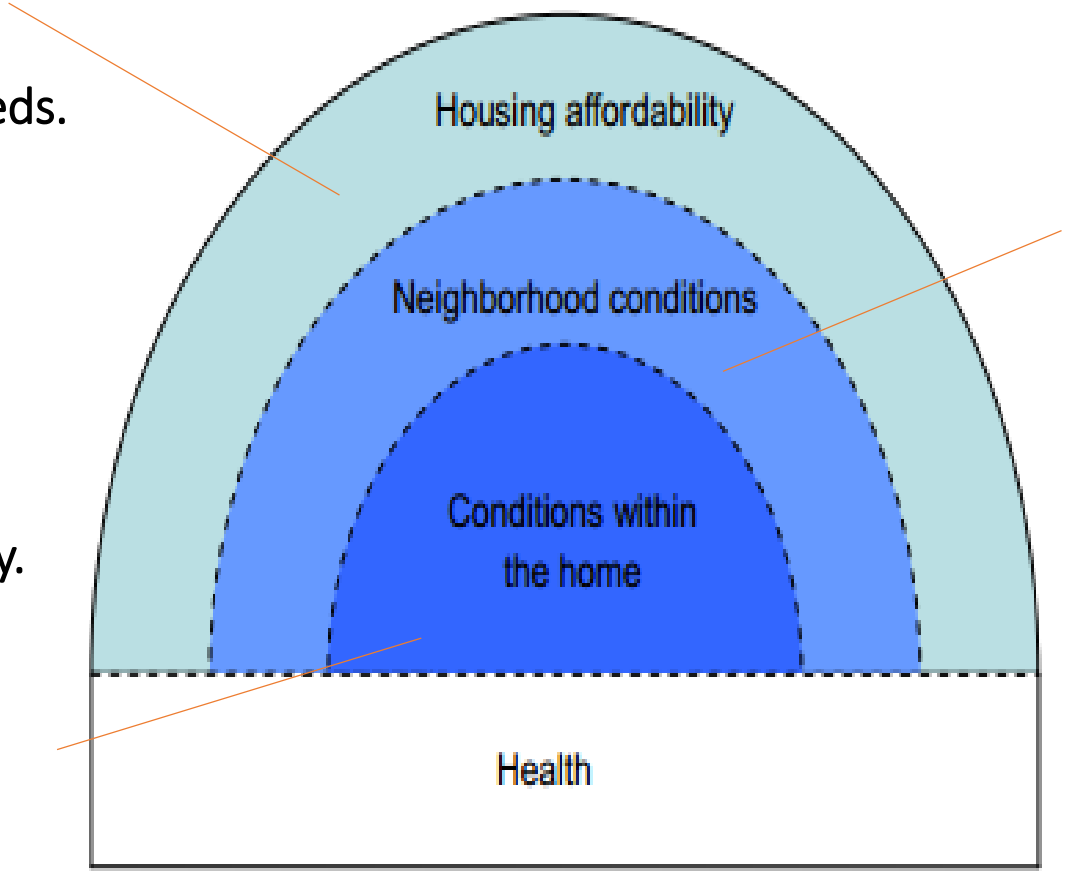


Figure 1. Housing influences health in many ways.

- Safe, clean air and water.
- Access to public resources.
- Access to healthy food.
- Options for exercise.

- Privacy and security.
- Stability
- Toxin-free.
- Injury free structure.

Source: Commission on Health http://asthmaregionalcouncil.org/uploads/Healthy%20Homes/commissionhousing102008.pdf

Built environment

Access to healthy foods!

Source:
https://thrive.novascotia.ca/about

The earlier the better!

Early Childhood Trajectory

Healthy Child Development → School Readiness; Coping & Social Skills → Reduced Likelihood of Academic, Social, Behavioral Difficulties & Risky Health Behaviors → Reduced Risk of Criminal Behavior; Tobacco, Alcohol, & Other Drug Use; Teen Pregnancy; Increased Capacity to Avoid Stress-Induced Conditions

Sources: https://www.chcs.org/media/Medicaid-Early-Childhood-Lab-Infographic_060917.pdf
http://www.eoionline.org/wp/wp-content/uploads/health-care/LinkECEHealth-Jul02.pdf

OPCA's SDH efforts

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Overall Project Goal

To create, implement/pilot test, and promote a ***national standardized patient risk assessment protocol*** to assess and address patients' social determinants of health (SDH).

In other words, position health centers to:

- Document the extent to which each patient and their total patient populations are **complex**
- Use that data to:
  - **improve** patient health
  - **affect change** at the community/population level, and
  - **sustain resources** and **create community partnerships** necessary to improve health.

PRAPARE domains

Core	
UDS SDH Domains	Non-UDS SDH Domains (MU-3)
1. Race	10. Education
2. Ethnicity	11. Employment
3. Veteran Status	12. Material Security
4. Farmworker Status	13. Social Isolation
5. English Proficiency	14. Stress
6. Income	15. Transportation
7. Insurance	16. Housing Stability
8. Neighborhood	
9. Housing Status	

Optional	
1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

Spanish and Chinese (Mandarin) translated versions

Find the tool at:
www.nachc.org/prapare

How can clinics use the data

Catalog current resources available to address SDH needs, both in-house and in community (community resource guide)

Identify resources that need to be developed and/or community partnerships that need to be initiated or strengthened

Incorporate PRAPARE into other aspects and initiatives at health center: QI meetings, board meetings, ACO discussions so staff see value in this work

Challenge: Inability to Address SDH

Solution: Message "Have to start somewhere and do the best we can with what we have. Collecting information will help us figure out what services to provide".

<u>Models to Address SDH:</u>

1) Referrals with partnerships
2) Active/Formal Collaboration of multiple agencies under one funded mechanism
3) Co-location

Opportunities and other plans to use the data

Inform Care and Services:

- Build/strengthen partnerships with local orgs. Ex: Negotiate bulk discounts and new bus routes with local transportation agency
- Inform services provided in Collaborative Consortia Model and Co-Location Model
- Guide work of co-located foundation to pay for non-clinical services
- Streamline and expand care management plans
- Build on SDH and "Touches" work

Inform Payment

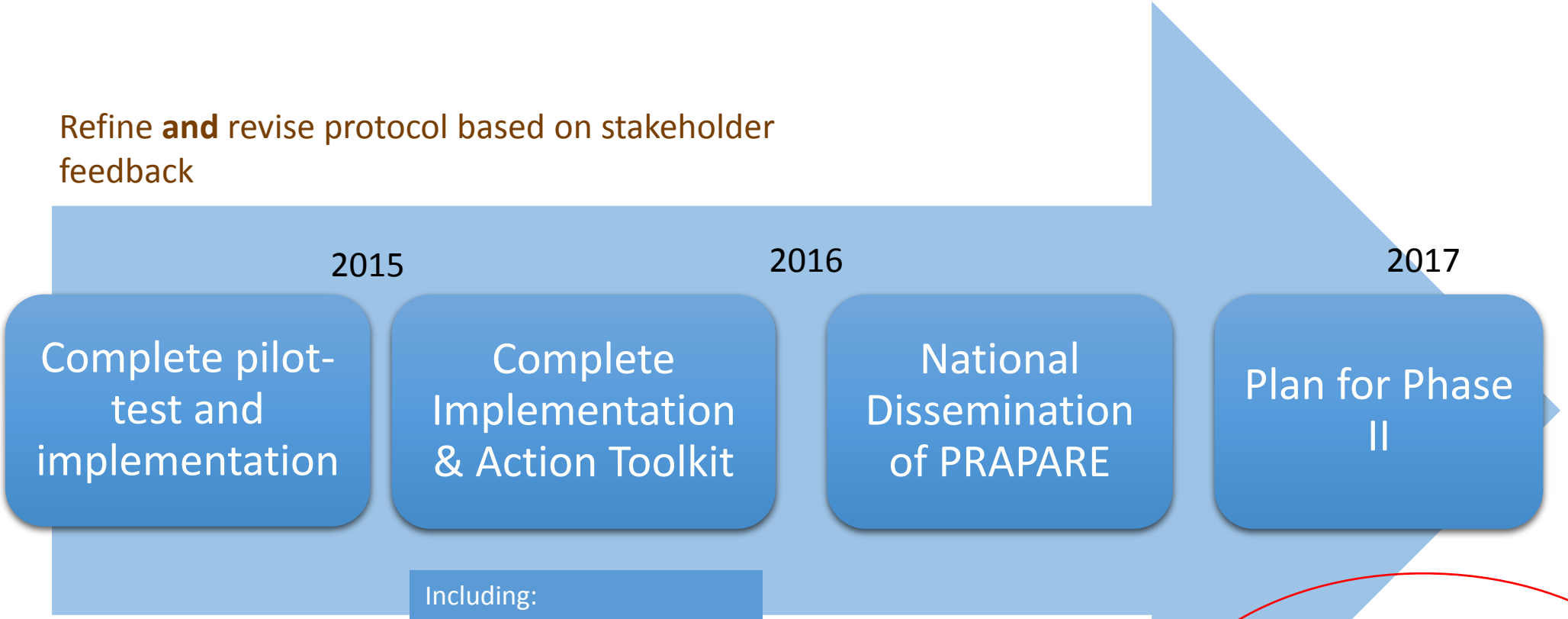
- Inform APM discussions at state level
- Inform payment reform discussions with state Medicaid agency
- Inform both Medicaid and Medicare ACO discussions and care management policies

Inform Risk Adjustment

- Assign weights: Put every PRAPARE element in regression model with certain outcome or cost
- Create SDH risk score for risk stratification and risk adjustment

Next steps with PRAPARE

Refine **and** revise protocol based on stakeholder feedback



Population segmentation

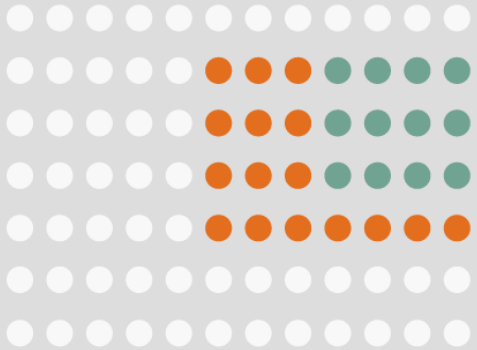
10,000 PEOPLE

POPULATION

Use analytics to piece together target population characteristics.

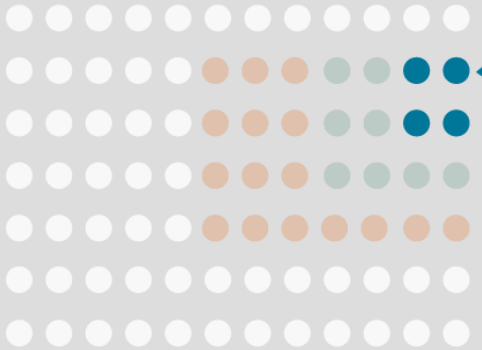
May require multiple data sources and analytic processes.

SUB-POPULATION(S)



- 834 diabetics
- 223 with HbA1c >9

TARGET POPULATION



- 56 out of the 223 diabetics with HbA1c >9 who also:
  - Missed 2 appointments in the last 6 months
  - Live below 100% FPL
  - Are non-native English speaker
  - Have a co-occurring mental health diagnosis
  - Did not graduate from high school

Understanding Their Needs

- Empathic inquiry and community data ***(PRAPARE)***

Responding to Their Needs

- Redesigning care teams
- Developing strong community partnerships
- Expanding social determinants of health/upstream interventions

Demonstrating Impact

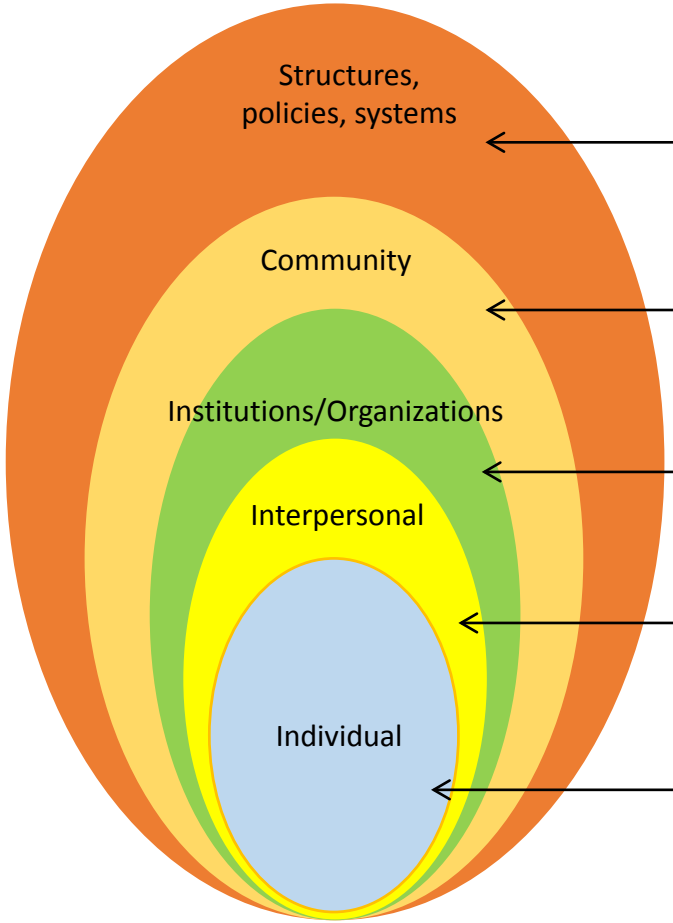
- Metrics of success
- Understanding cost and ROI

Clinicians and the SDH

What impacts health?

Largest impact

Smallest impact



Local, state, federal policies and laws to regulate/support health actions

Social networks, norms and standards

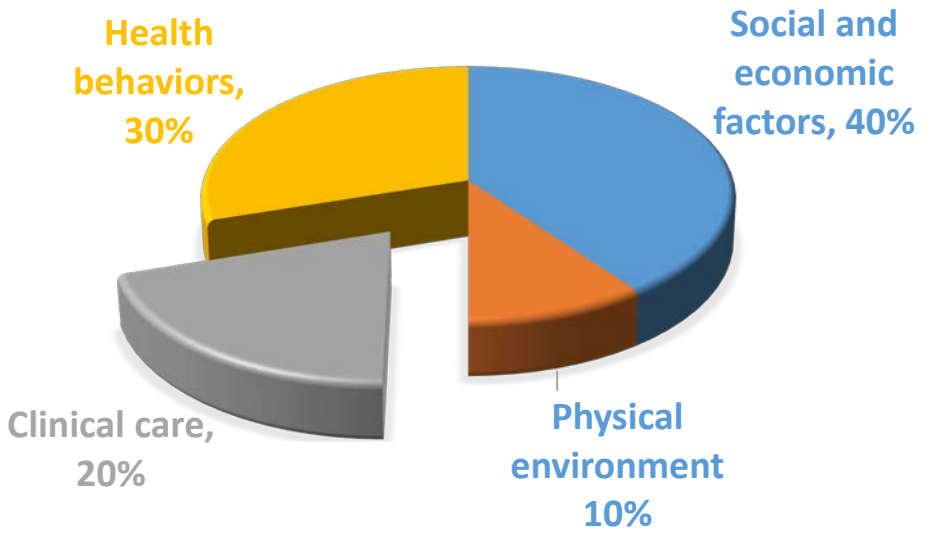
Rules, regulations, policies and informal structures

Family, peers, social networks and associations

Knowledge, attitudes, beliefs and behaviors

Why primary care?

Return on Investment = $13 to $1



4 in 5

physicians believe that unmet social needs are leading to worse health among Americans.

yet...

4 in 5

physicians feel unable to address their patients health concerns caused by unmet social needs.

Sources:
Oregon Health Authority and Portland State University: https://www.oregon.gov/oha/pcpch/Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf
RWJF 2011 http://www.rwjf.org/content/dam/web-assets/2011/11/2011-physicians--daily-life-report

What can clinicians do?

Meet legislator(s)

Engage with media

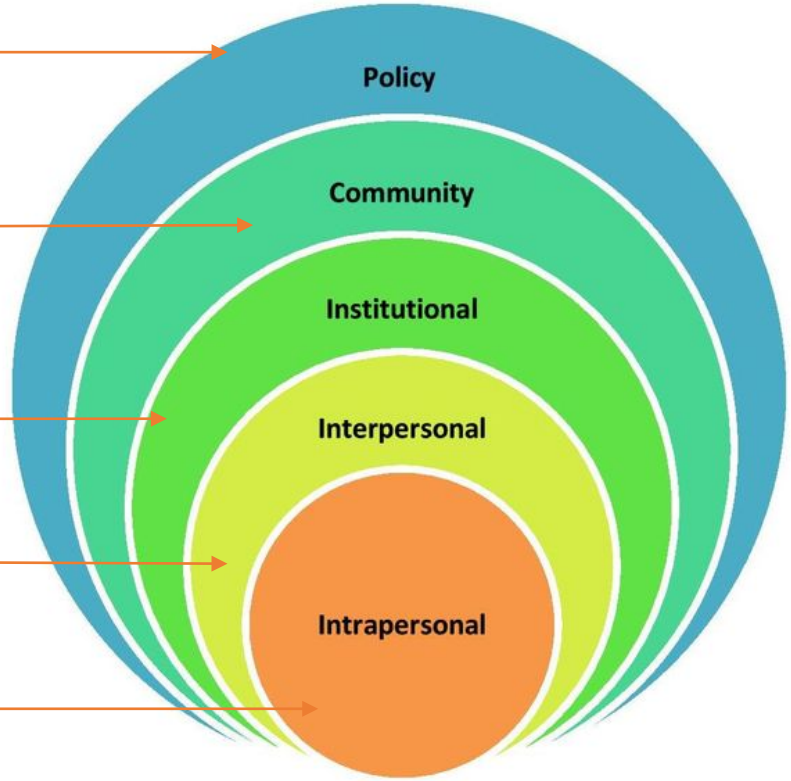
Be involved in local community organizing

Share SDoH with professional associations

Link patients to community services

Record social, economic patient information

Listen, empathize, connect



"As a physician, I generally cannot discuss health with a patient who lives in poverty without talking about the areas where community development works: affordable housing, access to nutritious food, and safe places to play and exercise."

~Risa Lavizzo-Mourey, MD MBA
President and CEO, Robert Wood Johnson Foundation

Source: Health Affairs Blog 2013 http://healthaffairs.org/blog/2013/02/22/the-us-health-disadvantage-and-clinicians-an-interview-with-paula-braveman/

CCOs and the SDH

What Can Systems Do?

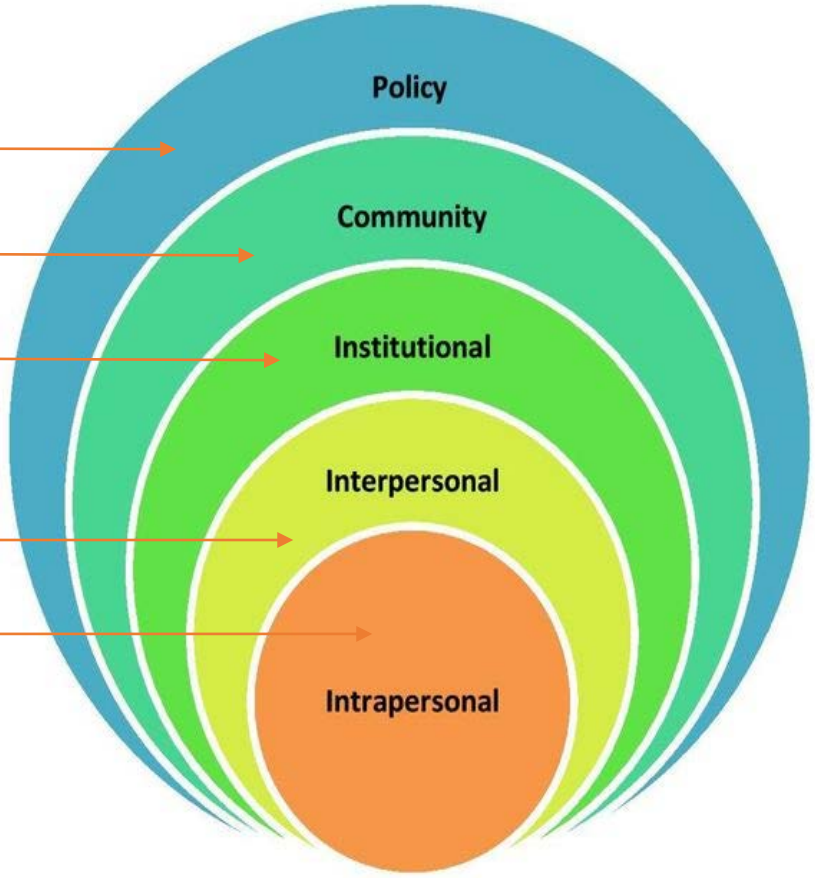
Advocate

Support community investments

Fund clinics to do upstream projects

Provide incentives for providers to screen/link patients with upstream resources

Incent patients to make healthy choices

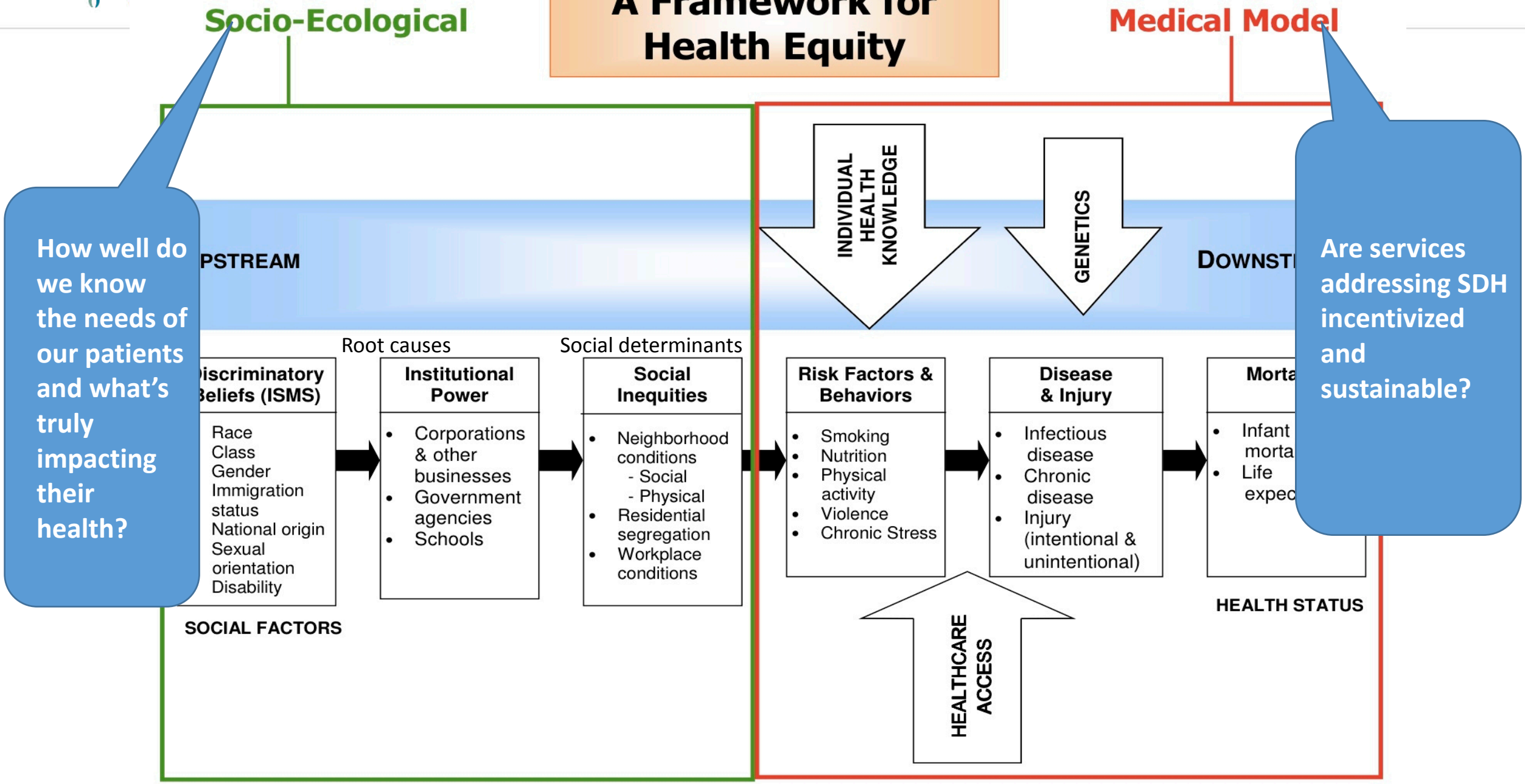


Flexible/health-related services

- Incentivize!! Through…
  - ✓ Workforce support
  - ✓ Funding upstream
  - ✓ HIT
  - ✓ APCM

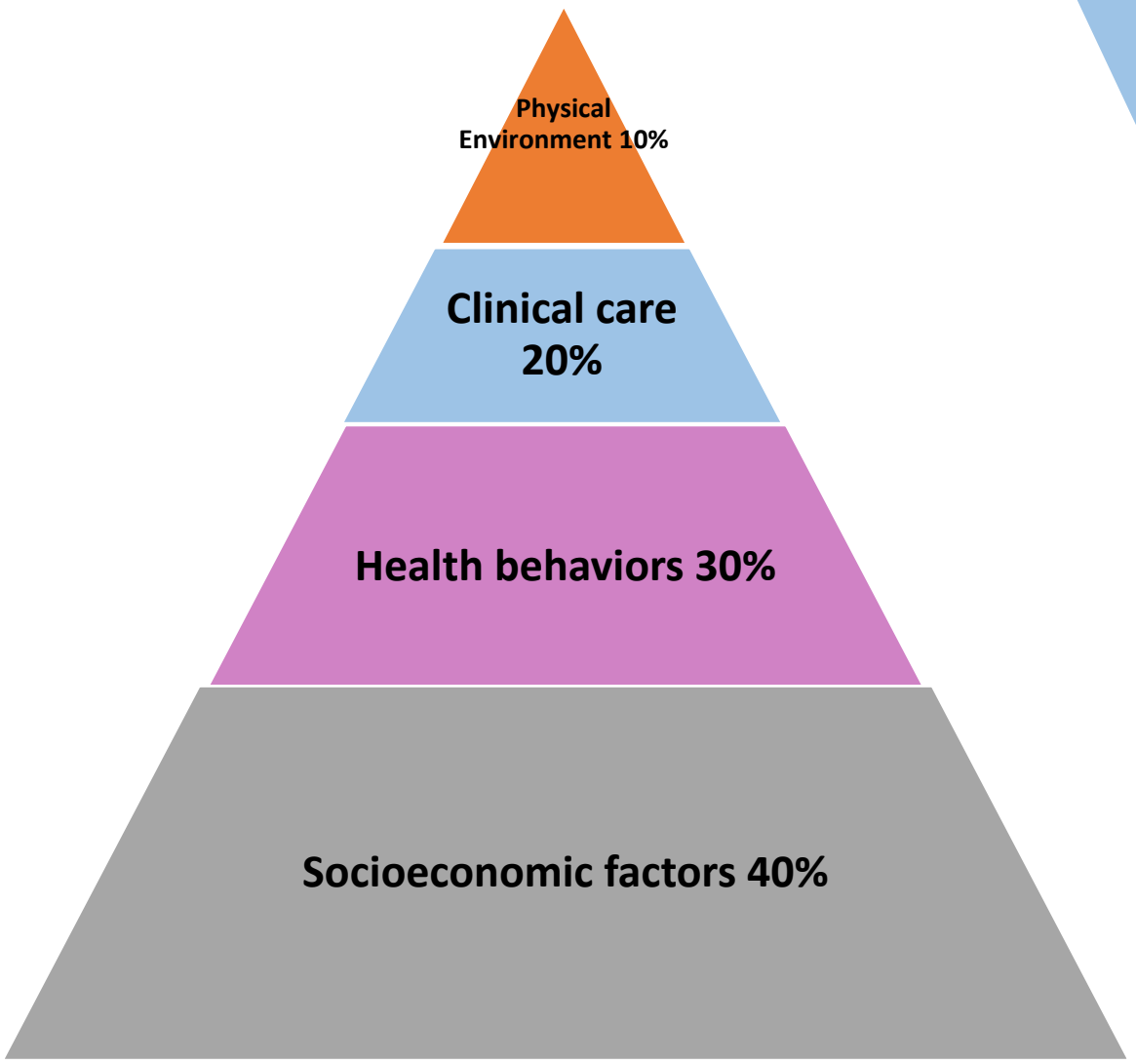
Why this work matters

A Framework for Health Equity



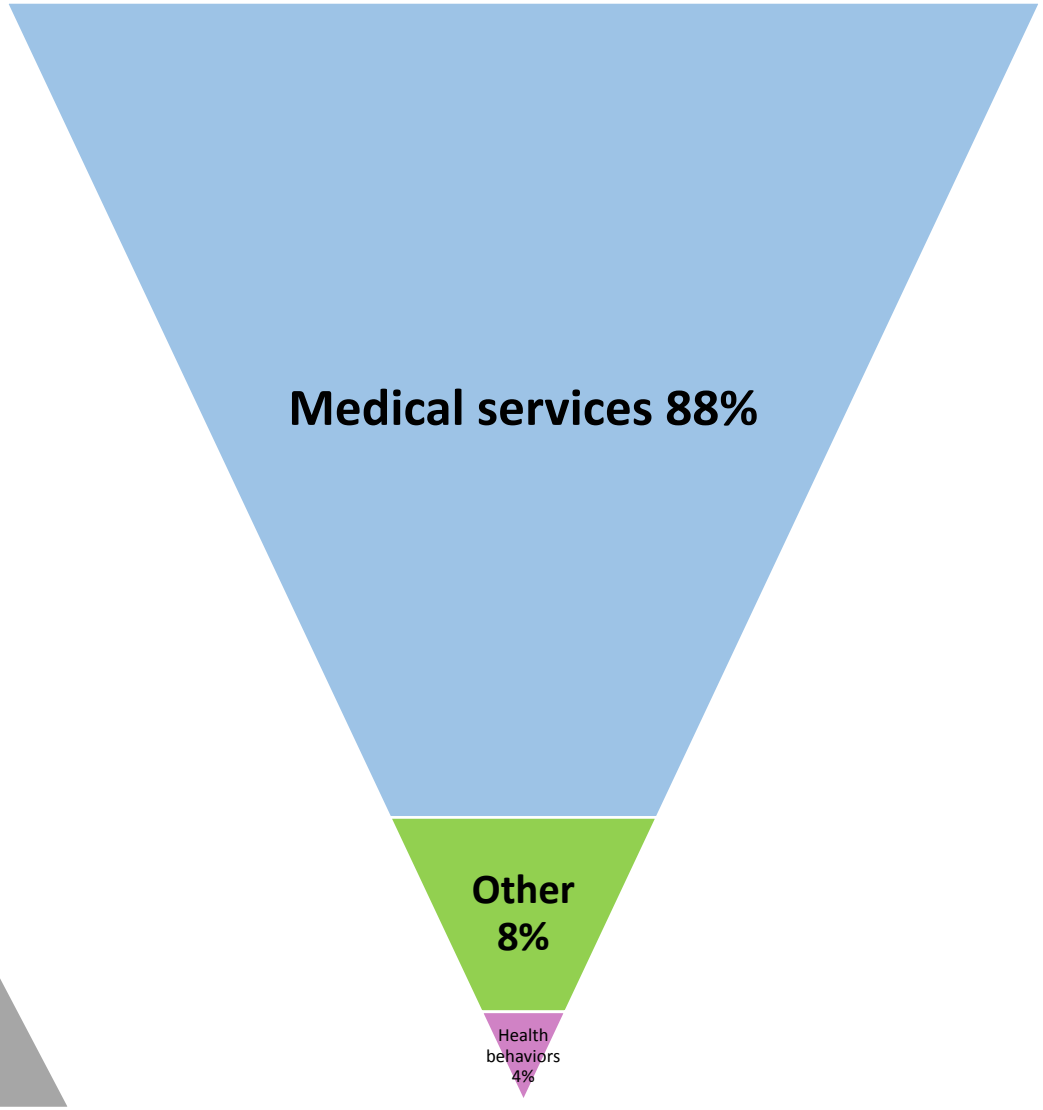
Priorities

What Makes Us Healthy



Source: RWJF County Health Rankings

What We Spend On Being Healthy



Source: Derived from information from the Boston Foundation (June 2007).

Reshaping the model

Source: Braveman,P et al. The Social Determinants of Health: Coming of Age. Annual Review of Public Health 2011; 389-98.

Questions?

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Health Systems Tackling Social Determinants of Health: Promises, Pitfalls, and Opportunities of Current Policies

Krisda H. Chaiyachati, MD, MPH; David T. Grande, MD, MPA; and Jaya Aysola, MD, DTMH, MPH

In 2005, Seattle's Downtown Emergency Service Center opened 1811 Eastlake, a supportive housing program for homeless residents with chronic alcohol addiction.[1] The goal was to reverse the treatment-first paradigm, addressing the debilitating social need (homelessness) before the medical disease (addiction). After a year, societal costs were approximately $40,000 lower for residents enrolled in this Housing First program, with cost savings driven, in part, by healthcare spending reductions. Other social interventions have shown similarly promising effects on health outcomes. In a randomized controlled experiment in 5 large US cities, low-income individuals who received vouchers to move from high-poverty to low-poverty neighborhoods had lower rates of obesity and diabetes.[2] These 2 examples are part of the accumulating evidence that supportive interventions directed toward the social and environmental barriers faced by patients—the social determinants of health—can influence health outcomes and healthcare spending.

Given the mounting evidence, a growing number of policies are beginning to direct the healthcare sector toward playing a more substantial role in addressing these social determinants with a population health lens. New requirements for nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) create a mechanism for public accountability of tax-exempt healthcare providers. New payment models, such as shared savings programs, make overall health—and thereby, social determinants—a part of the financial equation for health systems. Lastly, new models being tested by CMS, like the Accountable Health Communities program, explore the impact of bridges created between social services and the healthcare sector.

All of these policy initiatives lead the public and the medical community to believe we have reached a moment in healthcare where population health is part of the healthcare sector's mission. Indeed, in recent years, healthcare has begun incorporating "population health" in the strategic plans at a growing number of hospitals; however, many population health programs fall short of addressing social determinants.[3] Instead, they often limit their focus to disease-specific initiatives or quality and spending goals set by payers. The discordance between the promise of health policies and the current practice of population health creates the following signal: although these policies may drive the healthcare systems toward improving population health, in their current form, they will not sufficiently change our system of delivering care.

Community Health Needs Assessment

Tax-exempt, nonprofit hospitals are required to file a Section H form with the Internal Revenue Service (IRS), detailing how they benefit the community, with a so-called community benefit standard threshold required to receive nonprofit tax exemption. Historically, nonprofit hospitals defined "community benefit" loosely, often reporting charity care or lost revenue due to lower payment rates from public insurance programs rather than direct investments in social services or contributions to organizations addressing the social determinants faced by their patients. In 2009, hospital-led initiatives that focused locally on the health and infrastructure needs of their community constituted just 8% of current community benefit spending, representing less than 1% of total hospital expenditures.[4]

In response, the Affordable Care Act modified the nonprofit tax code to encourage more socially focused initiatives, requiring nonprofit hospitals to conduct a CHNA every 3 years by convening local public health and community leaders. CHNAs have a number of strengths, including defining a community by the geographic area served, rather than patients currently served by a specific hospital, and making needs assessments and implementation plans explicit and public. However, CHNA requirements could go further by requiring certain types of community needs to be assessed, particularly initiatives that are evidence-based, like housing. Moreover, current IRS guidelines do not require hospitals to actually implement these plans to meet the community benefit standard. The CHNA could be strengthened by improving the transparency around the requirements to address those identified needs as part of the standard for nonprofit tax exemption.

TAKE-AWAY POINTS

We propose modifications to 3 policies driving health systems toward intervening on social determinants of health, but fall short because of the passive role required of health systems:

- The Internal Revenue Service should strengthen the Community Health Needs Assessment program by requiring nonprofit hospitals to address identified needs as part of the standard for nonprofit tax exemption.
- Value-based payment models should incorporate financial support for at-risk hospitals implementing strategies to address social determinants because of their influence on quality-of-care outcomes.
- The Accountable Health Communities program by CMS should test and evaluate models that allow health systems to fund social services directly.

Payment Models

New payment models, such as shared savings programs, intentionally or unintentionally insert social determinants into the financial equation facing healthcare systems. These models emphasize outcomes, like 30-day readmissions for the Hospital Readmission Reduction Program, which are significantly impacted not only by the quality of care, but also by the out-of-hospital social needs of patients. Current policy debates have focused on whether to risk-adjust these performance measures with socioeconomic factors to avoid financially penalizing hospitals that disproportionately serve lower-socioeconomic populations.[5] We believe this represents a false choice between adjusting away important social differences versus applying financial penalties to address outcomes like readmissions. Alternatively, CMS could reapply funds from penalties to support at-risk hospitals that are implementing strategies to address social determinants that influence quality-of-care outcomes, such as reliable transportation services and improved food security.[5]

Accountable Health Communities

The new Accountable Health Communities program by CMS works toward public health engagement by supporting experimental models that strengthen the linkages between the health sector and public health. Although encouraging, funding does not allow hospitals to experiment with providing services or material needs for patients directly. As a result, the scalability of successful models relies heavily on the existence of sustainable, well-resourced services being widely available, which is not the case in many communities.[6] In addition to testing models that link the healthcare system to existing social services, there is a severe need to evaluate models that allow health systems to fund these services directly.

Conclusions

The predominant view of healthcare's role has been providing high-quality medical care and delivering biomedical cures. As a result, health systems have deferred addressing the social and economic needs of patients to public health departments and the government in general. Although improving the quality and delivery of clinical care is important, in order to improve the overall health of the population, the healthcare sector requires a broader strategy that develops and tests direct interventions targeting social determinants. We have highlighted the potential of current policies to integrate social determinants into the business of healthcare; however, these policies fall short because they ask health systems to play a passive role. For meaningful change to occur, the health sector must lead the effort to address the health-related social needs of patients.

Acknowledgments

The authors would like to thank Dr David Asch for looking at early drafts of this manuscript.

Author Affiliations: University of Pennsylvania (JA, KC, DG), Philadelphia, PA.

Source of Funding: None.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article. The University of Pennsylvania owns a nonprofit academic health center.

Authorship Information: Concept and design (JA, KC, DG); drafting of the manuscript (JA, KC, DG); critical revision of the manuscript for important intellectual content (JA, KC, DG); administrative, technical, or logistic support (KC); and supervision (JA).

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REFERENCES

1. Larimer ME, Malone DK, Garner MD, et al. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. *JAMA*. 2009;301(13):1349-1357. doi: 10.1001/jama.2009.414.
2. Ludwig J, Sanbonmatsu L, Gennetian L, et al. Neighborhoods, obesity, and diabetes—a randomized social experiment. *N Engl J Med*. 2011;365(16):1509-1519. doi: 10.1056/NEJMsa1103216.
3. Sharfstein JM. The strange journey of population health. *Milbank Q*. 2014;92(4):640-643. doi: 10.1111/1468-0009.12082.
4. Young GJ, Chou CH, Alexander J, Lee SY, Raver E. Provision of community benefits by tax-exempt U.S. hospitals. *N Engl J Med*. 2013;368(16):1519-1527. doi: 10.1056/NEJMsa1210239.
5. Committee on Accounting for Socioeconomic Status in Medicare Payment Programs; Board on Population Health and Public Health Practice; Board on Health Care Services; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Washington, DC: The National Academies Press; 2016.
6. Levi J, Segal LM, St. Laurent R, Lang A. Investing in America's health: a state-by-state look at public health funding and key health facts. Robert Wood Johnson Foundation website. http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf72503. Published March 2012. Accessed October 2016. ■

EDITORIAL

Bending the Trends

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Ann Fam Med 2017;15:304-306. https://doi.org/10.1370/afm.2101.

In this issue of the *Annals of Family Medicine*, Dr Johansen adds to our understanding that despite efforts to control health care costs over the past 2 decades, we are quickly approaching a reality in which health care spending subsumes one-fifth of our economy, which is well above our international peers.[1,2] As Dr Johansen notes, this rising spending is the result of continued utilization of higher cost services such as specialty and hospital care, as well as increased prices. Increases in health care spending are not associated with better outcomes or more equitable health. The health status of the people in the United States continues to be burdened with high rates of chronic disease and for the first time in generations, life expectancy is declining.[3]

The Triple Aim has been the national call to action that drives the goals of "improving the experience of care, improving the health of populations, and reducing per capita costs of health care."[4] To date, the strategy for achieving the Triple Aim has been predominately focused on improving the health care system through the adoption of value-based payment design in lieu of fee-for-service payment models, and on reducing variability in health service delivery.[5] Early results indicate that cost growth is slowing and that innovative delivery models are improving quality and safety of care and decreasing unnecessary utilization such as avoidable hospital readmissions.[6]

ADDRESSING THE SOCIAL NEEDS

As delivery system reform has progressed, payers and health systems are assuming greater financial risk for health outcomes. Even the highest performing health systems are finding the medical model insufficient to adequately constrain costs and improve health outcomes due to the social needs of their patients. Failure to appropriately contextualize the health care plan can have significant consequences.[7] Providing the best quality care for a patient with COPD in the clinical setting is an important goal. But if that patient cannot afford the medication or does not have access to transportation for their follow up care, their disease will quickly become uncontrolled, leading to worse health outcomes and higher utilization-related costs.

In response, public and private payers are piloting payment models that encourage the health care system to address social needs. For example, the Centers for Medicare and Medicaid Services recently announced the Accountable Health Communities demonstration model that encourages health care providers to build linkages with community organizations, such as Meals on Wheels, that can address their patients' social needs such as hunger or poor nutrition.[8] Pay-for-success models, such as the South Carolina Nurse Family Partnership, are a version of social impact bonds that go a step further by encouraging community linkages and providing resources to support them.[9]

Community-oriented primary care providers are especially likely to welcome these types of payment models and the new technologies that support them because addressing the social factors of health is fundamental yet complex and rarely compensated. Encouragingly, evidence is building that addressing social factors improves health outcomes at a lower cost[10,11]; investing in coordinators who connect patients to social services can save between $15 and $72 billion annually.[12]

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Though integrating health care with social care is critical for improving health at a lower cost, reforming

Conflicts of interest: authors report none.

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payment models alone is insufficient.[13] Leaders must work to create healthy communities by addressing factors further upstream such as the environment, housing, transportation, and access to healthy food and safe spaces. By moving to a public health model, rather than a purely medical model, communities can create the conditions where everyone can be healthy and reverse health disparities.[14-16]

This undertaking requires collaboration and resources from many community sectors, and cannot be the sole responsibility of the health care system. The promising news is that communities across the country are pioneering a new approach to improving the health of their communities by addressing all the determinants of health.[17,18] These "Public Health 3.0" communities are coming together to create new umbrella organizations to set a shared vision and shared goals about the health of their communities, to share data and funding, and to coordinate activities aimed at improving health. Their efforts are showing promise, including improvements in health outcomes and reductions in mortality.[19,20] For patients with COPD, this would mean not only that their community's health care system can link them to support services for their social needs, but also that they can live in smoke-free housing.

DISRUPTION NEEDED TO CREATE AFFORDABLE, EQUITABLE HEALTH FOR ALL

These collaborations will only be successful if we address the social needs of our patients and make structural changes to funding and accountability for individual and community health. First, clinical teams should identify and support the social needs of our patients with the rigor they would apply to avoiding other medical errors. Second, health systems should show leadership by holding their executives accountable not only for outcomes for their patient population, but also for the health outcomes of their communities. Third, communities can only advance health if they have access to timely, specific data. Data availability will require continued focus on creating a culture of data sharing for public health advancement. Fourth, federal and state policy makers should work with states to maximize funding flexibility to accommodate local innovations aimed at investing in upstream social determinants of health. Fifth, education of the clinical and public health workforce should encourage an understanding of the social determinants of health and provide training in working across sectors. Sixth, it will require an increase in investment in the social determinants of health. Currently, US spending on social services is on par with other Organisation for Economic Co-operation and Development countries, but we spend a significantly greater proportion on health care. This spending pattern may need to change if we seek to improve health outcomes.[21]

CONCLUSION

The health system that Johansen describes is one that has been on a relentless path of increasing high-cost utilization without clear return on investment. While the health system is working to achieve the triple aim by improving the health care delivery system, it alone will not be sufficient to bend the cost curve and reverse declining life expectancy and increasing disparities. This will be true even if we build better delivery models that address the social needs of patients. To improve overall population health, we will need to embrace disruptive models of health that address health care needs as well as the social factors and enable leaders to build healthier communities that support affordable, equitable health for all.

To read or post commentaries in response to this article, see it online at http://www.AnnFamMed.org/content/15/4/304.

Key words: health care reform; health care costs; social determinants of health; health equity; public health; Public Health 3.0

Submitted March 22, 2017; accepted April 26, 2017.

References

1. Johansen ME. Comparing medical ecology, utilization, and expenditures between 1996-1997 and 2011-2012. *Ann Fam Med*. 2017;15(4):313-321.
2. National Health Expenditure Projections 2016-2025. Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf.
3. Xu J, Murphy SL, Kochanek KD, Arias E. Mortality in the United States, 2015. NCHS Data Brief No. 267; December 2016. https://www.cdc.gov/nchs/data/databriefs/db267.pdf.
4. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769.
5. Burwell SM. Setting value-based payment goals–HHS efforts to improve U.S. health care. *N Engl J Med*. 2015;372(10):897-899.
6. Fryhofer SL, Seshmani M, DeSalvo KB, Conway PH. Progress and a path forward. *N Engl J of Med Catalyst*. 2017. http://catalyst.nejm.org/delivery-system-reform-progress-path. Published Feb 5, 2017. Accessed Mar 20, 2017.
7. Weiner SJ, Schwartz A. Contextual errors in medical decision making: Overlooked and understudied. *Acad Med*. 2016;91(5):657-662.
8. Alley DE, Asomugha CN, Conway PH, Sanghavi DM. Accountable health communities—addressing social needs through Medicare and Medicaid. *N Engl J Med*. 2016;374(1):8-11.
9. South Carolina Pay for Success Model for Nurse Family Partnership. https://www.scdhhs.gov/sites/default/files/2-16-16-SC-NFP-PFS-Fact-Sheet_3.pdf.
10. Edwards PK, Levine M, Cullinan K, Newbern G, Barnes CL. Avoiding readmissions-support systems required after discharge to continue rapid recovery? *J Arthroplasty*. 2015;30(4):527-530.

11. Berkowitz SA, Hulberg AC, Standish S, Reznor G, Atlas SJ. Addressing unmet basic resource needs as part of chronic cardiometabolic disease management. *JAMA Intern Med*. 2017;177(2):244-252.

12. *Blueprint for a Healthier America 2016: Policy Priorities for the Next Administration and Congress*. Trust for America's Health. http://healthyamericans.org/report/129/. Accessed June 30, 2017.

13. Bikdeli B, Wayda B, Bao H, et al. Place of residence and outcomes of patients with heart failure: analysis from the telemonitoring to improve heart failure outcomes trial. *Circ Cardiovasc Qual Outcomes*. 2014;7(5):749-756.

14. Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. *JAMA*. 2016;315(16):1750-1766.

15. *Health, United States, 2015: with Special Feature on Racial and Ethnic Health Disparities*. Hyattsville, MD: National Center for Health Statistics; 2016.

16. Chapman DA, Kelley L, Woolf SH. Life expectancy maps. 2015-2016. Virginia Commonwealth University Center on Society and Health. http://www.societyhealth.vcu.edu/maps. Updated Apr 14, 2017. Accessed Mar 21, 2017.

17. National Academies of Sciences, Engineering, and Medicine. *Communities in Action: Pathways to Health Equity*. Washington, DC: The National Academies Press; 2017. doi:https://doi.org/10.17226/24624.

18. U.S. Department of Health and Human Services, Office of the Assistance Secretary for Health. Public health 3.0: A call to action to create a 21st century public health infrastructure. https://www.healthypeople.gov/2020/tools-resources/public-health-3.

19. DeSalvo KB. New Orleans rises anew: Community health after Katrina. *Ann Intern Med*. 2016;164(1):57-58. 10.7326/M15-2284.

20. Mays CP, Mamaril CB, Timsina LR. Preventable death rates fell where communities expanded population health activities through multi-sector networks. *Health Aff*. 2016;35(11):205-213.

21. Bradley EH, Elkins BR, Herrin J, Elbel B. Health and social services expenditures: associations with health outcomes. *BMJ Qual Saf*. 2011;20(10):826-831.

EDITORIAL

Now is the Time to Address Substance Use Disorders in Primary Care

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Ann Fam Med 2017;15:306-308. https://doi.org/10.1370/afm.2111.

Although over 21 million people in the United States have substance use disorders, most individuals with addiction do not receive treatment.[1] Of those who are fortunate enough to receive therapy, less than 7% access it through their doctor.[2] In addition, fewer than 10% of people with opioid use disorder in specialty care receive buprenorphine.[3]

Primary care physicians are on the front lines of this epidemic and we see it in the faces and stories of our patients: in the night sweats or gastrointestinal symptoms that are due to alcohol or opioid withdrawal; in the anxiety symptoms that are associated with cocaine use; in managing chronic pain that raises concerns about possible addiction. We are good at managing people with many coexisting conditions, and at prioritizing and knowing when we and our patients need specialists. The current opioid epidemic and marginalization of substance use disorders away from primary care has been a disaster, however, and it is a marker for the overextension of primary care. The most complex functions in health care—the much needed integrating, prioritizing, and personalizing care across prevention, acute illness care, mental health care, and management of multiple chronic illnesses—crammed into 10 minutes.

This issue of *Annals of Family Medicine* contains several studies that address substance use disorders and may point to a way forward for primary care physicians. The study by Anderson and colleagues found that primary

Conflicts of interest: See online at http://www.annfammed.org/content/15/4/306/suppl/DC1.

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