

## **ACMHA ARM CHAIR REFLECTIONS**

### **Community Care Organizations (ACOs for the rest of us)**

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I was in a meeting today in Washington, DC sharing the podium with a wonderful physician from Deloitte's healthcare group. One of his observations was that many healthcare providers are moving away from becoming Medicare-approved Accountable Care Organizations (ACOs) because the potential rewards pale in comparison to the cost and complexity of playing in the Medicare ACO game. He predicted that we will continue to move toward "accountable care" in the United States, but it may not take the form of a Medicare ACO.

This is an interesting contrast to projects I have been working on in the Pacific Northwest and learning about in my travels. Rather than debating whether "to ACO" or "not to ACO," safety net organizations are organizing themselves to improve the lives of the people they serve through new organizations and new ways of providing integrated care.

For example, I was just in Trenton, New Jersey, up the road from Camden where Jeffrey Brenner is working with the Camden Coalition of Healthcare Providers to develop a safety-net ACO. You may remember Dr. Brenner from Atul Gawande's article "The Hot Spotters." In that New Yorker piece we learned how Dr. Brenner focused on finding "hot spots" of sick people in Camden that were not only the sickest but also receiving the worst care and developed the equivalent of ACT teams for this population.

In the Pacific Northwest we are working to transform safety net systems in several communities with the goal of becoming "hospital prevention organizations" by wrapping care around the highest users of the emergency room and the most expensive healthcare users in the community. Early results are in from the Bend area of Central Oregon and they are sweet – 13% reduction in emergency room use and 19% reduction in inpatient admissions compared with rates prior to their hot spotting efforts.

So what's going on here? Are ACOs a fad that never got off the ground or the future? My prediction? Similar to how managed care models have continued to be used in Medicaid while being rejected in the commercially insured world, ACOs – the right kind of ACOs – will begin to flourish in safety net systems in communities throughout the country. Let's explore what I mean by the "right kind" of ACO.

To create a distinction between a Medicare ACO and a safety-net ACO, I'm going to call this new entity a Community Care Organization (CCO), building on and expanding the emerging ACO work being piloted by the Dartmouth-Brookings ACO Learning Network, the Premier Healthcare Alliance, and others at the vanguard of the field.

A Community Care Organization is an ACO that is designed to focus on the needs of the safety net population in a community, with special emphasis on addressing the social determinants of health such as poverty, unemployment, homelessness, poor housing, neighborhood violence, and other factors. Designed by a broad cross-section of community residents and community partners, the core of the CCO is made up of existing community service agencies including:

- Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- Community Mental Health and Substance Use Disorder Treatment Providers
- Recovery, Peer and Wellness Organizations
- Public Health Departments
- Hospitals
- Social Service Agencies
- Child Welfare Providers and Family Resource Centers
- Housing and Homeless Services Providers
- Oral Health Providers
- Pre-Schools and Schools
- Job Training and Employment Support Organizations

The purpose of the CCO is to organize a Healthcare Neighborhood that will help all community members move toward the triple aim: better health for the population, better care for individuals, resulting in reduced cost growth. A core objective of the CCO is to develop an integrated network of community groups that see themselves as hospital and institution prevention organizations, helping prevent admission and readmission to acute care and psychiatric hospitals; nursing homes; youth residential treatment facilities; jails, prisons, and juvenile justice facilities; and other restrictive, high cost, non-community based institutions. Health, wellness and recovery are at the center of the CCO and major changes are needed to update the existing service delivery paradigm and payment models to support this work.

In several communities in Washington State we are organizing the payors of safety net services – health plans, counties, foundations, tribes, state payors – to rethink how they purchase care, including providing seed money to support the transformation of the delivery system. Our list of improvement projects include:

1. **Hot Spotting:** Support work to identify and support persons with complex, high cost conditions
2. **Emergency Room Diversion:** Work with community partners to reduce the number of community members using the emergency rooms
3. **Access:** Expand access to primary care, specialty medical care, and behavioral health services
4. **Prevention Strategies:** Identify the primary, secondary, and tertiary prevention strategies that should be provided in the community, where and how they should be provided, and how they can be funded
5. **IDS/ACO Design:** Support the development of community-based integrated delivery systems/accountable care organizations
6. **Health Homes:** Support Health Home design, development and deployment
7. **Community Health Teams:** Build on the work underway in Vermont and North Carolina to fund and deploy community health teams to provide prevention, early intervention and care management services

8. **Health Neighborhood Development:** Support medical specialists, behavioral health providers, and providers of support services to integrate with health homes

A common element among these change projects is their grassroots nature. One leader in rural Oregon put it this way: *"It's our money, paid for with our tax dollars and our paychecks. We know our neighbors and what they need and it's up to us to redesign the healthcare system in our community."*

What are the leaders in your community doing?