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CONFERENCE ABSTRACT

Improving integrated models of care for people with complex health and social needs

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Introduction and targeted population: A relatively small (5) percentage of patients use a disproportionate share of health care services and account for more than half of health care costs. They face multiple medical, behavioral health and social challenges and require more intensive, ongoing treatment models than the fragmented care in emergency departments and many care settings. Recognizing the major roles of social and economic determinants such as housing, social connectedness and access to food and housing, innovative system-level efforts towards community –based, preventive, health and social services rather than hospital-based services have arisen.

Theory of change: A literature review, interviews and small group consultation with expert stakeholders across the United States pointed to six critical domains that contribute to sustainable better lower cost care for complex individuals and identified promising practice models.

Transferability: The key components of these innovative approaches, can and have been transferred across a range of payment and delivery systems, indeed lessons learned from outside the United States were integrated into some approaches. These six key components and examples are outlined below.

Practice changes and highlights:

1- Care model enhancements focus on clinical integration and care coordination. Montefiore Medical Center in New York mobilizes their care team to respond to triggering medical and social events such as eviction notices or incarceration while other models focus on "accompaniment" with peers with common lived experiences who help patients navigate the system and work with community organizations to build capacity for social supports.

Sustainability: 2- Financing and accountability approaches include payments for value rather than volume and innovative approaches such as the Pathways Community Hub ties payment to positive outcomes and requires a central organization to oversee all care coordination activity in a region.

3- Data and analytics include risk stratification and predictive analysis to identify high need patients, implement tailored strategies and inform system-wide policies. The Michigan

Department of Community Health has a data warehouse integrating 12 separate health-related agencies and 34 data sources into a single environment to improve service delivery; determine utilization patterns; evaluate program effectiveness; detect and reports fraud and prioritize strategies to improve outcomes.

4- The workforce needed to address the unique needs of this population go beyond clinician to peers and leverages human resources already in the community. Project ECHO uses a supervision model of video-conferencing technology to create expert -led communities of practice in complex care while the Commonwealth Care Alliance in Massachusetts uses specially trained paramedics to prevent unnecessary hospitalizations.

5- New governance models focus on inter-agency collaboration. Hennepin Health in Minnesota partners with community agencies to develop reinvestment plans in which savings generated through coordinated care management are allocated to community –development efforts.

6- Policies that support innovations in practice and payment promote sustainability. Washington developed Accountable Communities of Health that bring together leaders from multiple health sectors to better align resources and activities to improve health and health equity.

Conclusion: Approaches that address the six domains involved in care for complex populations hold great promise to improve outcomes and lives.

Keywords: complex populations; practice modelsr