EVALUATING CLINICAL-COMMUNITY INTEGRATION
THROUGH A SYSTEMS & POLICY LENS: WASHINGTON'S ACH MODEL

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STATE OF THE SCIENCE

A National Research Meeting on
Medical & Social Care Integration

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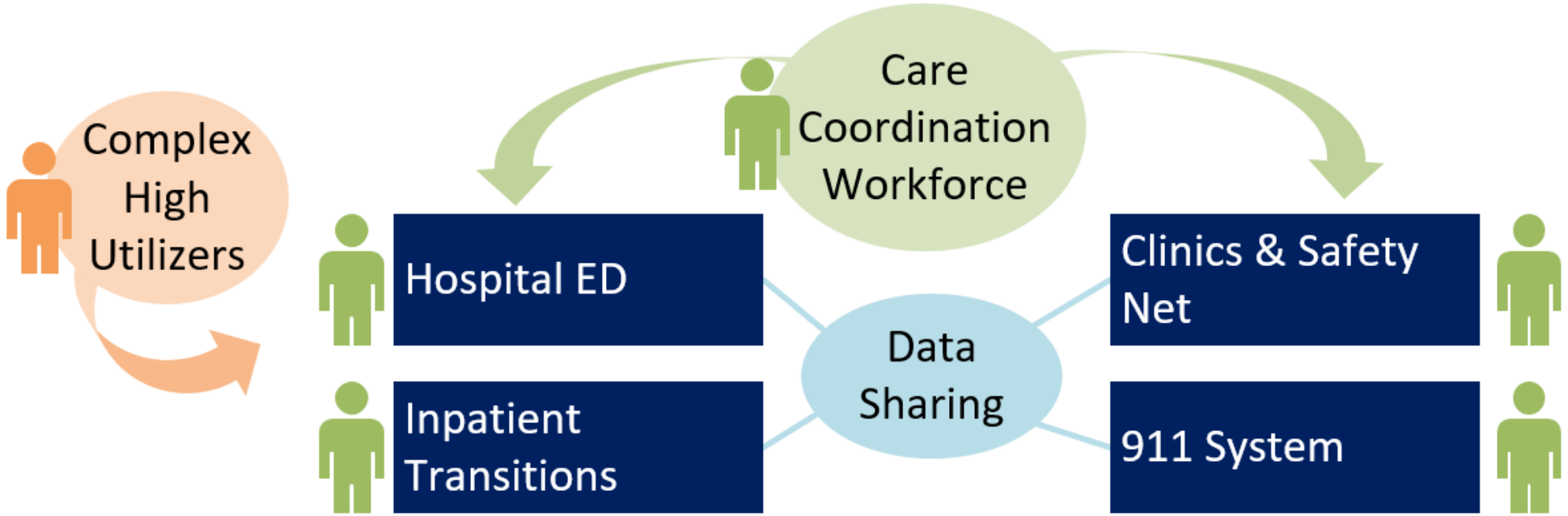
PART 1. BETTER CARE COORDINATION WILL SAVE US ALL.

Tri-County Care Collaborative: Super Care Coordination for Complex High Utilizers



HOW IT WORKED | Specialized care coordination workforce embedded in a wide range of settings with a coordinating data and learning infrastructure.

THE GOAL:	Reduced total cost of care.	THE RESULT:	*Whomp Whomp.*

PART 2. WAIT, IT'S NOT JUST ABOUT US?

..So we turned our evaluation toward learning *why* we weren't seeing cost savings.

WHAT WE LEARNED:

Triple aim outcomes are driven by "total complexity" across the entire continuum of health.

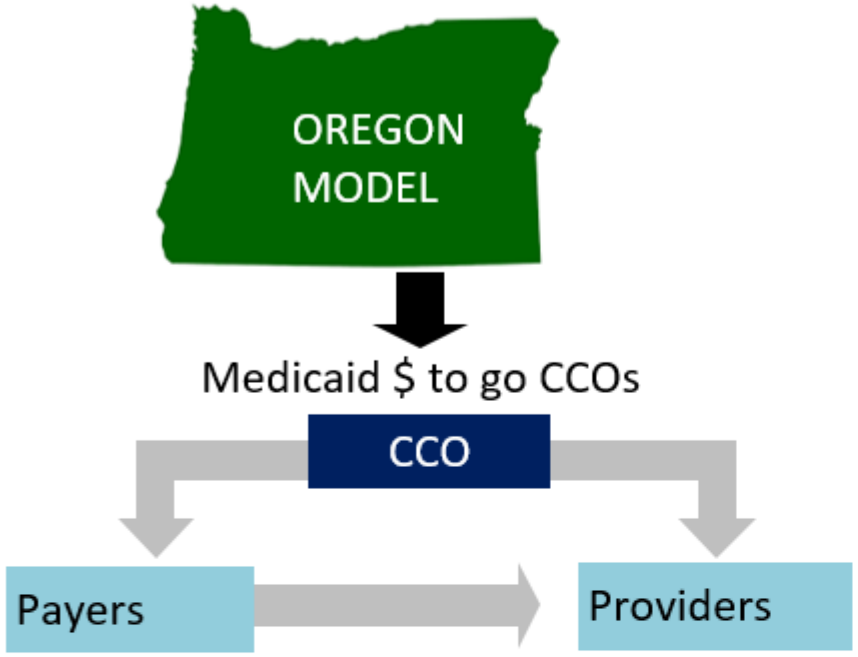
If we don't better integrate clinic and community, we don't have a prayer.

	All Medicaid	Complex High Utilizers
Childhood (<18)		
Four or more ACEs	42%	56%
History of childhood sexual abuse	28%	42%
Adulthood (18+)		
History of trouble finding work	39%	53%
History of homelessness as an adult	33%	62%
History of substance abuse	34%	60%
History of being physically abused as adult	26%	50%
History of being in jail at least once	35%	52%
In the Last Year		
Housing insecurity	18%	30%
Food insecurity	9%	23%
Transportation challenges	24%	43%

Analysis showed that social complexity was a key driver of utilization & costs, even when holding Medical complexity constant.

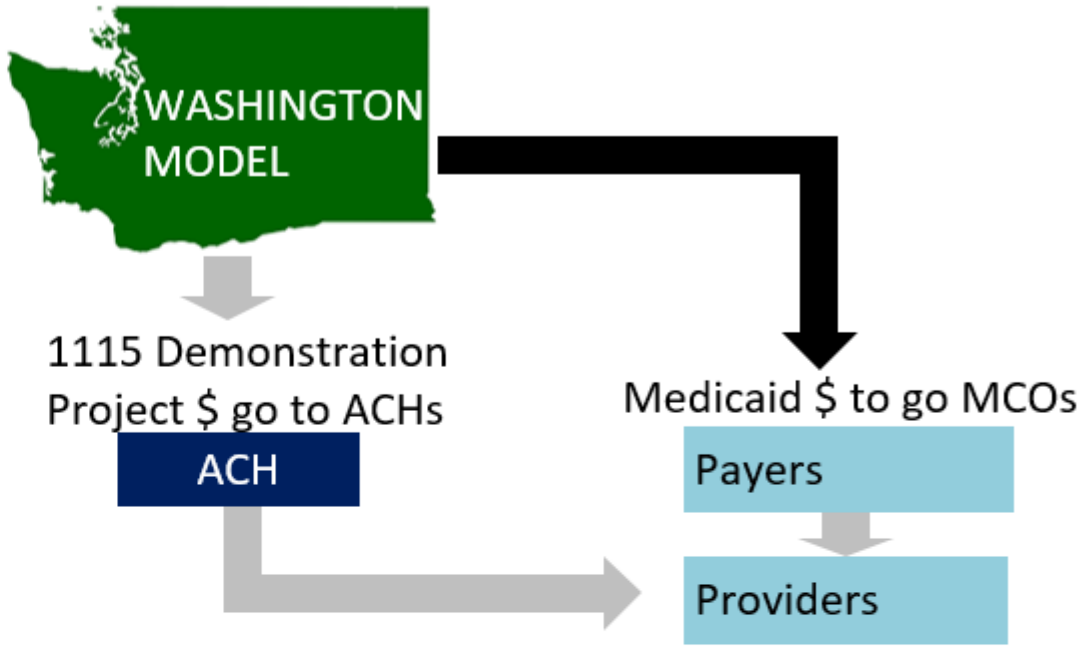
PART 3. IT'S ABOUT MORE THAN PROGRAMMATIC INTEGRATION.

MAKING CLINICAL-COMMUNITY CONNECTIONS THROUGH POLICY & SYSTEMS CHANGE



CLINICAL-COMMUNITY INTEGRATION LEVERAGE

- Starts with health care and "builds out" toward community.
- Direct flow of Medicaid dollars = contracting leverage.
- Flexibility to design models of care & approaches that meet local needs.
- CCO 2.0, launching soon, increases requirements around social determinants of health strategies.

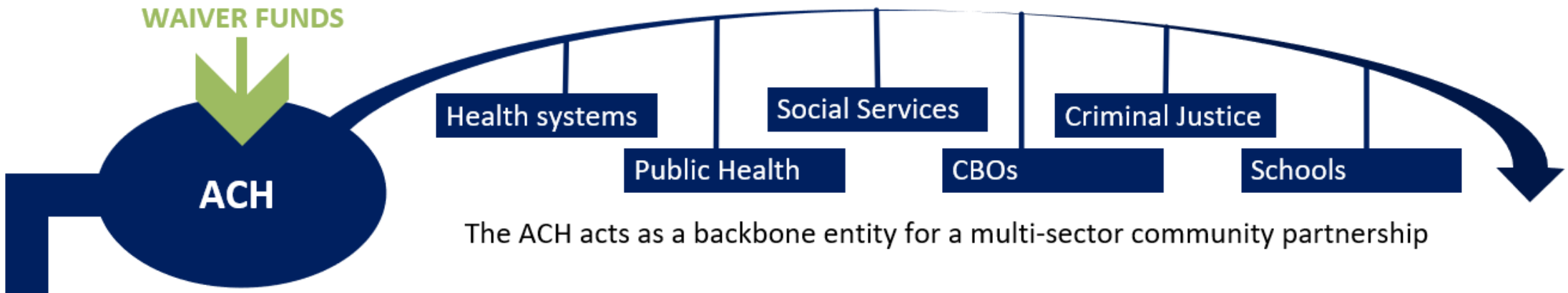


CLINICAL-COMMUNITY INTEGRATION LEVERAGE

- Starts in the community and "builds in" toward health care.
- WA 1115 waiver put ACHs at center of state's Medicaid transformation strategy
- Clinical-community integration is a key strategy for the state's waiver. Waiver resources can support this work.

PART 4. BUILDING INTEGRATION THROUGH CROSS-SECTOR PARTNERSHIPS

HOW THE WA ACH MODEL SUPPORTS CLINICAL-COMMUNITY INTEGRATION



The ACH acts as a backbone entity for a multi-sector community partnership

Transformation Levers

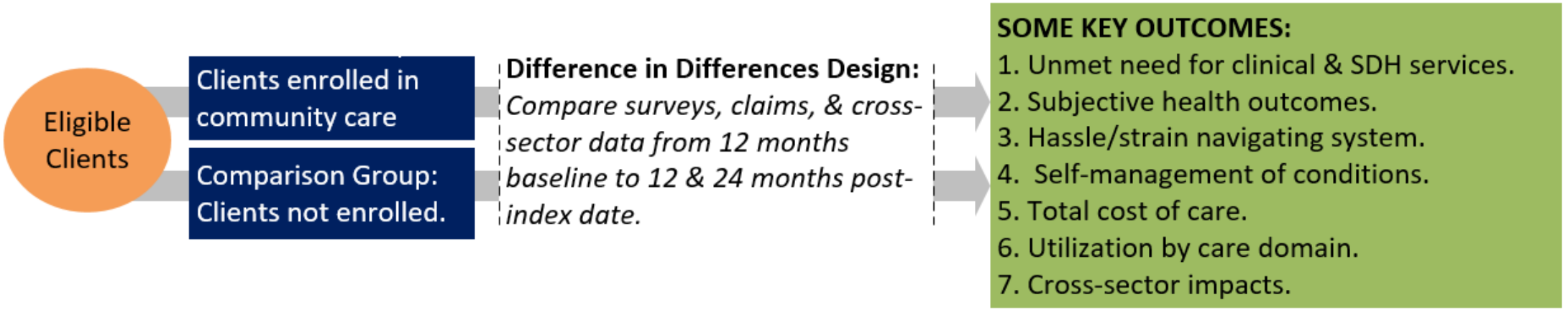
Community Hub	Centralized community platform for data sharing and “care traffic control.”
Contracting with Clinics Directly	ACH contracts with clinics and CBOs to support clinical-community integration model.
Programmatic Work	ACH supports complementary programs that utilize the coordinating structure.
Community Resiliency Fund	ACH establishes a flexible prevention fund to invest at key leverage points.

PART 5. BUILDING AN EVIDENCE BASE.

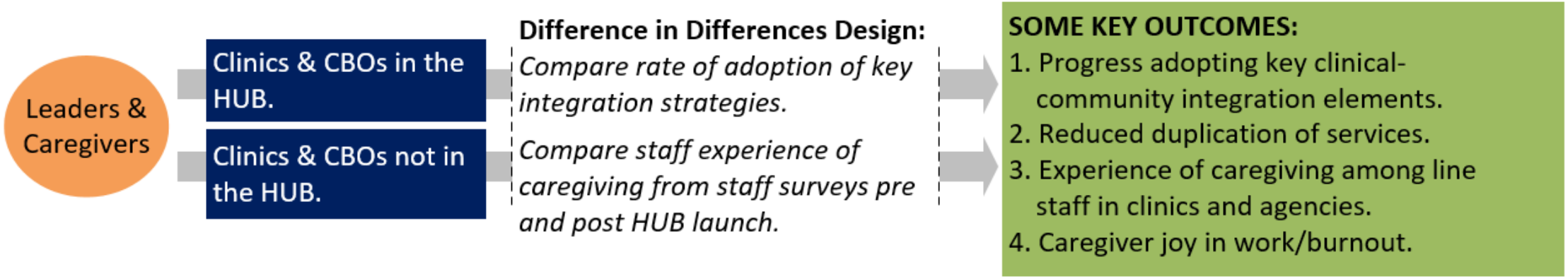
EVALUATING THE IMPACT OF A POLICY & SYSTEMS CHANGE APPROACH TO CLINICAL-COMMUNITY INTEGRATION

We are launching a 3.5 year comparative evaluation study across four different regions:

A. IMPACT OF THE ACH/HUB MODEL ON IMPROVING CLIENT & COMMUNITY OUTCOMES



B. IMPACT OF THE ACH/HUB INFRASTRUCTURE ON ACCELERATING ADOPTION OF CLINICAL-COMMUNITY INTEGRATION



PART 6. NOTHING IS EVER EASY.

THE KEY CHALLENGES OF BUILDING EVIDENCE FOR SYSTEMS INTEGRATION VS PROGRAMMATIC INTEGRATION

Data Integration Ain't Easy.	Data sharing rules were developed sector by sector (HIPAA, FERPA, etc.) & don't play well together. Plenty of technical solutions exist, but the legal architecture is still stuck in the old world.
Wait, It's Everywhere?	Programs are easier to evaluate than systems changes, which are often rolled out at scale that makes comparison groups hard. It's as if helping us collect good evidence isn't their top priority.
Wait, It's Every*thing?*	Policy & systems changes are multidimensional, so it's really hard to know which pieces moved the needle. Can't they just change one thing at a time?
Hold Still for a Minute!	Policy and systems shift quickly, so the effects of change are really hard to study. Just when you think you have the answers, they change all the questions!
Who's Got That Kind of Time?	Collective impact efforts are hard and tend to fall apart without some early evidence of impact that keeps partners coming. But good evidence takes time to compile!

PART 7. BUT IT JUST MIGHT BE WORTH IT!

THE EXTRAORDINARY OPPORTUNITY THIS WORK REPRESENTS -- IF WE CAN PULL IT OFF.

If we can convincingly demonstrate how populations, outcomes, and root causes are interconnected, we can support, sustain, and catalyze systems change.

Common Populations	To what extent are the people struggling in one sector's outcomes the same as those struggling in another? Can we build systems and workflows to **better coordinate** across these common populations?
Common Outcomes	To what extent are better outcomes in one sector dependent on outcomes in another? What does this tell us about how to partner effectively and create **aligned incentives** for everyone involved?
Common Root Causes	To what extent are everyone's poor outcomes mutually predicted by the same set of determinants? Can we invest at these "maximum leverage points" in order to maximize the **total community good** of our efforts?

We intuitively know this. To boost transformation, we need to understand it empirically.