

## SIM Symposium: From Accountable Care to Accountable Communities

***“Every system is perfectly designed to get the results it gets.”*** Although Connecticut ranks 6<sup>th</sup> in America’s Health Rankings, it is among the worst for health disparities. Hospitalizations for asthma, for example, are five times worse for African Americans than for the white population. These and other disparities cost the state \$263 million dollars in 2013. (Dr. Dalal, Department of Public Health).

At the same time, models that attempt to connect health care providers with community organizations to address individuals’ basic needs are the exception and not the norm.



A SIM Symposium was held at the end of March to explore what it might take to expand and improve newer accountable care or “2.0” models, which reward better and more affordable care, to an accountable community or “3.0” model, which rewards better health.

The State Innovation Model (SIM), promotes movement from the fee-for-service payment system or “sick care,” as some panelists called it, towards accountability for health outcomes. Medicare, Medicaid, and commercial plans are entering into this “2.0” version of accountable care, where they are holding providers accountable for the quality and cost of the care they provide.



*Keynote Address by Mark Schaefer, the Director of the Connecticut State Innovation Model Program Management Office*

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Patrick Charmel (pictured right), the CEO of Griffin Hospital, said that the 2.0 model has to be transitional, in order for it to be sustainable.



Griffin Hospital decided to be on the leading edge of accountable care, instead of what he called a “wait and see” stance. So Griffin entered into shared savings contracts with Medicare and Aetna. If they are able to improve care and reduce costs, they are rewarded a portion of these savings.

Griffin Hospital and other accountable care providers are recognizing how important it is to recognize when social factors, such as safe or stable housing, are affecting a person’s ability to manage their health conditions. The biggest challenge they are working on is how to connect that individual with community supports that can address those social factors.

At the same time, community organizations are increasingly expecting a return from the provider systems for the work they are doing to keep their patients healthy in the community. Mr. Charmel said the 3.0 model must have a payment system that gives provider systems more flexibility to succeed in this new role and that rewards key community partners who are needed to address the root causes of poor health.



Dr. Mario Garcia (pictured left), of the Department of Public Health, is launching a SIM Population Health Council this month to begin tackling some of the complexities involved in getting to 3.0, including launching Health Enhancement Communities, also known as Accountable Care Communities. These aim to take a regional approach to hold multiple organizations

accountable for the health of a community.

The Population Health Council will tackle how to combine historically separate public health and clinical care approaches to improve health. This will require a payment system that brings healthcare and community providers to the table, and creates a collaborative culture where they work together on common community wellbeing goals. Although incredibly complex, getting to 3.0 is increasingly more critical if want to design a system that will get us the results we need.

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## Examples of Community & Clinical Integration in Connecticut

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The **Health Leads model** connects individuals at risk with a community resources. These individuals are referred to someone (usually a college student volunteer) who uses a community resource database to connect them to resources that address their social needs. This model will soon be piloted by Yale New Haven Health System in Bridgeport.

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**Community Solutions**, in Northeast Hartford, created a collaborative with Cigna, UConn, the state, St. Francis hospital, and a home care agency. They work together to target individuals with high ED rates to connect them to Community Health Workers. For 11 individuals that were served over 9 months, ED usage went down 57%, and billed cost was reduced by 60%.

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The **Vita Wellness district** uses a collective impact model to improve health in a community in Stamford. Vita brings together a collaborative with strategic partners. Together they take on hospital services, public housing revitalization, urban agriculture, pre-k, and immigrant services.

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