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Building Baltimore's Accountable Health Community

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While 96% of health care costs are spent on medical care delivered in hospitals, only 10% of what drives health outcomes is attributable to clinical care. This is markedly true in Baltimore, which is home to some of the best health care institutions in the country. Yet our city faces a mortality rate that is 30% higher than that of the rest of Maryland and ranks last in the state on nearly all key health outcomes.

> *How could we move beyond one-off programs that connect patients to resources and toward a city-wide ecosystem that addresses patients' social needs comprehensively?"*

These outcomes are compounded by a series of complex social, economic, and political determinants of health: more than 1 in 3 children in Baltimore live below the federal poverty line, and more than 30% of Baltimore households earn less than $25,000 per year. Stark disparities exist as a result: residents of the city's wealthiest neighborhoods can expect to live up to 20 years longer than their less affluent peers, even though their homes may be less than a mile apart.

At the Baltimore City Health Department (BCHD), we know that tackling these health disparities requires a multi-pronged approach to social determinants of health. For decades, our public health programs and services have involved identifying and then addressing a wide range of health-related social needs and issues, including food insecurity, opioid addiction, lack of transportation, utilities assistance, homelessness, job training, and more.

Addressing Patients' Social Needs Is Not a New Phenomenon

We have not been alone in this effort, and many of our partners across the city have actively promoted connections from the clinic to community services. For example, B'more for Healthy Babies is a public-private partnership focused on reducing infant mortality that leverages referrals from local health care providers to ensure wraparound services and home visits for at-risk moms.

Several other programs, ranging from lone social workers to teams of care coordinators, also exist within individual institutions but are highly fragmented. Providers and community members alike have voiced frustration that a high-utilizing patient might have four care managers across multiple institutions, each with its own protocols and data collection systems, resulting in poorer coordination and patient experience.

So, we were thrilled when the Center for Medicaid & Medicare Services (CMS) Innovation Center took a major step forward by acknowledging the necessity of addressing health-related social needs. Last spring, the CMS announced a $157 million innovation round focused on building "Accountable Health Communities" (AHCs) — models that comprehensively address health-related social needs by screening patients and then connecting them from the health care system to community resources.

Leveraging Federal Models to Catalyze Local Change

Initially, we knew that the announcement — with its grant dollars attached — would attract proposals from a wide variety of organizations with excellent ideas. However, we also knew that many of these organizations would have limited ability to support and track thousands of patients across multiple care settings, care plan recommendations, and social service categories — and therefore would have limited ability to actually move the needle on outcomes. So, we at BCHD decided to answer an essential question: how could we move beyond one-off programs that connect patients to resources and toward a city-wide ecosystem that addresses patients' social needs comprehensively?

This move involved the unorthodox work of reaching out not just to our health systems and Federally Qualified Health Center partners, but also to community-based service providers with extensive experience in addressing social needs, to begin aligning around a shared vision and approach."

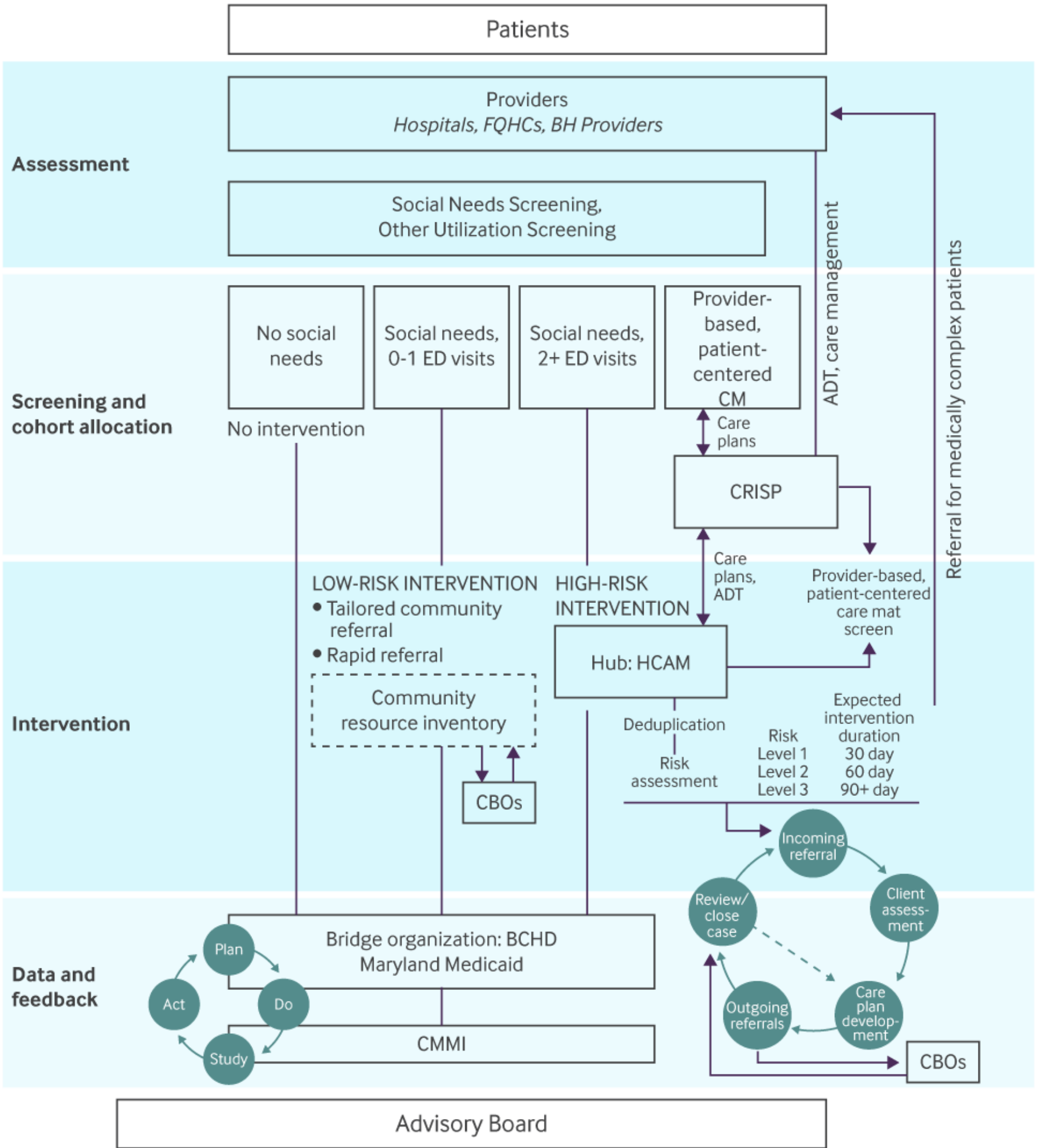
To go about designing this solution, we moved to join with our partners in one city-wide proposal. This move involved the unorthodox work of reaching out not just to our health systems and Federally Qualified Health Center (FQHC) partners — Johns Hopkins, Bon Secours Health System Baltimore, LifeBridge Health, MedStar Health, Mercy Medical Center, University of Maryland Medical Center, St. Agnes Hospital, Chase Brexton, Total Health Care, and HealthCare Access Maryland — but also to community-based service providers with extensive experience in addressing social needs, to begin aligning around a shared vision and approach.

Over the course of dozens of one-on-one and cohort meetings, our AHC proposal team identified *four key strategies* to ensure successful implementation:

- **Identify and scale best practices.** The first goal is to develop a unified learning community in which practitioners and administrators can share experiences covering the full spectrum of activities related to addressing patients' social needs: screening, referral, connection to a resource, and ongoing follow-up back to the referring provider.
- **Gain maximum efficiency.** Given that patients access different care points, the second goal is to implement a central hub of trained and supervised community health workers that is accessible to any participating provider.
- **Enable unified data-insight and technology systems.** In order to facilitate the first two goals, the third goal is to establish an integrated technology system that merges with the regional health information exchange to provide care team members insight into a patient's social needs just as they are able to view clinical information.
- **Ensure true community partnership.** In partnership with a robust community advisory board, the fourth goal is to track and assess community referral outcomes data in order to (1) develop a quantitative business case for resource connections and (2) determine where

additional community advocacy and resources are necessary.

Baltimore City's Accountable Health Community model will stratify patients on the basis of risk and then identify their social needs as well as direct them to relevant community resources. Given the existing landscape of care coordination programs and related technology systems that currently exist across the city, this diagram demonstrates how Medicaid and Medicare beneficiaries who flow through the intervention will receive the services that meet their needs.



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Moving Forward to Build Baltimore's Accountable Health Community

In April 2017, CMS announced that Baltimore City had been selected as one of 32 award recipients for the AHC program. Over the next 5 years, we will move forward with implementing a comprehensive community health worker hub, building technology infrastructure to support thousands of patient screenings and community resource referrals, and conducting ongoing data collection at the community level.

Redefining health care to address patients' social needs is a necessary next frontier of increasing quality and lowering costs. Here in Baltimore, we are committed to moving forward with this vision and building the necessary evidence base to transform care for our residents.

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