Mission Health Partners:
A Community-Based Social Determinants Driven Accountable Care Organization

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Mission Health Partners Accountable Care Organization's population health strategy is based on the idea that improvements in outcomes are best achieved by addressing social determinants gaps for its members. Our network of service providers and a process for referrals and tracking streamlines the limited resources available to meet these needs.

When hospital leaders and primary care physicians in Western North Carolina came together in 2013 to discuss forming a clinically integrated network, we knew that our region provided high quality care. Our ambulatory practices had a long history of independence, but they shared a common vision with Mission Health, our largest hospital system, around coordinating care to achieve the best outcomes at the lowest cost for patients. The product of this discussion was Mission Health Partners (MHP) Accountable Care Organization (ACO), a network of over 1000 physicians and 75,000 covered lives including almost 50,000 Medicare beneficiaries. Apparent to us as we started this work were the challenges that often prevent patients from achieving desired outcomes, including access to health care, high rates of poverty, transportation, and housing, among others. While these challenges are not unique to MHP, they require innovative and regionally sensitive solutions to be effective across our 18 counties. Borrowing from the Pathways Hub model used in the Medicaid world of other states, we designed a community-based model for addressing these social determinants of health by aligning appropriate community resources around our highest risk patients [1, 2].

ACO leaders agree that the goals of care management include improved outcomes and more effective and efficient utilization of services. How care management is operationalized, however, varies widely depending on the context. A primary care practice, for instance, may use a medical assistant to coordinate services or do basic teaching, while a hospital may utilize a registered nurse (RN) with advanced training to provide care management services for those with complex chronic conditions. In almost any possible model, care management tries to resolve conflicts between clinical outcomes and social determinants of health. Patients are often referred to a care management team because the patient has not achieved a desired clinical outcome or is at risk of not achieving his/her clinical goals. In most cases, social determinants of health stand in the way of desired outcomes.

Mission Health Partners Clinical Operations

The Pathways Hub model is a community-based care coordination approach where referrals to community social service agencies originate from a care coordination center call a hub. In our version of this model, the care manager completes an assessment and collects social determinants data. That information helps the care manager identify needs or gaps in the clinical and psychosocial aspects of a patient's life. Those gaps, or "pathways," can include anything from adequate housing to medication access, or a host of other opportunities. Each engaged community partner is assigned a pathway to complete. For example, a patient suffering from an unsafe housing situation may have a housing pathway addressed by a sustainable housing agency or a medical-legal partnership (Pisgah Legal in our area). In this way, the model allows us to engage community agencies in care coordination based on appropriateness for the patient (eg, educational level, geography, and other factors).

Our care coordination team is divided into pods, which are assigned to practices in the network based on patient attribution. Those pods consist of RN care managers, certified pharmacy technician care coordinators (CPhTs), clinical pharmacists, licensed clinical social workers, and others working within their scopes of practice. The goal of the pod approach is to create intentional relationships between the MHP Care Coordination team members and the staff and providers at the individual practices. Services like clinical pharmacy and behavioral health, as well as administrative support, are shared resources available to multiple pods (see Figure 1).

Additionally, MHP utilizes a community paramedic

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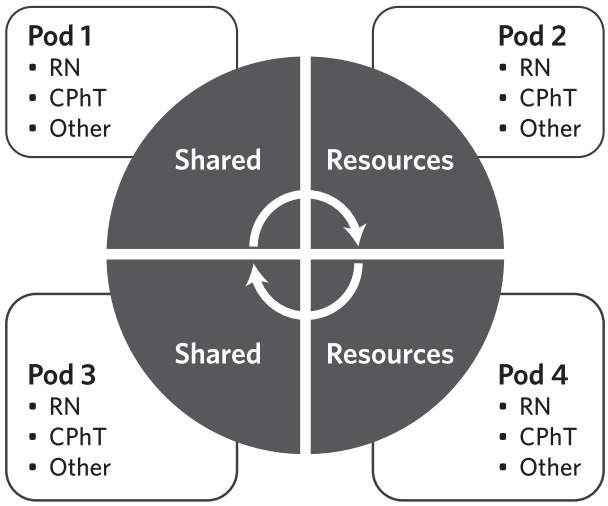
program (Caramedics) to perform various services in the home. Recently, Caramedics has engaged with the Asheville-Buncombe Institute for Parity Achievement to provide trained community health worker services in our highest risk ZIP codes. Both of these groups receive referrals via the hub model.

Even with this talented and multidisciplinary team, it was crucial to include other community partners given

the volume and scope of social determinants gaps in our region. We developed a cloud-based platform that allows community partners (mostly local non-profit agencies) to receive referrals and document progress on gap closure as part of a comprehensive community care plan for our highest risk patients. While the overarching goals of reducing cost and improving quality are fundamental to our work, we also have specific operational goals for the hub model in our community.

First, we seek to create an efficient system of care coordination across multiple entities that addresses the issue of "who coordinates the care coordinators?" It is not unusual for our highest risk patients to receive multiple phone calls or visits from well-intentioned care coordinators from various agencies trying to solve overlapping problems. The patients, unfortunately, are often left confused, stressed, and unsure of whom to call when things go wrong. By clarifying which agencies should provide which services, we can avoid duplication of efforts and inappropriate utilization of resources.

FIGURE 1.
Mission Health Partners Care Management Pod Model



Second, we seek to augment our standard productivity measures (eg, number of patients enrolled) with amelioration of factors and closure of pathways as another measure of productivity. Our fundamental belief is that to affect meaningful behavior change and improve our patients' ability to manage their medical conditions, we must close some of the social determinants of health gaps that often drive patients to make unhealthy decisions. For instance, it is difficult to manage insulin-dependent diabetes if a patient cannot afford his/her medication or does not have stable housing to store his/her insulin. We foresee that eventually the data we collect will help advocacy efforts in our community and beyond, so that policy changes can address these issues broadly and sustainably.

Mission Health Partners believes our highest risk patients require coordinated efforts to meet their complex needs. While we continue to provide condition management resources and education in the vein of traditional care management, MHP also works to build a community-based, patient-centered care coordination strategy for our network. NCMJ

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