ACA BODES WELL FOR INTEGRATED CARE

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The Affordable Care Act has brought new urgency to two important and interrelated health care topics: delivery reform and community benefit. The goals of the groundbreaking health reform legislation are to increase the quality, effectiveness and efficiency of the health system for all, but especially for persons who have historically been left out. Hospitals can help deliver on this promise by integrating their health care delivery and community benefit when it comes to expanded coverage, prevention and patient care improvements.

EXPANDED COVERAGE

The most significant impact of the ACA on the delivery of care comes from provisions related to expanded coverage. In the past, uninsured and underinsured persons went without or received care in the least efficient and effective setting — hospital emergency rooms. Many of these people now will have access to a range of services including primary care, prevention services and follow-up care.

Community benefit programs can play a leading role in expanding coverage by helping to enroll uninsured and underinsured persons into new coverage programs. Most hospital community benefit programs already have initiatives for enrolling eligible persons into Medicaid and other means-tested programs. These activities can be expanded to help enroll the over 30 million people newly eligible for coverage, through community outreach as well as in the facility.

With increased enrollment will come new challenges for health care delivery. Those who have been left out of the system are apt to have untreated conditions and may lack understanding about how the health system works. Low income persons may lack social supports, health literacy and resources needed to take full advantage of their new coverage. They may come from environments not conducive to health and healing.

Community benefit programs, having experience working with low-income populations, can help their hospitals develop strategies for Medicaid and other newly insured low-income patients that take into consideration the social, economic, and cultural challenges faced by these patients.

PREVENTION

Health care reform calls for a new emphasis on prevention, including primary prevention, actually preventing disease or injury, as in administering immunizations, secondary prevention, which includes services for early detection of health problems, such as in mammograms and other screening tests, and tertiary prevention, which is management of conditions to prevent avoidable progression and complications.

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Many provisions within the ACA address prevention. First, the law provides incentives that include no cost-sharing — that is, the patient has no co-pay — for many evidence-based clinical prevention services. Community benefit programs, already working with community partners on prevention of disease, can expand these efforts.

Second, the law provides for funding at the state and local levels for public health prevention services, including:

- **A community prevention and public health fund** — a funding stream for improving health through community-based programs by expanding awareness of clinical prevention services, improving the public health infrastructure, training for public health workers and expanding data collection for research and tracking.
- **Community transformation grants** — federal grants to local or state partnerships for improving health and the prevention of chronic disease such as cancer, diabetes and heart disease. These grants can be the catalyst for community partners, including hospitals, to plan how to address community health problems and better coordinate activities.
- **Chronic disease prevention and health promotion grants** — funds for states to plan, coordinate, track and manage chronic diseases and the risk factors that underlie them — smoking, poor eating habits, lack of physical activity.

Community benefit programs can join community- and state-wide collaborations that use these funds. Hospitals focused on preventing and managing chronic illness, especially conditions that are the leading causes of death and disability (and often subject to frequent and avoidable hospitalizations) such as heart disease, cancer, stroke, diabetes and arthritis, can increase their impact by being part of broader efforts to address and better manage these health problems.

Community benefit programs also can tap into professional expertise within their organizations to enhance prevention programs. For example, oncology nurses and physicians can help promote cancer awareness, participate in screenings and help design community-based care.

PATIENT CARE IMPROVEMENTS

Several provisions in the ACA provide new incentives for hospitals to improve health care outcomes and decrease costs. Many deal with improving transitions to and from the community and coordinating care within the community. These include penalties for avoidable rehospitalizations, programs for "bundling" the cost of various services, accountable care organizations and value-based purchasing. Starting in FY2015, for example, the hospital value-based purchasing program will include an "efficiency" measure that assesses all Medicare Part A and Part B spending per beneficiary 30 days after and 3 days before a hospitalization.

What these programs and incentives have in common is the need to look beyond traditional health care delivery sites of care and to pay attention to patients and their circumstances before and after — and perhaps instead of — hospitalizations. Chronic conditions such as diabetes, hypertension and mental illness and risk factors such as smoking, obesity and inactivity can exacerbate or create acute problems and lead to complications. Hospitals can work to improve health outcomes and thereby reduce cost by improving the health of the populations they serve.

Many community benefit programs and their partners have a history of working to improve health of the overall community and targeted populations. Prevention and health improvement services can identify frequent users of emergency services for upstream primary and preventive care. They can help discharged patients get well and stay well with community supports and chronic disease management programs. For example, some community benefit programs work with faith congregations to provide volunteers to check on recently discharged patients. Another example is the Stanford Chronic Disease Management Program (http://patienteducation.stanford.edu/programs/cdsmp.html) which is a community-based program that has been successful in reducing rehospitalization.

Historically, community benefit programs have operated in isolation of other hospital services. However, if we are to better serve newly insured persons, promote the health of our patients, improve health outcomes and decrease health care costs, that isolation needs to break down. The integration of programs should be a desired goal throughout the hospital organization, with the ultimate goal of improving the health of people in our communities.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, January-February 2014