

Achieving Healthy Communities through Community-Centered Health Systems

BY DAVID D. FUKUZAWA

Thirteen years ago in *Public Health Reports*, Tyler Norris and Mary Pittman (2000) drew on the history of the Healthy Communities Movement to set forth an agenda for the emerging Coalition for Healthier Cities & Communities. The agenda included the recommendation to “align the incentives of health care providers with the public health and Healthy Communities emphasis on improving population health status and quality of life.”

With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the possibility of achieving such alignment now seems within reach. While the most visible provisions of the ACA are aimed at increasing coverage to the uninsured, the law also recognizes the importance of prevention and population health in holding down ever-rising health care costs. It also fosters experimentation with new payment methodologies that potentially move the system away from paying for volume (fee for service) and toward paying for value.

This article charts the evolution of the Kresge Foundation’s Health Program and its programmatic goal of reducing health disparities by promoting population health, specifically addressing the conditions and environments that lead to positive health outcomes for all Americans.

A Bit of Background

The Accountable Care Organization (ACO) is at the core of the ACA experiments. An ACO comprises a group of health care providers, whose goal is to provide coordinated care and achieve improved overall health for its patient population. What distinguishes the ACO from the traditional fee-for-service model is that it aims to achieve cost savings through quality patient care *and* better population health management, which includes an emphasis on prevention. The incentive for providers to keep people healthy is the cost savings that

accrues and can be shared among them. The ACO therefore is structured to meet the goals of the Institute for Healthcare Improvement’s Triple Aim Initiative: to improve the patient experience of care, to lower the per-capita cost of care, and to improve population health.

ACOs, however, are not without their critics. Besides the charge that it’s still too early to determine their effectiveness, many argue that ACOs are still too delivery and provider centric. Better population health, they contend, should refer to the entire community rather than specific populations, such as people with diabetes. They believe better value can be produced by prevention, not more treatment, no matter how good or efficient. Resources are too concentrated on medical services, they add, instead of on upstream determinants.

Journey toward a Community-Centered Health System

For us at the Kresge Foundation, that critique prompted us to ask what role health care systems could play in improving community-wide population health. That question, first asked three years ago, eventually led us to the conviction that ACA provides the opportunity and challenge to transform the health care system from one primarily focused on delivering services/treatment to one that is focused on population health: a community-centered, upstream-oriented system.

Our journey began with these questions:

- Given their history, what does the experience of community health centers (CHCs) tell us about linking clinical services and the social determinants of health?
- Could we develop a grant-making effort to help build models of community-centered care through a place-based, multisite demonstration project?

- Who are some current health system innovators that are integrating population health strategies into their care continuum?

Community Health Centers: How Are They Leveraging the Social Determinants of Health?

Dr. Jack Geiger is widely credited for the development of community-oriented primary care, based on his pioneering work in the Mississippi Delta in the 1960s. After opening one of the nation's first CHCs in Mississippi, he quickly recognized that medical care alone couldn't address the lack of clean drinking water, sanitation problems, and malnutrition, all of which were at the root of the community's health problems. The legacy of this work has continued through the creation and expansion of federally qualified health centers (FQHCs). Over the last forty years, FQHCs have become a critical part of the medical safety net, with the National Association of Community Health Centers reporting in 2013 that they serve more than 22 million patients through 9,000-plus locations.

Knowing this, we expected to find a robust record of research. Instead, based on a Kresge-funded study by the Institute for Alternative Futures (IAF), we learned the literature review of the work of leveraging social determinants by CHCs was scant. As of the printing of its 2012 report, IAF had created a database of 176 activities, projects, programs, and interventions by 52 different CHCs, plus several more intensive case studies. This research was carried out in partnership with the National Association of Community Health Centers (NACHC) and involved expert interviews, webinars, and numerous meetings with NACHC leadership and membership.

Some of the key lessons that emerged from the review indicated that:

- CHCs continue to be responsive to wider social and environmental issues that affect the health and well-being of their patients.
- CHCs frequently develop a diverse array of community and social service partnerships to address these issues.
- CHCs are often the first to recognize a problem and provide leadership to tackle it.
- Most of these efforts have not been evaluated.
- Funding is an ongoing and constant problem.

The effort by NACHC and IAF did not end with the report's 2012 publication. In addition to the research findings, the partnership was aware of potential policy and systemic implications that suggested new models of population health care. The "community-centered health home" developed by the Prevention Institute and described by Jeremy Cantor and coauthors (2011) is one example. As a result, the partnership has continued to explore how such models could be more fully developed through opportunities within ACA.

Developing New Models for Population Health: Safety-Net Enhancement Initiative

The Kresge Health Team's own early hunches about new models of population health led us to launch the Safety-Net Enhancement Initiative (SNEI) in 2009. It is a national demonstration project to develop new models of integrating population health strategies through local partnerships. Kresge is supporting eight sites nationwide. Projects encompass community health centers, health systems, public health departments, and community partners.

The sites were challenged to plan and implement a project with collective impact. Each focuses on a key disparity (common agenda) and includes predetermined evaluation outcomes (shared measurement systems), a set of specific activities (mutually reinforcing actions), an authentic community engagement/collaboration structure (continuous communication), and identification with an "anchor institution" (backbone support organization).

The partnerships are as varied as the places: between a public housing commission and a CHC aimed at reducing hypertension; among a health department, CHCs, and local food organizations to improve maternal and child health; among a local school, the health department, and a CHC to reduce childhood obesity. Some partnerships were led by health systems; some, by CHCs; one, by a health department; and one, by a nonprofit.

The models are equally diverse. Some important, common elements have emerged:

- Identifying and staying focused on a common goal (a community-identified health disparity) was the

first and most constant challenge, given these communities' many issues and problems.

- The partnerships have turned into robust and engaged collaborations, embedded in coalitions that oversee the projects' implementation. Critical to the success of these partnerships has been the involvement and engagement of community members as authentic partners.
- A major impact has been generating greater connectivity and social capital.
- While SNEI did not specifically focus on policy and financing, many of the sites' partners have found ways to sustain the effort through a new awareness of social determinants and new ways of working.

The eight sites will be completing the third and final year of their grant-funded projects by the end of 2013. Three years are obviously not enough time to see either measureable changes in health outcomes or other significant policy and environmental changes. But several sites have already begun to investigate opportunities under ACA to advance their community-centered models. A formal evaluation also will be completed within the next twelve months. It is our hope that these evaluations will be instructive for the field as well as for our SNEI partners and ourselves.

Survey of Regional Health System Innovators in Population Health

In 2011 we engaged a consultant, Ann Batdorf-Barnes, D.O., MPH, to conduct a study of innovative health systems that were actively addressing upstream determinants of health within vulnerable populations. She conducted the study from June to October of that year. It included three site visits and meetings with leading population health experts.

Batdorf-Barnes's unpublished study put forth this definition of what we were then calling a "population health system": an intersectoral system of care, including medicine, public health, and community resources, that is accountable to improve the health of the whole community by addressing all of the health needs, whether the individual seeks health services or not. It also ensures the conditions within which a person can be healthy by building healthy communities.

Health care systems are moving to create upstream, collective impact structures that are multisectoral, community centered, disparity reducing, and focused on improving population health while not sacrificing patient care quality.

The three sites she visited were Genesys Health System (Grand Blanc, Michigan), Memorial Healthcare System (Hollywood, Florida), and Southcentral Foundation (Anchorage, Alaska). Although space does not allow for a fuller description of what she found, the summary of the key elements of Southcentral Foundation were, in large part, shared by all:

- Think and act on the population (understand the needs of vulnerable populations).
- Redesign the system with integrated care teams based on the expressed needs of individuals in the population (understand the needs of the individual).
- Coordinate care across the health care delivery system.
- Address upstream determinants in the community, reorienting the health system through action on the social determinants of health.

As Batdorf-Barnes explained to me, Southcentral's approach to care extended even to the design of its main facility: The entrance area was large enough to act as a community meeting place, not just a waiting room. The area for action, in other words, was moved from the back to the front of the building. It emphasized that the community health center was above all a **community center**.

Moving Forward: Building the Field of Community-Centered Health Systems

This article tracks our journey to imagine a new kind of health care system. Over the past few years we also have become aware of many others who are on the same journey. Some of these include recent grantees of the Centers for Medicare & Medicaid Innovation Awards. Collectively, this emerging work has reinforced for us the impression that, around the country, health care systems are moving to create upstream, collective impact structures that are

multisectoral, community centered, disparity reducing, and focused on improving population health while not sacrificing patient care quality.

We believe that these are the elements of a community-centered health system, which includes medicine, public health, and community partners, all holding each other accountable within a partnership structure for achieving greater community health and well-being.

These developments potentially have profound significance for the Healthy Communities Movement because:

- They signal a shift away from a purely downstream understanding of health care.
- They begin to lay out the potential pathways for reallocating the resources with the health care system to address upstream factors of health.
- They suggest new frameworks and structures for communities to engage in building healthy communities.

It is impossible to predict which directions health care reform will take us, especially given the political noise surrounding it. But the future we would bet on—and invest in—is one in which health systems begin to operate outside the walls of patient exam rooms and operating tables to investing in

projects, efforts, and policies that create healthy communities.

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David D. Fukuzawa is the Kresge Foundation's program director for Health.
