hpio health policy institute of ohio ™

Health **Policy** Brief

Glide path framework for connecting primary care with upstream population health activities

Stronger connections to improve health

Recognizing that access to quality health care is necessary but not sufficient for good health, many health leaders are coming together to implement upstream population health activities that address the social determinants of health. The infrastructure and financing to successfully bridge health care with community-based organizations, however, is not yet fully developed. This policy brief describes a new framework for health leaders and policymakers to use as they build and strengthen these connections.

In response to stakeholder discussions on the challenges of addressing the social determinants of health in a primary care setting (see text box on page 2), the Health Policy Institute of Ohio developed a "glide path" framework outlining the activities and partners needed to:

- Connect primary care with community-based resources
- Create linkages between primary care and the broader environmental conditions that impact health

Framework description

The glide path framework (see Figure 1) provides a structure for aligning health care payment and delivery system transformation activities with state and community-level population health planning efforts. The glide path also serves as a tool to prompt discussions about specific strategies and financing mechanisms that build and support structural connections between primary care and community-based prevention and social service organizations.

Policy recommendations

Executive branch

1. Develop a strong state health improvement plan (SHIP) that addresses all levels of the glide path framework.
2. Provide adequate resources and staffing for **backbone organizations** housed within the Ohio Department of Health (such as the Ohio Chronic Disease Collaborative) and allow grant or contract funds to be used for backbone coordination activities that address the social determinants of health (glide path levels C, D and E).
3. Explore single-instrument grant awards to local health departments that allow for flexibility in addressing needs across sectors or silos, including activities at levels C, D and E of the glide path that may not fit into existing categorical grants.
4. Continue to identify and incorporate outcome measures and pay-for-performance (P4P) models in Medicaid managed care contracts that incentivize providers and managed care plans to more effectively address behavior change and basic needs (glide path levels A and B).
5. Explore waivers that allow Medicaid to cover community-based programs that support behavior change and address basic needs (glide path levels A and B).
6. Develop payment models (e.g. accountable care models) that encourage and incentivize Medicaid managed care plans and providers to work with local health departments, social service agencies and other community-based organizations to address basic needs, behavior change and community conditions (glide path levels A, B, C and D).

Legislative branch

1. Routinely assess the potential impact of proposed legislation and policy decisions in sectors such as transportation, education and criminal justice (glide path level E) on population health outcomes, health equity and healthcare costs (similar to the Common Sense Initiative, referred to as a "**Health and Equity in All Policies**" approach).
2. Enact legislation to implement recommendations in the HPIO report, **Improving population health planning in Ohio**, including three new requirements for local health departments and tax-exempt hospitals designed to increase the effectiveness and efficiency of state- and community-level health planning in addressing all glide path levels.
3. Explore the establishment of a **wellness trust** for Ohio—a sustainable pool of public and/or private funds that could be used at either the state or the local level to address upstream factors that impact health and healthcare costs (glide path levels C, D and E).
4. Bring together local health departments, hospitals and other partners within a legislative district to identify, implement and evaluate strategies to improve upstream conditions that impact health (glide path levels A-E).

Background

In September 2015, the Ohio Department of Medicaid (ODM) and Ohio Department of Health (ODH) contracted with HPIO to facilitate stakeholder engagement and provide guidance on improving population health planning. One of the objectives of this project was to align population health priority areas and strategies with the design and implementation of **Ohio's patient-centered medical home (PCMH) model**.

Developed as part of Ohio's State Innovation Model (SIM) initiative, the Ohio PCMH model acknowledges that strong connections between primary care providers and community-based resources can help patients stay well or manage chronic conditions. Under Ohio's model, a fully transformed PCMH is expected to:

- Actively connect members to broader social services and community-based prevention programs
- Ensure ongoing bi-directional communication with social services and community-based prevention programs
- Collaborate meaningfully with partners based on achievement of health outcomes
- Actively engage in advocacy and collaborations to improve basic living conditions and opportunities for healthy behaviors

The glide path framework provides examples for how to operationalize the "potential community connectivity activities" component of the Ohio PCMH care delivery model.

The framework, which takes the shape of a funnel, illustrates the social, economic and physical environment factors that impact health at the top and downstream system impacts of specific health conditions at the bottom. Boxes labeled A-E describe the types of activities (on the left) and partners (on the right) involved in helping patients stay healthy at each level of the glide path.

Boxes A and B of the glide path outline activities and partners needed to directly connect primary care with community-based resources that help patients meet their basic needs and engage in behavior change. At the higher levels of the glide path (boxes C-E), sectors beyond health (such as education, transportation and social service organizations) are responsible for many of the decisions that impact population health outcomes.

Comparing the glide path to other public health models

Similar to the social-ecological model,[1] the glide path describes the role of community conditions (such as nurturing school environments/positive school climate), and the broader social, economic and physical environment that shapes those community conditions (such as educational attainment, residential segregation and air pollution). More importantly, the glide path framework describes the types of activities and partners needed to make improvements at each of these levels.

The glide path also complements the **Health Impact Pyramid**, a framework developed by Dr. Thomas Frieden that describes different types of public health interventions and emphasizes the critical importance of addressing socioeconomic factors to improve health.[2] The glide path differs from the Health Impact Pyramid in two key ways. First, the pyramid focuses on public health interventions, while the glide path centers on primary care and pathways to connect primary care with community-based prevention resources, including public health organizations and sectors beyond public health. Second, socio-economic factors are positioned at the top of the glide path diagram to illustrate upstream determinants, contrasted with downstream consequences. The pyramid does not refer to the upstream/downstream concept and places socio-economic factors at the base of the pyramid.

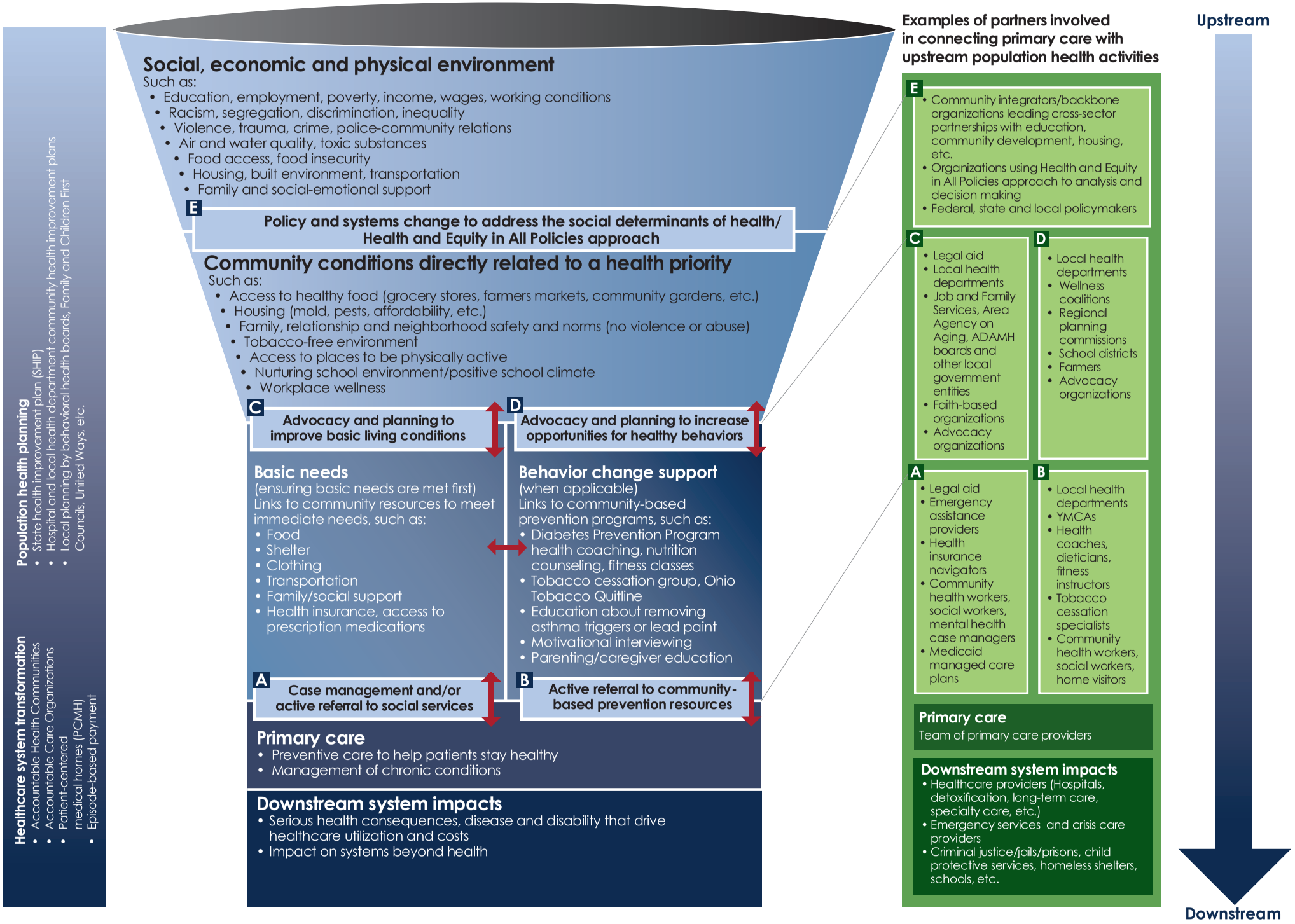
Role of public health and other community partners

Figure 1 provides examples of partners involved in connecting the various levels of the glide path framework. Public health plays a strong role in coordinating or leading many of these activities, particularly at levels B, C and D on the glide path. Local health departments, for example, often coordinate wellness coalitions that lead efforts to reduce tobacco use or partner with school districts on farm-to-school projects or Safe Routes to School programs. Local health departments are also getting involved in policy and systems changes to address the social determinants of health such as paid sick and family leave and criminal justice policies (box E on the glide path).

Addressing boxes C through E of the glide path requires coordination between health care, public health and sectors beyond health through:

- **Health and Equity in All Policies**: A collaborative approach to incorporating health considerations into decision-making across sectors and policy areas, including the use of Health Impact Assessments to identify ways that policy decisions in sectors such as education, criminal justice and housing may affect population health outcomes
- **Community integrators or backbone organizations**: An distinct entity with the capacity to bring partners together to define, measure and achieve common goals

Figure 1. **"Glide path" framework to connect primary care with upstream population health activities**



Source: Developed by HPIO as part of a population health planning project commissioned by the Governor's Office of Health Transformation, Ohio Department of Health and Ohio Department of Medicaid.

Implementation examples and financing mechanisms

HPIO's report **Improving population health planning in Ohio** provides specific examples of models and programs that can connect primary care practices with community-based resources to help patients with basic needs and behavior change (levels A and B). The report also describes how activities in levels A-E of the glide path are most commonly funded, as well as innovative financing mechanisms to support these activities, such as:

- Wellness trusts
- Block grants or single instrument grant awards that allow for flexibility in addressing needs across sectors or silos
- Gain sharing and outcome-based payment
- Global payment

Under a traditional fee-for-service payment system, there is little incentive for providers to address a patient's health-related social needs. However, as healthcare payments transition to more value-based arrangements, financial incentives are changing. Within a fully transformed health system, savings to downstream systems brought about by improved health outcomes should be reinvested upstream to increase the capacity of community-based organizations to address levels A-E of the glide path.

Recognizing the relationship between health-related social needs and healthcare costs and outcomes, the Centers for Medicare & Medicaid Innovation recently launched the Accountable Health Communities (AHC) model (see text box). The glide path framework provides health leaders with a tool to ensure that innovative healthcare payment and delivery models, such as AHCs and Accountable Care Organizations (ACOs), include the wide range of factors that impact health and deliberately build structural connections between downstream and upstream partners.

Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities model

In January 2016 CMS launched the **Accountable Health Communities model** funding opportunity, a pilot program designed to test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' impacts total health care costs and improves both health and quality of care. The model encourages alignment and connectivity between clinical and community services and focuses on identifying and addressing health-related social needs in at least the following areas:

- Housing instability and quality
- Food insecurity
- Utility needs
- Interpersonal violence
- Transportation needs beyond medical transportation

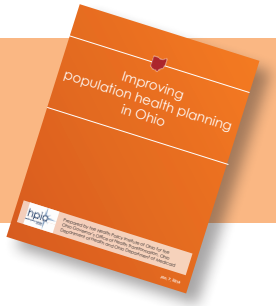
CMS will fund 44 cooperative agreements and plans to announce awards in the fall of 2016.

Questions to prompt alignment between primary care and population health planning

1. **PCMH provider to patient:** What do you need to stay healthy, recover or manage your condition?
2. **Patient to PCMH provider:** What programs and services are available in my community to help me stay healthy, recover or manage my condition?
3. **PCMH provider to community organizations:** What resources do you have to help my patients meet their needs and how can they get connected? What is your current capacity?
4. **Community organizations to PCMH providers:** What are your patients' biggest strengths, needs and challenges? How can we help?
5. **Health improvement planning groups (SHIP, local health departments, nonprofit hospitals):** What are the community conditions and characteristics of the broader social, economic and physical environment that are promoting or harming health? What evidence-based policies and programs are available to address these issues? What partners do we need to implement these policies and programs?

To download the complete report, "Improving population health planning in Ohio," visit

www.hpio.net/populationhealth



Notes

1. Krug, Etienne G., et. al., eds. "World report on violence and health." Geneva, Switzerland: World Health Organization, 2002
2. Frieden, TR. "A framework for public health action: The Health Impact Pyramid." American Journal of Public Health. 2010.