A Key to Health Care Reform: An Organized Coalition in Every Community

ALLIANCE FOR ADVANCING NONPROFIT HEALTH CARE
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While the Patient Protection and Affordable Care Act (ACA) provides expanded health care benefit coverage for an estimated 30 million Americans, the ability of government at both the federal and state levels, businesses, individuals and families to afford coverage will hinge on reducing the rate of increase in health care costs, i.e., "bending the cost curve."

The key to bending the cost curve will be reducing the rate of increase in chronic care[1] costs for those with public and private coverage, *as well as* for the many millions of uninsured residents whose needs were not addressed by ACA, as these costs account for about 75 percent of total U.S. health care spending.[2] Moreover, if not effectively addressed, these costs will increase even more rapidly given the nation's growing aging population.

There are two basic strategies available to reduce the rate of increase in chronic care costs:

- Improve the efficiency and effectiveness of the care provided to chronic care patients, which can produce some significant cost savings in both the short and near terms.
- Reduce the incidence of chronic illness (the primary causes of which are lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption), which can produce the greatest savings over the long term.

ACA includes a number of key initiatives that hold promise for improving the efficiency and effectiveness of care provided to many chronic care patients, including but not limited to experimentation under Medicare with accountable care organization (ACO) and other bundled payment arrangements; however, those provisions do not address, and were not intended to address, the care of those currently uninsured—chronically ill patients who will not have coverage until 2014—nor the care of those chronically ill patients who will continue to be uninsured after 2014. Nonprofit health care providers and nonprofit health plans can and do individually seek ways to improve care for these uninsured patients as part of their community benefit responsibilities. *But is there a better way to do so?*

ACA also includes a number of key provisions that hold promise for reducing the incidence of chronic disease. Here again, experimentation with ACO and other bundled payment arrangements, as well as Medicare Advantage (MA) plans and Medicaid managed care plans, may to some extent help to reduce the incidence of chronic illness; however, such arrangements cannot be expected to blanket the country in the foreseeable future, and the incentives for such arrangements to reduce the incidence of chronic illness in the populations they serve may not be strong enough if members frequently change plans or providers. Here again, nonprofit health care providers and nonprofit health plans can and do individually seek ways to prevent chronic illnesses and promote health as part of their community benefit responsibilities. *But, if the primary causes of chronic illnesses are lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption, is there a more efficient and effective way to address many of these and other causes than relying on the above?*

The Department of Health and Human Services (HHS), under the leadership of Secretary Sebelius, should be commended for moving rapidly to implement other provisions of ACA that hold promise for reducing the incidence of chronic illness, as well as for working closely with the First Lady to implement the "Let's Move" initiative to reduce childhood obesity. HHS has launched numerous grant programs[3] as well as other initiatives to prevent chronic illnesses and promote health. Moreover, in June 2011 the Obama Administration's National Prevention Council, which included Secretary Sebelius, announced the release of an impressive National Prevention and Health Promotion Strategy, called for in ACA. Rather than including an implementation plan, the Strategy relies on "the National Prevention Council, the advisory group, and private and public partners to work together to help implement the strategy at the national, state and local levels and recognize the importance of activity engaging all sectors of society in improving the health and well-being of our communities." *But how exactly are private and public partners to be engaged at the local level?*

The Alliance's Answer to the Above Questions

The Alliance strongly believes that the answer to all three of the above questions lies in the establishment and ongoing operation of an organized health care coalition in every community, consisting of leaders of all relevant private and public stakeholders—pooling their respective resources, knowledge, and ideas to: (1) improve care for uninsured chronic care patients; and (2) prevent illness and promote health for all residents of the community.

Health and health care problems are fundamentally local, as are the solutions, and coordinated efforts among stakeholders, within an organized structure, are likely to produce the best results.

Organized health care coalitions have already emerged in some states and communities, although the current missions of at least some may vary from, but could be expanded to include, what is proposed here. A February 2011 report, "Regional Health Improvement Collaboratives," funded by the Jewish Healthcare Foundation, documents that key stakeholders have already established formal collaboratives in thirty-one geographic areas,[4] which share the following four common characteristics:

1. They are nonprofit organizations based in a specific geographic region;
2. They are governed by a multi-stakeholder board composed of providers, health plans, purchasers, and consumers;
3. They help the stakeholders in their community identify opportunities for improving health care value, and facilitate planning and implementation of strategies for addressing those opportunities;
4. They are sustained through member dues, private or public grants, or a combination thereof.

In our view, in-kind contributions of staff and/or other resources by individual stakeholders may also play an important role in sustaining such coalitions, and they may not necessarily want or need to establish any legal structure or other legal agreements to carry our their collaborative efforts.

How to Proceed

While the Alliance can and will use every opportunity to urge nonprofit health care leaders to join together and with their other key stakeholders to establish and actively participate in such coalitions in their communities, this will not be enough. We believe that the federal government in particular can and should play a vital role in promoting the establishment and effective operation of such community collaboratives. For example:

- The Secretary and other appropriate federal officials should invite national health care leaders, business leaders, union leaders, leaders of other consumer groups, and other leaders as appropriate to join them in a national press conference supporting such coalitions and urging their constituencies to establish and actively participate in them.
- Federal officials and other national leaders should identify and highlight to their constituencies such coalitions that are already working, to prove that it can be done and to provide role models.
- The federal government should provide grants to such coalitions for start-up and/or research and demonstration projects, and should provide user-friendly data and reports to assist such coalitions in conducting community health needs assessments.
- The federal government should support a national clearinghouse for collecting and disseminating information on the best practices of such coalitions.

The Alliance stands ready to assist the Administration and the Congress in helping to build this community infrastructure in order to improve care for uninsured chronic care patients and to prevent chronic illness and promote health for all Americans.

[1] Alzheimer's disease, stroke, diabetes, end-stage renal disease, chronic lung disease, heart disease, and cancer.

[2] Centers for Disease Control and Prevention, Chronic Disease Overview.

[3] Examples in just the first half of 2011 include: $750 million in February to states and communities for various uses, including improving the public health infrastructure, community prevention projects, etc; $100 million in May for up to 75 community transformation programs; $40 million in June for statewide chronic disease prevention programs; $4 million in June for national networks of community-based organizations to help reduce chronic illnesses; and $10 million in June for comprehensive workplace health programs.

[4] In this report, available at www.nrhi.org, "Healthy Memphis Common Table" appears to come the closest in organization and focus to what the Alliance is proposing here.