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It's About My Health—Not Healthcare or Human Services

Convergence and the future of person-centered health and human services

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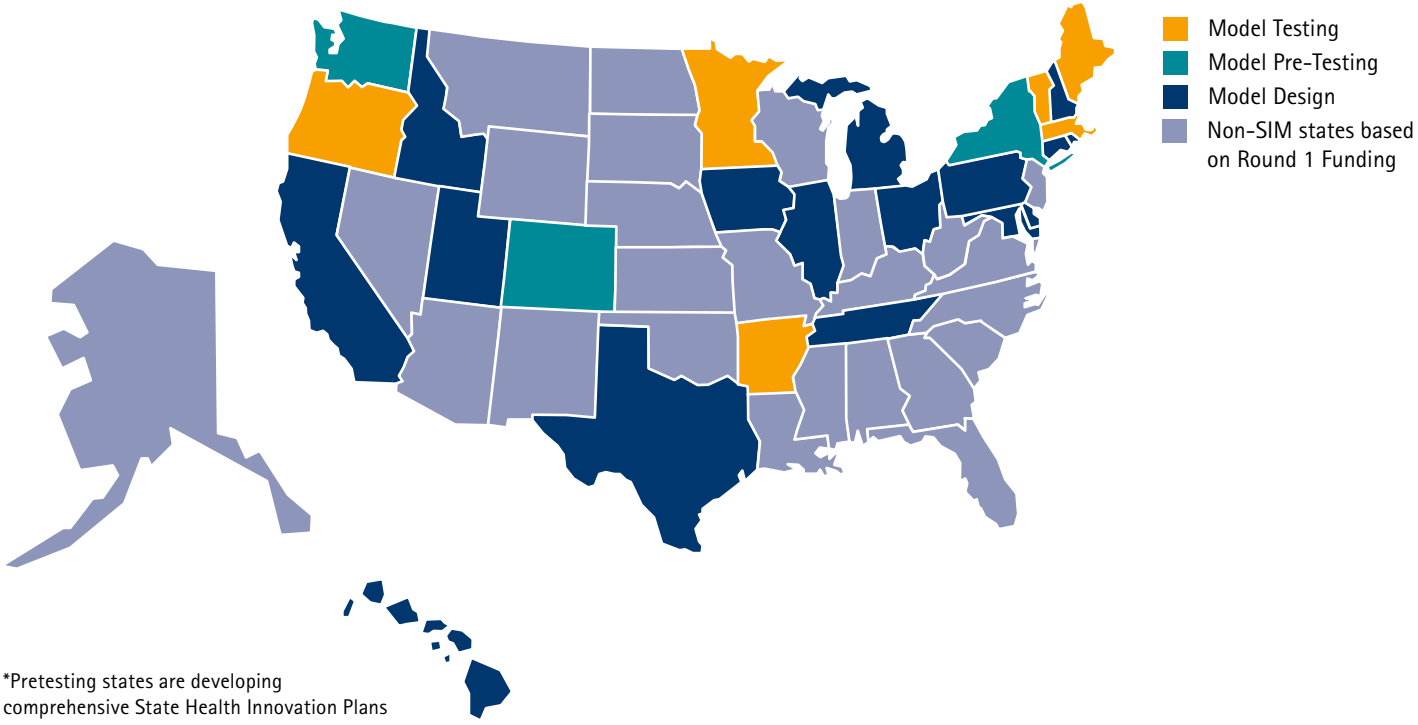
Accenture analysis of State Health Innovation Plans (SHIPs) reveals that truly person-centered health and human services is not an empty vision. SHIPs show early momentum around the next generation of health and human services convergence—if states can effectively implement and scale their strategies.

States envision coordinated, collaborative and cost-effective health and social care models that are much different from "the system" as it is today. People will own healthcare decisions and work closely with family, medical and human services professionals, and community organizations—without silos or redundancies. In a converged landscape, health, social and financial outcomes will improve dramatically.

Status of the State Innovation Model Initiative



*Pretesting states are developing comprehensive State Health Innovation Plans

Source: CMS.gov

Where innovation begins

SHIPs represent a critical planning step in the State Innovation Model (SIM) Initiative. The Centers for Medicare and Medicaid Services (CMS) awarded $300 million in 2013 to 25 states to design or test improvements to care delivery systems and payment models across Medicare, Medicaid and the Children's Health Insurance Program. Nine states are in pre-testing and testing phases, and 16 have completed model design. A second funding round has begun, which brings the CMS investment to just over $1 billion to date and will spur development of more plans and increase model test funding.[1]

Collectively, SHIPs represent the current state view on the art of the possible in reinventing care delivery. SHIPs emphasize the need to address influences beyond healthcare—behavioral and social dimensions—to improve health outcomes. The vision is an ecosystem for health and human services convergence. Analysis reveals three forces of change that, if executed effectively at scale, will positively transform the future of health and human services delivery.

1. From dependence to empowered digital citizen

The immediacy, accessibility and personalization of digital interactions have changed people's behaviors and expectations across their lives, and healthcare is no exception. An Accenture survey reveals that 86 percent of US consumers believe it is important to have control over their health information—but just 16 percent believe that they have complete control. What's more, 75 percent believe that the use of technology has the potential to improve their health.[2]

Digital transforms traditional patient-provider relationships. Rather than passively receiving care, many people and their families want to cooperatively manage their health. Practical and pragmatic, digital channels take empowerment to the next level. Digital tools that enable targeted healthcare literacy, self management or remote patient monitoring among other examples make it easier for people to be more proactive and accountable for their well being. Digital tools can connect people to medical and human services professionals in profound ways to open dialogues that go beyond a traditional episode of healthcare to address social and behavioral determinants of health.

States are exploring an array of digital tools. Accenture estimates that 60 percent are making investments for equipping consumers with patient portals/tools for self-health management. Connecticut has a website that provides people with the information to access community health services. Delaware will commission mobile apps that will allow people to access their personal electronic health records as well as obtain information on value-based health choices and access to care delivery options.

2. From care management to community care

Historically, payer and health system-focused care management has provided some reduction in cost and improvement in health outcomes. However, it traditionally did not address the social conditions that substantially influence people's health, particularly in the case of high-cost chronic care.

Building on a growing evidence base, Dr. Michael Marmot suggests that obtaining better health outcomes may require a focus on human services, rather than just health measures. He points out that the greatest cause of death, by far, is chronic disease created or exacerbated by the very social conditions that human services agencies address.[3]

This is clearly a rallying cry for health and human services convergence—and one that has been amplified by the evolving shift from volume to value. SHIPs focus on integrated and whole-person care, expanded access, population health and progression toward Health-in-All Policies for effective outcomes. All SHIPs are investing in current or future programming for integrating either behavioral or preventative care into their primary care system—85 percent of these integrate behavioral care. Maryland is engaging human services navigators as liaisons between primary care coordinators and social services programs. Michigan is developing Community Health Innovation Regions that engage cross-sector partners to improve health and wellness.

Scaling concepts like these means moving from health system-centered to family and community-centered care models and coordinating care holistically. In practical terms, this is making the most of community-based assets in the public, private and nonprofit sectors while aligning with federal resources to eliminate gaps and redundancies.

3. From data silos to seamless insight

Health and human services organizations across the United States have evolved in silos primarily due to a combination of regulation and categorical funding. It is time to reintroduce them to each other, starting with the data they gather and the outcomes they achieve. Understanding this data is at the heart of any organization's ability to deliver truly person-centered care. As such, it will take navigating through the silos and creating transparency across the data and operations of these two domains to rewrite the future of health and human services delivery.

States recognize the importance of improved data sharing. In fact, 55 percent of states with SHIP models are making investments in constructing or modifying all payer claims databases to provide access to more stakeholders. Washington uses claims data to identify costs, risk and outcomes for people receiving services across health and human services programs.

States are also integrating their health data and human services program data, which enables them to view people and families holistically so that they can design more effective program interventions. There is also a move to integrate public health data to ensure public health efforts are aligned with care delivery. States are focusing too on improving reporting and evaluation to enhance data quality. Some are using geographic information systems (GIS) to match community supports to hotspots of chronic disease burden. Pennsylvania plans to use GIS to enhance surveillance of chronic disease to support evidence-based decision making, overlaying data from multiple sources for an improved view of disease burden and risk factors.

From vision to reality

States are exploring exciting ways of delivering person-centered care and services that will dramatically change care delivery. Yet there is work to do to implement and scale states' strategies. Even so, the consensus around the importance of health and human services convergence and person-centered care, which is already happening in local hotspots nationwide, is a promising sign of good things to come for My Health—and yours.

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1. Centers for Medicare & Medicaid, "State Innovation Models Initiative: General Information," accessed September 5, 2014 http://innovation.cms.gov/initiatives/state-innovations/

2. 2014 Accenture Patient Engagement Survey

3. Michael Marmot, "Social Determinants of Health Inequalities," The Lancet, 2005, vol. 365, 1099-1104.

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