

A Sustainable Financial Model for Improving Population Health

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CHAOS – Where Brilliant Dreams Are Born™ – I CHING IMAGE™, image #3

Before the beginning of great brilliance, there must be Chaos.

Before a brilliant person begins something great, they must look foolish to the crowd.

Theme

- Bending the health care cost curve requires transformation of the system to deliver Triple Aims outcomes, particularly improved population health
- The determinants of health imply that improving population health requires integrating clinical services with public health and community based interventions
- A sustainable model will include a community health system integrator and a balanced portfolio of interventions financed by diverse funding vehicles
- National initiatives create a window of opportunity to create an exemplar community health system.



Agenda

- ✓ Introduction: Integrating population health into delivery system reform
- ✓ Components of a sustainable model for improving population health
- ✓ From concept to reality



I. Population Health and Delivery System Payment Reform

US Health Care Delivery System Evolution

Health Delivery System Transformation Critical Path

Acute Care System 1.0

Episodic Non-Integrated Care

- Episodic health care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly coordinated chronic care management

Coordinated Seamless Healthcare System 2.0

Outcome Accountable Care

- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- HIT integrated
- Focus on care management and preventive care

Community Integrated Healthcare System 3.0

Community Integrated Healthcare

- Healthy population centered
- Population health focused strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable



Measures of Success

- Better health care:** Improving patients' experience of care within the Institute of Medicine's 6 domains of quality: *Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity.*
- Better health:** Keeping patients well so they can do what they want to do. Increasing the overall health of populations: address behavioral risk factors and focus on preventive care.
- Lower costs through Improvement:** Lowering the total cost of care while improving quality, resulting in reduced expenditures for Medicare, Medicaid, and CHIP beneficiaries.



Providers Are Driving Transformation

- More than 50,000 providers are providing care to beneficiaries as part of the Innovation Center's current initiatives
- 522 ACO's: doubled in last year (360 Medicare ACOs)
- More than 5 million Medicare FFS beneficiaries are receiving care from ACOs
- More than 1 million Medicare FFS beneficiaries are participating in primary care initiatives

Status: Growing Opportunity

- Broad diffusion of language supporting better health for populations
- New payment models being tested at scale
- Signs of payers aligning in initial regional markets, e.g., Comprehensive Primary Care Initiative
- **BUT**, delivery system evolution lags rhetoric, with broad distribution across Halfon's scale
 - A very few exploring path to 3.0



Challenges for Population Health Financial Models

- Other dimensions of value have a long history in payment models
 - Interventions better understood
 - Measures and instruments developed
 - Accountability more clear cut
- Tasks of transforming to manage total cost and patient experience are all consuming
- Population health business case is complex and involves impacts from multiple sectors over extended times
- Confusion between quality of care and population health



Threats

Payment models for population health in early stage

- Population health traditionally funded by grants
- Infrastructure and tools for population health are not well developed.
 - Analytic models for projecting long term impacts
 - Evidence for business case – fundamentally different from impact on risk factors (CMS vs. CDC)
 - Robust measures for learning, accountability and payment
- Risk:
 - new payment models will be established with no meaningful population health component
 - Savings realized without reallocation upstream



II. Key Components of Sustainable Financial Model

- ✓ Theory of action
- ✓ Inventory of financing vehicles
- ✓ Building a balanced portfolio
- ✓ Community level structure:
Community Health System

Definitions

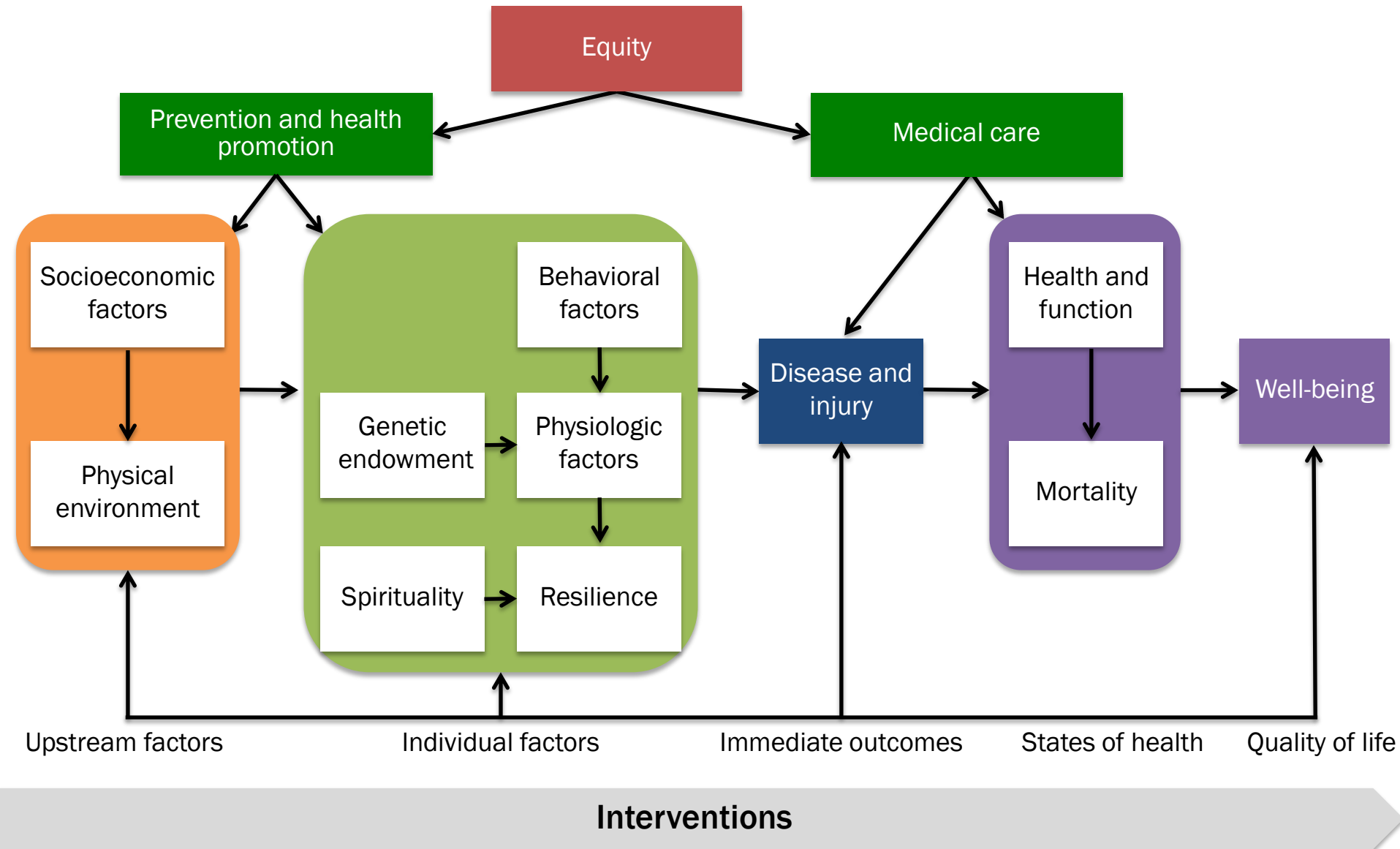
- Public health refers to programs and infrastructure, i.e., the means
- Population health refers to the outcome of improved longevity and quality of life

Population health is the health outcomes of a group of individuals, including the distribution of such outcomes within the group... It is understood that population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors and environmental factors.

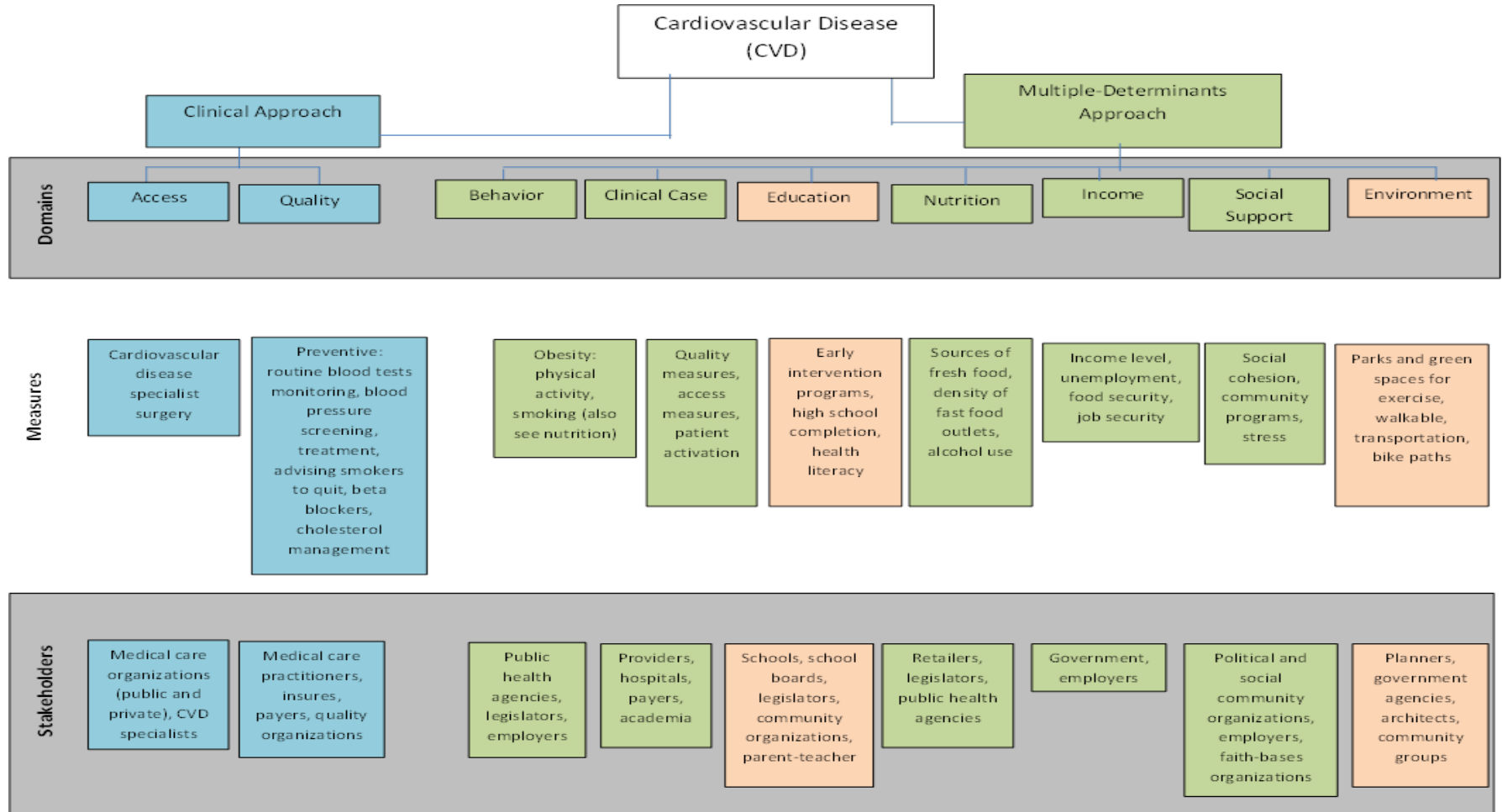
IOM Roundtable on Improving Health 2013



What determines population health?



Contrasting Multiple-determinants and Clinical Approaches



IOM (Institute of Medicine). 2011. For the Public's Health: The Role of Measurement in Action and Accountability. Washington, DC: The National Academies Press.

Theory of Action

- Multiple levels of action: practice, community, region/state, federal
- Integration at community level of clinical services, public health programs and community based interventions
- Balanced portfolio of interventions with
 - full spectrum of time horizons
 - different degrees of evidence (critical to include tests of innovations)



Theory of Action (cont.)

- Address need for both operating revenue stream and capital for infrastructure development
- Multi-sector investments and benefits
- Capture portion of savings/benefits for reinvestment for long term sustainability
- Tap into innovative sources of financing

Inventory of Financing Vehicles

- Payment for clinical services- (2.0 based)
 - Global Budget
 - Shared savings
 - Capitation
 - Total Accountable Care Organization (TACO)
 - PMPM care coordination fee modified by performance
- Public financing: single sector
- Multi-sector programs
- Innovative funding vehicles

Inventory of Financing Vehicles

Public Financing from single sector programs

- **Housing and community development:** HUD (about \$30 billion) e.g. Community Development Block Grants, Choice Neighborhoods
- **Public safety:** DOJ (\$630 million) in state, local law enforcement e.g. Community-Oriented Policing Services (COPS)
- **Transportation:** DOT and EPA (more than \$20 billion) e.g. Sustainable Communities Grants
- **Education:** Department of Education, USDA, HHS (about \$30 billion) e.g. School meals programs, Head Start, Race to the Top,

Inventory of Financing Vehicles

- Multi-sector programs
 - Blended: comingled
 - Braided: coordinated targeting
 - Medicaid/Medicare waiver:
 - TX 1115 for social determinants of health
 - MD global hospital budget

Inventory of Financing Models

Innovative funding vehicles

- Hospital community benefit
- Community development, e.g., CDFI
- Social capital, e.g., social impact bonds
- Foundations: Program Related Investments (PRI)
- Prevention/wellness trusts

Issue: fragmentation, lack of coordination

Resource: IOM Roundtable on Pop Health 2/2014

Model: Charitable Hospital Community Benefit

- Payment mechanism: how does it work
 - 3000 tax exempt hospitals/systems must file an annual report (schedule H) of their “community benefit” with IRS.
 - \$15-20B federal/state tax exemption benefits
 - Heavy funding of ER charity care/Medicaid losses
- Time frame: Annual –linked at IRS reporting on community health needs assessment
- Risk profile: Low/Medium
- Status: As ACA coverage for current uninsured increases, charity care should decrease, freeing resources for non-clinical investments

Model: Community Development Financial Institutions (CDFI)

- Payment mechanism: how does it work?
 - Tied to banks' Community Reinvestment Act compliance
 - Helps structure subsidized financing to community development corporations and other investors for projects in low income areas
 - Heavy emphasis on affordable housing, but moving to support development of grocery stores, and other “upstream” areas
- Time frame: Longer term (10-30 years)
- Risk profile: CDFI functions to reduce financial risk for projects
- Status: ~1,000 nationwide, weighted toward urban areas

Model: Pay for Success or Social Impact Bond

- Payment mechanism: how does it work?
 - Publicly financed program identified with known interventions and proven returns.
 - Capital needed to scale intervention
 - Create investment model for returns based on performance metrics and private investors deliver capital.
- Time frame: Short term (1-3 years)
- Risk profile: Moderate (with experience). Needs risk mitigation and high financial returns to attract capital.
- Status: Started in UK. Some uptake in USA in social sector/early in health

Building a Balanced Portfolio

No silver bullet – need to

- Balance portfolio in terms of
 - Spectrum of time horizons for impacts
 - Level of evidence/risk: test innovative interventions
 - Scale
- Build case and close on specific transactions
- Aggregate and align financing streams
- Manage and leverage private and public investment to achieve greater impact

TABLE 1 Sample Balanced Portfolio for Community Health System

Intervention	Target population	Implementation partners	Financing vehicle	Time frame	Risk/evidence	Savings sharing vehicle
Intensive care coordination	Dual eligible high utilizers	Accountable care organizations	Shared savings	Short	Low risk	Community benefit
Integrated housing-based services	Medicaid eligible, multiple chronic illness	Medicaid managed care plan, housing corporation	Capitation	Short	Low risk	Performance contract
Innovative use of remote monitoring	Medicare eligible, multiple chronic illness	Medicare Advantage Plan, private foundation	Grant	Short	High risk	None
YMCA diabetes prevention program	Commercial insured and self insured	Commercial health plan, self-insured employers	Shared savings	Medium	Medium	Performance contract
Expand early childhood education	Reduce adverse childhood events	Preschool educators	Pay for Success, Social Impact Bonds	Long	Medium	Investing in Social Impact Bond
Community walking trails	Community	Nonprofit hospital	Community benefit	Long	Medium	

Source: Hester, J.A. and P.V. Stange. 2014. *A sustainable financial model for community health systems*. Discussion Paper, Institute of Medicine, Washington, DC. <http://www.iom.edu/Global/Perspectives/2014/SustainableFinancialModel>.

Community Level Structure: Community Health System



Building a Community Health System

‘Every system is perfectly designed to obtain the results it achieves.’

Approach

- System redesign at multiple levels
 - Primary care practice level: Enhanced medical homes
 - Community health system: ‘neighborhood’ for medical home
 - State/regional infrastructure and support e.g. Health IT, multi-payer payment reform
 - National: Medicare participation, SIMs
- Start in pilot communities with early adopters

Structure of an CHS

The CHS is made up of

- Backbone organization for governance structure and key functions
- Intervention partners to implement specific short, intermediate, and long term health-related interventions
- Financing partners who engage in specific transactions

Key Functions of a CHS

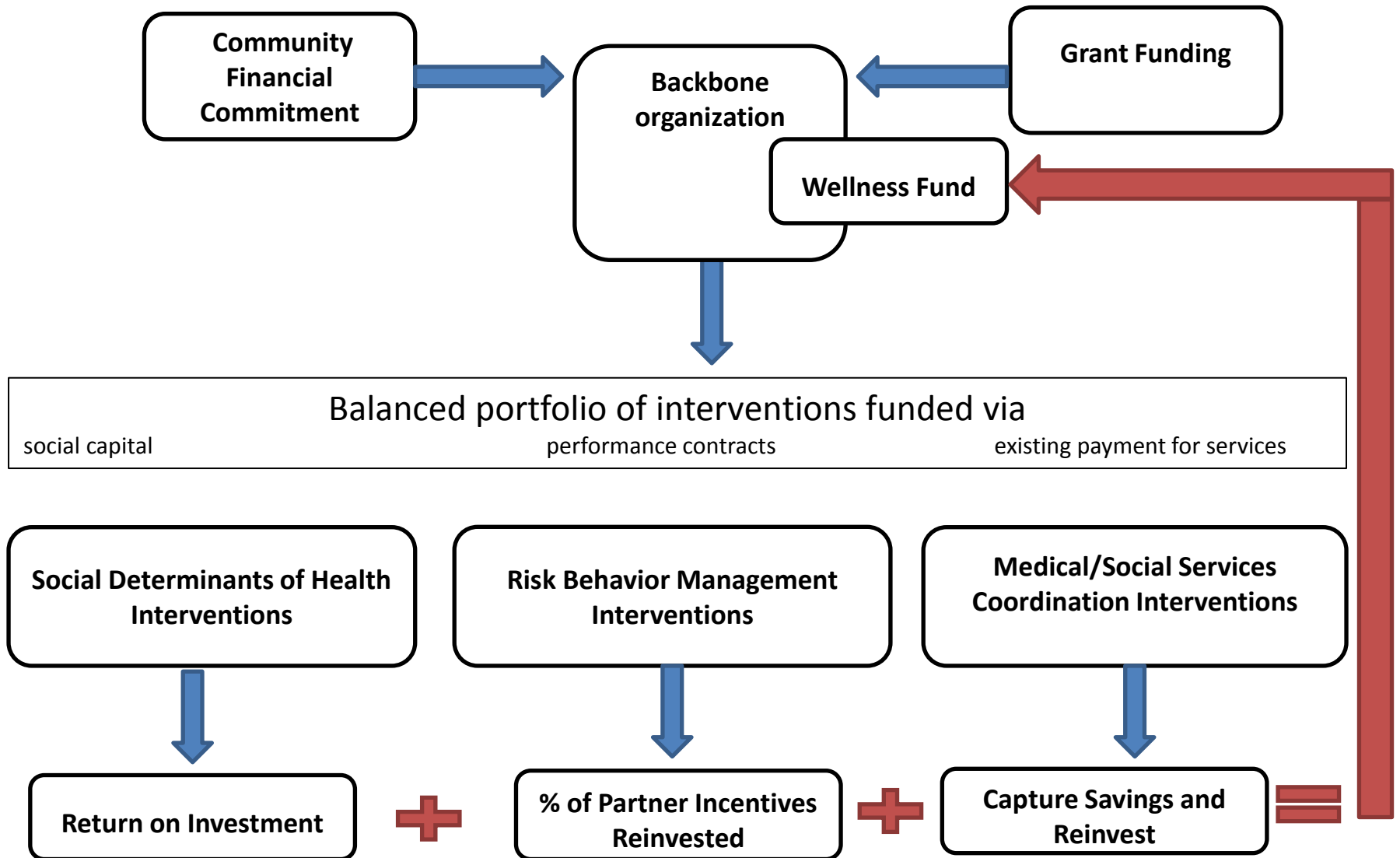
A community centered entity responsible for improving the health of a defined population in a geographic area by integrating clinical services, public health and community services

- Convene diverse stakeholders and create common vision
- Conduct a community health needs assessment and prioritize needs
- Build and manage portfolio of interventions
- Monitor outcomes and implement rapid cycle improvements
- Support transition to value based payment and global budgets
- Facilitate coordinated network of community based services

CHS: Financial Role

- **Oversees the implementation of a balanced portfolio of programs**
- **Uses a diverse set of financing vehicles to make community-wide investments in multiple sectors**
 - Builds business case for each transaction specific to population and implementation partner: ~ bond issue
- **Contracts with Intervention partners for short, intermediate, and long term health-related interventions**
- **Measures the "savings" in the health care and non-health sectors and captures a portion of these savings for reinvestment**
- **Supports transition to value based payment**
 - Potential vehicle for global payments for integrated bundle of medical and social services

Backbone Organization's Aggregation and Alignment of Investments and Reinvestments



Partial Examples

- Akron, OH Accountable Care Community
- Minnesota AHC
 - Hennepin Health: Hennepin County
 - SIMs testing award; 15 sites 2016
- San Diego County: Live Well
- Hospital based examples
 - Franklin County ME
 - Washington Heights NY
 - Mt. Ascutney VT (2011 Foster McGaw award)
- ReThink Health communities
 - Pueblo CO PTAC
 - Atlanta: ARCHI

III. From Concept to Reality

Vermont SIM Grant

Population Health Workgroup

Charge:

- ◆ **State Population Health Improvement Plan**
- ◆ **Resource for other working groups: payment models, performance reporting, care coordination**
 - ◆ ways to incorporate population health principles
 - ◆ how to contribute toward improving the health of Vermonters

Priorities:

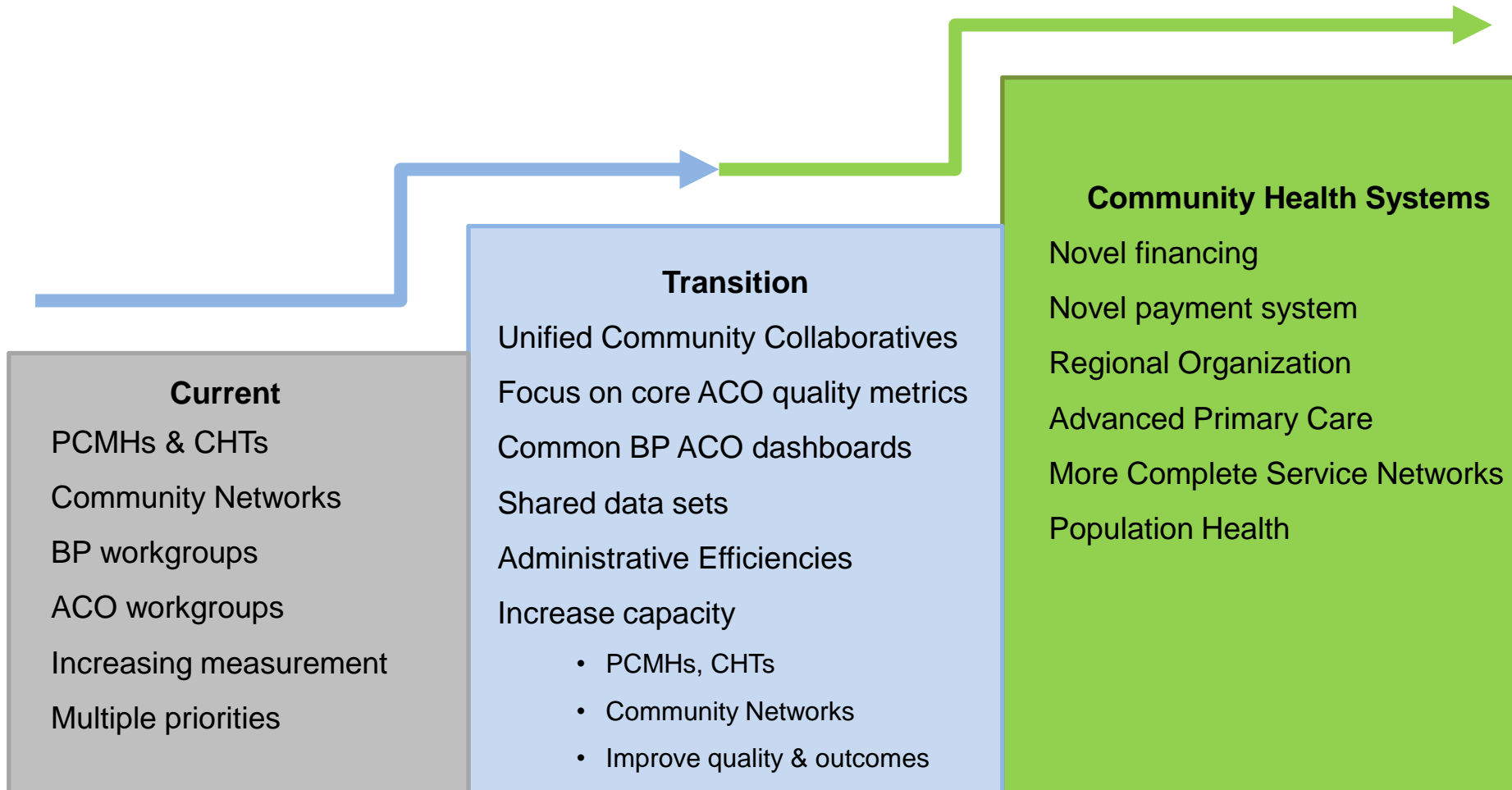
- Measures of population health eg ACO payment and monitoring
- Support innovative financing options for paying for population health eg, global population based budget
- Identify and support exemplars of effective community-focused interventions. Build on existing reforms eg Blueprint

VT Accountable Health Community Initiative

Contract with Prevention Institute

- Create template for assessing national and Vermont based initiatives
- Identify national exemplars and lessons learned
- Identify potential ACH sites within VT
- Design a pilot ACH program for potential fielding in late 2015

Transition to a Community Health Focus



Strategies for Community Health Systems

Design Principles

- Services that improve population health thru prevention
- Services organized at a community level
- Integration of medical and social services
- Enhanced primary care with a central coordinating role
- Coordination and shared interests across providers in each area
- Capitated payment that drives desired outcomes

Seizing the Opportunity



Period of Experimentation to Create

- Working examples of community integrators with enhanced financial competencies
- Successful collaboration with stakeholders with innovative financing vehicles
- Better tools
 - Analytic models for projecting impacts
 - Measures for monitoring, accountability and payment: CMMI project
- Evidence on financial impact across sectors

Challenges

- **Timeframe: Need to lengthen time for outcomes**
- **Tapping shared savings from medical and other sectors**
- **Creating community Integrator:**
 - Easing transition from planning to implementation
 - Developing financial role
 - Avoiding competing integrator models
- **Collaborating with and adding value to innovative financing sectors**
- **Clash of cultures of major stakeholders: hospital executives, public health officers, CMS operating engine, private investors**

Opportunities for Developing Working Models

- CMS State Innovation Models:
 - Round 1: 6 testing and 16 design states
 - Round 2: 11 testing and 21 design awards
- Moving Health Care Upstream: Nemours/UCLA/
- AHEAD (Alignment for Health Equity and Development): PHI and The Reinvestment Fund)
- Collaborative Health Network: NRHI
- BUILD Health Challenge: Kresge, RWJ and deBeaumont
- Escape Velocity to a Culture of Health: IHI
100 million people, 1000 communities by 2020
- Way to Wellville contest (HICCup): 5 communities for 5 years

SIMS States with AHC test

- MN: Accountable Health Communities expanding on Hennepin Health
- WA: planning grants to 10 Accountable Communities of Health, aligned RSA's
- OR: Care Coordination Organizations
- IA: Wellpoint replicate 'Blue Zones'
- MI: Community Health Innovation Regions
- DE: Healthy Neighborhoods
- VT: AHC initiative

Evolving Role of Public Health

Public health can accelerate the transition to 3.0

➤ National

- National Prevention Council: aligning efforts across agencies
- Treasury and Fed Reserve explore new roles for financing vehicles such as CDFI's
- CDC collaboration with CMS to incorporate population health into care and payment models

➤ Local: create strategic partnerships with CHS's

- Value add through traditional skills eg CHNA
- Develop new skills for collaborating with new partners: financial, social services
- Adapt to new role as participant, not lead for community

What Can You Do?

Use the window of opportunity created by the transformation to 2.0 and 3.0

- Identify early adopter communities and create initial successful community integrators
- Invite stakeholders from innovative finance vehicles to the table: seek them out
- Learn their language and culture
- Identify new value add roles for public health and facilitate the transition

Resource

“Towards Sustainable Improvements in Population Health: Overview of Community Integration Structures and Emerging Innovations in Financing”

Hester JA, Stange PV, Seeff LC, Davis JB, Craft CA

CDC Health Policy Series, January 2015

How to Finance Population Health?

A simple question to ask, but one remarkably difficult to answer

We won't get the community health system we need until we learn how to answer it.



*It may be when we no
longer know what to do,
we have come to our real work,
and that when we no longer know
which way to go,
we have begun our real journey*

Wendell Berry