

Attachment 1 - Population Health
Work Group Meeting Agenda 6-10-14

VT Health Care Innovation Project Population Health Work Group Meeting Agenda

Date: Tuesday, June 10, 2014 Time: 2:30-4:00 pm

Location ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier

Call-In Number: 1-877-273-4202; Passcode: 9883496

All Participants: Please ensure that you sign in on the attendance sheet the will be circularized at the beginning of the meeting, Thank you.

AGENDA					
Item #	Time	Topic	Presenter	Relevant Attachments	Action #
1	2:30	Welcome, roll call and agenda review	Tracy Dolan	Attachment 1: Agenda	
2	2:40	Approval of minutes	Karen Hein	Attachment 2: Minutes	
3	2:45	Updates ACO Measures Consultant Contract Accountable Communities: RFP Approved	Tracy Dolan Heidi Klein	Attachment 3: Memo	
4	2:50	Criteria for Next Round of Provider Grants <i>What considerations/criteria do we want reviewers will use in selecting the next round of grantees?</i>	Tracy Dolan	Attachment 4: Scoring Criteria	
5	3:00	Financing Population Health	Jim Hester	Attachments: 5a: Finance Presentation PP 5b: Resources for Sustainable Financing 5c: How to Pay for a Healthy Population 5d: IOM Model	
6	3:40	Work Group Plan– Reflections and Refinement <ul style="list-style-type: none"> • Is this the right direction to yield the desired results? • Are these the right levers to influence the project? What might be misdirected or missing? • Thoughts on setting the broader agenda 	Tracy Dolan	Attachment 6: Alignment with Operational Plan	
7	3:55	Public Comment and Next Steps Plans underway for a process evaluation <i>What information do work group members need in order to continue our work together?</i>	Karen Hein		

OPEN ACTION ITEM LOG					
Date Added	Action Number	Assigned to:	Action /Status	Due Date	Date Closed
			•		
			•		
			•		
			•		

Attachment 2 - Population Health
Work Group Minutes 5-13-14



**VT Health Care Innovation Project
Population Health Work Group Meeting Minutes**

Date of meeting: Tuesday, May 13, 2014; 2:30 to 4:00 PM, DVHA Large Conference Room, 312 Hurricane Lane, Williston, VT.

Attendees: Tracy Dolan, Karen Hein, Co-Chairs; Heidi Klein, VDH; Georgia Maheras, AoA; Pat Jones, GMCB; Peter Cobb, VNAs of VT; Mark Burke, Brattleboro Memorial Hospital; Jill Berry Bowen, NMC; Judy Ashley, VDH; Ted Mable, NW Counseling & Support; Laural Ruggles, NVRH; Geera Demers, BCBS; Shawn Skaflestad, AHS; Jim Hester, Consultant; Deborah Shannon, Shannon Resources; Jen Woodard, DAIL; Brian Costello; Jesse de la Rosa, VWED; Penrose Jackson, FAHC; Melissa Miles, Bi-State; Daljit Clark, DVHA; JoEllen Tarallo-Falk, Center for Health and Learning; Julia Shaw, VT Legal Aid; Nick Nichols, DMH; Miriam Sheehey, OneCare; Dee Burroughs-Biron, DOC; Jessica Mendizabal, George Sales, Project Management Team.

Agenda Item	Discussion	Next Steps
1. Welcome, roll call and agenda review	Tracy Dolan called the meeting to order at 2:35 pm. After introductions she reviewed the agenda and the following: Goal: Refine recommendations for measures of Population Health Obj: Report on ACO “pending” measure process Obj: Explore Northwest Medical Innovation Proposal	
2. Approval of minutes	Karen Hein reviewed the content of the minutes. Penrose Jackson moved to approve the minutes and Dr. Dee Burroughs-Biron seconded. There was no discussion and the motion passed unanimously.	
3. Report on Measures Work Group on Criteria and Pending Measures	Heidi Klein gave the following update: over the past few meetings the Population Health work group generated feedback to the QPM work group on the process of how to develop measures and how those will be used. There are several types of measures: payment, reporting, and evaluation and monitoring. The pending measures category was reviewed by the Population	Heidi will share the response to the QPM work group.

Agenda Item	Discussion	Next Steps
	<p>Health work group and considered a priority. The group developed a set of the most important criteria and recommended set of first measures to the QPM work group (attachment 3). The recommendations were reviewed with the QPM consultants to see if the measures are already being collected or tracked; how to collect them if they are not being tracked; and if there are other standards already in place.</p> <p>Responses from the QPM work group were positive, with the exception of the extended timeframe. If the criteria is adopted it would change which measures were included in year two. Heidi sent a response to the QPM work group which she will share with this group. The response indicates the following:</p> <ul style="list-style-type: none"> • Focusing up stream on risk and protective factors and clarifies that wellness measures should payment measures. • Social determinants should be under monitoring and evaluating since they were not collected in clinical settings. • Reporting and monitoring measures have traditionally not been tied to payment. • The population health measures may be collected in other settings and would not necessarily affect the clinical burden for providers. <p>Heidi and Co-Chairs will refine the definition of population health.</p> <p>Attachment 3 contains pending measures which have been shared with the QPM. Some are being recommended for reporting and/or payment. Reporting is a mixture of patient experience and clinical data which is required to be reported but won't impact shared savings. Monitoring and reporting are collected more at a statewide level or at an ACO level and don't impact shared savings.</p> <p>DAs are very interested in making sure there is a shared message for Mental Health, Substance Abuse and DLTSS.</p> <p>Shawn Skaflestad is in charge of AHS measures and the lead agencies are working on aligning efforts. All departments in the state are working together on an ongoing basis.</p>	

Agenda Item	Discussion	Next Steps
<p>4. Northwest Medical Presentation and Discussion</p>	<p>Jill Berry Bowen from Northwestern Medical Center and Judy Ashley from VT Department of Health presented <i>RISE VT</i> (attachment 4), which depicts their provider grant proposal. The proposal was referred back to the Population Health work group so the group could help strengthen their proposal for possible resubmission in round two of the grant program</p> <p>The group discussed the following after the presentation:</p> <ul style="list-style-type: none"> • Northwestern Medical Center (NMC) would like to take the program statewide, and they will retool the application and budget. • They received a second grant for literacy and education medication reconciliation and they will work that in as well. • Regarding tracking savings: 85% of employees are involved in the <i>Healthy You</i> program- so claims were tracked for those individuals. <ul style="list-style-type: none"> ○ Data is easier to track with a defined population. • Refining how this program will help test out innovative payment models and care delivery models would strengthen the application. • NMC will meet with BCBS to discuss payment models. Part of the project is to create an actual clinic. • They are also looking into how to provide wellness in group scenarios with an educational component possibly following the Medical Home Model. • The learning collaborative includes the Blueprint. • Part of the application focuses on how to use the software system to coordinate care and put attention on certain areas to see if they can impact a certain population. • Partnerships outside of St. Albans- they will use a software package that can map networks and partnerships. <ul style="list-style-type: none"> ○ A recommendation was made for them to show where the strengths are already in their application. • Under the current program no employee had to pay more in premiums if their behavior was worse, they're not being penalized. There are incentives for those who participate in healthy lifestyles. • Some organizations can't afford to implement the worksite wellness. An example is Samaritan House which can't afford to implement an employee wellness program, but RISE VT is going to assist them in the set up. 	

Agenda Item	Discussion	Next Steps
	<ul style="list-style-type: none"> • Regarding testing, there are several ways to evaluate the program: patient experience, data, by federal government, contractor evaluation, quality and financial savings. They are fielding a patient experience survey themselves. • The VHCIP grant program is scheduled to begin a self-evaluation plan in August. The VHCIP doesn't specifically take into account reduction in disease prevalence, but we are being evaluated on that topic by our federal partners. • A recommendation was made for the RISE team to trademark their logo. 	
5. Work Group Work Plan and Charter Update	<p>The group will begin looking at deliverables and work backwards to see what work needs to take place in order to achieve those deliverables possibly focusing more on child health.</p>	
6. Next Steps	<p>Karen asked the group to think about what information they need in order to continue their work together.</p> <p>There will be a total work group process evaluation as part of the grant's self-evaluation plan in July/August. In the meantime Karen welcomes informal feedback from work group participants.</p> <p>The Co-Chairs and Heidi are putting together a Population Health 101 reference guide and participants are welcome to give input.</p> <p>Karen thanked the group for taking the time to participate in the work group initiatives and the meeting was adjourned.</p> <p>Next Meeting: Tuesday, June 8th 2:30 – 4:00 pm. ACCD - Calvin Coolidge Conference Room, 1 National Life Drive, Montpelier.</p>	

Attachment 3 - Pop Health Memo for Measures working group 6-2-14

Date: June 2, 2014

To: Quality and Performance Measures Working Group, VHCIP

From: Tracy Dolan and Karen Hein, Population Health Working Group, VHCIP

Re: Updated Recommendations for ACO measures

The overall charge of the Population Health Work Group is to recommend ways in which the Vermont Health Care Innovation Project could better coordinate population health ¹improvement activities and more directly impact population health.

I. Proposed Criteria

The criteria proposed are in line with the population health framework which recognizes the multiple factors that contribute to health outcomes, focuses on primary prevention, and seeks opportunities to impact upstream factors that affect health outcomes. The Population Health Working Group submits this clarification on the **intended use** of the population health criteria originally proposed to the Quality and Performance Measures Work Group.

Payment and Reporting

Use data on health trends and burden of illness to identify priorities (existing criteria)

Focus on identified state priorities given burden of illness, known preventable diseases and evidence-based actions that have proven successful in changing health outcomes. The measure is evidence-based, important to making significant gains in population health and improving determinants of health and health outcomes of a population.

Focus on broader population and health outcomes (existing criteria)

Consider the health outcomes of a group of individuals, **including the distribution of such outcomes within the group**, in order to develop priorities and target action. The measure enables evaluation of subpopulations and especially those most vulnerable – due to disability, age, income, etc. The measure can be applied to the entire population – those already presenting with illness and disease as well as those at risk in the future.

Focus on prevention and wellness by patient, physician and system

Focus on prevention, self-care and maintaining wellness. The measure would include actions taken to maintain wellness rather than solely on identifying and treating disease and illness.

¹ Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement**
<http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx>

Focus upstream to include risk and protective factors

Risk factors are conditions or variables associated with a lower likelihood of positive outcomes and a higher likelihood of negative or socially undesirable outcomes. **Protective factors** have the reverse effect: they enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk. http://www.who.int/hiv/pub/me/en/me_prev_ch4.pdf. The measure would capture personal health behaviors such as tobacco, diet and exercise, alcohol uses, sexual activity, as well as other health and mental health conditions that are known to contribute to health outcomes.

Monitoring and Evaluation

Link to social determinants and environmental factors

The social determinants of health are the circumstances in which people are born; grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics <http://www.cdc.gov/socialdeterminants/>

The measures would include social factors and the physical environment such as: education, employment, income, family support, community, the built environment and environmental quality.

Expanded Timeframe

Many changes to population health will require a longer time frame than the duration of this project. Develop a balanced portfolio of measures with the potential for short term impact (within 3-5 years) and other measures with impact over a longer time frame (5-20 years).

II. Priority Measures

The Population Health Working Group previously submitted our recommendation regarding which pending measures should be moved into payment or reporting status based on the criteria above.

First priority to be moved into payment or reporting status:

Core-40	MSSP-21	Screening for High Blood Pressure and Follow-Up Plan Documented
Core-36	MSSP-17	Tobacco Use Assessment and Tobacco Cessation Intervention
Core-44		Percentage of Patients with Self-Management Plans
Core-34		Prenatal and Postpartum Care Timeliness

Second priority to be moved into payment or reporting status:

Core-9		Depression Screening by 18 Years of Age
Core-30		Cervical Cancer Screening
Core-35	MSSP-14	Influenza Immunization
Core-39	MSSP-28	Hypertension (HTN): Controlling High Blood Pressure
Core-45		Screening, Brief Intervention, and Referral to Treatment

We are glad the measures above are being considered by the QPM work group.

We now submit our support for moving the following selected measures from reporting to payment:

Core-15	MSSP	Pediatric Weight Assessment and Counseling
Core-16	MSSP-22-26	Diabetes composite
Core-17	MSSP-27	Diabetes Mellitus
Core-19	MSSP-18	Depression Screening and Follow Up
Core-20	MSSP-16	Adult Weight Screening and Follow Up

In addition, we expect to continue to explore in the longer term other options for developing a shared accountability for improving the health of the population which may include measures that demonstrate more 'upstream' factors for a broader set of stakeholders or geographic regions.

Thank you for the opportunity to contribute to this discussion. We would be glad to engage in more exploration of how measurement can play a role in incentivizing change in the system to improve the health of the population.

Attachment 4 - Scoring Criteria for VHCIP Grant Program

Population Health Integration in VT Health Care Innovation Project
Scoring Criteria for Evaluating Provider Grant Proposals
Updated 6-2-14

The Vermont Health Care Innovation Project (VHCIP) is testing new payment and service delivery models as part of larger health system transformation based on the Triple Aim – reducing cost, improving quality, and improving health. The charge of the Population Health Work Group is to recommend ways the Project could better coordinate population health improvement activities and more directly impact population health¹.

The following proposed criteria are in line with the population health framework which recognizes the multiple factors that contribute to health outcomes, focuses on primary prevention, and looks at opportunity to impact upstream factors that affect health outcomes. The following criteria are proposed for use when reviewing the provider grant proposals for testing innovation in payment and care delivery models.

Focus on and Funding Towards Primary Prevention and Wellness

The proposal should include efforts aimed at primary prevention², self-care and maintaining wellness rather than solely on identifying and treating disease and illness. The model being tested should show intended investment of savings or budget in prevention and wellness activities and partners.

Focus on broader population and health outcomes

The innovation should include efforts to maintain or improve the health of all people – young, old, healthy, sick, etc. The proposal should consider the health outcomes of a group of individuals, **including the distribution of such outcomes within the group**, in order to develop priorities and target action. Specific attention should be given to the maintenance of health and wellness of subpopulations and especially those most vulnerable – due to disability, age, income, etc.

Connects Clinical Service Delivery with Broad Set of Community Partners

The proposed innovation in care delivery should build upon existing infrastructure (Blueprint Medical Homes, Community Health Teams, ACOs), connect to a broad range of community based resources and address the interconnection between physical health, mental health, and substance abuse.

Scalable

While the innovation must be tested in particular community, potential application to other communities or other scales should be outlined.

¹ Population Health is "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003). While not a part of the definition itself, it is understood that such population health outcomes are the product of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, and environmental factors. **Working Definition of Population Health, Institute Of Medicine, Roundtable on Population Health Improvement** <http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT.aspx>

² Primary prevention is a program of activities directed at improving general well-being while also involving specific protection for selected diseases, such as immunization against measles. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier. Primary prevention aims to prevent disease from developing in the first place. Secondary prevention aims to detect and treat disease that has not yet become symptomatic. Tertiary prevention is directed at those who already have symptomatic disease, in an attempt to prevent further deterioration, recurrent symptoms and subsequent events.

Attachment 5a - Finance Presentation

A Sustainable Financial Model for Improving Population Health

Population Health Workgroup:
June, 2014

Jim Hester



Theme

- The health care system is transitioning from payment rewarding volume to value based on the Triple Aim
- This could enable sustainable funding for population health.
- A sustainable model will include a community health system integrator and a balanced portfolio of interventions financed by diverse funding vehicles
- However, key building blocks need to be developed rapidly before the window of opportunity closes

Outline

- ✓ Improving health: theory of action
- ✓ Components of a sustainable model
 - ✓ Community Integrator
 - ✓ Building and managing a portfolio
 - ✓ Example: Upper CT River Valley
- ✓ Seizing the opportunity

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

Status: Growing Opportunity

- Broad diffusion of language supporting better health for populations
- New payment models being tested at scale
- **BUT**, delivery system evolution lags rhetoric, with broad distribution across Halton'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 managing 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

II. Improving Population Health



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 initial sustainability
- Tap into innovative sources of capital

III. Key Components of Sustainable Financial Model

- ✓ Overview of innovative financing vehicles
- ✓ Building a balanced portfolio of interventions
- ✓ Community level structure: Community Health System

Inventory of Financing Models

- Payment for clinical services- (2.0 based)
 - Global Budget/Capitation
 - Shared savings
 - PMPM care coordination fee modified by performance
- Other funding sources

Inventory of Financing Models

Other funding sources

- Hospital community benefit
- Community development, e.g., CDFI
- Social capital, e.g., social impact bonds
- Prevention/wellness trusts

Issue: fragmentation, lack of coordination

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/local tax exemption benefits
 - Heavy accounting for charity care/Medicaid losses
- Time frame: Annual –linked at IRS reporting
- Risk profile: Low/Medium
- Status: As ACA coverage for current uninsured increases, charity care should decrease, freeing resources for non-clinical investments
- Examples/Resources:
 - Cincinnati Children’s Hospital Community Health Initiative (CHI): Asthma Readmissions/Housing Policy ++
 - Catholic Health Association (900 Hospitals)
www.chausa.org/communitybenefit

Model: Community Development Financing (CDFI)

- Payment mechanism: how does it work?
 - Tied to banks' Community Reinvestment Act compliance
 - subsidized financing to community development corporations and other investors for projects in low income areas
 - Past emphasis on affordable housing, moving to community health centers, 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
- Example(s) and resources:
 - The Reinvestment Fund: Pennsylvania Fresh Food Financing Initiative
 - New Jersey Community Capital (NJCC): construction of child care facilities

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
 - 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... implemented in social sector. Some uptake in USA in social sector/early in health
- Example(s) and resources:
 - Health Impact Bond (Fresno), asthma—Collective Health LLC/The California Endowment, MediCal program
 - Rikers Island/NYC: recidivism Goldman Sachs/Bloomberg Foundation
 - Utah: early childhood education: Pritzker/Goldman Sachs/United Way

Building a Balanced Portfolio

No silver bullet – need to

- Build case and close on specific transactions
- Balance portfolio in terms of
 - Spectrum of time horizons for impacts
 - Level of evidence/risk: test innovative interventions
 - Scale
- Aggregate and align revenue streams and capital
- 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 contact
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

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

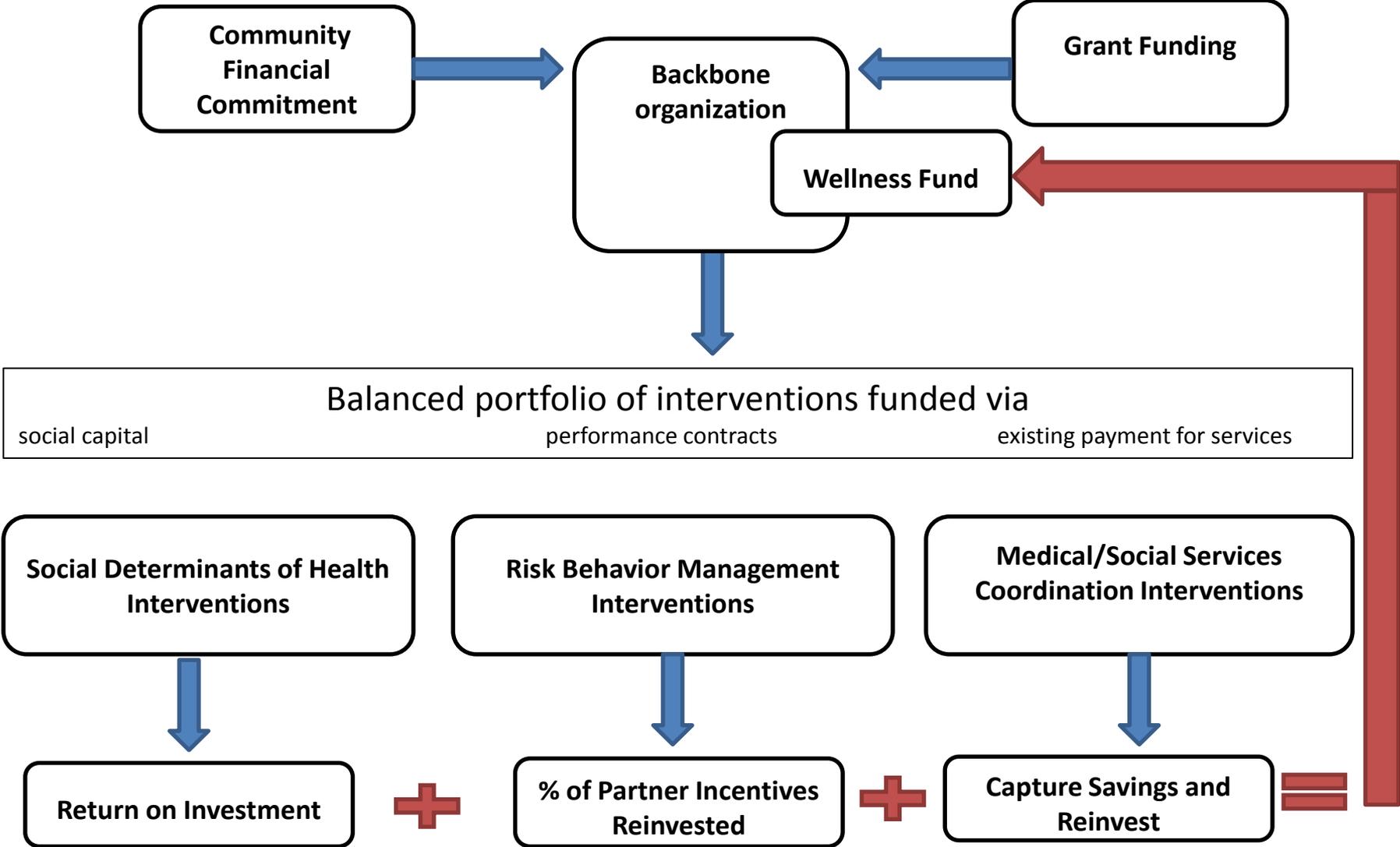
A community centered entity responsible for improving the health of a defined population in a geographic area by integrating clinical services, public health and community services

- 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: Enhanced 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, Ohio (Accountable Care Community)
- Minnesota (Accountable Health Community)
 - Hennepin Health: Hennepin County
 - SIMs testing award
- ReThink Health communities
 - Atlanta: ARCHI
 - Upper Connecticut River Valley
 - Pueblo, Colorado

RETHINK HEALTH UPPER VALLEY: SHARED VISION

“Healthy people, healthy communities.”

We will be an exceptional place for individuals and families to live, play and work; a region where we individually and collectively recognize and act on our right and responsibility to shape our own health and health care system. To support this vision, **we will develop a sustainable, integrated community-centered health, healthcare and human services system** that makes the Upper Connecticut River Valley a region with:

- (a) the healthiest population;
- (b) timely access to what is needed to be healthy;
- (c) the highest quality, lowest cost health care possible;
- (d) a vibrant, innovative economy; and
- (e) a population engaged in shaping our own health system.

Strategy

Build a balanced set of initiatives –combining both upstream and downstream interventions as well as balancing focus on specific populations and the entire population

Create a sustainable funding structure for initiatives:

- Identify strategies for reinvesting a portion of healthcare savings upstream in creating a Healthy Community
- Explore using community benefit funds to seed a Wellness Trust

Shift health care payment models to align financial incentives with desired results: Analyze options for

- Transitioning to global health care payment programs and
- Aligning provider incentives with value

Sequence the implementation of initiatives in the context of both short term and long term strategies

V. 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: FFRDC project
- Evidence on financial impact across sectors

Some Promising Opportunities for Developing Working Models

- CMS State Innovation Models
- Possible CMS test of models that incentivize lifelong health management eg community Accountable Health Systems (Aspen Institute 9/25/13)
- Way to Wellville contest (HICCup): 5 communities for 5 years
- Advancing Frontiers in Sustainable Financing: ReThink Health/RWJ
- Moving Health Care Upstream: Nemours and UCLA/Kresge

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.

Attachment 5b - Resources on Sustainable Financing

Resources on Sustainable Financing Model

Updated 6-2-14

Overview

- 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>

Innovative financing vehicles

- Prevention Institute, "How Can We Pay for a Healthy Population?", 2013
- Institute of Medicine, Roundtable on Population Health Improvement, workshop on innovative financing <http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT/2014-FEB-06.aspx>
 - o Donald Hinkle-Brown, president and chief executive officer, The Reinvestment Fund
 - o Nancy O. Andrews, president and chief executive officer, Low Income Investment Fund
 - o Robert H. Dugger, founder and managing partner, Hanover Provident Capital, LLC

Community Health System/Integrator models

- Magnan, S., Fisher, E., Kindig, D., Isham, G., Wood, D., Eustis, M., Backstrom, C. & Leitz, S. (2012). Achieving Accountability for Health and Health Care. *Minnesota Medicine*, 37-39.
- Hennepin County, Minnesota
 - o Bridging the Gap Between Health Care and Population Health. (2013). *Robert Wood Johnson Foundation*. Retrieved on October 24, 2013, from <http://forces4quality.org/bridging-gap-between-health-care-and-population-health-handout-book>
 - o An Integrated Health System - Medicaid Demonstration Project. (2012). *Hennepin Health*. Retrieved from www.hennepinhealth.com.
- Akron, Ohio
 - o The First Accountable Care Community In action. (2013). *Healthy Americans*. Retrieved on October 24, 2013, from <http://healthyamericans.org/assets/files/TFAH2013HealthierAmericaXrpt04.pdf>
- Atlanta, Georgia
 - o ARCHI Playbook. (2013). *The Atlanta Regional Collaborative for Health Improvement*. Atlanta, GA. Retrieved November 1, 2013, from http://www.archicollaborative.org/archi_playbook.pdf
- Seattle, King County
 - o Building a Healthier King County: A Forum at the Intersection of Community Development, Health and Human Services. (2013). *Federal Reserve Bank of San Francisco and King County*. Retrieved on December 10, 2013 from <http://www.kingcounty.gov/exec/HHStransformation.aspx>

Attachment 5c - How Can We Pay For a Healthy Population

HOW CAN WE PAY FOR A HEALTHY POPULATION?

Innovative New Ways to Redirect Funds to Community Prevention

THIS DOCUMENT WAS PREPARED BY PREVENTION INSTITUTE WITH PRIMARY FUNDING FROM THE KRESGE FOUNDATION AND ADDITIONAL SUPPORT FROM THE CALIFORNIA ENDOWMENT AND THE ROBERT WOOD JOHNSON FOUNDATION.

PRINCIPAL AUTHORS:

Jeremy Cantor, MPH
Leslie Mikkelsen, MPH, RD
Ben Simons, MA
Rob Waters, BA

© January 2013

Prevention Institute is a non-profit, national center dedicated to improving community health and wellbeing by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development. This and other Prevention Institute documents are available at no cost on our website.

Prevention
and
equity
Institute
at the center of community well-being

221 Oak Street

Oakland, CA 94607

Tel 510.444.7738

Fax 510.663.1280

HOW CAN WE PAY FOR A HEALTHY POPULATION?

Innovative New Ways to Redirect Funds to Community Prevention

INTRODUCTION

The US health system, the most expensive in the world, has long been hampered by a fundamental paradox: resources are systematically allocated in ways that neither maximize health nor control costs. Seven of ten deaths among Americans are caused by often preventable conditions including heart disease, stroke, diabetes, injuries and some kinds of cancer.^{2,3} These conditions account for roughly three-fourths of the national healthcare bill.⁴ Yet one of the historic shortcomings of the U.S. healthcare system is that there are few incentives for insurers or providers to invest in prevention. In a fee-for-service model that pays doctors to treat sick patients, there's no financial inducement to try to keep people well and few sources of funds to pay for the things that would address the social and environmental conditions that shape people's health in the first place.

While the main goal of the Affordable Care Act (ACA) is to increase access to healthcare, it also recognizes that broad improvement in health outcomes requires shifting the focus of the US healthcare system from the delivery of services to individuals toward prevention-oriented strategies that can improve the health of populations. With encouragement and funding from the ACA and foundations, community health planners, advocates and health-systems executives are now engaged in innovating and developing new concepts and models of healthcare delivery that can improve outcomes and reduce costs.

As new ideas for health reform emerge, a growing literature is examining new ways to broaden health care delivery to incorporate expanded use of clinical preventive services and prevention education efforts aimed at improving the health of large numbers of people, not just individuals. What's missing from most of these "pay for population health" approaches is a clear focus on community prevention—efforts aimed at improving the social, physical, and economic environments of communities and reducing health inequities. This reflects a potentially important missed opportunity

to better align clinical and non-clinical activity, to provide clinicians and clinical institutions support in addressing chronic illness, and to apply the most effective strategies for improving health, safety, and equity.^{5,6}

A case in point: When staff at Asian Health Services in Oakland became aware of high rates of automobile injury and fatality among pedestrians in the Chinatown neighborhood, they realized that the only way to reduce the number of injuries to community members was to engage with community leaders, local officials and city planners to instigate changes in the physical environment. At the urging of the community, the city modified the timing of traffic lights, improved signage, and created "scramble" intersections that allow pedestrians to cross an intersection in every direction, including diagonally. Here's the catch: although the

THE COMMUNITY-CENTERED HEALTH HOME

Better integration of clinical service and community prevention is increasingly being seen as an integral component of a reformed and efficient health system. In 2011, Prevention Institute described a comprehensive approach for health institutions to systematically engage in community prevention in our report *Community-Centered Health Homes*.¹ The report lays out a three step process of *Inquiry, Analysis, and Action* to identify the social and environmental conditions causing the greatest impact on health outcomes in communities, develop strategies to address those conditions, and then implement those strategies to ultimately improve health outcomes at a population level. Identifying and elevating promising approaches for leveraging health care funds to pay for community prevention is a key step in creating a health system that encourages community-centered health activities.

agency's staff was able to document reduced rates of injury and fatality, there was no way to use healthcare dollars to fund the traffic-safety work and no way to capture the savings to invest in further prevention.

In this brief, we lay out four promising approaches for sustainably generating resources to pay for community prevention within and outside the health care system. The approaches profiled below are not intended to be a comprehensive overview of all potential pay-for-population health initiatives that could support community prevention. Rather they represent those that stood out based on a broad scan of the academic and grey literature and popular media, as well as discussions with key informants in the field. Our intent is not to recommend any specific approach but rather to catalyze further discussion and analysis. Each of the four approaches profiled here has the potential to sustainably generate funding for community prevention and is either being put into practice or is in the process of being piloted by health systems and/or local and state governments.

Wellness Trusts

A Wellness Trust, at its most basic level, is a funding pool raised and set aside specifically to support prevention and wellness interventions to improve health outcomes of targeted populations. While funds to support the Trust can come from many sources, one key option is to levy a small tax on insurers and hospitals. This can help address a key obstacle: the reluctance of any one insurer to invest in a strategy that might improve the health of the entire population, thereby dispersing the potential financial benefit beyond the pool of its insured members (who may also switch coverage before benefits are realized). Requiring all insurers to pay into the Trust may address this reluctance. Public policy advocates including the Brookings Institution have called for the establishment of wellness trusts.⁷

The Massachusetts Legislature recently passed a health-cost control bill that creates a \$60-million Prevention and Wellness Trust to support prevention efforts over the next four years⁸ –the first state-based prevention fund in the nation. The money for the Trust will be raised by a tax on insurers and an assessment on larger hospitals. Beginning in the summer of 2013, the Massachusetts Department of Public Health will distribute the funds, in consultation with a new Wellness and Prevention Advisory Board, to local communities, regional planning agencies and healthcare providers. These groups would use grants from the Trust to carry out community-based prevention initiatives that reduce rates of costly preventable health conditions, lessen health disparities, and increase healthy behaviors.⁹ All grant recipients must partner with a local health department. Ten percent of the money will also be

used to provide tax credits to employers that set up workplace wellness programs. The bill also requires health insurers to provide premium discounts to small businesses that launch workplace wellness programs.

A 20-member commission will be established to evaluate the effectiveness of the prevention initiatives started through the Prevention and Wellness Trust and to measure the impact on healthcare costs. An outside organization will be hired to conduct the evaluation and results must be posted on the state's website by June 30, 2015. The bill was introduced and moved through the state legislature by a broad-based coalition of organizations, led by the Massachusetts Public Health Association.

While taxing insurers guarantees a sustainable source of revenue, other options exist for establishing wellness trusts, including pooling private foundation resources or redirecting existing government funding. For instance, the North Carolina Health and Wellness Trust Fund was created with funding received by the state through the Tobacco Master Settlement Agreement.¹⁰

Social Impact Bonds/Health Impact Bonds

Health impact bonds (HIBs) provide a market-based approach to pay for “evidence-based interventions that reduce health care costs by improving social, environmental and economic conditions essential to health.”¹¹ The basic idea involves raising capital from private investors to invest in prevention

interventions, capturing the healthcare cost-savings that result from the interventions, and then returning a portion of those savings to the investors as profit. It is based on the broader concepts of social impact investing and social impact bonds that have garnered significant attention in the academic and popular press lately.^{12,13} For example, a social impact bond now being tested in the United Kingdom has raised \$8 million to invest in measures that would reduce the recidivism of 3,000 prisoners in Petersborough Prison.¹⁴ The goal is a 7.5 percent reduction in six years. If successful, the UK government will save a substantial amount of money and return some to investors, beginning in 2013. New York City is also initiating a social impact bond to reduce recidivism among juveniles in the justice system.

Health impact bonds provide a financial instrument for making investments to improve health outcomes within a community. In a recent brief, the initiator of the first health impact bond to be tested in the US identified five components needed to create a successful investment opportunity:

- “Target outcomes must be clearly defined and achievable;
- The proposed intervention should reflect best practices;
- Measuring outcomes must be independently validated;
- A clearly defined “savings” or return value should be established; and
- Public agencies, nonprofits, investors and community stakeholders must all be willing to work together.”¹⁵

An investment firm may assist community stakeholders by issuing the health impact bonds and offering to investors and social entrepreneurs. With capital raised from the bond sales, the community stakeholders would implement the prevention intervention. If the intervention generates savings, a portion of those savings would be returned to investors and any additional savings could be used to identify or seed new prevention-oriented investment opportunities.

The first-ever health impact bond is now being set up in Fresno, California, with the aim of reducing

the incidence and severity of asthma, a condition that disproportionately affects low-income people and communities of color due to poor environmental conditions in communities and homes. Fresno is the second-most impoverished and the second-most polluted city in the U.S.^{16,17} Over 17 percent of Fresno residents have asthma, more than twice the national average.¹⁸ Every day in Fresno, 20 asthma sufferers go to the emergency department and three are hospitalized.

Researchers at the University Of California Berkeley School of Public Health, working with a health impact investing firm called Collective Health, studied the potential for reducing healthcare costs by investing in home-based remediation of environmental conditions in the homes of Fresno residents with severe asthma who are frequent users of emergency and hospital treatment. They found that the intervention would generate net savings of over \$4.5 million and a return on investment of \$1.69 for every dollar spent on the intervention.¹⁹

Health impact bonds are also being envisioned to fund interventions that would reduce hospital admissions for acute conditions such as asthma, traffic injuries, or environmental poisonings, in which a reduction in health care costs and return on investment might be easily identified and attributed to the intervention. Such interventions aim to prevent or reduce the severity of conditions experienced by individuals—as with the Fresno effort to change conditions in people’s homes. A next step in developing this approach will be to find ways to use the bonds to fund community-based interventions intended to reduce illness and injury for populations. For example, could the Fresno effort also yield returns by funding broader community prevention strategies such as enforcement of housing codes related to asthma triggers, establishing smoke-free housing policies, or reducing local sources of pollution?^{20,21} Health impact bonds might also be used to invest in community improvements with the potential to result in identifiable healthcare savings. Examples might include upgrading pedestrian and bicycle infrastructure to decrease traffic-related injuries and deaths and to prevent chronic conditions such as diabetes.^{22,23}

Community Benefits from Non-Profit Hospitals

The “community benefit” requirements imposed on nonprofit hospitals and health plans may represent a significant and sustainable source of funds for community-prevention initiatives. Legislation passed in 1994 requires these hospitals “to provide community benefits in the public interest” as a condition of their tax-exempt status. This is a substantial resource estimated at around \$13 billion annually nationwide.²⁴ The bulk of community benefit funds have historically gone to cover the costs of charity care given to people who are unable to pay for treatment. However, IRS has recently begun asking hospitals to track “Community Building” expenditures, defined as support for physical improvement and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, and workforce development.²⁵ As of 2012, “community building” activities are now allowed to be counted as “community benefit” expenditures, opening up the potential for significant new investments in community prevention.²⁶

As part of the move toward expanding “community building” activities with their community benefit dollars, new ACA regulations require each tax-exempt hospital to do a “Community Health Needs Assessment” every three years. This assessment must include input from the community served by the hospital and from those with expertise in public health. Hospitals must adopt an implementation strategy that addresses the community health needs identified by the assessment.²⁷ Also, most analysts believe the ACA will reduce the number of uninsured people and thus the burden of uncompensated treatment on hospitals, freeing up community benefit dollars formerly dedicated to “charity care” to be used for “community building” and community prevention initiatives.

Many hospital systems are already engaging in this type of activity. In 2008, Nationwide Children’s Hospital in downtown Columbus launched and invested community-benefit funds into

the Healthy Neighborhoods, Healthy Families (HNHF) collaboration, a partnership with the city and community-based organizations to address affordable housing, healthy food access, education, safe and accessible neighborhoods, and workforce and economic development.²⁸ Under the auspices of HNHF, the hospital invested over \$3 million in affordable housing and \$6 million in local women- and minority-owned business, while the city of Columbus invested \$15 million in pedestrian and bicycle infrastructure improvements on unsafe streets in downtown Columbus.²⁹

COMMUNITY PREVENTION REDUCES THE BURDEN ON THE HEALTH CARE SYSTEM

Community prevention interventions improve health and safety outcomes for all members of the population and as a result can reduce both long- and short-term demand for clinical services. For example, improving air quality in a neighborhood reduces the chance that those who are healthy will need medical care for conditions such as respiratory illnesses and COPD, helps those with conditions such as asthma manage their illness, and also has benefits in terms of encouraging physical activity and reducing climate impacts.

The Cincinnati Children’s Hospital Medical Center has used community-benefit dollars to fund a Community Health Initiative (CHI), which partners with community-based organizations to address asthma, accidental injuries, poor nutrition, and other preventable illnesses and injuries in their community.³⁰ CHI uses geographic information systems (GIS) technology to identify “hotspots,” or communities with the highest incidence of preventable health conditions, and to develop strategies to address those conditions. For instance, by mapping the homes of re-admitted asthma patients, they identified clusters of patients living in substandard housing units owned by the same landlord. CHI then partnered with a local legal aid association to help tenants compel the landlord to make necessary housing improvements.

Accountable Care Organizations

In an effort to shift the focus from individual patient care to population health management, the Affordable Care Act promotes the establishment of accountable care organizations (ACOs). An ACO, at its most fundamental level, is a group of coordinated health care providers (i.e. a hospital and all of its affiliated primary care and specialist providers) that work in concert to coordinate a continuum of care for a designated population of patients. The ACO model seeks to improve health outcomes and reduce total costs of care for a specified population of patients by tying reimbursements to quality metrics that demonstrate improved outcome, rather than quantity metrics based on units of services provided.

If an ACO is able to achieve reductions in the total cost of care for a designated population of patients, a portion of those savings could potentially be set aside to invest in community-prevention initiatives aimed at improving community environments. These initiatives could further lower costs by reducing the need for health care services over time.

The potential of ACOs is being demonstrated by a collaborative of health providers, local government agencies, and community-based organizations in Akron, Ohio, led by the Austen BioInnovation Institute (ABIA), which is developing the nation's first "Accountable Care Community" (ACC).³¹ According to ABIA, "An ACC encompasses not only medical care delivery systems, but the public health system, community stakeholders at the grassroots level, and community organizations whose work often encompasses the entire spectrum of the determinants of health."³² The ACC reflects a broad vision of how an ACO can focus on health promotion and disease prevention as well as access to quality services.

The primary distinguishing factor between an ACO and an ACC is that while an ACO may only be responsible for the health outcomes of its own population of patients (i.e. members of a single insurance plan that covers only a small percentage of the residents within a community), an ACC is responsible for the health outcomes of the entire population of a defined geographic region or community, in this case Summit County, Ohio.

Participating health providers cover 85 percent of the county's half-million residents as well as a substantial population in surrounding counties that will also benefit from the ACC's activity. The Akron ACC integrates medical and public health models, making use of teams that include doctors, pharmacists, nurses, social workers, mental health professionals, and nutritionists. It is fostering collaboration between health providers, public health officials, other local government agencies, and community-based organizations and is developing new health information tools while also engaging in policy analysis and advocacy work needed to promote wellness.

"An ACC encompasses not only medical care delivery systems, but the public health system, community stakeholders at the grassroots level, and community organizations whose work often encompasses the entire spectrum of the determinants of health."

The ACC has already gained recognition for its work addressing community environments in Akron. One example: Members of the ACC identified an underserved Akron neighborhood that has no public transportation access to a national park located just outside the city, Cuyahoga Valley National Park, and the recreational and physical activity opportunities it provides. The ACC worked with the local public transit agency to establish a new bus line connecting the community to the park. The ACC is also partnering with the metropolitan housing authority and the city planning department to improve local housing and pedestrian and bicyclist infrastructure. In addition, it has established partnerships with local employers of all sizes to set up worksite wellness initiatives.

While the initial development phase of the Akron ACC is being funded through grants, including a Community Transformation Grant from the Center for Disease Control and Prevention (CDC), and community benefit funds from local hospital systems, leaders of the Akron effort believe they have developed a model that will be financially

self-sustaining in the long term. They project that health care costs will be lowered by 10 percent as a result of the new programs and interventions. These savings will be captured through cost-avoidance and cost-recovery financial models, which quantify the dollars saved through reductions in health care utilization by Summit County residents, and will be shared with the ACC by participating health systems, providers, and payers through negotiated agreements with each entity. The portion of the savings that gets returned to the ACC is projected to cover all of the collaborative's operating costs and provide additional funds for future investment in the community. The Innovation Institute has developed "impact equations" that will demonstrate the overall costs and benefits of the ACC implementation and calculate the savings achieved. This work should enable the model to be replicated elsewhere if it succeeds.

The Potential for Replicating and Scaling Up Promising Approaches

Because each of the efforts described here is in the early stages of testing and implementation, it will be important to monitor their progress and viability to determine whether they are useful models for funding community prevention work elsewhere. The Massachusetts Wellness Trust, the Ohio hospital community benefit efforts, the Fresno Health Impact Bond, and the Akron Accountable Care Community

Mounting evidence indicates that interventions and policy changes that promote community prevention constitute the most cost-effective strategies for improving health outcomes at a population level.

all include robust evaluation components that will measure the effectiveness and success of each. These approaches for generating consistent, sustainable sources of revenue for community prevention should help inform the broader debate of how best to allocate healthcare resources to achieve the best possible outcomes for the least possible cost. To save money and lives, it is essential not only to develop dedicated streams of funding that can pay

for prevention but also to consider how existing funding streams are utilized to maximize health, safety, and equity. For example, California recently adopted a Health in All Policies approach, directing 19 government agencies to work collaboratively to advance health and equity goals in all decision-making and funding.

With the implementation of the Affordable Care Act, the expansion of insurance coverage, and the mandate to control health care costs, it is vital to ask big questions about the types of activities and efforts that should be incentivized in the US health system. Mounting evidence indicates that interventions and policy changes that promote community prevention constitute the most cost-effective strategies for improving health outcomes at a population level.^{33,34} This brief is intended to spark interest and advance research in a new wave of groundbreaking approaches that are aimed at improving health outcomes and controlling healthcare costs. We hope the pioneering efforts described here will catalyze more innovation and become beacons that others can develop and refine.

Acknowledgements

The findings and analysis herein are the responsibility of Prevention Institute alone; however, our thinking was shaped by the insights of the following individuals. We would like to thank them for their generosity and thoughtfulness:

Laurie Stillman

Chief Strategy Officer
Health Resources in Action

Kevin Barnett

Senior Investigator
Public Health Institute

Rick Brush

Founder and CEO
Collective Health

Janine Janosky

Vice President
Head, Center for Community Health Improvement
Austen BioInnovations

Endnotes

- 1 Cantor J, Cohen L, Mikkelsen L, Pañares R, Srikantharajah J, Valdovinos E (2011). Community Centered Health Homes: Bridging the Gap between Health Services and Community Prevention. Available at: <http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html>.
- 2 Kung HC, Hoyert DL, Xu JQ, Murphy SL (2008). Deaths: final data for 2005. National Vital Statistics Reports 2008;56(10). Available from: http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf
- 3 Centers for Disease Control and Prevention (2011), 10 Leading Causes of Death by Age Group, United States – 2010. Available at: http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf
- 4 Institute of Medicine (2012). For the Public's Health: Investing in a Healthier Future. Available at: <http://www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx>.
- 5 Chokshi, DA and Farley, TA (2012). The Cost-Effectiveness of Environmental Approaches to Disease Prevention. N Engl J Med; 367:295–297, July 26, 2012.
- 6 Goetzel, RZ (2009). Do Prevention Or Treatment Services Save Money? The Wrong Debate. Health Affairs. Vol. 28 no. 1 37–41.
- 7 Lambrew JM (2007). A Wellness Trust to Prioritize Disease Prevention. The Brookings Institution. Available at: <http://www.brookings.edu/research/papers/2007/04/useconomics-lambrew>
- 8 Lazar K (2012). Massachusetts health cost-control bill contains first-in-nation fund for prevention programs. The Boston Globe. Available at: <http://www.boston.com/whitecoatnotes/2012/07/31/massachusetts-health-cost-control-bill-contains-first-nation-fund-for-prevention-programs/Z4b1qhC9UwAgnDTsNRWn5I/story.html?comments=all#readerComm>
- 9 Massachusetts Public Health Association (2012). Fact Sheet: The Massachusetts Prevention and Wellness Trust Fund. Available at <http://www.mphaweb.org/documents/PrevandWellnessTrustFund-MPHAFactSheetupdatedOct12.pdf>
- 10 North Carolina Health and Wellness Trust Fund website. Available at <http://www.healthwellnc.com/AboutUs.aspx>
- 11 Hernandez M, Syme SL, Brush R (2012). A Market for Health: Shifting the Paradigm for Investing in Health. Available at: http://collectivehealth.net/new/about_files/Health%20Capital%20Market%20FINAL%20March%202012.pdf
- 12 Rosenberg, T. The Promise of Social Impact Bonds. NY Times. June 20, 2012. Available at: <http://opinionator.blogs.nytimes.com/2012/06/20/the-promise-of-social-impact-bonds/>
- 13 The Economist. Being good pays: A scheme that can help keep youngsters out of jail comes to America. August 18, 2012. Available at: <http://www.economist.com/node/21560561>
- 14 Glahn D.V., Whistler (2011). Translating plain English: can the Peterborough Social Impact Bond construct apply stateside? Community Development Investment Review.
- 15 Hernandez M, Syme SL, Brush R (2012). A Market for Health: Shifting the Paradigm for Investing in Health. Available at: http://collectivehealth.net/new/about_files/Health%20Capital%20Market%20FINAL%20March%202012.pdf
- 16 American Lung Association (2011), State of the Air. Available at: <http://www.stateoftheair.org/>
- 17 U.S. Census Bureau (2012), Statistical Abstract of the United States: 2012 (131st Edition) Washington, DC. Available at: <http://www.census.gov/compendia/statab/>.
- 18 California Health Interview Survey (2009). Available at: <http://ask.chis.ucla.edu/main/default.asp>
- 19 Hernandez M, Syme SL, Brush R (2012).
- 20 Healthy Neighborhoods Same Neighbors Collaborative (2010). Shame of the City—The Sequel. Available at: http://www.wellchild.org/slumhousing_sequel_paper.pdf
- 21 American Lung Association in California (2012). Growing Healthy in Southern California. Available at: <http://www.lung.org/associations/states/california/advocacy/fight-for-air-quality/smart-growth-for-california.html>
- 22 Gotschi, T (2011). Costs and Benefits of Bicycling Investments in Portland, Oregon. Journal of Physical Activity and Health, 8, S49– S58.
- 23 World Health Organization (2012). Health Economic Assessment Tool. Available at: <http://www.heatwalkingcycling.org>
- 24 Robert Wood Johnson Foundation (2012). What's New with Community Health Benefit? Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf402124
- 25 Internal Revenue Service (2012a). 2011 Instructions for Schedule H (Form 990). Available at: <http://irs.gov/pub/irs-pdf/i990sh.pdf>.
- 26 The Hilltop Institute (2012). Community Benefit Briefing. Available at: http://www.hilltopinstitute.org/hcbp_newsletter_2012mar.cfm
- 27 US Department of Health and Human Services (2012). Community Benefit Issue Brief. Available at: <http://www.healthcare.gov/prevention/nphpphc/advisorygrp/gw-community-benefit-issue-brief.pdf>
- 28 Nationwide Children's Hospital (2010). 2010 progress report. Available at: <http://www.nationwidechildrens.org/document/get/87352>
- 29 Nationwide Children's Hospital (2010). 2010 progress report. Available at: <http://www.nationwidechildrens.org/document/get/87352>
- 30 Cincinnati Children's Hospital Medical Center (2011). Cincinnati Children's launches community health improvement initiative. Retrieved from <http://www.cincinnatichildrens.org/news/release/2011/community-health-10-11-2011/>
- 31 Austin BioInnovation Institute (2012). Healthier by Design: Creating Accountable Care Communities. Available at: <http://abiakron.org/acc-white-paper>
- 32 Austin BioInnovation Institute (2012).
- 33 Chokshi, DA and Farley, TA (2012).
- 34 Goetzel, RZ (2009).

Attachment 5d - IOM Sustainable Financial Model

A Sustainable Financial Model for Community Health Systems

James A. Hester, Paul V. Stange*

March 6, 2014

**The authors are participants in the activities of the IOM Roundtable on Population Health Improvement*

The views expressed in this discussion paper are those of the authors and not necessarily of the Institute of Medicine. The paper is intended to help inform and stimulate discussion. It has not been subjected to the review procedures of the Institute of Medicine and is not a report of the Institute of Medicine or of the National Research Council.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the nation • Improving health

Copyright 2014 by the National Academy of Sciences. All rights reserved.

A Sustainable Financial Model for Community Health Systems

James A. Hester, Paul V. Stange^{1,2}

The key to the long term survival of the health care reforms being implemented under the Affordable Care Act (ACA) has little to do with the enrollment websites that have attracted so much attention and everything to do with transforming the performance of the systems that provide health care and promote health. The common framework for measuring the change in performance is the Triple Aim—better control of total per capita costs, better experience of care for those who need it, and better health for the population (Berwick et al., 2008). An impressive array of new payment and service models is being tested with encouraging signs of success with the first two aims—total cost and patient experience. Models for improving the health of the population have proven to be more elusive both because less attention has been focused on them and because the issue is more challenging (Hester, 2013). Timing is a major challenge in order to utilize the window of opportunity created by the current wave of reform initiatives (Auerbach et al., 2013). One such example is the State Innovation Model program sponsored by the Centers for Medicare & Medicaid Services (CMS) Center for Medicare & Medicaid Innovation to propose and implement novel integrated approaches to achieve the three elements of the Triple Aim, including improved population health.³

Improving population health requires a coordinated strategy at multiple levels including individual provider practice, community, state, and national levels, with the community level recognized as an increasingly important locus of efforts (Hester et al., 2010). In a recent commentary, Stephen M. Shortell made a “bold proposal” to improve population health in which a community health management system would be paid a per capita budget for achieving specific quality and health status targets (Shortell, 2013). This proposal built on a number of other conceptual models that identified the need for an integrator function at the community level to mesh clinical care, public health programs and community-based initiatives in a coherent strategy to meet the community’s needs. This is the common denominator among several roughly analogous concepts Healthcare 3.0 (Halfon, 2012), Accountable Health Communities (Magnan et al., 2012), community integrators (Chang, 2012), community quarterbacks for community development (Erickson et al., 2012) and the “backbone organization” of the collective impact movement (Hanleybrown et al., 2012). These articles begin to identify the structure and functions of a community-level population health infrastructure that we will call a Community Health System (CHS). The CHS is accountable for the health of the population in a geographic area, including reducing disparities in the distribution of health. Its major functions include

¹ The authors are participants in the activities of the IOM Roundtable on Population Health Improvement.

² Suggested citation: 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>.

³ Information about the CMS State Innovation Models Initiative is available at <http://innovation.cms.gov/initiatives/state-innovations>.

- convening a broad set of key stakeholders such as governmental public health agencies, communities, the health care delivery system, employers and businesses, and the education sector (IOM, 2012)
- reconciling diverse perspectives and defining a shared vision and goals
- assessing the needs of the community, identifying gaps and potential interventions and prioritizing actions to achieve shared goals
- managing a population health budget and allocating resources, and
- creating the information systems and capability to assess performance and implement rapid cycle changes

The elusive “holy grail” for the population health movement has been a sustainable financial model that would break the cycle of dependence on limited-term grants and provide long term support for both infrastructure and interventions. What could be a sustainable financial model for a CHS? One part of the answer comes from the diverse set of new financial vehicles for financing population health interventions and infrastructure that have been emerging in recent years. These instruments fall into three broad categories: (1) new payment models for clinical services that reward Triple Aim outcomes instead of volume, (2) breaking down funding silos to create multi-sector programs that blend resources into a common pool, e.g., through a Medicaid Section 1115 waiver, and (3) a diverse set of innovative funding models that tap into new and existing pools of public and private capital (Cantor et al., 2013). Some examples include

- new ACA requirements for non-profit hospitals to conduct Community Health Needs Assessments and adopt implementation strategies with specific resources to address priority needs;
- recognition of the connection between healthy populations and strong, economically vibrant communities opening the door to access Community Reinvestment Act vehicles such as Community Development Financial Institutions and Community Development Banks (Sprong and Stillman, 2014);
- the growing social capital movement, implementation of the first pay for success agreements (social impact bonds) and creation of new social mission corporate vehicles such as Low-Profit Limited Liability Companies;
- the use of Program Related Investments by philanthropic institutions as a complement to traditional grants; and
- the funding of Health and Wellness Funds at the state and local levels.

The diversity of interests, structures and objectives is valuable because it increases the likelihood that a given intervention will find a good match, however, it also raises the specter of fragmentation and conflicting efforts. The challenges and opportunities for improving population health vary widely from community to community. Achieving the goal of reduced disparities and better quality of life will require implementing a combination of interventions that are tailored to each community’s needs and that enhance each other, thus generating a community multiplier effect. Simply implementing an uncoordinated series of interventions is unlikely to be either effective or sustainable.

To avoid this, the CHS would use a solid grounding in the determinants of health to create and manage a portfolio of interventions that is balanced along the full spectrum of three

perspectives: (1) time frames for effects of interventions, (2) the level of scientific evidence (investment risks) and (3) scale of return using both health and financial metrics. Table 1 illustrates how the CHS integrator organization would partner with other organizations to create a balanced portfolio that includes interventions with short, medium and long term impacts. Using its needs assessment process, it would prioritize interventions and combine them into a coherent strategy that realized short term opportunities for savings in medical costs, implemented medium term interventions for changing risky behaviors and addressed longer term upstream determinants of health such as early childhood development and the built environment. For each intervention, the CHS would identify an implementation partner with the appropriate skills (as well as a financing vehicle), facilitate the connection, and provide oversight to monitor results. In many cases, the CHS would also play a key role in identifying and securing financing. The more innovative financing vehicles are transaction driven. Just as securing a mortgage on a house is specific to the particular owner of a specific house, closing on financing for a given intervention would be based on a specific intervention managed by a specific service provider in a specific place. Closing each deal would require a thorough feasibility study that documents both the business case of the financial flows and the capabilities of the organizations involved. Matching the time horizon, risk profile and returns of each intervention with the appropriate organization and financing vehicle, negotiating the agreement governing the relationship, and monitoring performance would be critical responsibilities of the CHS. These have not been identified previously as essential functions for population health improvement.

The sample portfolio in Table 1 shows the intervention, target population, implementation partner, financing vehicle, time horizon and risk profile for nine interventions targeted to address the needs of a hypothetical community. The combination covers a broad cross-section of the population and represents complementary efforts to improve the management of chronic illnesses, support changes in risky behaviors and change upstream determinants of health such as the built environment.

A key component of each intervention is identifying an explicit way in which the CHS could share in the savings generated by a successful intervention. Modeling of a variety of population health strategies has indicated that for the community to be able to sustain a balanced portfolio over time, the CHS must capture a portion of the savings and keep them available for reinvestment (Milstein et al., 2011). Different financing vehicles would provide different options for the CHS to capture savings. In short term initiatives using shared savings payment models or capitation, the CHS could negotiate receiving a percentage of savings which the provider organization could classify as a community benefit. At the other end of the spectrum, the CHS could use its Health and Wellness Fund to participate as an investor in a pay for success agreement and capture savings as its investment is repaid. The CHS share from each intervention flows into its Health and Wellness Fund. Initially, the CHS would have to be supported by startup grants and investments, but as its portfolio grows and matures, it would shift to support primarily from shared savings. In each case, the CHS would have to demonstrate a clear added value to the transaction to justify its sharing in the results. Understanding the specific ways it could do this is an area in which we have much to learn.

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
Asthma medical management	School-aged children	Commercial and Medicaid health plan	Shared savings	Medium	Medium	Performance contract
Asthma environmental hot spots	Children with asthma	Public health agency	1115 Medicaid waiver	Medium	Medium	Savings sharing
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	
New grocery store	Residents of U.S. Department of Agriculture food deserts	Community Development Financial Institution	Community reinvestment	Long	Medium	None

The financial model presented here is conceptual, not based on current experience. Although a variety of examples of community-based structures for improving the health of the population exists, no single organization has either the full range of competencies required for the integrator organization as described here, or the accountability to manage a broad spectrum of interventions with shared savings flowing to a Health and Wellness Fund. The next 3-5 years will be an important period of experimentation and development to translate this concept into a scalable reality. The timing is critical for a number of reasons. First, the innovative financing vehicles appear poised to develop and spread very rapidly with little, if any, focus on coordination with other population health initiatives in the community. This creates the very real danger that they will outrun our ability to create community-based structures to integrate them effectively to meet local needs. Second, there is not an unlimited pool of potential savings to be harvested and once the savings are gone, it will be more difficult to create a balanced portfolio. Third, the

community development and population health movements are evolving on parallel tracks in creating community integrator structures. The last thing we need is to have dueling community infrastructure.

The State Innovation Models program created by CMS will provide a major opportunity for states to help test alternative approaches to a community integrator. The Transformation Plans of several states such as Washington and Minnesota explicitly call for the development of CHS's and other states, such as Oregon, Colorado and Maryland are creating a regional accountability framework that could be a starting point for a CHS. Learning collaboratives such as the Robert Wood Johnson Foundation's Aligning Forces for Quality and the Institute for Healthcare Improvement's Triple Aim Collaborative, are other promising sources for early adopter organizations. It is essential that the public sector and private foundations combine resources to test how to create sustainable financial models and community-level infrastructure to support and reward improvements in the health of the population. Without them we will not be able to maintain the hard won gains in expanding coverage for millions of Americans, or improve their health status.

REFERENCES

- Auerbach, J., D. I. Chang, J. Hester, and S. Magnan. 2013. *Opportunity knocks: Population health in state innovation models*. Discussion Paper, Institute of Medicine, Washington, DC.
- Berwick, D.M., T.W. Nolan, and J. Whittington. 2008. The Triple Aim: Care, health, and cost. *Health Affairs* 27(3):759-769.
- Cantor, J., L. Mikkelsen, B. Simons, and R. Waters. 2013. *How can we pay for a healthy population? Innovative new ways to redirect funds to community prevention*. Oakland, CA: Prevention Institute.
- Chang, D. 2012. *Integrator role and functions in population health improvement initiatives*. Nemours. http://www.improvingpopulationhealth.org/Integrator%20role%20and%20functions_FINAL.pdf (accessed November 27, 2013).
- Erickson, D., I. Galloway, and N. Cytron. 2012. Routinizing the extraordinary. *Investing in what works for America's communities*. <http://www.whatworksforamerica.org/the-book> (accessed November 27, 2013).
- Halfon, N. 2012. *Transforming the child health system: Moving from Child Health 2.0 to 3.0*. Aspen Institute's Children's Forum presentation, July 23. <http://www.aspeninstitute.org/sites/default/files/content/docs/psi/TransformingtheChildHealthSystem-HalfonNeal.pdf> (accessed November 27, 2013).
- Hanleybrown, F., J. Kania, and M. Kramer. 2012. Channeling change: Making collective impact work. *Stanford Social Innovation Review*. <http://partnership2012.com/download/Collective%20Impact%20II.pdf> (accessed November 27, 2013).
- Hester, J. A. 2013. *Paying for population health: A view of the opportunity and challenges in health care reform*. Discussion Paper, Institute of Medicine, Washington, DC. <http://iom.edu/Global/Perspectives/2013/PayingForPopulationHealth> (accessed March 3, 2014).
- Hester, J., J. Lewis, and A. McKethan. 2010. *The Vermont Accountable Care Organization Pilot: A community health system to control total medical costs and improve population health*. Commonwealth Fund, 1-22. http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/May/1403_Hester_Vermont_accountable_care_org_pilot.pdf (accessed November 1, 2013).
- IOM (Institute of Medicine). 2012. *For the Public's Health: Investing in a Healthier Future*. Washington, DC: National Academies Press. http://www.nap.edu/openbook.php?record_id=13268 (accessed March 3, 2014).

- Magnan, S., E. Fisher, D. Kindig, G. Isham, D. Wood, M. Eustis, C. Backstrom, and S. Leitz. 2012. Achieving accountability for health and health care. *Minnesota Medicine* 95(11):37-39.
- Milstein, B., J. Homer, P. Briss, D. Burton, T. Pechacek. 2011. Why behavioral and environmental interventions are needed to improve health at lower cost. *Health Affairs* 30(5):823-832.
- Shortell, S. M. 2013. *A bold proposal for advancing population health*. Discussion Paper, Institute of Medicine, Washington, DC. <http://www.iom.edu/Global/Perspectives/2013/BoldProposal> (accessed March 3, 2014).
- Sprong, S., and L. Stillman, 2014. Leveraging multi-sector investments: New opportunities to improve the health and vitality of communities. *Health Resources in Action*. http://hria.org/uploads/reports/PPReport_r3_011614_pages.pdf (accessed November 27, 2013).

Attachment 6 - Alignment with Operational Plan

Population Health Integration in VT Health Care Innovation Project

Alignment with Operational Plan

June 2, 2014

Goals:

- Assure alignment of the Population Health Work Group Charter with VHCIP Areas of Innovation and Operational Plan
- Add specificity to the Population Health Work Group proposed work plan
- Identify enhanced opportunities, not currently specified in VHCIP Operational Plan, which could further improve population health

Three Areas of Innovation Being Tested

- Payment models
- Care models
- Population health plan

Population Health Work Group (From Operational Plan)

This group will examine current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:

- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by gov't or non-gov't organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

Three Areas of Work According To Population Health Work Group Charter

- 1) Population Health Measures for payment and evaluation of project
- 2) How to pay for population health – financing models
- 3) Exemplars for integrating clinical and population health – delivery system models

Population Health Integration in VT Health Care Innovation Project

Alignment with Operational Plan

June 2, 2014

Areas of innovation through VHCIP:	Operational Plan	Population Health Work Group approaches	Enhanced Approaches
Payment Models		<ul style="list-style-type: none"> • Payment Measures • Modification to the models being tested • Other financial models 	Financial Models <ul style="list-style-type: none"> • Social impact bonds • Community Development Financial institute • Wellness Trust • CDC/CMMI Funding • RWJ Project Ideas
Bundled (Episodes)		<ul style="list-style-type: none"> • Educate PH work group members about model • Share population health frameworks with Payment Models Work Group • Identify best lever and strategy to include payment for and/or activity related to population health 	
Pay for Performance		<ul style="list-style-type: none"> • Educate PH work group members about model • Share population health frameworks with Payment Models Work Group • Identify best lever and strategy to include payment for and/or activity related to population health 	
Pop. Based Global payments (ACO)		<ul style="list-style-type: none"> • Educate PH work group members about model • Share population health frameworks with Payment Models Work Group • Recommend criteria and measures for payment that will shift funding and practice to actions that will improve population health 	Question to be asked: Who shares in the savings? How can the savings be shared with population health and prevention partners?
Areas of innovation	Operational Plan	Population Health Work Group	Enhanced Approaches

Population Health Integration in VT Health Care Innovation Project

Alignment with Operational Plan

June 2, 2014

through VHCIP:		approaches	
Delivery System (system of care)	Expansion of scope of delivery models to include PH	<ul style="list-style-type: none"> • Share population health frameworks with Care Models Work Group • Build upon Blueprint delivery system <ul style="list-style-type: none"> ○ Review BP via Network Analysis for enhancing pop. Health ○ How best build on CHT Structure? ○ Look at strengths of “Integrated Health Team” ○ Consider BP for kids? • Review ACO system of care (C. Hinds, OneCare; J. Gallimore, FQHC) • Identify exemplars of community integration of clinical and population health efforts 	<p>Systems of Care</p> <p>Connect to Community Health Needs Assessment</p> <p>System which includes children – BBF, IFS, etc.</p> <p>Accountable Health Community</p>
Areas of innovation through VHCIP:	Operational Plan	Population Health Work Group approaches	Enhanced Approaches
Pop. Health Plan (CDC/CMMI)	<ol style="list-style-type: none"> 1. Examine current PH efforts in VT & SIM <u>potential impact</u> on health of VT 2. Recommend how the project could <u>help to coordinate</u> health improvement activities + more directly impact population health: <ol style="list-style-type: none"> a. Enhance state initiatives b. Support or enhance Local or regional initiatives c. Expansion of scope of delivery models or preexisting initiatives to include PH 	<p>Share population health frameworks (where money goes; determinants of health outcomes)</p> <p>Create materials that show connection between social determinants, population health and clinical measures</p>	<p>Examine models that connect payment models & system of care for population health improvement</p>