

## TWIN PILLARS

### *How to Develop Sustainable Financing for Population Health Early Lessons Learned From Asthma: Braiding Funding Methods Is Key*

In the wake of enactment of the Affordable Care Act, the Trust for America's Health (TFAH) began a series of convenings to define practical steps to reform the health system to better address population health and reduce health disparities. The convenings focused on the twin pillars of transformation—delivery system and payment reforms—that need to be aligned to achieve these goals.

With support from the Robert Wood Johnson Foundation, The California Endowment and The Kresge Foundation, over the last several years, TFAH has brought together national experts and local innovators to identify policies and practices to advance population health models that address the complex social needs of individuals as well as incorporate community-based prevention, which has the potential to improve the health of all Americans.

As a result of these discussions, TFAH identified nine elements that are critical to a population health initiative:

1. A dedicated integrator that is resourced and has a governance structure;
2. A broad coalition that can exert influence from both the top down (community leaders) and the bottom up (local neighborhoods);
3. A sustained commitment and willingness from the partners to the process;
4. An ability to listen and respond to the community's needs;
5. Adaptability to create the workforce required (such as community health workers) even if the competencies and curricula are not yet defined;
6. Bi-directional referral linkages among clinical, community and social systems;
7. A business model that includes cost transparency, reinvests in the integrator, and rewards improved health outcomes and reduced health care utilization/costs;
8. The ability to braid various funding streams together; and, most of all
9. Hard work.

In August 2015, TFAH hosted a convening to focus on one of the key financing elements identified above: braiding of funding streams. Although many, if not most, programs of all kinds braid two or three funding sources together as a matter of course, TFAH wanted to explore the benefits, challenges and strategies for braiding multiple revenue streams to implement a broad-based and comprehensive population health initiative. This is particularly important because population health improvement depend on multi-sector partnerships. No single agency or intervention can produce the desired population health outcome. It takes a comprehensive set of actions and actors, which are typically beyond the scope of a single funding stream.

## Case models: Comprehensive Asthma Initiatives

In order to understand in greater depth the benefits and challenges of braiding funding, the convening focused on asthma as an ideal case example. Communities around the country have been implementing comprehensive asthma programs for many years, with proven health outcomes and results. As a result, asthma programs have developed some of the robust braiding strategies associated with any chronic disease.

The goals of the convening were to:

- Review and discuss models that braid various financing approaches that support interventions to improve population health, focusing on asthma programs that include home-based assessments and interventions
- Identify the challenges associated with these financing methods and their implications for long-term sustainability
- Explore the applicability of lessons learned for a broader range of population health interventions

Three cases were presented:

- Alameda County Public Health Department Asthma Start Program
- New England Asthma Innovations Collaborative
- Asthma Network of West Michigan

Programmatically, these models have many elements in common:

- Multi-faceted, including self-management education, home visiting and assessments
- Utilize Community Health Workers, Certified Asthma Educators, and Social Workers
- Provide environmental supplies
- Include remediation of asthma triggers
- Involve multiple partnerships with clinical providers/hospitals, workforce development agencies, housing/healthy homes, schools, day care, District Attorney, and health care payers

Although the funding source vary from program to program, collectively, they include:

- CMMI grants
- First5 (cigarette tax support of early childhood programs)
- Community development
- Hospital community benefits
- Master tobacco settlement
- Medicaid managed care (education funds)
- Medicaid administrative claiming and targeted case management
- Commercial health insurance reimbursement
- Grants
- Local sales tax that supports the public hospital
- Ports-related mitigation funds from the Air Quality Management District
- Healthy homes/housing
- United Way

Each program is also in various stages of pursuing a Pay-For-Success funding model. For further details of each asthma program's revenue streams, see Table 1.

For in depth descriptions of these models, see:

[http://healthyamericans.org/health-issues/prevention\\_story/how-an-entire-community-can-come-together-to-help-control-asthma/](http://healthyamericans.org/health-issues/prevention_story/how-an-entire-community-can-come-together-to-help-control-asthma/)

[http://healthyamericans.org/health-issues/prevention\\_story/improving-lives-saving-money-by-extending-care-from-the-clinic-into-the-community/](http://healthyamericans.org/health-issues/prevention_story/improving-lives-saving-money-by-extending-care-from-the-clinic-into-the-community/)

<http://asthmaregionalcouncil.org/our-work/neaic/>

### **Braiding Funding**

Through the presentations and subsequent discussions, seven major themes emerged that can inform both practice and policy development with the goal of making braiding strategies easier to implement.

#### **1. Strategic braiding can help take a population health improvement program to scale.**

Although many community projects braid two or even three funding streams, these case studies point to the role of a more strategic and intentional strategy that can scale up interventions.

Most braiding efforts began with one funding source, which dictates what aspects of the program get implemented. The programs grew as new resources were identified to support additional elements of a program or extend the program to additional populations. One funding source will seldom pay for any multi-dimensional and comprehensive program, such as the asthma programs described above, which span clinical services, screening and testing, upstream prevention, remediation activities, such as enforcement of housing codes and clean-up of housing stock, and policy change.

For each of the asthma programs, the hardest resources to come by were for remediation, including enforcement activities and policy change. In part, this is because remediation can be expensive, certainly more than education and assessments. However, it is also because remediation activities are viewed as being outside the purview of the health care sector. Therefore, the asthma programs partnered with healthy homes programs and sought funding from the Department of Housing and Urban Development and private funders to support those aspects of the program.

“With braiding, I can reach more people.”

#### **2. Braiding can be cumbersome, but it also brings significant value and benefits.**

Many participants expressed that in an ideal world there would be just one funding pool, which would cover the full range of program interventions and all populations. However, that is highly unlikely and may not, in fact, be ideal, unless it was truly flexible. For example, public health insurance dollars generally cannot be used for individuals who are undocumented, a significant

population at-risk for asthma. Moreover, an over-reliance of health care financing may drive programs to focus primarily on clinical interventions and place lower priority on broad-based population improvement strategies and policy change to address the upstream triggers of asthma, impacting entire populations. Finally, a single source carries more risk, should that funding stream go away. When asked about what an optimum approach would consist of, one presenter said, “I like the idea of a central source with wrap around or supplemental funding for other populations or strategies.”

Braiding resources from a variety of sectors, in addition to health related funding, diversifies the revenue base to spread the risk and share the burden. To be clear, although more education and evidence are needed to demonstrate to the health care delivery system that it has a role in addressing some social determinants of health, not all interventions necessary to improve health outcomes are or should be the responsibility of the health care system. Braiding strategies can help guard against the “healthization” of all contributing factors. Nevertheless, a health framework can provide a pathway to integrating these services.

### **3. An integrator is critical—and must be supported—for facilitating braiding, especially when there are multiple and complex funding streams involved.**

A dedicated integrator was identified as one of the key elements of a population health improvement initiative. It is particularly important for braiding strategies. Participants noted the substantial effort involved in braiding funding. Activities include obtaining the resources, negotiating rates, tracking and managing the expenditures, and reporting to the different funding agencies. Unfortunately, this function is seldom resourced. Therefore, finding core support for the integrator to carry out the various activities associated with braiding is critical for sustainability

### **4. New methods—beyond a traditional Return on Investment model—for determining impact are needed.**

Requirements to show a Return on Investment (ROI) within a grant period of three years was a challenge to the programs. First, obtaining health care data from providers takes a significant amount of time. Managed Care Organizations (MCOs) participating in the New England Asthma Innovation Collaborative indicated that if an ROI could be demonstrated, they would pay for services provided initially under a CMMI grant. Unfortunately, the grant funds have ended, even though a full cost analysis won't be complete until the end of 2016. Some of the participating providers have curtailed their activities while others are seeking bridge funding in the interim.

Moreover, with population health improvement efforts, data needs can extend beyond the health care system. For example, asthma program have impacts beyond reduced utilization of the emergency department. Children with fewer asthma attacks miss fewer school days and their parents miss fewer work days. There are economic costs to those absences, which should be captured in some type of Social ROI. Even within the health care system it's important to capture the value of improved health beyond costs. One participant noted that forward-looking

MCOs value improvements in quality improvement and quality of life measures they're accountable for, as well as the financial benefits of asthma programs. The shift to value-based payment will give further incentive to MCOs to invest in population health efforts.

A second challenge associated with an ROI is timing. As one participant asked, "How do we scale activities that have been shown to improve outcomes but not yet shown ROI? For example, with obesity, BMI might be coming down but we are not able to show ROI yet. Can you still scale?"

Another challenge of ROIs is that each funder/contributor often wants to see an ROI for their specific contribution. Because it's the combination of interventions that produces the health outcome, clarity about what the ROI is associated with needs to be addressed up front.

#### **5. Identification of a standard set of data requirements could streamline data collection and sharing efforts.**

Data collection, sharing and analysis must be built into any braiding strategy in order to track costs, outcomes and build the business case. Yet, this was identified as one of the most significant challenges experienced by the asthma programs. Health outcomes and population-level data, as well as financial data and net program costs are important in order to demonstrate impact and build the business case. Data on cost savings has been the hardest to collect. In fact, two of the programs highlighted at the convening have engaged with a research partner to evaluate the data and conduct economic analysis.

Local programs are often challenged with determining which data to prioritize. For example, the New England Asthma Innovation Collaborative was seeking all claims data for patients enrolled in their program, not just data associated with the home visiting program or asthma-related health care expenses because savings/cost avoidance may show up in other clinical categories. At the same time, the need for broad based data must be balanced with the expense and burden of data requested from providers.

Providing guidance on a standard set of data requirements could alleviate the need for each program to "reinvent the wheel."

#### **6. The infrastructure built for one program, like asthma, can be a platform for other population health initiatives, which can broaden the funding base to support it.**

Although the convening focused on braiding funding for asthma programs, the goal was broader—to explore the applicability of braiding strategies for other chronic diseases. Several programs were, in fact, already extending their experience and infrastructure for other conditions. For example, the Asthma Network of West Michigan has expanded its service line to include COPD case management at the request of the largest payer.

Participants discussed innovations underway that could serve as a “super-braider.” The Asthma Network of West Michigan serves as the hub for the asthma initiative. In addition to braiding the funding, it has developed a web-based referral system. “We can upload documents and download referral forms.” All of the hospitals paid for the development of the system, which is now being used as a platform for other services.

“Are we designing for asthma interventions or designing infrastructure for many health outcomes?”

Wellness Trusts or Funds are an emerging concept that could be designated by a local community to integrate categorical program funding associated with a range of social determinants of health, health plan reimbursement, community benefits and philanthropic investments for a variety of population health initiatives. Such an effort could streamline administration and achieve some economies of scale.

The National Prevention Strategy as well as state and community health improvement plans can serve as organizing frameworks to guide the work of a “super-braider”.

## **7. Payment reforms and policy changes can facilitate and incentivize braiding.**

Several potential payment reform and policy changes were identified that could facilitate and, even, incentivize braiding. They applied to the variety of revenue streams that support asthma management programs, including health care reimbursement and categorical funding.

With regard to health care reimbursement, global budgets hold the greatest promise for population health improvement initiatives. However, as an interim step, virtual global budgets can also provide transparency for the various programs and contributors to the initiative. Initiatives that incentivize geographic accountability for the health of a community may help motivate different players to invest in prevention. The Oregon Coordinated Care Organizations model is one such example.

“How do we go from where these programs are discretionary and the prerogative of the states and MCOs to a culture change where this is just how things are done?”

An interim payment reform being sought by the New England Asthma Innovations Collaborative is to move from fee-for-service to a case rate; however, it is challenging for hospitals since asthma-related services are a relatively small part of the hospital’s budget. The model is Family Health Network in Chicago, which pays \$1,500 for home visiting. It is paid on a quarterly basis with 50% up front to recognize the higher initial costs, including the recruitment of families. The rate also includes supplies.

In addition, adding incentives or mandates within health reimbursement mechanisms can encourage health plans and providers to integrate programs and braid funding to address a common problem. The three programs report engaging with payers early in the process, and that a strong business case is needed to convince them to support the program.

With regard to federal categorical or block grant programs, one policy idea is for such programs to provide authority to states and localities to braid funding, particularly with regard to other federal funding programs that address the range of social determinants of health, to address a common problem. This would also entail aligning reporting requirements. Ultimately, whether such braiding efforts could also include insurance reimbursement should be explored.

Policy recommendations specific to asthma include: mandatory coverage for home-based care management and education services under Medicaid, Medicare and commercial insurance; enabling Community Health Workers to be reimbursed for the full range of activities; providing a bump to MCOs if they cover CHW services; and development and implementation of case rates that would include supplies as well as cover costs of recruiting families and home visiting.

### **Conclusion**

The convening demonstrated how strategic braiding can enable communities to provide a comprehensive set of interventions to address asthma. Programs reported braiding together as many as 8 or more different revenue streams, which while challenging, also enables the programs to cover a broad range of populations, geographies, and interventions.

Strategic braiding can also help expand programs by covering additional populations and new geographies. The reverse is also true: scaling programs can attract more interest and payers to the effort. West Michigan Asthma Network reported that a statewide health insurer only became interested in its program when they were able to reach more communities across the state.

The next step is to bring together funding to support a community infrastructure that can facilitate braiding of revenue streams for a variety of chronic disease conditions. This would not only achieve economies of scale, but enable communities to more holistically address the upstream determinants of health.

TABLE 1

	Alameda County	Asthma Network of West MI	NEAIC
<b>Medicaid</b>			
Managed Care	YES--Admin \$	YES	Pursuing
Targeted Case Management	YES		
Administrative Claiming	YES		
Waiver			
Chronic Health Home			
<b>Medicare</b>			
Medicare		YES	
<b>Commercial and Private Sector</b>			
Commercial Insurance		YES	
Community Benefit	YES	YES	
Private Grants	YES	YES	Pursuing
Social Impact Investment	Planning now	Planning now	One site pursuing
<b>Other Public Sector</b>			
Public Grants			Past, current for 1 site & pursuing
Tax Revenue	YES--Sales tax		
Other	YES--Tobacco Settlement Funds		

Legend
Pursuing or planning financing source
Alameda County Current/Past Sources
Asthma Network of W.MI Current/Past Sources
NEAIC Current Sources
NEAIC Individual Provider (Bridge source)