Convening Highlights:
Twin Pillars of Transforming a Sick Care System to a Health System: Delivery System Redesign and Payment for Prevention

The Trust for America's Health (TFAH) hosted a convening of leaders from health care, public health, health insurance, philanthropy and government on July 24th, 2013 in Oakland, CA. The meeting was funded by the Kresge Foundation, Robert Wood Johnson Foundation, and The California Endowment. The purpose of this meeting was to explore the opportunities and challenges for advancing population health in a reformed health system. While the field of population health has advanced rapidly since the Triple Aim became our national goal, population health is still the least understood leg of that triad, since we have less experience defining success and paying for population health than for health care quality and cost of care. To begin addressing this gap, this meeting was designed to:

1. Review the landscape on delivery system redesign and prevention financing and identify models promoting linkages at the intersection of health care, public health and community prevention; and
2. Build the business case for incorporating population health goals into the new financing and delivery systems.

The meeting was organized around three key questions that have emerged from many discussions, including a TFAH-hosted meeting in August 2012, *Coordinating and Integrating Community Prevention, Public Health, and Primary Care: Building an Inventory of Evidence and Developing the Business Case*. Those questions are the following:

1. How do these models at the intersection of health care, public health and community prevention make connections at the individual and systems levels?
2. What metrics and accountability measures are needed to promote population health and demonstrate a return on investment?
3. What financing mechanisms and payment reforms are needed to sustain population health models?

Framing Population Health and Lessons from the Front Lines

TFAH Executive Director Jeff Levi, Ph.D., began the discussion by citing the evidence that the U.S. spends more per capita on health care than other high-income countries, yet Americans live shorter lives and experience more illness and injuries.[1]

Although total U.S. spending on health and social services is roughly the same as other high-income countries, what differs is the balance—the U.S. spends more on health care and less on social services, prompting the need for population health models to better link with social services. Dr. Levi also noted the different definitions of population health held by various stakeholders. He posited that, while population health is defined differently across stakeholders, improving the health of any population requires partnerships to link individuals and clinical care with public health, community-based prevention and social services. Prevention and disease management cannot be achieved in the clinical setting alone or in the community alone. Moreover, a combined approach is required to address the vast disparities in health in the U.S.

John Auerbach, M.P.H., the former Commissioner of Public Health in Massachusetts, shared lessons learned from the **Massachusetts health reform** experience, where community-based prevention was successfully included in a comprehensive legislative package after a lengthy education and negotiation process. Communicating the value of investing in prevention and public health is paramount, and must be done in terms all stakeholders understand. Massachusetts lawmakers found that demonstrating return on investment is the most convincing argument. By speaking the language of health care providers and policy makers, and remaining open to how public health and community-based prevention would fit into health reform, public health advocates were able to establish a Wellness Trust as part of a cost containment bill.

There is growing recognition of the need to engage sectors not only within, but also beyond health care to prevent chronic disease. Each sector has its own culture (including health care and public health), and stakeholders from different sectors speak different languages. Bridging the cultures and languages of the various sectors that impact health (public health, health care and social support services such as housing) is challenging but essential. For collaborations to succeed, partners must be "multi-cultural" and "multi-lingual," and through these connections, build on shared goals

Improving Population Health by Linking and Coordinating at the Individual and Systems Levels

The group next discussed population health models that integrate public health, community-based prevention programs, clinical care and social services, noting that integration occurs at both the individual and systems levels. Regardless of the level of integration, the goal is to ensure that individuals and populations have access to environments that facilitate healthy choices. One important takeaway is that improving health literacy increases the opportunity to engage consumers and activate them to adopt healthier behaviors.

Presenters shared examples of models that help health care providers link patients to community-prevention programs that will promote their health, such as referring a pre-diabetic patient to a Diabetes Prevention Program or connecting an overweight patient with a physical activity program at a church or local YMCA. Increasingly, community health workers are utilized to make these connections.

At the systems level, cross-sector partnerships often develop when diverse stakeholders sit at a community-level table, collaborating to achieve a shared population health outcome. This concept has been termed an "integrator." At the meeting TFAH hosted in 2012, the attributes of an integrator were explored in depth.[2] As noted by one participant, the integrator model is analogous to structures that arose in other industries where fragmentation was an issue, such as community development corporations, workforce investment boards and children's services councils.

In addition to leading the charge on a common goal and convening the relevant stakeholders, integrators often perform critical functions such as data aggregation, analysis and measurement. Increasing pressure to reduce health care costs has spurred local models that aggregate and analyze data to pinpoint "hotspots" – groups of patients that have higher than average health care needs, utilization and/or costs, or geographic areas where there are higher than average risk factors, disease prevalence and/or health care utilization/costs. Identification of hotspots highlights opportunities for partners to effectively coordinate services, resources and/or funds to address an issue. Andrea Hallowell Miller shared the hot-spotting experience of the **Camden Coalition of Health Care Providers**. The Coalition was able to lower health care costs in their area by providing case management support and other care delivery innovations for the highest cost users.

Integrators can work at the systems level to make policy and environmental changes that promote population health. For example, hot-spotting has been used to identify environmental interventions, including removal of allergens such as dust mites or cockroaches in a building where patients are experiencing asthmatic episodes leading to repeated emergency room visits.

Loel Solomon, Ph.D., described **Kaiser Permanente's Total Health,** a socio-ecological model focused on clinical-community integration that has been endorsed by the organization's leaders and Board of Directors. Kaiser participates in numerous community-based collaboratives that connect them to other sectors to work jointly on policy, environmental and systems changes to promote health. For example, they identified lack of access to healthy foods in certain neighborhoods and worked to establish local sources for healthy foods, benefitting all the residents of the area.

One challenge noted by several participants is spreading and scaling these population health initiatives. While solutions differ community by community, it was suggested that variability can be addressed if a systems engineering approach is taken, with leadership being one of the key success factors for all population health models.

Metrics and Accountability Measures Needed to Promote Population Health & Demonstrate a Return on Investment

Peter Long, Ph.D., President and CEO of the **Blue Shield Foundation of California**, reviewed current national initiatives developing population health measures to address the need for a parsimonious, actionable set of core metrics to determine and quantify success. In addition to measuring the population-level outcomes, these metrics should also measure progress toward eliminating health disparities, recognizing that establishing causality is a challenge in measuring population health improvements.

Population health models in Hennepin, Minnesota and Beach Cities Health District, California were discussed in depth. Nancy Garrett, Ph.D., described **Hennepin Health,** which combines clinical and social services within an Accountable Care Organization (ACO) structure. They have found innovative and effective ways to manage high cost users and reduce unnecessary utilization, including a Coordinated Care Center, dental clinic, sobering center, transitional housing and vocational services. Since the model combines health and social services for a Medicaid population, they are able to make cross-sector investments that result in improved health outcomes and reduced costs, such as providing transitional housing to ensure a safe discharge and thus reduce inpatient days. Hennepin Health has cost-reduction goals that can be measured, since the County operates the clinical facilities. In other communities, linking the prevention intervention to outcomes can be challenging, since the provider of the intervention might not be connected to the health care system, and therefore there is no established route for information exchange essential for linking investments to savings. Like the Camden initiative, data analysis is a core function of Hennepin Health; however, they have been challenged by data sharing issues, including patient privacy.

Lisa Santora, M.D., M.P.H., explained that **Beach Cities Health District** began with a workplace wellness program and broadened their scope by adopting a district-wide wellness index to ensure consistent population-level metrics over time. To date they have made progress reducing both obesity and smoking and have been able to estimate a return on investment for each of these initiatives, which helps justify the tax set aside for their wellness program.

The participants discussed the need for a core set of measures of population health and the time is ripe, given the various efforts underway, to define measures for each component of the Triple Aim. The new requirement for non-profit hospitals to conduct Community Health Needs Assessments as part of their community-benefit obligations is an opportunity to engage hospitals in population health measurement. Identifying what should be measured is an important first consideration. As one participant asked, "What do we value in population health – change in risk factors, disease burden and/or perceived health status?"

Aligning data and data sharing are necessary for coordination and integration of activities across various sectors. At the same time, selection and alignment of measures will be complicated by privacy and data sharing challenges, as well as the costs involved.

Financing Mechanisms and Payment Reforms Needed for Sustainability

There is increasing evidence that investments in community-based prevention programs yield savings in health care costs[3]. The lack of integration between the health care, public health and community health systems, however, has been a barrier to measuring and capturing these savings to reinvest them in new or expanded community prevention programs. The Affordable Care Act established new funding streams for both prevention and delivery system innovation[4]. Moreover, as new value-based payment methodologies take hold, there are increasing incentives to invest in community-based primary prevention programs. As a participant said, "We need to create incentives for health care providers based on the health of the population, rather than only the health of their patients."

Like any other system, population health initiatives need both capital and operating investments, described by one participant as payment for infrastructure and payment for performance. John Auerbach explained the two approaches to funding population health in Massachusetts: 1) a dedicated public health funding stream, and 2) health care financing mechanisms. After a presentation by Jim Hester, Ph.D., former Director of the Population Health Models Group at the Centers for Medicare and Medicaid Innovation, various financing ideas were discussed, including:

- *Health Care Financing Mechanisms*: payment for community health workers who connect patients to the community and social supports they need to get and stay healthy, payment for group education visits.
- *Dedication of existing funds*: public health funds; prevention grants; pooling funds from various sources via an integrator; wellness trusts.
- *Non-traditional funding sources*: community-benefit requirements for non-profit hospitals, Community Reinvestment Act; social impact bonds and other venture capital.

Incentives and Challenges to Linking Health Care, Public Health, Community Prevention and Social Services for Population Health Improvement

As with all innovation, there are challenges to sustaining and spreading population health initiatives:

Lack of connection between health care, public health, community prevention and social services.

- Data exchange is complicated between disconnected organizations and sectors.
- Models of integrators that seek to connect the sectors vary greatly, making replication challenging.
- Cultural divide between the sectors—including trust building and bridging different "languages"—needs to be attended to.

The benefits of prevention and population health models are not broadly understood.

- The evidence base for community-based prevention and cross-sector population health initiatives is growing, but not yet widely embraced.
- Savings have not always been measured, particularly across sectors.
- Establishing causality between programs and benefits is a challenge.
- Prevention initiatives often take a long time to demonstrate outcomes.
- The benefits of prevention need to be articulated for each sector.

Payments incentives are not aligned between sectors.

- Health care reimbursement does not currently finance population health. Fee-for-service reimbursement in health care rewards service volume, yet successful population health initiatives can reduce utilization in health care.
- Value-based payment (payment tied to quality and outcomes), which holds greater potential for population health, is still in its infancy.
- Data and metrics are still being developed to document population health improvements.
- The "wrong pocket" issue is complex and will require broad thinking and creativity to solve.

Participants also identified incentives and opportunities that they believe are driving system transformation to include population health outcomes:

- Population health approaches have the potential to improve the health of our nation and reduce health disparities.
- Financing reform is changing the incentives and shifting risk from purchasers to providers of care.
  - Providers are becoming more accountable for population health outcomes.
  - Health care payment is shifting from volume to value-based.
- Delivery reform is forcing/fostering partnerships and provider consolidation (for example, Accountable Care Organizations).
- New federal investments in prevention and innovation are opportunities for initial investment, model development and evaluation (such as the Prevention and Public Health Fund and its Community Transformation Grants and the Centers for Medicare and Medicaid Innovation Health Care Innovation Awards and State Innovation Models).

The group discussed the challenge in balancing short-term savings, as required by public and private payers and funders, with the time necessary to document savings from preventing the onset of chronic conditions. The concept of a "balanced health/ wealth portfolio" for population health emerged, which would include short-term savings from addressing issues faced by heavy utilizers of the health care system, medium-term savings from effectively managing chronic disease and long-term savings from preventing diseases and improving health. Short- and long-term investments have different risks and payouts, and therefore could appeal to different investors.

Population health financing is complex because of the multiple sectors that are involved in the interventions as well as the multiple sectors that accrue the benefits – sometimes lacking a direct "cause and effect" connection. For example, savings from investments in social services that reduce health care costs do not typically pay dividends to the social services sector. Similarly, investments in preventing childhood asthma result in savings to schools and reduced absenteeism for students, as well as the children's parents, producing financial benefits not necessarily captured.

The Centers for Medicare and Medicaid Innovation State Innovation Models and Health Care Innovation Awards provide a current opportunity for testing models to address these issues, though the three year timeframe for showing returns on investment is limiting for community-level primary prevention initiatives which require a longer timeframe to show results. John Weisman, Dr.P.H., M.P.H., and Dorothy Teeter, M.H.A, from **Washington** and Pat Powers, M.P.P.A, from **California** shared their plans for incorporating population health in their **State Innovation Models** and discussed initial thoughts about how it might be financed.

Next Steps

This convening was one in a series that TFAH has hosted to identify policy changes that will accelerate health system reforms to enhance population health integration and initiatives. A number of specific steps emerged from the meeting that can advance the field:

Broaden the discussion and engage more stakeholders through meetings, conferences and by disseminating relevant publications:

- Conduct messaging research and develop a communications strategy to bridge the cultures of the various sectors.
- Engage health stakeholders such as health insurance plans and self-insured companies.
- Engage other sectors, including social services, community development and venture capital. Delineate and demonstrate returns on investments, or at minimum the "co-benefits" that accrue to those sectors.

Create a tool to support efforts to advance population health across the country:i

- Include a review of the evidence-base.
- Document and share models.
- Identify resources from the various efforts to advance the field springing up across the country.
- Provide tools that can help communities engage in population health partnerships.

Conduct additional research and engage in more dialogue on key issues and insights discussed during this convening series:

- Integrator
  - Further define the common attributes of integrators that bring community, clinical, public health and social services together to improve population health.
  - Identify models for coordinating investments.
- Financing
  - Identify financing mechanisms that support both infrastructure and ongoing activities and services.
  - Consider the balance between short- and long-term investments as well as the potential funding sources for each.
  - Grapple with the issue of the timeframe for returns on investment, given the long horizons for returns in prevention. The Centers for Medicare and Medicaid Innovation grants require a return within three years, and the Congressional Budget Office uses a five year timeframe to score proposals.
  - Explore realignment of federal resources to support population health.
- Measurement
  - Engage with organizations, such as the National Quality Forum and the Institutes of Medicine, working to identify population health measures.
  - Explore how to leverage the requirement for non-profit hospitals to conduct Community Health Needs Assessments.
  - Explore regulatory approaches and financing incentives to increase the use of population health measures by new delivery structures such as ACOs.

The window of opportunity is *now* for integrating various prevention initiatives with efforts to reform the health care system. The Trust for America's Health will continue convening experts and thought leaders to identify policy recommendations to advance the field and spread efforts across the country.

Endnotes

[1] National Research Council. *U.S. Health in International Perspective: Shorter Lives,*

[2] http://healthyamericans.org/health-issues/wp-content/uploads/2013/07/10-9-12-Revised-summary_Aug20_convening-FINAL.pdf

[3] New York Academy of Medicine. *Compendium of Proven Community-Based Prevention Programs*. New York, NY. New York Academy of Medicine and Trust for America's Health, 2009. http://www.tfah.org/assets/files/NYAM_Compendium.pdf. (accessed August 12, 2013)

[4] http://healthyamericans.org/health-issues/wp-content/uploads/2013/05/Prevention-fund-strategic-investments.pdf and http://innovation.cms.gov/initiatives/index.html#views=models