Robert Wood Johnson Foundation

nrhi Network for Regional Healthcare Improvement

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Striving Toward A Culture Of Health: How Do Care And Costs For Non-Medical Needs Get Factored Into Alternative Payment Models?

Workshop Summary & Lessons Learned

January 26 - 27, 2017
Austin, TX

Under the Auspices of: Payment Reform for Population Health Initiative
Conducted by: AcademyHealth & Network for Regional Healthcare Improvement
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To learn more about the Payment Reform for Population Health initiative, visit www.academyhealth.org/p4ph

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Introduction

Addressing the Social Determinants of Health Through Payment Reform

In a time of significant health care transformation, many health insurers and health care providers are moving toward payment models based on the quality of care delivered in an effort to attain the Triple Aim of better care, smarter spending, and healthier people. Right now, most of these value-based payment models focus on clinical services and, more specifically, the needs and outcomes of a health care provider's patient panel, a health plan's enrollees, or the purchaser's employee subscribers. Still other payment models focus on a targeted sub-population of individuals with a defined chronic clinical condition, such as patients with diabetes or depression.

As such, payment and financing models are not yet adequately supporting *community-wide*, geographically-based, population health (see side box). The incentives in these models do not yet reward health care providers for creating healthy communities, nor do they incentivize other sectors—e,g., transportation, housing, education—contributing to population health improvements.

As health care organizations continue to move along the continuum of paying for value, not volume, a pressing question is: how might the cost of non-medical support services be factored into alternative payment models to advance population health? How might those non-medical support services impact the overall quality and cost of health in communities? And what are the barriers to progress facing communities?

With support from the Robert Wood Johnson Foundation, AcademyHealth's Payment Reform for Population Health (P4PH) initiative aims to develop a comprehensive understanding of current efforts and successes related to payment reform activities that support community-wide population health improvement. To inform this effort, AcademyHealth collaborated with the Network for Regional Healthcare Improvement (NRHI) to explore challenges and successes related to how health care purchasers, plans, and providers could support strategies for sustainable investment in non-clinical community-wide population health activities.

On January 26-27, 2017, AcademyHealth and NRHI hosted a two-day, highly interactive workshop called "Striving Toward a Culture of Health: How Does Care and Costs for Non-Medical Needs Get Factored into Alternative Payment Models?" This workshop convened five multi-sector teams led by regional health improvement collaboratives (RHICs) to foster shared learning with each other as well as content experts to inform next steps in their own specific community-based collaborative projects. The workshop focused on four key topic areas and the related barriers that potentially influence the conditions and collaborations necessary to support non-clinical community-wide population health services.

This report reflects the discussions had by participants, their shared experiences with the topics and with each other, and the common barriers and facilitators identified in pursuing collaborative community-based population health interventions.

Defining Health

Population Health

"Health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart, 2003)

Determinants of Health

- 10% Physical Environment
  - Environmental Quality
  - Built Environment
- 20% Health Care
  - Access to Care
  - Quality of Care
- 30% Health Behaviors
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Unsafe Sex
- 40% Socioeconomic Factors
  - Education
  - Employment
  - Income
  - Social Support
  - Community Safety

Source: County Health Rankings, Population Health Institute, University of Wisconsin-Madison.

What is the Opportunity Facing Communities?

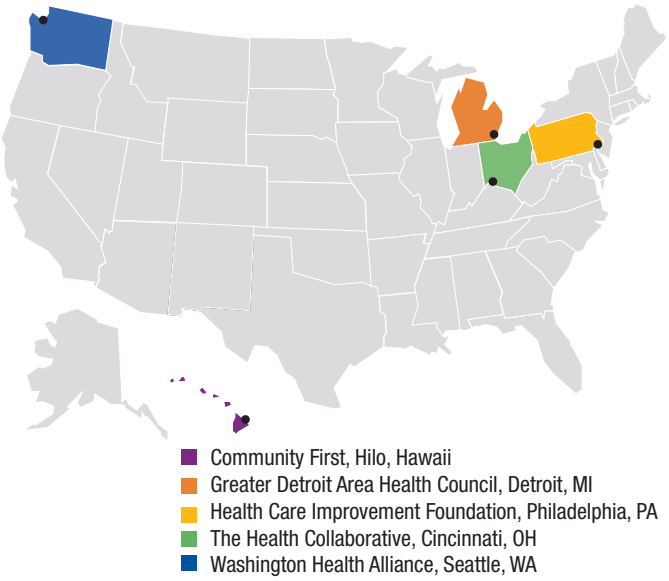
Elizabeth Mitchell, President and CEO of the Network for Regional Healthcare Improvement (NRHI), described the problems we are currently facing in health care and the role of financial incentives. We are, in fact, getting what we are paying for—high volume and high priced services that are not achieving health. To change this incentive structure we will need to change our thinking and our payment systems and align across communities and sectors to promote health.

"In the current system, no one gets paid if people stay healthy. We cannot bring down costs until we restructure the payments and incentives to reward health."

The rising cost of health care is a growing threat for families, employers, government, and the U.S. economy. The money going to health care is coming from investments in what could promote better health. Ten years of U.S. wage growth has been lost to health care cost increases and more families are losing their discretionary incomes for housing, food and recreation to out-of-pocket health care expenses. Though the national debate has focused largely on insurance coverage and access, recognition is growing that coverage will not be affordable unless health care is affordable. And keeping people healthy will require redirecting our investment outside of the health care system. Savings from health care could be reallocated upstream to pay for non-medical support services to advance health.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed with bipartisan support and promises to fundamentally change the way the United State evaluates and pays for health care. It includes specific provisions to help build community-wide payment models, creates the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to vet alternative payment models (APMs) from the field, and encourages aligned multi-payer approaches. To the extent MACRA creates incentives for the health care system to become accountable for cost and outcomes, ***it creates an opportunity to change payment systems to promote health.*** To achieve population health, we will need to seek out new community partners, relationships, and care models.

Participating Regional Health Care Improvement Collaboratives (RHICs)



The Network for Regional Healthcare Improvement (NRHI) is a network comprising more than 30 regional health improvement collaboratives (RHICs) and three state-affiliated partners. RHICs are non-profit, multi-stakeholder organizations working in regions and collaborating across regions to transform the health care delivery system and achieve the Triple Aim.

The RHICs are accomplishing this transformation by working directly with physicians and other health care providers, provider organizations, commercial and government payers, employers, consumers, and other health care related organizations.

Teams from five communities were invited to attend the workshop and participate in interactive sessions focusing on issues related to addressing non-clinical needs within the health care payment system. With representation from diverse communities spanning the country, these five teams worked together closely, sharing experiences and grappling with tough questions. A description of each community's project is below:

- Community First in **Hilo, HI** is developing a new payment model for emergency department (ED) services that includes a "retainer" to help cover fixed costs while reducing per visit fees, thereby eliminating incentives to provide more ED visits than appropriate. Coupled with this approach is the development of a medical home for high-needs/high-cost patients to link them to food, shelter, home health supports, and transportation, as needed.

- The Healthcare Improvement Foundation in **Philadelphia, PA** will incorporate a tool to help identify patients with food insecurity and test interventions to improve access and referrals to community resources, programs, and services. The team will consider how to incorporate related costs for non-medical needs into payment models.
- **Washington State's** Washington Health Alliance will focus on the connection between stable housing, health, and health care. While this effort is currently part of Washington's §1115 Medicaid waiver, the team is exploring scenarios related to governance, decision-making, and funding that is not dependent on state or federal funds.
- With **Cincinnati, OH** being one of the Comprehensive Primary Care Plus sites, the Health Collaborative will focus on how to connect hospitals and primary care providers to community-based resources as they address social support needs. The team is considering various strategies for payment reform.
- The Greater Detroit Area Health Council of **Detroit, MI** will focus on aligning health sector services, programs, activities, and community development sector investments. Under this project, leveraging health system and banking industry obligations related to community investment will be a critical component of a financing approach.

Cross-Sector Collaboration

Trusted Convener and Governance

This session, led by Jane Brock and Elizabeth Mitchell, discussed collaboration across sectors and the **role of a trusted convener and its governance structure** in effectively managing a collaborative community partnership focused on population health interventions.

A community-wide population health intervention's success can hinge on the strength of the multi-sector partnership and its structure. A trusted convening organization, represented by diverse community partners from social services, health care, and public health sectors, can be a catalyst— helping to identify and align interests and foster investment in community population health interventions. A trusted convener, agreed upon by community partners to serve as the organizing entity, can foster relationship-building and facilitate the management of a community-wide population health intervention.

If structured appropriately, it can serve to ensure equitable and productive participation among multi-sector partners. However, inequitable power dynamics can lead to mistrust and misaligned interests. This mistrust can further challenge the task of building a multi-sector partnership and establishing a governance structure, which can all contribute to ultimately unsuccessful collaborations.

Many questions arose among participants when considering the role of a trusted convener and establishing a governance structure. Two primary components were identified when describing the role of a trusted convener:

- Organizational issues (e.g., identifying partners, decision-making approach)
- Structural issues (e.g., management structure, key functions)

Health care systems and community social service organization participants cited an interest in understanding best practices for establishing a trusted convener and governance structure that can ensure equitable and productive participation among partners across sectors.

Key Barriers

There are several critical components that, if not recognized and addressed, could limit the effectiveness of the trusted convener and undermine the success of the collaborative's intervention. Understanding who or what the "right" convener for the community—based on the landscape and health care market—is a critical first step for success. The convener must also be adept at reconciling the tension between work on governance and work on interventions. This means being able to differentiate and equally support both organizational efforts of the convener itself and efforts to address and implement the intervention the convener coordinates. Another persistent challenge is identifying sustainable financing for the convener and the interventions. Many efforts supported by grants or other unsustainable financing sources run the risk of losing support if the grant is not renewed or funding priorities change. Finally, determining the needs of the convener's internal workforce capacity (e.g., staffing and analytic capabilities), and establishing accountability and transparency (i.e., decision-making approach, value proposition, etc.) are critical components for the success of the trusted convener.

Understanding the Issues: Trusted Convener

Organizational

- How are all multi-sector community partners identified?
- How much time and energy should be spent on establishing governance?
- How are collective decisions made?
- How to come to agreement across partners who may have different expectations?

Structural

- Who is the entity? How is that entity selected?
- What is the management structure?
- What internal workforce capacity is needed?

Session Learnings

During this discussion, participants shared the following lessons:

- Recognize all partners' diverse viewpoints/perspectives, regardless of respective power.
- Identify common interests.
- Build trust in each other and the convener.
- Find and foster a community voice/ownership of the efforts.
- Exhibit adaptive leadership qualities.
- Utilize community organizing principles.
- Demonstrate effective communication practices.
- Separate form (i.e., who is the convener) from function (i.e., what the convener does).

Small Group Discussions

On Day Two of the workshop, each collaborative RHIC team had an opportunity to meet with each of the topic-based experts to address specific issues with respect to convening a partnership and designing and/or implementing their payment reform effort. The following are examples of such challenges and approaches to solutions regarding cross-sector collaboration and governance.

Community First – Hilo, HI

Community First began the session by reviewing their strengths (e.g., established community consensus, identified community champion, and leaders from multi-sector partners to ensure collective buy-in and a singular, unified voice). They then identified challenges and outlined tasks to address those needs.

- **Challenge:** Community First recognized there were gaps in partners (i.e., emergency medical services [EMS]) that can assist in addressing needs of returning ED patients that are lacking a physician.

– ***Solution*:** Engage EMS and paramedicine team of providers that make interim follow-up visits to frequent fliers (i.e., frequent EMS users that are identified as potentially avoidable ED users).

- **Challenge:** Community First could list off all the partners that they have received "buy-in" from, but there was no established structure that identified partner leads and roles they could share when speaking with potential new partners, including the community at large and state agencies.

– ***Solution*:** Create a governance organization chart.

- **Challenge:** Community First recognized a need for broad understanding and education on the value of addressing social determinants of health, the negative impact of the unmet non-medical needs on the community and potential opportunities to treat these unmet needs through a PCMH clinic on the campus of their community's sole medical center.

– ***Solution*:** Develop a shared understanding through on-going collaborative meetings, and creation of a "business case" (i.e., cost-benefit) document that outlines the data on frequent ED users without primary physician, hospital revenue loss, and calculated savings in the creation of the primary care clinic.

The Health Care Improvement Foundation (HCIF) – Philadelphia, PA

- **Challenge:** HCIF discussed a number of workgroups and opportunities related to this effort resulting in an overlap of initiatives—several team members raised the issue that many non-profits and community-based organizations are participating in similar workgroups formed by the city public health department or stakeholders responding to federal and state funding opportunities (often made up of the same individuals) to work on these same issues.

– ***Solution*:** Together, the team noted it would be useful to "plug into" and align with community-based workgroups and committees working on similar issues in order to streamline efforts.

- **Challenge:** While HCIF noted the significant progress made to get key players in the community to engage in this planning process and agree to implement components of the intervention, team members noted the continued need to "make the case" to their internal leadership and also remind themselves of the overarching purpose of this project.

– ***Solution*:** Drawing on her experiences with the techniques of community organizing, this session's facilitator, Dr. Jane Brock, suggested that team members work on crafting a personal narrative that can be used to explain to both internal and external stakeholders the connection and reason they are engaging in this work.

Greater Detroit Area Health Council (GDAHC) – Detroit, MI

- **Challenge:** Members of the GDAHC RHIC discussed several issues related to an existing Convergence Workgroup (CWG), including the decreasing energy and accountability among workgroup members.

– ***Solution*:** Continue to promote and build on the Alignment for Health Equity and Development (AHEAD) platform whereby stakeholders who historically compete with each other for isolated grants come together and work collaboratively.

– ***Solution*:** Formalize structures and roles among Workgroup members to increase accountability and reenergize the mission and vision of the group.

Metrics, Data and Evidence

Measuring, Sharing, and Building Infrastructure

In this session, Aaron Truchill and Jonathan Mathieu prompted workshop participants with the following question:

What must be considered when addressing the data and population metrics needed by organizations seeking to support improvements in population health?

The need to support sufficient data infrastructure across health care systems and community social service providers is an important step in measuring and improving population health. Health care systems have shown increasing interest in investing in non-clinical population health supports, with some systems (i.e., health care delivery systems and health plans) developing partnerships with social service providers in their communities (e.g., collaborations with local housing authorities, homeless shelters, food banks, and employment centers, among others). Others recognize the importance, but have yet to test the waters. No matter their place along the spectrum, health care systems face certain barriers as they strive to measure, evaluate, and improve upon these joint efforts to improve population health.

Recognizing the importance of data in their collaborative efforts, health care systems and community social service organizations cited an interest in understanding best practices for establishing, governing, and evaluating successful data-sharing partnerships across sectors.

Key Barriers

Data Measures

Data collection and analysis efforts within the health care system often focus solely on measures of cost and utilization rather than social determinants of health, making it difficult to identify population needs and measure progress. Clinical-community collaborations need to supplement administrative and clinical data with non-clinical data to provide a rich illustration of a person's needs and to better understand the health of a community.

Understanding the Issues: Metrics, Data and Evidence

- How should health care systems and community social service providers begin the process of collecting, sharing, and analyzing data?
- What are the key components of a successful data-sharing partnership?
- What entity is the most suitable to receive, analyze, house and report out data/information?
- What problems are communities trying to solve using the data?
- When should organizations "build versus buy" their own tools and platforms for data integration?

Data Sharing

Health care systems and their community-based partners often hesitate to share data across sectors due to lack of trust, and tend to lack common data definitions for specific measures which limits collaboration opportunities. They also face technical interoperability as well as legal/privacy challenges when attempting to integrate data sets such as electronic health records and claims data, which collectively limits the ability to share, integrate, and analyze data for a common purpose.

Data Infrastructure

Health care systems and their community-based partners often lack the financial resources necessary to make investments in the health information technology and workforce needed to build and maintain collaborative data efforts. In addition, they can be resistant to being the primary investor in these efforts and assuming the majority of the costs. There is also frequently a knowledge gap regarding the selection of adequate data-sharing platforms to support collaborative efforts.

Session Learnings

During this discussion, participants shared the following lessons:

- Ground efforts to collect and use data within a shared understanding across partners of what fundamental goals all are trying to achieve and why.
- Use available data as an acceptable starting point in order to set the stage for larger-scale projects (e.g., if you have claims data, start with that; if you have clinical data, start with that).

- Stay pragmatic and realistic when establishing expectations between partners.
- Identify the most effective data platform for collective use that includes key elements such as identity management between partners, a shared set of data definitions, and a user-friendly interface.
- Establish a governance process for data collection, sharing, and analysis between partners.
- Identify a target population that lends to short-term results (i.e., low-hanging fruit) in order to build momentum.

Small Group Discussions

On Day Two of the workshop, each collaborative RHIC team had an opportunity to meet with each of the topic-based experts to address specific issues with respect to convening a partnership and designing and/or implementing their payment reform effort. The following are examples of such challenges and approaches to solutions regarding data and metrics.

Community First – Hilo, HI

In partnership with Community First, the Hilo Medical Center provided assistance with data analytics, helping to identify the top 200 emergency department super-utilizers, which formed the initial target population for their primary care medical home (PCMH) intervention.

- **Challenge:** Community First wished to understand which data metrics are the most relevant to demonstrate the intervention's effectiveness and how best to design an evaluation.

– ***Solution*:** Start simple.

  - Consider a pilot of 20 patients to look at the different characteristics.
  - Create two to three graphs that easily illustrate a compelling reason for targeting identified group. Avoid being overwhelmed by expensive software systems; a spreadsheet can generally suffice in the beginning.

Washington Health Alliance – Seattle, WA

- **Challenge:** The Washington team acknowledged the importance of having adequate data to better understand causes of their housing issues and determine capacity before they can move toward developing clinical-community integration solutions. Many sources of housing data are currently being collected and the group agreed to focus on leveraging current measures and collected data sets.

– ***Solution*:** The following next steps were proposed:

  - Identify the current program measures from all sources (i.e., identify list of all measures collected from all relevant sectors and determine if avoidable hospital admissions or inappropriate avoidable Emergency Department visits is a better measure);
  - Inventory the available data sources (e.g., housing data currently being collected by the county, Regional Health Needs Inventory, Department of Corrections, Continuum of Care programs [COCs], Accountable Communities of Health, hospital emergency rooms, mandatory and voluntary All-Payer Claims Databases [APCDs], clinical data repositories); and
  - Assess current measures and match to goals (i.e., take the "single person" approach to evaluate the value of measurement, determine related incentives for each stakeholder group, and identify any Housing and Urban Development [HUD] rules that may interfere with proposed solutions).

The Health Care Improvement Foundation – Philadelphia, PA

During the discussion, HCIF recognized the importance of data in all aspects of the project, including the screening, referral, and evaluation process. Use of data and information systems for the referral component of the intervention (i.e., the connection and referral of an individual who has been identified as food-insecure to community-based food resources like a food pantry) rose to the top as a key issue among the team members:

- **Challenge**: HCIF team members discussed how to leverage the multiple referral systems that already exist in the Philadelphia area. Several members noted it may be useful to build upon a system like the United Way's 2-1-1, or tools such as Healthify, to connect individuals with the appropriate resources. In addition to selecting a referral system, the task of maintaining and ensuring a "closed loop" (i.e., verifying that an individual received food assistance), and monitoring the overall quality of the resource were also important factors to consider.

  – ***Solution***: Evaluate the potential utility in building from the existing 2-1-1 system versus exploring alternative systems such as those used by session facilitators Aaron Truchil and Jonathan Mathieu.

Care Delivery Requirements and Incentives

Transforming Care Delivery

This session, led by Lisa Dulsky Watkins was framed around lessons learned in the last decade from transforming care delivery in Vermont, particularly in primary care, and spurred discussion on how that care delivery model could be expanded and supported to connect non-clinical community services into those clinically-focused models. Watkins posed two essential questions that RHICs should tackle as multi-sector teams in terms of redesigning how care is delivered:

1. How do you collect and present data that are credible, demonstrative and easily digestible by funders?

2. What type of enhanced mechanism for communication should be employed in order to achieve this?

Workshop participants discussed many issues that should be considered by collaborative partners when addressing multi-sector clinical and non-clinical care delivery integration. Establishing mutual understanding of how care is currently delivered among partners in a community – as well as who the key providers are – was integral to the conversation.

Key Barriers

Accountability is an incredibly important factor to consider in care delivery integration. The issue of how/should health care providers be held responsible for outcomes outside of their clinical control is a challenging one. It is critical for collaborating partners to recognize and appreciate the power dynamics that affect the success of the collaborative relationships, as they can serve as both negative and positive factors. It is also important to bring and consistently keep everyone at the table to ensure the community voice is recognized. Finally, the importance of community-based organizations and social service providers understanding if they can meet needed capacity resulting from increased referrals to address newly identified gaps and patient needs cannot be understated. To be successful, they must always ask the basic question: Is the quality of the services being delivered sufficient?

Understanding the Issues: Care Delivery Integration

- Need to understand how health care and social services currently are delivered among the partners/ community– who are the key providers?
- What are the key care delivery interventions?
- How can social services be integrated and coordinated?
- How can you ensure the quality/capacity of social services?
- What are the desired shared outcomes/goals?
- Should social services organizations be financially at risk for performance?

Session Learnings

During this discussion, participants shared the following lessons:

- Start small. Identify practical interventions and data collection activities to build trust and demonstrate proof of concept to those participating in the collaborative.
- Invest in the planning process by equally involving health care and non-health care sector decision makers. Start with agreement on where to focus.
- Continue ongoing engagement to ensure commitment and leadership of collaborative partners.
- Ensure data collection and analysis is credible for the intervention's proof of concept by making it straightforward and consistent.
- Collaborative partners should coordinate related programs to make use of existing data tools, which can create momentum.
- Use social determinants of health screeners to link individual needs with community services.
- Involve all collaborating partners in key decision-making.
- Engage all payers to ensure care coordination is a "utility" for total community (i.e., limit "free riders").

Small Group Discussions

On Day Two of the workshop, each collaborative RHIC team had an opportunity to meet with each of the topic-based experts to address specific issues with respect to convening a partnership and designing and/or implementing their payment reform effort. The following are examples of such challenges and approaches to solutions regarding care delivery transformation.

Community First – Hilo, HI

Community First has broad community buy-in across the health care and non-health care sectors, including the sole hospital, the largest physician group, the dominant health plan, the State Medicaid director, and community-based social service organizations. They also have a strong "community champion" to help build trust in a community where medical providers have a history of miscommunication and "baggage" from the past.

- **Challenge:** Community First noted that care models across health plans must be aligned, but there needs to be a collective understanding about who is designing the models. Functional data integration across systems is needed to allow social service organizations, such as the local aging agency, to easily identify the "jurisdiction" of the patient and prevent duplication of services.

– ***Solution*:** Unite the payers at the table and find consensus on coordinating care coordination. Also, engage housing and aging agencies to address data integration issues and facilitate data sharing.

Greater Detroit Area Health Council (GDAHC) – Detroit, MI

- **Challenge:** In discussing the AHEAD project, members noted that a continuous challenge of the project is to build a healthy community that benefits the people in culturally competent ways and address the fact that creating and sustaining healthier habits is difficult in communities that lack social services needed to support and improve health.

– ***Solution*:** GDAC found it difficult to collectively apply for community improvement and development grants that acknowledge cultural competency, empower people in the neighborhood, and utilize their members to implement them.

- **Challenge:** GDAC found it difficult to coalesce around areas of greatest need to deploy limited resources efficiently and effectively.

– ***Solution*:** Create inventories of programs and services of health care, community development, and organizations currently active in the neighborhood(s).

  - Demonstrate ways these organizations can better align their programs, services, expertise, and other resources to improve community health and development.
  - Identify priorities, drawing upon the synergy of the alignments achieved, that may become a common focus of the aligned partners.
  - Identify metrics, collect data and report.

– ***Solution***: Use AHEAD as a case study on ways to collaborate successfully on population health.

Payment and Financing

Value-Based Payment and Population Health

Concluding Day One of the workshop, Tricia McGinnis led participants in discussing the many issues related to the payment and financing of non-clinical population health interventions. Payment and financing is a substantial barrier that greatly influences a health care system's consideration to invest in non-clinical population health. While health care systems recognize the value of providing wrap-around social support services that can benefit their patients, beneficiaries and community's overall well-being, these health plans and providers are uncertain how to use the payment system to support such linkages.

At this workshop, health care systems and community-based organizations expressed an interest in understanding how to sustainably finance non-clinical interventions using health care resources as well as how to fund the trusted convener tasked with facilitating the community-wide effort. In addition, participants wished to learn how each partner in the collaboration could share in potential savings based on their proportionate investment/role in the intervention.

Key Barriers

Participants expressed and discussed at length several barriers relating to payment and financing. For example, the need for analyses of promising upstream investments with short-term return-on-investment (ROI), understanding how systems can reconcile up-front investments with longer-term ROI, as well as the need to differentiate (and appreciate distinction) between financial ROI and "social" ROI were all cited as major barriers. Again, the issue of accountability comes into play, specifically the need to understand how to measure accountability based on providing services to individuals (e.g., *screening for* and *coordinating of* social services) vs. outcomes for community-wide populations. There is also the need to identify *who* and *how* much should be paid for *what* action/outcomes, such as exploring shared-risk models between health care sector and non-health care sector partners. Affected parties must be educated about and understand how alternative payment models actually determine payment for the rendered service, as well as how savings generated from population health investments might be recaptured in order to support a continuous cycle of reinvestment that sustains these interventions.

Understanding the Issues: Payment and Financing

- How can payment for community investments be appropriately linked to outcomes measures? Can health care organizations be held responsible for individuals and activities outside its four walls?
- How can the payments flow between health care systems and social service organizations?
- How can communities determine how much funding should/ can be shifted from clinical services to social services?
- How will the intervention be sustainably funded? What source of funds will be used?
- How can health systems differentiate between/ align financing coming from core operational dollars, community benefit dollars, and premium/ provider reimbursement dollars?
- What level of evidence is "sufficient" to demonstrate the value proposition of funding both the trusted convener and intervention(s)?

Session Learnings

During this discussion, participants shared the following lessons:

- Leverage and align existing payment models and measures as a starting point when exploring a population health intervention.
- Identify those payment models that best serve the collective partners' needs and capacities.
- Recognize other funding sources may be collectively aligned and used (i.e., funding from multiple sectors; other types of funding from the health care sector like community benefit dollars).
- Explore innovative Medicaid financing changes currently under consideration/development that could support these efforts.
- Start small, but be sure to use evidence from pilot programs to provide support and scale up the intervention. It is valuable to:
  - Identify and prioritize the few population health interventions that offer positive ROI;
  - Use existing data and basic analyses to begin; and
  - Include qualitative data and storytelling to illustrate the value in reinvestment and rebalancing of funds.

Small Group Discussions

On Day Two of the workshop, each collaborative RHIC team had an opportunity to meet with each of the topic-based experts to address specific issues with respect to convening a partnership and designing and/or implementing their payment reform effort. The following are examples of such challenges and approaches to solutions regarding payment and financing.

The Health Care Improvement Foundation – Philadelphia, PA
HCIF recognized the importance of planning for long-term sustainability of the intervention within the health care system and supporting community resources. The team discussed that, at this point, many health systems involved in this intervention are contributing the staff resources needed for the screening process on a pro bono basis because of the importance of the initiative.

- **Challenge:** Health care systems and other partners are interested in ways to reimburse or find sustainable funding for the time staff spend screening and referring patients to food resources within the community.

– ***Solution*:** While no immediate solutions were presented, the team noted this would be an important consideration moving forward.

Community First – Hilo, HI
Community First has upfront financial commitments from both the Hilo Medical Center in building the PCMH, and their largest local health care plan, HMSA, in providing data and committing to design alternate payment models.

- **Challenge:** Community First has gaps in funds for ongoing PCMH operations.

  – ***Solution*:** Explore Hawaii Medicaid's interest in implementing a Health Homes program (Section 2703) that would allow Medicaid managed care organizations to leverage a two-year enhanced payment to providers for comprehensive care management and for connecting patients with multiple chronic conditions to social determinants of health resources.

    - Leverage other federal funding opportunities, such as the Centers for Medicare and Medicaid Services' (CMS) Comprehensive Primary Care Plus (CPC+) advanced PCMH model program.
    - Explore acceptable return-on-investment (ROI) analyses (i.e., measurement and timeframe) to help with the business case needed to rationalize ongoing funding.

The Health Collaborative – Cincinnati, OH
The Health Collaborative has an established history as the community's health system data management, quality improvement, and analytic hub, making it well-positioned to help implement system-wide social determinants of health (SDH) screening tools, develop a closed-loop referral system, and aggregate several cost and quality data elements across the partners.

- **Challenge**: Residing in a competitive health care market, The Health Collaborative recognizes the likelihood of overlapping initiatives and opportunity to align interventions.

  – ***Solution*:** Leverage existing community initiatives and federal innovation programs, such as CPC+, and the Innovation Center's Accountable Health Communities (AHC) model. (NOTE: at the time of the workshop, The Health Collaborative had applied to be an AHC; subsequently, they have been notified of award).

    - Explore ability to enter risk-bearing contracts between payers and social service organizations.
    - Scale down project to more readily achieve short-term realistic goals.

Washington Health Alliance – Seattle, WA

- **Challenge:** Although Washington has received a Medicaid §1115 waiver, they wish to access other sources of funding to ensure downstream payments to those responsible for changing behavior.

– ***Solution*:** The group began to create an inventory of all possible funding sources for housing. From that list they determined the additional information that is needed including: what is needed to address the housing issues; how much money will it take; how is the funding currently being used; and are there any constraints with the funding available. This knowledge will help enable identification of gaps and possible ways to leverage dollars. The following housing funding sources were identified:

  – Recording Fees, Medicaid Waiver, County, Coordinated Care Organizations (CCOs), United Way, Community Service Block Grants, Charge Grants, Development & Disability, Mental Health Mileage, AAA, Public Health, Community Action, Catholic Family Charities and PAC team.

Conclusion

In exploring the challenges and barriers related to how health care purchasers, plans, and providers could support strategies for sustainable investment in non-clinical community-wide population health activities, this workshop succeeded. Participating community teams received guidance and encouragement from faculty members and, more importantly, from peers to continue this work. Participants benefitted from a sense of shared-learning and worthwhile investment, as well as sharpened skills and enhanced knowledge to apply in their own community interventions.

The Payment Reform for Population Health (P4PH) initiative, through technical assistance support by NRHI, will continue to provide follow-up to the five RHICs that participated in this workshop as well as the HealthDoers online community (https://healthdoers.org) via a series of virtual engagement events. These events will relate to the four main topics addressed throughout the workshop and provide opportunities for additional key stakeholders to engage with these ideas, best practices, and innovations.

Workshop Participants

FACULTY MEMBERS

Jane Brock
Chief Medical Officer and Clinical Coordinator
Colorado Foundation for Medical Care (CFMC)

Jane Brock, M.D., M.S.P.H, is a medical director at Telligen, the Medicare Quality Improvement Innovation-Quality Improvement Organization (QIN-QIO) for Colorado. She is currently the medical director of the CMS QIO 11th Statement of Work for the National Coordinating Center (NCC). The NCC provides leadership and support to the QIN-QIOs in all their various initiatives including the reduction of unwanted hospital readmissions. Dr. Brock has provided clinical and quality improvement expertise in all care settings to a variety of CMS-funded projects. From 2008 – 2011, She served as the medical director of a 14-state QIO initiative to improve care transitions by improving information transfer between health care providers and patients, developing consistent workflow processes and increasing patient activation and satisfaction. This body of work has expanded into numerous QIN-QIO and other national initiatives aiming to improve the effectiveness and efficiency of care delivery through collective community action, integrating the efforts of medical service providers, community health support agencies and consumers/patients. Dr. Brock spent 18 years as a general practice physician and assistant director of the urgent care department at the Boulder Medical Center, and provided occupational medical services as the medical director of the medical department of a Lexmark printer manufacturing facility.

Jonathan Mathieu
Vice President for Research and Compliance
Center for Improving Value in Health Care

Jonathan Mathieu, Ph.D., currently serves as Vice President for Research & Compliance and Chief Economist at the Center for Improving Value in Health Care (CIVHC) in Colorado. In this capacity, he is responsible for managing research activities related to CIVHC's strategic initiatives and ensuring compliance with applicable privacy, security and anti-trust laws and regulations. Prior to joining CIVHC, Dr. Mathieu served as an economist at the Food and Drug Administration and was also employed as an Assistant Professor of Public Policy at Georgetown University. Dr. Mathieu holds M.A. and Ph.D. degrees in Economics from the University of Colorado, and a B.S. in Applied Mathematical Economics from Oswego State University.

Tricia McGinnis
Vice President of Programs
Center for Health Care Strategies

Tricia McGinnis, M.P.P., M.P.H., is Vice President of Programs at the Center for Health Care Strategies (CHCS). In this role, she helps guide CHCS's program development and leads initiatives to transform how care is paid for and delivered to improve the quality and reduce the cost of care received by Medicaid beneficiaries. Within this portfolio, Ms. McGinnis oversees a wide range of projects working directly with state Medicaid agencies, health plans, and providers to advance value-based payment models. Her team leads the organization's technical assistance to 38 states awarded the CMMI State Innovation Models (SIM) grants. She directs CHCS's multi-pronged efforts to advance Accountable Care Organizations (ACOs) in Medicaid programs. She also supports initiatives to promote greater linkages between population health and payment reform, including Medicaid participation in CDC's 6/18 Initiative; deliver technical assistance and tools that promote value-based purchasing in Medicaid; and address the social determinants of health. Prior to joining CHCS, Ms. McGinnis managed the provider performance measurement, improvement, and transparency program as a senior program manager at Blue Shield of California. Ms. McGinnis holds master's degrees in public policy and public health from the University of California, Berkeley. She received a bachelor of arts in political science and economics from Kenyon College.

Elizabeth Mitchell
President/CEO
Network for Regional Healthcare Improvement

Elizabeth Mitchell serves as President & CEO of the Network for Regional Healthcare Improvement, a national network of multi-stakeholder Regional Health Improvement Collaboratives with over 35 members across the U.S. She is the Vice Chair of the Physician Focused Payment Technical Advisory Committee, a Guiding Committee Member of the Health Care Payment Learning and Action Network (LAN), and on the Quality Improvement Strategy (QIS) Technical Expert Panel (TEP). Prior to leading NRHI, she was the CEO of the Maine Health Management Coalition, an employer-led, multi-stakeholder regional collaborative working to improve the value of healthcare in Maine. Ms. Mitchell led the Coalition's performance measurement and public reporting program, and its strategy for engaging the public in the use of cost and quality information. While at the Coalition, she led many multi-stakeholder payment reform and healthcare system redesign efforts, established the Coalition's Data and Analytics program with a multi-payer claims database and was the nation's 4th designee in CMS's Qualified Entity Certification Program. Ms. Mitchell was integral to the development of Maine's successful State Innovation Model (SIM) grant in which the Coalition was named as the State's 'Implementation Partner.'

Ms. Mitchell served on the Board and Executive Committee of the National Quality Forum (NQF). She was a member of the Institute of Medicine's Consensus Committee on Core Metrics for Better Care and Lower Costs, and chaired this committee's Implementation Task Force. She served for several years on the Board of the National Business Coalition on Health and was the Chair of its Government Affairs Committee, and Vice-Chair and Chair of the Board of NRHI. Prior to being appointed CEO of the Maine Health Management Coalition, Ms. Mitchell worked for MaineHealth, Maine's largest integrated health system where she worked with employers and led several transparency and quality improvement efforts. She served two terms representing Portland in the Maine State Legislature, and chaired the Health and Human Services Committee. Ms. Mitchell has held posts at the National Academy for State Health Policy, and London's Nuffield Trust. She was selected for an Atlantic Fellowship in Public Policy by the Commonwealth Fund and the British Council. While in the UK, she completed the International Health Leadership Program at Cambridge University's Judge School of Management, while pursuing graduate studies at the London School of Economics.

Aaron Truchil
Director, Strategy and Analytics
Camden Coalition of Healthcare Providers

Aaron Truchil, M.S., serves as the Director for Strategy & Analytics at the Camden Coalition, where he oversees the organization's applied data and research activities, including an integrated data system of health and social service data and applied population health research initiatives aimed developing an evidence base around community-based care and value-based care. Mr. Truchil's interests revolve around the intersection of data to promote greater transparency, more-informed decision-making, and more compassionate social policy. Prior to joining the Coalition, he worked as a Program Manager for CamConnect, a non-profit data warehouse in Camden that analyzes and reports on data on the City of Camden's revitalization. Mr. Truchil earned a Masters of Science in Social Policy from the University of Pennsylvania and a Bachelor of Arts from Wesleyan University.

Lisa Dulsky Watkins
Director, Multi-State Collaborative
Milbank Memorial Fund

Lisa Dulsky Watkins, M.D., is the Director of the Milbank Memorial Fund Multi-State Collaborative (MC), a consortium of 22 state and regional multi payer primary care transformation programs. She is actively engaged in advocacy for new and continued support for these efforts and other innovations at the state and federal levels, specifically with the Innovation Center of the Centers for Medicare and Medicaid Services. The work of the MC is now focused chiefly on the Comprehensive Primary Care Plus program, the largest primary care transformation program ever introduced in the US. She is the former Chief of Operations for the Vermont Blueprint for Health, an early and successful state-wide health system reform program. She developed and led a multi-state learning collaborative for the National Academy for State Health Policy. Dr. Dulsky Watkins received her M.D. from the Perelman School of Medicine at the University of Pennsylvania and her B.S. from the City College of New York. She completed her internship and residency in Pediatrics at the University of Vermont College of Medicine and was in primary care practice as a board-certified pediatrician in Middlebury and Essex Junction, Vermont.

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