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Striving Toward a Culture of Health: How Regional Collaboratives Can Advance Funding and Financing to Improve Population Health

With support from the Robert Wood Johnson Foundation, AcademyHealth launched the Payment Reform for Population Health initiative in 2016 to explore improving community-wide health through the transformation of the health care payment system. As part of their efforts to identify the opportunities and challenges associated with linking payment reform to population health, AcademyHealth contracted with the Network for Regional Healthcare Improvement to explore the role regional collaboratives play in both engaging health care systems and community based organizations in community-wide funding and financing initiatives, and coordinating valuable functions to ensure alignment of efforts and outcomes with the population health needs of the community.

To learn more about the Payment Reform for Population Health initiative, visit www.academyhealth.org/p4ph

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Introduction

The United States spent $3.2 trillion on health care in 2016—more than any other country in the world. But it spent just a quarter of what other developed countries typically pay for social services that help keep people healthy and out of the hospital[1]. That's problematic because medical care accounts for just 20 percent of the modifiable contributors to healthy populations. Social determinants of health (SDOH) including personal behaviors, socioeconomic factors and physical environments account for the rest. So to cut health care spending overall and have a healthier population, communities have to spend smarter. In particular, they need to incentivize the health care and non-health care sectors to integrate social services—such as transportation, housing, and education— and identify innovative funding and financing models to support this integration and contribute to population health improvements.

Adding this capacity does not necessarily imply that funding will be redirected away from clinical care. Rather, it calls for new payment models which give more participants a greater stake in improving health in their communities. Since all health is local, the models will by necessity differ according to regional circumstances. But fundamentally, they should all support geographically-based initiatives, and reward providers for their role in creating healthy communities.

What do communities require to take on this new challenge? Perhaps most importantly, they need an accountable entity that brings a diversity of voices to the table and helps align broader financing strategies. Given their experience working with providers, payers, employers, government, and other organizations, regional collaboratives could potentially play the role of this trusted convener. This is ever more relevant given state and national initiatives that are establishing accountable communities, including those state-initiated Accountable Communities for Health (ACHs) as a component of their Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) initiatives, and the more recently CMMI-selected regionally-based Accountable Health Communities (AHCs).

Consider the example of Community First, a RHIC and NRHI member established in 2014 to serve population health needs in East Hawaii. Community First helped support a new payment model for emergency department (ED) services that include a "retainer" to help cover fixed costs while reducing per visit fees. The model was developed in response to claims data analyses that identified just a few patients were costing the local hospital millions of dollars in uncompensated ED visits and inpatient care. Community First is now overseeing the development of a medical home that coordinates services for high-needs/high-cost patients; linking them with community-based organizations and social service agencies that provide food, shelter, home health supports, and transportation, as needed. At the same time, Community First is convening regional health plans around a value-based payment model that supports the medical home, and is establishing an advisory board to monitor its funding.

For population health payment models like this to succeed, key players have to be willing to cooperate on shared goals (See Appendix A), and agree on social service gaps that need to be filled. Communities also need buy-in from government leaders, direct service providers, business interests, and front-line clinicians. Any one of these groups might be skeptical at first, particularly if they feel that social services are already covered by other means, or that health care dollars should be reserved for the clinic. They should instead be convinced that addressing population health gaps can serve wide-ranging interests, including their own. Broadening services for people with mental illness, for instance, improves their quality of life and avoids costly hospital emergency room visits.

At the outset, communities can perform a readiness assessment (See Appendix B) to confirm that the essential components for a population health financing mechanism are available. Such components include a trusted convener, consensus around shared goals, sufficient data and analytic capacity to understand the issues being addressed, and an entity, such as the trusted convener, that receives population health payments, coordinates services, and deals with measurements of performance and accountability Communities should also identify "champions" who can rally support, identify opportunities to build on existing projects that show promise, and select opportunities for short-term wins that build confidence and trust (See Appendix A).

Once the essential components are in place, communities can test the waters with focused projects, allowing regional collaboratives to serve as trusted conveners that evaluate what works. Health care providers, purchasers and payers should contribute funding to sustain the collaborative organization that will coordinate activities related to improving population health. Example projects might include the creation of a new shared data system on social determinants of health, or perhaps a system for identifying and referring high-risk members of the community for services. Purchasers—including those from government—should be encouraged to supply needed payments and to set aside funding for initiatives that build population health infrastructure. At the same time, large health systems should be encouraged to establish goals

for population health, and to allocate a portion of retained earnings for activities that improve population health. What is important is for communities to start small and set reasonable expectations, so that they may document returns on investment over time.

These new payment models almost certainly will not function adequately if they simply funnel money through health care organizations. Such organizations should be encouraged to participate, but if they direct financing, then it is less likely that funds will be used outside the existing health care system. For example: Health plans pay for hip surgeries, but may not pay for home-health services that protect the elderly from falling. Payment models should instead be governed by a trusted collaborative organization with balanced representation of all member interests. In the end, population health improvements don't result from the actions of a single sector or organization—they come from collaborative efforts to redirect funding from an acute care fee-for-service model to preventative interventions encouraged by value-based payment models.

New Funding Models for Population Health

An important role for a regional collaborative is to test and encourage the implementation of new funding models for population health. The following are some recommendations for these funding activities gleaned from conversations with regional collaboratives working on population health improvement. These recommendations could be useful for ACHs and communities testing AHC models that are at various stages of development.

Develop a Funding Commitment for the Regional Collaborative

To most effectively impact population health, communities need a trusted convener, which can facilitate action across many organizations that must work together in new ways. This coordinating body needs to establish governance rules (See Appendix A) that will ensure engagement and trust across participants from multiple stakeholder groups, ascertain common goals for the community, identify common data elements, analyze and share data, support and test new approaches to improve outcomes, and evaluate and communicate results. The regional collaborative, thus, needs sustainable funding to support its activities in the community. The best source of this funding can be the regional collaborative's participating community members (e.g. health plans, care systems, social service organizations, employers and others).

The Role of a Regional Collaborative in Population Health

- Gather broad community participation from health care, social services, community groups, payers and government.
- Establish ground rules and processes to ensure trust among participants.
- Conduct a readiness assessment and take action to fill gaps. (See Appendix B)
- Establish base funding from the participants for the work of the convener.
- Encourage implementation of new funding models for population health.
- Gain consensus around shared goals and establish a plan to measure results.
- Find and recognize champions that will drive change in their organizations.
- Collect and share data that can be used to improve results and support accountability.
- Support the coordination of services between health care and social services.
- Evaluate outcomes and report to the community.

The leadership of the regional collaborative and other champions of population health work in the community should meet with potential member organizations early on in the process to discuss sustainability. There are several options for this financial support, but regular funding commitments from the member organizations participating in the work can increase engagement by the parties in sharing responsibility for the outcomes and encourage the development of reasonable goals. Collaborative organizations, such as Regional Health Improvement Collaboratives, that have worked in population health have found the following steps may increase success in these participation requests:

- Hold meetings with the senior leadership of potential member organizations and the population health champions early in the process to gain commitment. These meetings should be both group and one-on-one.
- Encourage the leaders of member organizations to meet with their peers in the community (CEO to CEO, Finance to Finance) to connect with them about the request to participate.

- Include both a financial and a participation commitment.
- Combine the request with a commitment to specific short and long-term goals. Articulate the benefit to individual member participants in achieving the goals.
- Make the connection wherever possible to other work of the collaborative, such as data sharing or reporting, that member participants value.

Encourage Health Care System Boards to Establish Population Health Goals and Funding

Health care systems are often some of the largest businesses in their communities and they have an interest in the community beyond their health care role since they are a major employer, a purchaser, and a business whose customers are local. Health care systems have funding and other resources that communities can access to meet population health needs, but these requests must compete with other community needs and the momentum to continue to fund the growth in the health care they provide. Health care system boards of directors are often actively engaged in establishing the mission and goals for their organizations and overseeing the long-term investment of their resources to meet that mission. Regional collaborative participants can lead efforts to educate health care system boards on the need for investment in population health. This can include having community leaders reach out to their peers on health care system boards; provide standard education materials and presentations for boards on population health; and make requests to these boards to establish specific organizational goals on population health, set aside specific funding in their capital budgets, set internal incentives for action on these goals, and evaluate and report progress. The regional collaborative can also advocate for the boards of non-profit health care organizations to include specific population health strategies to address challenges identified through their annual community health needs assessments.

Develop Methods to Track the Return on Investment of Population Health Efforts

In order to have a greater impact on population health, communities will need to invest significant financial, as well as other administrative resources, over time. This support will need to come from many different organizations and community members. Funders and other participants will be more likely to provide support when they believe the project will regularly assess the costs and benefits of the population health work and redirect efforts to the most impactful activities. This analysis should demonstrate the impact on both the community and the member organizations. Since many outcomes are not easy to assess in the short term, regional collaboratives may need to include both qualitative and quantitative assessments. Stories that demonstrate impact may also be important to the decision makers and should be combined with the data wherever possible. Process measures that are tied to outcomes or even assessments on the amount of new services provided can be used. Regular communication of the results to the community and the participants is critical. Regional collaboratives have advised that communities may wish to start small and add more complex analysis over time, wherever possible use the data that the collaborative is collecting as part of the assessment, and to bring in outside expertise to add credibility to the evaluations, if needed.

Encourage Purchasers to Test Payment for Social Services that Improve Health and Wellness

Improving access to social services can reduce health care costs and improve health outcomes for some individuals. For example, employing community health workers can help address social determinants of health in high-risk neighborhoods. These services may not have been traditionally paid for by health insurance plans due to regulatory or administrative barriers or lack of recognition of the savings the services can provide. Regional collaboratives can work together with others to identify the best opportunities for these enhanced payments for social services to benefit both health plans and the community. Regional collaboratives can help demonstrate the return on investment to health plans and purchasers, identify ways to overcome administrative barriers to coverage, align administrative processes to increase efficiency, collect and distribute data for payment authorization or evaluation, gain commitment from multiple payers to avoid "free riders" or competitive disadvantages to coverage, publicly recognize and promote participating organizations, and monitor and report results.

Advocate for Non-profit Health Care System's Community Needs Assessments (CNAs) to Include Population Health Investments

Non-profit health care systems are required to annually report to the public on how their resources and activities are benefitting the community to justify their tax-exempt status. Communities are also often conducting assessments that identify unmet health needs of their population. These reports can be a catalyst to engage the health care systems' boards in opportunities for population health investment. A non-profit's CNA can both encourage these systems to invest in more population health activities and recognize those that are aligning their efforts with others in the community. The regional collaborative can start by requesting that their member organizations include population health impacts in their CNAs. They can also provide sample goals that can be included and aligned with others in the community, provide data to support the assessment of impact, provide analysis of results, publicly recognize those organizations that take action, and promote the results of these population health efforts in the final CNA report to policy makers and the public.

Include Population Health Goals in Health Care System Payment Contracts

Health care systems in many communities are seeing more requirements in their payment contracts with health plans, large employers, and government purchasers to meet specific outcome goals for the populations they serve. These goals are often initially related to the direct care outcomes of these providers, but given the impact of the social determinants of health on overall cost and outcomes, many plans are considering the inclusion of population health goals in their financial contracts with providers. Regional collaborative organizations can support this process by:

- Encouraging participation across payers to avoid "free riders" and increase efficiency;
- Advocating aligned public payer participation and serving as public forum for input;
- Gaining alignment of methods across payers in a community to reduce the burden on providers and increase the impact;
- Identifying and gaining consensus on the goals and the performance measures for population health that should be included which are most amenable to impact through healthcare system investment and participation;
- Serving as a trusted source for data and analysis of outcomes under these contracts; and
- Providing support on interventions that may be necessary across providers to improve results.

Encourage Purchasers to Establish a Centralized Funding Pool to Build the Infrastructure to Support Population Health Improvement

Multiple challenges face health care payers that recognize the benefit of increasing their investment in population health. Interventions that impact population health touch people spread across all payers and health care providers in a community. Unlike healthcare services, these interventions are not always discreet services for individuals and therefore do not lend themselves to a traditional claims payment function. These population health efforts need to be coordinated across payers and providers in new ways. The infrastructure to support these new efforts, such as provider agreements, payment methods, or data collection systems, may not be in place or be effectively run by only one health care provider or plan. There is still much to be learned about what works best to improve population health. The total resources available from one payer are unlikely to meet all the demands in the foreseeable future; a community-wide effort is needed.

One opportunity to address these challenges is for payers to establish a centralized funding pool that can help build the needed infrastructure to adequately address the needs across all payers and providers. This funding pool could be administered by an existing regional collaborative or others with broad governance (See Appendix A) and efficient implementation processes. A centralized pool could serve as a mechanism to transition some traditional health care funds to population health activities that can yield similar health improvements at a lower total cost. The use of these funds could be directed by the participants through a consensus process and guided by improvement targets and evaluation of results. The regional collaborative can serve to discourage "free riders", encourage participation of additional payers, provide a mechanism for establishing standard payment levels, and collect and distribute the funds. The collaborative can also advocate for broader community participation in population health funding (e.g., funding from other non-health care sectors like education, housing and transportation).

Advocate for Community-Wide Population Health Funding with Improvement Targets and Evaluation of Results

Beyond establishing a payer funding pool for population health, the collaborative may wish to advocate for a community-wide population health funding pool with a process for establishing improvement targets and evaluating of results. A few states have already established population health pools for local communities from general tax dollars that allow for broad funding regardless of health care payer. Similar to the structure of Accountable Care Organizations (ACOs), Oregon established Coordinated Care Organizations (CCOs) in 2012.[2,3] Prior to that, Minnesota established the Statewide Health Improvement Partnership (SHIP) in 2008.[4] This approach may also have the advantage of providing more funding while spreading the cost across many organizations who will benefit from improved population health.

Conclusion

Regional collaboratives can have an important role in encouraging, developing, and testing the implementation of new funding and financing models for population health. These innovative funding models can enhance care delivery in order to address the social determinants of health and improve the lives and wellbeing of people in their communities without increasing health care costs. The eight recommendations above are just a starting point for communities, such as ACHs or AHCs, to consider when working on population health improvement. By bringing key stakeholders together, the regional collaborative, serving as a trusted convener, can also help generate new ideas that can be tested to improve funding for population health.

Appendices

Appendix A: Multi-Stakeholder Governance for Population Health

The following is a list of key attributes for the governance of successful multi-stakeholder regional collaboratives to improve the financing and implementation of population health.

- Broad participation of stakeholders in the community
  - Balanced participation – no one stakeholder has greater authority in decision making
  - Expand the tent - the focus on population health will require new participants to the collaboration – they need to be empowered to have an equal role
  - Participants must be willing listen and learn from each other, especially when resolving differences
  - Participants must be willing to give and take
- Participants have a shared value that the interests of people, patients, and the community come first
- Be seen as a trusted source
  - Transparency in decision making, spending, results, and potential conflicts
  - No surprises: agreement in advance about priorities, how information will be shared between members, how decisions will be made, and how results will be used
  - Ability to avoid bias to individual participants interests
  - Commitment to common goals and evaluation of progress
  - Shared responsibility for ensuring appropriate resources are available to meet mutual goals
  - Consistent requirements for financial and operational participation across members
  - Shared data and knowledge resources (compete on execution, not on information)
  - Multi-year commitment to funding the regional collaborative based on the time required to achieve the goals
- Consensus-based decision making
  - Does not require all to agree
  - Does require a process to understand and resolve differences
  - Ability of participants and/or others to appeal decisions and determinations
- Commitment to maintaining the collaboration
  - Deliberate effort to build relationships at all levels of the participating organizations
  - Identification and specific role for champions at each organization
  - Build depth in each participating organization beyond the champions
  - Demonstrate the return on investment for the community avoid bias to individual participants interests
- Commitment to common goals and evaluation of progress
- Shared responsibility for ensuring appropriate resources are available to meet mutual goals
  - Consistent requirements for financial and operational participation across members
  - Shared data and knowledge and the participants
  - Plan ahead for future transitions in organizational leadership

Appendix B: Community-Based Population Health Payment Reform Readiness Assessment Tool

The following readiness assessment tool is designed to help you determine your community's readiness to implement collaborative projects for population health payment reform. The tool focuses on four key topic areas and the related barriers that potentially influence the conditions and collaborations necessary to support community-wide population health services. The four topics are:

- Approaches to collect and analyze data for patient and community health outcomes including population health status, social determinants of health, total cost of care, return on investment, and the mechanics of capturing the cost of non-medical services and the potential savings from their use;
- Governance issues related to how participants will work together to ensure accountability for outcomes;
- Multi-sector care delivery and the importance of forming new partnerships among the traditional health care delivery system, the public health system, and social service sectors; and
- Payment and financing arrangements for providers (clinical and non-clinical), including cost sharing/attribution of potential savings.

Please complete one assessment on behalf of your organization. You may choose to gather feedback from other subject matter experts to help select the answer that best reflects your community's position today.

Instructions:

Each statement below presents an ideal state of readiness in the four key topic areas and takes into consideration the related barriers that potentially influence the conditions and collaborations necessary to support community-wide population health improve. Following each statement are three descriptions of what your organization may look like today on a scale of 1-3. A self-assessment of (1) indicates no or little development of competency in the readiness area, (2) signals substantial progress and competency, and (3) shows maturity of a competence.

We understand that these descriptions may not reflect your state of readiness exactly, but we ask that you select the description that best matches your organization's current state.

Demographics
Organization Name:
Your Name:
Your Title / Role:
Region Served:
Contact Information:

This section addresses accessibility and utilization of data to support improvements in population health.

Our community has consistent access to clinical and claims data and has established relationships to share data across sectors including those outside of traditional healthcare settings.

☐ Data sets exist, but we have no or limited access to clinical or claims data. (1)

☐ Data sets exist and we have some access, but have not established clinical-community relationships. (2)

☐ Data sets exist, and data collection and analysis efforts include clinical-community collaborations. (3)

Our community has access to new or existing sources of data on social determinants of health and is sharing those data among community partners.

☐ Data sets exist, but we have no or limited access to data on social determinants of health. (1)

☐ Data sets exist and we have some access, but have not established ways to share data on social determinants of heath. (2)

☐ Data sets exist, and data collection, sharing and analysis efforts exist for social determinants of health. (3)

Our community has established a governance process for data sharing among community partners.

☐ Local health systems and community-based partners in our region do not currently share data across sectors due to lack of trust. (1)

☐ Local health systems and community-based partners are willing to discuss common definitions for specific measures and to share data across sectors. (2)

☐ Our organization has established a governance process for data collection, analysis and sharing among partners and efforts are grounded in a shared understanding of what fundamental goals all are trying to achieve and why. (3)

Our organization has the financial resources necessary to build and maintain collaborative data efforts.

☐ Our organization does not have the financial capacity to establish and maintain collaborative data efforts. (1)

☐ Our organization has identified resources for the data efforts, but lacks knowledge regarding the selection of adequate data-sharing platforms to support collaborative efforts. (2)

☐ Our organization has established and maintains collaborative data efforts that invest in the necessary technology and human capital. (3)

Trusted Convener and Governance

This section addresses the establishment and role of a trusted convener and its governance structure to effectively manage a collaborative community partnership focused on population health improvement.

Our community has identified an entity to serve as a trusted convener that brings together multiple perspectives to a common table.

☐ Our community does not have an organization in place to become the trusted convener for this work. (1)

☐ Our community has an existing organization in place that could serve as the convening entity. (2)

☐ Our community has established a trusted convener and governance structure with a deep knowledge of the community landscape and health care market that can ensure equitable and productive participation among partners across sectors. (3)

Our community has an operationalized trusted convener with access and ability to manage funds for this work.

☐ A trusted convener exists, but lacks access to the resources to support this work. (1)

☐ A trusted convener exists and efforts are underway to establish funding and mechanisms to properly manage and distribute funds. (2)

☐ A trusted convener exists, has identified funds, and has demonstrated success in managing funds in complex or challenging projects with a high level of trust. (3)

Our community has established a trusted convener that is able to be the authority on decision-making.

☐ Our trusted convener does not have experience serving as the decision maker. (1)

☐ Our trusted convener could be described as having decision-making abilities, but faces competing priorities. (2)

☐ Our trusted convener provides a transparent environment for decision-making with demonstrated results. (3)

Multi-sector Care Delivery

This section highlights the need to create a care delivery model that integrates non-clinical social services into those clinically-focused models.

We have established a collaborative forum where partners have a shared desire to undertake community interventions and work together to integrate clinical and non-clinical care delivery interventions.

☐ Our community recognizes the need for a forum, but nothing is in place currently. (1)

☐ Our community has the capacity to create a forum, but we lack an understanding of key providers of clinical services and community interventions that are available and/or needed. (2)

☐ Our community has a forum in place where collaborative partners can work together to integrate clinical and non-clinical care delivery interventions and want to undertake these community interventions. (3)

Our community has the capacity and capability to support a referral system for social services and community interventions to improve health outcomes.

☐ Our community recognizes the need for a referral system process, but has no established relationships with social service agencies, community-based organizations or behavioral health providers. (1)

☐ Relationships with social service agencies, community-based organizations or behavioral health providers are established, but our trusted convener does not have the capacity to take on referral responsibilities. (2)

☐ Our trusted convener has adequate capacity and resources to support a robust referral system for non-clinical care services. (3)

Our community has one or more shared financial risk payment model(s) across clinical and non-clinical providers in place.

☐ Our community does not have experience with shared risk and no such model(s) exists. (1)

☐ Our community has discussed the need for a shared risk model and efforts are underway to develop and implement. (2)

☐ Our community has developed a shared risk model; clinical and non-clinical providers presently share financial risk for performance. (3)

Payment and Financing

This section highlights issues related to the payment and financing of non-clinical interventions.

There is a willingness to have shared financial accountability among clinical and non-clinical providers, regardless of direct influence.

☐ Clinical and non-clinical providers are unwilling to discuss shared accountability. (1)

☐ Clinical and non-clinical providers have a mutual sense of shared responsibility for overall community goals. (2)

☐ We have a model in place for clinical and non-clinical providers to share financial responsibility for community outcomes. (3)

Our community has developed mechanisms for reimbursements to pay for non-clinical interventions.

☐ There is no mechanism for reimbursement for non-clinical interventions to flow from health plans to both clinical and non-clinical providers. (1)

☐ Discussions are underway to develop a mechanism for reimbursement for non-clinical interventions to flow from health plans to clinical and non-clinical providers. (2)

☐ Our community has fully functioning mechanisms for reimbursements for non-clinical interventions from health plans. (3)

Our community has developed a mechanism to measure and reward non-clinical care interventions.

☐ Our community has no way to measure the value of non-clinical care interventions. (1)

☐ Our community recognizes the need to measure and reward non-clinical care interventions and work is underway to demonstrate the value proposition of funding non-clinical care interventions. (2)

☐ Our community has analyzed the upstream investments with short-term ROI and possesses the ability to reconcile up-front investments with longer-term ROI to rationalize the investment. (3)

Endnotes

1. Bradley E, Taylor L. The American Health Care Paradox: Why Spending More is Getting Us Less. PublicAffairs; 2013.

2. S. Klein, D. McCarthy and A. Cohen, Health Share of Oregon: A Community Oriented Approach to Accountable Care for Medicaid Beneficiaries (New York: The Commonwealth Fund. October 2014). Available from: http://www.commonwealthfund.org/~/media/files/publications/case-study/2014/oct/1769_klein_hlt_share_oregon_aco_case_study.pdf.

3. For a list of accountable care efforts by state, see the National Academy for State Health Policy's State Accountable Care Activity Map, available from: http://nashp.org/state-accountable-care-activity-map

4. The Statewide Health Improvement Partnership. Available from: http://www.health.state.mn.us/ship/