Organizing and Financing Population Health: Systems, Policies & Incentives

Glen P. Mays, University of Kentucky

Available at: https://works.bepress.com/glen_mays/307/
Organizing and Financing Population Health: Systems, Policies & Incentives

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Overview

- Population health: concepts and key ingredients
- Social determinants of health
  - Key drivers
  - Policy & incentives
  - Services & supports
- Health systems & population health
  - Organization
  - Financing
  - Influence on population health
- Success stories & directions for the future
Part 1: Population Health

This section covers:
✓ Definitions
✓ Components & capabilities
✓ Benefits of population health approaches

- What’s your definition?
- How is this different from “routine” public health?
- Why the increased attention?
Losing ground in population health

U.S. LIFE EXPECTANCY FALLS

<table>
<thead>
<tr>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015: 78.8</td>
<td>2015: 76.3</td>
<td>2015: 81.2</td>
</tr>
<tr>
<td>2014: 78.9</td>
<td>2014: 76.5</td>
<td>2014: 81.3</td>
</tr>
</tbody>
</table>

SOURCE: CDC
Jim Sergent, USA TODAY

Published December 8, 2016
Losing ground in population health

Life expectancy at birth, years vs. Total expenditure on health per capita, US $ PPP

1. Or latest year available.

Source: OECD Health Data 2010.
Losing ground in population health

Mortality rates, 45 to 54 age group, per 100,000 people

Mortality by cause for white non-Hispanics, 45 to 54 age group, per 100,000 people

Drug/alcohol overdoses
Lung cancer
Suicides
Chronic liver diseases
Diabetes

Case A, Deaton A. Proceedings of the National Academy of Sciences 2015
Defining population health strategies

- Designed to achieve large-scale health improvement: neighborhood, city/county, region
- Improve the mean and reduce the variance (equity)
- Target fundamental and often multiple determinants of health
- Mobilize the collective actions of multiple stakeholders in government & private sector
  - Infrastructure
  - Information
  - Incentives

How are populations defined?

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>Assignment: patients assigned to a source of care</td>
</tr>
<tr>
<td>Payor</td>
<td>Attribution: patients receiving services at a source of care</td>
</tr>
<tr>
<td>Sponsor</td>
<td>Enrollment: persons enrolled in a source of coverage</td>
</tr>
<tr>
<td>Societal</td>
<td>Contract or affiliation: employer, worksite, school, church, association, etc.</td>
</tr>
<tr>
<td></td>
<td>Total population: residence within a neighborhood, community, or region</td>
</tr>
</tbody>
</table>
Multiple systems & sectors drive health...

Proportional Contribution to Premature Death

- Genetic predisposition: 30%
- Behavioral patterns: 40%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%

But existing systems often fail to connect

**Medical Care**
- Fragmentation
- Duplication
- Variability in practice
- Limited accessibility
- Episodic and reactive care
- Insensitivity to consumer values & preferences
- Limited targeting of resources to community needs

**Social Services & Supports**

**Public Health**
- Fragmentation
- Variability in practice
- Resource constrained
- Limited reach
- Insufficient scale
- Limited public visibility & understanding
- Limited evidence base
- Slow to innovate & adapt

Waste & inefficiency

Inequitable outcomes

Limited population health impact
Challenge: overcoming collective action problems across systems & sectors

- Incentive compatibility → public goods
- Concentrated costs & diffuse benefits
- Time lags: costs vs. improvements
- Uncertainties about what works
- Asymmetry in information
- Difficulties measuring progress
- Weak and variable institutions & infrastructure
- Imbalance: resources vs. needs
- Stability & sustainability of funding

Ostrom E. 1994
Q: How do we build robust, coordinated systems that support population-wide improvements in health status?
Widely recommended activities to support multi-sector initiatives in population health

- Engage stakeholders
- Assess needs & risks
- Identify evidence-based actions
- Develop shared priorities & plans
- Commit shared resources & responsibilities
- Coordinate Implementation
- Monitor, evaluate, feedback

Population Health Capabilities

Core Components of Population Health Capabilities

- Convene population stakeholders
- Data aggregation: claims, EHR, surveys, mobile
- Data analysis and risk stratification
- Evidence review & synthesis
- Performance metrics, scorecards, reports
- Health homes, ACOs, accountable communities
- Navigators, community health workers
- Incentives, shared savings, pay for success
- Interdisciplinary teams
- Multi-sector partnerships & alliances
- Collaborative care plans
- Goal elicitation & measurement
- Community, Patient & caregiver engagement
- Identify evidence-based actions
- Develop shared priorities & plans
- Commit shared resources & responsibilities
- Coordinate Implementation
- Monitor, evaluate, feedback
- Engage stakeholders
A useful lens for studying multi-sector pop health work

National Longitudinal Survey of Public Health Systems

- Cohort of 360 communities with at least 100,000 residents
- Local public health officials report:
  - **Scope**: availability of 20 recommended population health activities
  - **Network density**: organizations contributing to each activity
  - **Network centrality**: strongest central actor
  - **Quality**: perceived effectiveness of each activity

** Expanded sample of 500 communities<100,000 added in 2014 wave
Comprehensive System Capital
One of RWJF’s Culture of Health National Metrics

- **Broad scope** of population health activities
- **Dense network** of multi-sector relationships
- **Central actors** to coordinate actions

Access to public health

Overall, 47.2 percent of the population is covered by a comprehensive public health system. Individuals are more likely to have access if they are non-White (51.5 percent vs. 45.5 percent White) or live in a metropolitan area (48.7 percent vs. 34.1 percent in nonmetropolitan areas).

Data linkages expand analytic possibilities

- **Area Health Resource File**: health resources, demographics, socioeconomic status, insurance coverage
- **NACCHO Profile data**: public health agency institutional and financial characteristics
- **CMS Impact File & Cost Report**: hospital ownership, market share, uncompensated care
- **Dartmouth Atlas**: Area-level medical spending (Medicare)
- **CDC Compressed Mortality File**: Cause-specific death rates by county
- **Equality of Opportunity Project (Chetty)**: local estimates of life expectancy by income
- **National Health Interview Survey**: individual-level health
- **HCUP**: area-level hospital and ED use, readmissions
Variation in implementing foundational population health activities


Percent of U.S. communities

Percent of activities performed

0
20%
40%
60%
80%
100%
## Implementation of foundational activities, 1998-2016

<table>
<thead>
<tr>
<th>Activity</th>
<th>1998</th>
<th>2016</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conduct periodic assessment of community health status and needs</td>
<td>71.5%</td>
<td>87.1%</td>
<td>21.8%</td>
</tr>
<tr>
<td>2. Survey community for behavioral risk factors</td>
<td>45.8%</td>
<td>71.1%</td>
<td>55.2%</td>
</tr>
<tr>
<td>3. Investigate adverse health events, outbreaks and hazards</td>
<td>98.6%</td>
<td>100.0%</td>
<td>1.4%</td>
</tr>
<tr>
<td>4. Conduct laboratory testing to identify health hazards and risks</td>
<td>96.3%</td>
<td>96.1%</td>
<td>-0.2%</td>
</tr>
<tr>
<td>5. Analyze data on community health status and health determinants</td>
<td>61.3%</td>
<td>72.7%</td>
<td>18.6%</td>
</tr>
<tr>
<td>6. Analyze data on preventive services use</td>
<td>28.4%</td>
<td>39.0%</td>
<td>37.3%</td>
</tr>
<tr>
<td>7. Routinely provide community health information to elected officials</td>
<td>80.9%</td>
<td>84.0%</td>
<td>3.8%</td>
</tr>
<tr>
<td>8. Routinely provide community health information to the public</td>
<td>75.4%</td>
<td>82.3%</td>
<td>9.1%</td>
</tr>
<tr>
<td>9. Routinely provide community health information to the media</td>
<td>75.2%</td>
<td>89.0%</td>
<td>18.3%</td>
</tr>
<tr>
<td>10. Prioritize community health needs</td>
<td>66.1%</td>
<td>83.6%</td>
<td>26.5%</td>
</tr>
<tr>
<td>11. Engage community stakeholders in health improvement planning</td>
<td>41.5%</td>
<td>68.8%</td>
<td>65.7%</td>
</tr>
<tr>
<td>12. Develop a community-wide health improvement plan</td>
<td>81.9%</td>
<td>87.9%</td>
<td>7.3%</td>
</tr>
<tr>
<td>13. Allocate resources based on community health plan</td>
<td>26.2%</td>
<td>41.9%</td>
<td>59.9%</td>
</tr>
<tr>
<td>14. Develop policies to address priorities in community health plan</td>
<td>48.6%</td>
<td>56.8%</td>
<td>16.9%</td>
</tr>
<tr>
<td>15. Maintain a communication network among health-related organizations</td>
<td>78.8%</td>
<td>85.3%</td>
<td>8.2%</td>
</tr>
<tr>
<td>16. Link people to needed health and social services</td>
<td>75.6%</td>
<td>50.0%</td>
<td>-33.8%</td>
</tr>
<tr>
<td>17. Implement legally mandated public health activities</td>
<td>91.4%</td>
<td>92.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>18. Evaluate health programs and services in the community</td>
<td>34.7%</td>
<td>37.9%</td>
<td>9.4%</td>
</tr>
<tr>
<td>19. Evaluate public health agency capacity and performance</td>
<td>56.3%</td>
<td>56.1%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>20. Monitor and improve implementation of health programs and policies</td>
<td>47.3%</td>
<td>46.4%</td>
<td>-1.9%</td>
</tr>
</tbody>
</table>

Mean performance of assessment activities (#1-6) 67.0%  77.7%  15.9%
Mean performance of policy and planning activities (#7-15) 63.9%  75.5%  18.3%
Mean performance of implementation and assurance activities (#16-20) 61.1%  56.6%  -7.3%
Mean performance of all activities 63.8%  67.6%  6.0%
Mapping who contributes to population health

Node size = degree centrality
Line size = % activities jointly contributed (tie strength)

Mays GP et al. Understanding the organization of public health delivery systems: an empirical typology. 
Classifying multi-sector delivery systems for population health

Network density and scope of activities

Comprehensive System Capital

Mays GP et al. Health Affairs 2016
Variation and change in comprehensive system capital
## Organizational contributions to foundational activities, 1998-2016

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>1998</th>
<th>2016</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local public health agencies</td>
<td>60.7%</td>
<td>67.5%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Other local government agencies</td>
<td>31.8%</td>
<td>33.2%</td>
<td>4.4%</td>
</tr>
<tr>
<td>State public health agencies</td>
<td>46.0%</td>
<td>34.3%</td>
<td>-25.4%</td>
</tr>
<tr>
<td>Other state government agencies</td>
<td>17.2%</td>
<td>12.3%</td>
<td>-28.8%</td>
</tr>
<tr>
<td>Federal government agencies</td>
<td>7.0%</td>
<td>7.2%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>37.3%</td>
<td>46.6%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Physician practices</td>
<td>20.2%</td>
<td>18.0%</td>
<td>-10.6%</td>
</tr>
<tr>
<td>Community health centers</td>
<td>12.4%</td>
<td>29.0%</td>
<td>134.6%</td>
</tr>
<tr>
<td>Health insurers</td>
<td>8.6%</td>
<td>10.6%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Employers/businesses</td>
<td>16.9%</td>
<td>15.3%</td>
<td>-9.6%</td>
</tr>
<tr>
<td>Schools</td>
<td>30.7%</td>
<td>25.2%</td>
<td>-17.9%</td>
</tr>
<tr>
<td>Universities/colleges</td>
<td>15.6%</td>
<td>22.6%</td>
<td>44.7%</td>
</tr>
<tr>
<td>Faith-based organizations</td>
<td>19.2%</td>
<td>17.5%</td>
<td>-9.1%</td>
</tr>
<tr>
<td>Other nonprofit organizations</td>
<td>31.9%</td>
<td>32.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Other</td>
<td>8.5%</td>
<td>5.2%</td>
<td>-38.4%</td>
</tr>
</tbody>
</table>
Inequities in the implementation of population health activities

Health effects attributable to system capital

Impact of Comprehensive Systems on Mortality, 1998-2014

Fixed-effects instrumental variables estimates controlling for racial composition, unemployment, health insurance coverage, educational attainment, age composition, and state and year fixed effects. N=1019 community-years

Mays GP et al. Health Affairs 2016
Economic effects attributable to system capital

Impact of Comprehensive Systems on Medical Spending (Medicare) 1998-2014

Models also control for racial composition, unemployment, health insurance coverage, educational attainment, age composition, and state and year fixed effects. N=1019 community-years. Vertical lines are 95% confidence intervals

Mays GP et al. Health Services Research 2017
Economic effects attributable to system capital

Impact of Comprehensive Systems on Life Expectancy by Income (Chetty), 2001-2014

Models also control for racial composition, unemployment, health insurance coverage, educational attainment, age composition, and state and year fixed effects. N=1019 community-years. Vertical lines are 95% confidence intervals

Mays GP et al. *forthcoming* 2017
RECAP Part 1: Population Health

This section covers:

✓ Definitions
✓ Components & capabilities
✓ Benefits of population health approaches
RECAP: What’s population health?

- Designed to achieve large-scale health improvement: neighborhood, city/county, region
- Improve the mean and reduce the variance (equity)
- Target fundamental and often multiple determinants of health
- Mobilize the collective actions of multiple stakeholders in government & private sector
  - Infrastructure
  - Information
  - Incentives

RECAP: How to support pop health initiatives?

- Coordinate Implementation
- Engage stakeholders
- Assess needs & risks
- Identify evidence-based actions
- Develop shared priorities & plans
- Commit shared resources & responsibilities
- Monitor, evaluate, feedback

Foundational Capabilities

RECAP: Benefits of pop health approaches?

- 7% reduction in mortality
- 8% reduction in medical costs
- 3 year reduction in life expectancy inequity
EXERCISE Part 1: Population Health

1. Choose a pop health problem to tackle in your community.

2. Specify the organizations most important to engage in this work.

3. What incentives can be leveraged to get these organizations to the table?

4. Which of the 7 Pop Health Capabilities will be most challenging for your community to realize?
Part 2: Social Determinants of Health

This section covers:
- Key drivers
- Potential solutions: policies, services & supports

- What are social determinants?
- Who is responsible for them?
- Who has opportunity to intervene on them?
Multiple systems & sectors drive health...

Proportional Contribution to Premature Death

- Genetic predisposition: 30%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%
- Behavioral patterns: 40%

Geographic & socioeconomic inequities in population health

Chetty et al.  JAMA 2016
Social, economic & environmental circumstances

- Childhood experiences
- Family & caregiver support
- Education
- Housing
- Nutrition and food security
- Transportation
- Job opportunities & risks
- Income & financial assistance
- Social support
- Bias and discrimination
- Neighborhood segregation
- Cultural & recreational resources
- Interpersonal & community violence
- Criminal justice involvement
- Civic engagement
- Environmental exposures
- Disability support
- Mental health & substance abuse services
Adverse child experiences are key mechanisms

Source: Felitti et al. AJPM; 1998
The role of early child education

- Lower risky behaviors
- Lower crime
- Higher earnings
- Lower obesity & heart disease
- Higher parental investments

Source: Heckman (2008)
The role of neighborhood effects: Moving to Opportunity Trial

Average income in new community

Average income in old community

Age of child when moved

Age 9  Age 13  Age 17  Age 21

Neighborhood Mediators

- School quality
- Neighborhood integration
- Civic engagement

The role of labor force detachment

- Higher disability
- Lower family formation
- Lower social interaction
- Higher substance abuse & mental disorders
- Lower child engagement (men)
- Higher corrections involvement
Interventions for SDOH

- Evidence-based family planning
- High quality early childhood education
- Nurse home visiting
- Housing First programs
- School-based violence prevention
- Housing integration policies
- Public transportation expansion
- Earned income tax credit
- Work incentives benefit coordination
- Substance abuse treatment
- Post-release employment assistance

https://www.cdc.gov/sixeighteen
https://www.cdc.gov/policy/hst/hi5
REMEMBER: How to integrate SDOH interventions into pop health initiatives?

- Engage stakeholders
- Assess needs & risks
- Identify evidence-based actions
- Develop shared priorities & plans
- Commit shared resources & responsibilities
- Coordinate Implementation
- Monitor, evaluate, feed back

Foundational Capabilities

EXERCISE Part 2: SDOH

1. Choose a pop health problem to tackle in your community.

2. Identify SDOHs connected to your problem of interest.

3. What intervention strategies appear promising for these SDOH?

4. Which organizations can be engaged in supporting SDOH intervention strategies?
Part 3: Health Systems & Population Health

This section covers:

- Organization & financing mechanisms
- Strategies for engagement in population health approaches

- Why should health systems care about population health?

- Where do systems find the resources for population health approaches?
Who pays in the health system?

Federal, 28.7
Households, 27.7
Private employers, 19.9
State/local government, 17.1
Other private, 6.7

CMS National Health Expenditure Accounts, 2017
Who pays in the health system?

CMS National Health Expenditure Accounts, 2017
Drivers of health spending

>75% of US health spending is attributable to conditions that are largely preventable
  – Cardiovascular disease
  – Diabetes
  – Lung diseases
  – Cancer
  – Injuries
  – Vaccine-preventable diseases and sexually transmitted infections

<5% of US health spending is allocated to prevention and public health

CDC 2008 and CMS 2011
### Costly failures in population health

#### EXHIBIT 1

<table>
<thead>
<tr>
<th></th>
<th>Cost to Medicare and Medicaid&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total cost to US health care&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Midpoint</td>
</tr>
<tr>
<td>Failures of care delivery</td>
<td>$26</td>
<td>$36</td>
</tr>
<tr>
<td>Failures of care coordination</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Overtreatment</td>
<td>67</td>
<td>77</td>
</tr>
<tr>
<td>Administrative complexity</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>Pricing failures</td>
<td>36</td>
<td>56</td>
</tr>
<tr>
<td><strong>Subtotal (excluding fraud and abuse)</strong></td>
<td>166</td>
<td>235</td>
</tr>
<tr>
<td><strong>Percentage of total health care spending</strong></td>
<td>6%</td>
<td>9%</td>
</tr>
</tbody>
</table>

<sup>a</sup> Estimates based on data from the Centers for Medicare & Medicaid Services (2012).<br>
<sup>b</sup> Estimates based on data from the Office of Management and Budget (2012).
Health system organizational trends

- Health plan consolidation: commercial, Medicare (30%), Medicaid (76%)
- Hospital and health system consolidation
- Physician employment
- Post-acute care integration
- Accountable care organization formation
Health system financing trends

- Transition from fee-for-service to value-based payment models
- Bundled payment
- Shared savings
- Risk-based payments
- Penalties and withholds for readmissions, quality
- Global budgets (MD, VT)
- Accountable health community tests
ACA incentives & infrastructure for population health activities

- Coverage expansion: ability to redeploy charity-care resources
- Hospital community benefit requirements
- Insurer and employer incentives
- Value-based payment models for hospitals, physicians
- CMS Innovation Center demonstrations
- Prevention & Public Health Fund
- National public health accreditation standards
Connecting social needs and medical outcomes

- Unmet social needs have large effects on medical resource use and health outcomes.

- Most primary care physicians lack confidence in their capacity to address unmet social needs.

- Linking people to needed health and social support services is a core public health function that can add health and economic value.
Where navigators and connectors can add value

**Targeting**: identifying individuals with unmet health and social needs
- Reaching hard to reach (urban & rural settings)
- Mitigating “woodwork” effects

**Tailoring**: matching services and supports to consumer needs, preferences, values
- Education & self-management support
- Direct service provision
- Referral
- Care coordination & navigation
### Key components of leading models

<table>
<thead>
<tr>
<th>Intervention Process</th>
<th>VBH</th>
<th>SCO</th>
<th>CCP</th>
<th>Mercy</th>
<th>GRACE</th>
<th>CMP</th>
<th>EDPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline health assessment</td>
<td></td>
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<tr>
<td>Social assessment</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Individualized care plan</td>
<td></td>
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<td></td>
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<tr>
<td>Interdisciplinary care team</td>
<td></td>
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<tr>
<td>Specialized intervention protocols</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Specialized training for service providers</td>
<td></td>
<td></td>
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<tr>
<td>Ongoing monitoring</td>
<td></td>
<td></td>
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<tr>
<td>Coaching in self-management</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Link to or communication with primary care physician or practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of electronic health records</td>
<td></td>
<td></td>
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</tbody>
</table>
### Key components of leading models

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>VBH</th>
<th>SCO</th>
<th>CCP</th>
<th>Mercy</th>
<th>GRACE</th>
<th>CMP</th>
<th>EDPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Medication management</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Mental health services</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Referral to or arrangement for social or supportive services</td>
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<tr>
<td>Referral to or arrangement for medical services</td>
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<tr>
<td>Caregiver support</td>
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</tr>
</tbody>
</table>

Shier et al. *Health Affairs* 2013
Some Promising Examples
Arkansas Community Connector Program

- Use community health workers & public health infrastructure to identify people with unmet social support needs
- Connect people to home and community-based services & supports
- Link to hospitals and nursing homes for transition planning
- Use Medicaid and SIM financing, savings reinvestment
- ROI $2.92

Source: Felix, Mays et al. *Health Affairs* 2011
Economic impact of Arkansas CCP

By Holly C. Felix, Glen P. Mays, M. Kathryn Stewart, Naomi Cottoms, and Mary Olson

THE CARE SPAN

Medicaid Savings Resulted When Community Health Workers Matched Those With Needs To Home And Community Care
Some Promising Examples

Hennepin Health ACO

- Partnership of county health department, community hospital, and FQHC
- Accepts full risk payment for all medical care, public health, and social service needs for Medicaid enrollees
- Fully integrated electronic health information exchange
- Heavy investment in care coordinators and community health workers
- Savings from avoided medical care reinvested in prevention initiatives
  - Nutrition/food environment
  - Physical activity
Some Promising Examples

Chicago’s Comprehensive Care, Culture & Community Pgrm

- Partnership of University of Chicago, physician practices, CBOs
- Targets low income, frequently hospitalized patients
- “Comprehensivist” physicians provide all care for patients
- CHW links patients to community resources and cultural programs
- Savings from avoided medical care reinvested in community resources
Some Promising Examples

Indy’s Population Health Predictive Analytics Program

- Partnership of safety net hospital and clinics, and public health agency
- Incorporates population health and social determinants measures into the electronic health record
- Predictive analytics and EHR prompts notify clinicians of high risk conditions
- Public health nurses are added to the care team to link patients with needed resources
Some Promising Examples
Massachusetts Prevention & Wellness Trust Fund

- $60 million invested from nonprofit insurers and hospital systems
- Funds community coalitions of health systems, municipalities, businesses and schools
- Invests in community-wide, evidence-based prevention strategies with a focus on reducing health disparities
- Savings from avoided medical care are expected to be reinvested in the Trust Fund activities
Some Promising Examples
Maryland Global Budgets and Health Enterprise Zones

- CMS waiver for global capitated hospital budgets
- Community coalitions develop targeted plans for community health investments in geographic zones with high health disparities
- Tax credit incentives for health providers who operate in zones
- Savings from avoided medical care are expected to be reinvested in the community coalition activities
### Getting to sustainable financing

<table>
<thead>
<tr>
<th>Structural element</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strong multi-sector governance model</td>
<td>Do I have a seat at the table?</td>
</tr>
<tr>
<td>2. Clear goals, activities, division of responsibility</td>
<td>What are we buying?</td>
</tr>
<tr>
<td>3. Clarity on implementation costs</td>
<td>What is the investment?</td>
</tr>
<tr>
<td>4. Credible estimates of health &amp; economic outcomes</td>
<td>What are the returns?</td>
</tr>
<tr>
<td>5. Robust evaluation and monitoring systems</td>
<td>How will we know success?</td>
</tr>
</tbody>
</table>

**Willingness to Pay**
Financing sources & models

- Dedicated state and local government allocations (CO, OH, OR, WA)
- Medicaid administrative match/claiming (ME, AR, OR)
- Hospital community benefit allocations (MA, ME, MI)
- AHC/ACO shared savings models (WA, MN, MD)
- Community health trusts (MA)
- Public/private joint ventures (KY, OH, NC)
EXERCISE Part 3: Health Systems

1. Choose a pop health problem to tackle in your community.

2. Identify the health system actors relevant to your problem of interest.

3. What incentives do these health systems face for engaging in the problem?

4. What financing mechanisms could be leveraged for addressing the problem?
Finding the connections

- Act on aligned incentives
- Exploit the disruptive policy environment
- Innovate, prototype, study – then scale
- Pay careful attention to shared governance, decision-making, and financing structures
- Demonstrate value and accountability to the public
For More Information

Systems for Action
National Coordinating Center
Systems and Services Research to Build a Culture of Health

Supported by The Robert Wood Johnson Foundation

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