# Integrating Population Health into Delivery System Reform

## Population Health Roundtable IOM

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# Theme

- The health care system is transitioning from payment rewarding volume to value based on Triple Aims outcomes.
- This could create funding stream to reward improvements in population health and a window of opportunity to shift to more sustainable funding models for population health
- However, the complexity and relative weakness of key building blocks for population health payment models creates the threat that will not be incorporated in new payment models in a meaningful way

# Outline

- Context
- Examples of transformational models of service and payment
  - National: CMS
  - State/Local: Vermont
- Opportunities and threats for population health financing

# I. Context

Why Delivery System Reform?

- Goal: Universal access to affordable, quality health care for all
- Issue: performance of existing system results in unsustainable costs
- Approach: transformation of the current system to achieve and reward Triple Aims outcomes
- New aligned payment model is a necessary but not sufficient condition for transformation
- Conceptual Model: Halfon, Healthcare 3.0

# US Health Care Delivery System Evolution


## Acute Care System 1.0

Episodic Non-Integrated Care

- Episodic Health Care
- Lack integrated care networks
- Lack quality & cost performance transparency
- Poorly Coordinate Chronic Care Management

## Coordinated Seamless Healthcare System 2.0

Outcome Accountable Care

- Patient/Person Centered
- Transparent Cost and Quality Performance
- Accountable Provider Networks Designed Around the patient
- Shared Financial Risk
- HIT integrated
- Focus on care management and preventive care

## Community Integrated Healthcare System 3.0

Community Integrated Healthcare

- Healthy Population Centered
- Population Health Focused Strategies
- Integrated networks linked to community resources capable of addressing psycho social/economic needs
- Population based reimbursement
- Learning Organization: capable of rapid deployment of best practices
- Community Health Integrated
- E-health and telehealth capable

# II. Innovation in Payment Reform

- Federal: CMS Innovation Center (CMMI) Creating building blocks
- State: Vermont Delivery System Reform Assembling the building blocks

# 2011 Vision: CMS as a Catalyst

*The CMS Mission*

***CMS is a constructive force and a trustworthy partner for the continual improvement of health and health care for all Americans.***

Center for Medicare & Medicaid INNOVATION

# *The Innovation Center*

## ACA Charge (S 3021): Identify, Test, Evaluate, Scale

"The purpose of the Center is to test innovative payment and service delivery models to reduce program expenditures under Medicare, Medicaid, and CHIP…while preserving or enhancing the quality of care furnished."

- **Resources:** $10 billion funding for FY2011 through 2019
- **Opportunity to "scale up":** The HHS Secretary has the authority to expand successful models to the national level

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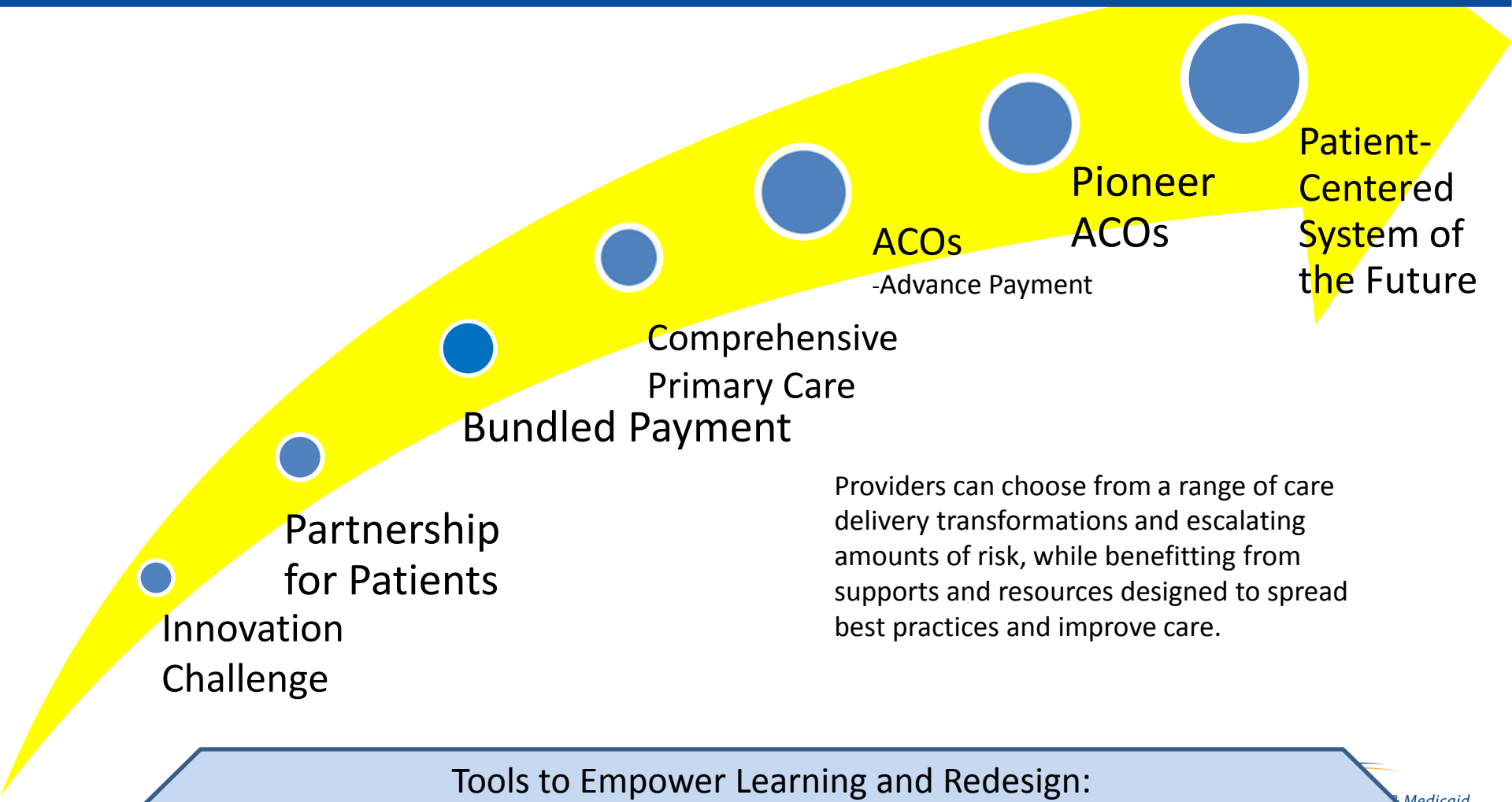
# *Delivery Transformation Continuum*




Providers can choose from a range of care delivery transformations and escalating amounts of risk, while benefitting from supports and resources designed to spread best practices and improve care.

Tools to Empower Learning and Redesign:
Data Sharing, Learning Networks, RECs, PCORI, Aligned Quality Standards

# *Measures of Success*

| | |
|---|---|
| **Better health care:** | Improving patients' experience of care within the Institute of Medicine's 6 domains of quality: *Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency,* and *Equity.* |
| **Better health:** | Keeping patients well so they can do what they want to do. Increasing the overall health of populations: address behavioral risk factors; focus on preventive care. |
| **Lower costs through Improvement:** | Lowering the total cost of care while improving quality, resulting in reduced expenditures for Medicare, Medicaid, and CHIP beneficiaries. |

# Population Health at CMMI

**Create the Vision**: Articulate a clear conceptual framework for evolution of health system built on national strategies for quality and prevention

1. **Measure**
   - Develop robust set of measures for tracking changes in population health
2. **Test New Models of Payment and Service**
   - Strengthen population health focus in all models
   - Identify and support innovations which integrate clinical care with community based focus on determinants of health: HCIA, SIM
3. **Build Collaborations**
   - State
   - Private payers
   - Federal Partners (e.g., CDC, AoA, HRSA, DOD)
   - Public health: e.g. ASTHO, NACCHO
   - Public/private coalitions
4. **Promote and Teach**
   - Catalyst , exemplary case studies, IAP

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# VT Health Reform

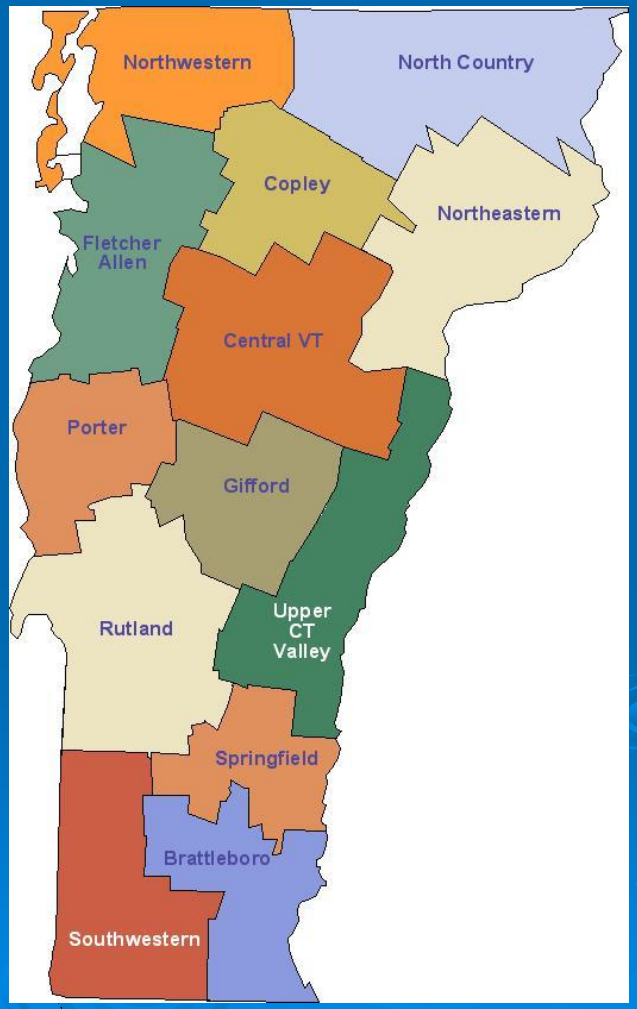
600,000 total population

Goal: improve the health of Vermonters

13 Hospital Service Areas define ‘community systems’

Payers: 3 commercial + 2 public

Laboratory for health reform



# Innovation in Service Models

- PCP level: Blueprint for Health enhanced medical homes cover 75% of population
  - Community linkages: e.g. smoking, DPP
  - SASH residential: 40 sites
  - Substance Abuse hub & spoke (Medicaid Health Home S 2703): state wide 1/2014
- Community level
  - Community Health Team: core and expanded
  - Medicare ACO: One Care,  50,000 seniors
  - Non profit hospital Community Health Needs Assessment guidance
  - Rethink Health: Upper CT River Valley

# Innovation in payment models

- PCP level
  - Capacity payment: NCQA score, all payer MAPCP demo
  - SASH: pmpm based on panel of 100 patients
  - MH/SA Health home: future model capacity + performance
    - Corrections, employment, foster care
  - Comprehensive support services Health Home:TBD
- Community level
  - Community Health Team: all payer,
  - Medicare ACO shared savings: quality measures
  - Hospital CHNA/budget review
- State level
  - State Innovation Model testing grant
    - Shared savings, bundled payment, P4P
    - population health workgroup

# III. Delivery System Reform and Population Health

- Status
- New population health financing models
  - Opportunities
  - Threats

# Status: Growing Opportunity

- Broad diffusion of language supporting better health for populations,
- New payment models being tested at scale
- New options: Hospital community benefit, bank community reinvestment, social impact bonds
- Signs of payers aligning in initial regional markets, eg Comprehensive Primary Care Initiative,
- BUT, Delivery system evolution lags rhetoric, with broad distribution across Halfon's scale
  - A very few exploring path to 3.0

# Challenges for Population Health Financial Models

- Other dimensions of value (total cost, patient experience) have a long history of being used in payment models
  - Interventions better understood
  - Measures and instruments developed
  - Accountability more clear cut
- Tasks of transforming  to managing total cost and patient experience are all consuming
- Population health business case is complex and requires reinvestment of shared savings from multiple sectors and valuing long term impacts

# Challenges

Integrating population health into delivery system reform is intimidating goal

- Determinants of health model not readily understood: Tendency to focus on the familiar, clinical services that health providers control directly.
- Portfolio of validated interventions for key risk factors eg obesity, is small
- Measures are poor: Confusion between quality of care and population health, focus on clinical measures

# Threat

Payment models for population health in early stage of development

- Population health traditionally funded by grants, taxes, not payment for services
- Infrastructure and tools for population health improvement are not well developed
  - Integrated service models for clinical care, public health and community based resources
  - Models for projecting long term impacts
  - Business case for payment models fundamentally diifferent from impact on risk factors: CMS vs CDC
  - Robust measures for learning, accountability and payment
- Risk: new payment models will be established with no meaningful population health component

# How to pay for population health?

A simple question to ask, but one remarkably difficult to answer.

We won't get the community health system we need (Healthcare 3.0) until we learn how to answer it.

# Recommendation

- Create greater awareness and sense of urgency in population health community re limited window of opportunity
- Endorse and support expansion of efforts to accelerate development of tools
- Provide technical assistance to state and local health officers to engage more effectively in health reform
  - CDC/OSTLTS
  - APHA Advisory Group on Public Health System Transformation
  - ASTHO/NAACHO