

“How Can We Pay for a Healthy Population?” Webinar: Follow Up Questions and Answers

On March 6th, 2013, Prevention Institute hosted a webinar entitled “How Can We Pay for a Healthy Population?” with four presenters describing promising approaches for generating sustainable and consistent funding for community prevention:

Janine Janosky, Head of the Center for Community Health Improvement, Austen BioInnovations, presented on the Accountable Care Community model;

Rick Brush, CEO and Founder, Collective Health, presented on Health Impact Bonds;

Kevin Barnett, Senior Investigator, Public Health Institute, presented on non-profit hospital community benefit funding;

and Maddie Ribble, Director of Policy and Communications, Massachusetts Public Health Association, presented on the Massachusetts Prevention and Wellness Trust.

We received so many thought provoking, valuable questions from participants that we decided to synthesize them into four overarching questions, and then posed to the webinar presenters. Their responses are recorded below.

1. What is the potential in scaling up the approach you presented on and/or replicating it elsewhere across the country?

Janine: For the Accountable Care Community (ACC) that we are leading in Akron OH, we have been working from the position that the ACC is scalable and can be replicated across communities. From our experiences, the minimum partners need to include a hospital, a public health district, and social service agencies, with the possibility of more partners. The scalability of the ACC is driven by the size of the community, the complexity of the health of the community, the availability of competing and diverse partners, among others. A number of areas have contacted us referencing the possibilities of implementing an ACC, and we look forward to working with all.

Rick: We think there is significant potential to scale up and replicate our asthma intervention in Fresno and other communities using Health Impact Bond financing. At the end of phase one, we will have validated cost savings using insurance claims data. This will support scale up of the program through shared-savings contracts between payers (insurers, employers, and others that directly benefit from reduced health care costs) and investors (foundations, individuals, and institutions that provide upfront capital for the intervention). While our project focuses on asthma, we see many opportunities to expand the application of Health Impact Bonds to other areas of prevention (comprehensive care coordination models to reduce avoidable emergency department visits, hospital re-admissions, at-risk maternity, serious mental illness, onsite/telehealth/in-home care).

Kevin: Community benefit is the entry point for hospitals to build the population health capacity that will be essential for their long term economic viability. As such, more visionary hospital leaders will start with a focus on preventable ED and inpatient utilization for

uninsured and underinsured populations, since the current system of FFS reimbursement does not incentivize doing so with insured populations. As they analyze and GIS code the data on these populations, they will quickly discover that they are concentrated in low income communities where there are substantial health inequities. They may start with a focus on care management, but they will have to ultimately move towards a more place-based focus to address the social and physical environmental factors that are drivers of negative health behaviors. In the process, they will have to build the kinds of working relationships with those stakeholders who are best positioned to impact those determinants, ranging from community health centers to financial institutions who have to meet their Community Reinvestment Act responsibilities

Maddie: In Massachusetts, we gained a victory because we were able to convince the legislature that prevention is a good investment. They only agreed to four years of funding, however, which means we have to show strong results and money saved within the four years. There will be a robust evaluation of the process from an external party, and if we can show results in four years, we will be well positioned to make the case that continued investment in prevention will save more money and therefore be able to expand and scale up. In terms of other states, various legislatures are looking at health care costs and cost containment, especially with implementing the ACA, and they will need to make sure prevention is an essential part of this process. It is a window to establish prevention as an integral part of health care and health reform.

2. Do you think the four approaches are potentially complimentary? If so, how?

Janine: Absolutely, there are touch points and alignments among the four approaches. As one example: Even though we have three competing health systems within our community, all three are working together to complete one community health needs assessment (per 990). As a second example: We are exploring referencing a potential secondary funding mechanism along the lines of a health impact bond to finance augmented innovation.

Rick: Yes, it is worth exploring potential connections among these approaches. For example, could Community Benefit or Wellness Trust dollars be invested into Health Impact Bonds that support evidence-based prevention and generate better health and financial outcomes? In this case, it might be possible for these investments to earn a financial return that could then be re-invested in additional programs and expansion. Another example might be using Health Impact Bonds to finance the initial start-up costs for Accountable Care Communities.

Kevin: The four approaches are complimentary, but it will be important to balance the imperative to be bold with a focus on what is practical in the near term. It will take some time to build common language and understanding of what is possible. For example, it is important to avoid the impression that hospitals have large pools of unencumbered funds that can be “freed up” for investment in community development. There are some institutions with large reserves that may be in a position to play a substantial role on the financing side of the equation, and some are already engaged in impact investing. To a significant degree, however, the near term focus should be on neighborhood and community level focus and leveraging resources through better alignment of interventions, activities, and investment.

Maddie: In Massachusetts, the legislative champions of the Wellness Trust have been looking into Social Impact Bonds as ways to increase funding for the Trust. At this point it is all theoretical, but it could turn into something in the future. Also, the Massachusetts Public Health Association works with hospital systems that have great community benefits programs as well as organizations that benefit from these programs. As hospitals think about community benefit investments, it's important that they look at how they can coordinate with broader issues, such as those being addressed through the Wellness Trust, in order to get a better bang for their buck.

3. Are there state policy levers that could enable each of these approaches to be adopted and implemented more effectively or more broadly?

Janine: Yes, there are state policy levers that could enable some of these approaches. As an example: Within the State of Ohio, under the Governor, we have an Office of Health Transformation that does and could serve as a driver.

Rick: Several states have either passed (MA) or are considering (NJ, MD, CA) legislation that would allow government payments to Social Impact Bond investors if success metrics are achieved.

Kevin: On the community benefit side of the equation, there are clear limits to what can be done at the state level in terms of direct oversight, but there are state agencies that serve as clearinghouses for hospital utilization data. These data can be analyzed by payer source, institution, and diagnosis at the zip code level and overlaid with demographic data and hospital location to drive a more targeted focus where disparities are concentrated. States with some analytic capacity will also be in a position to aggregate hospital 990 Schedule H data at regional level in a manner that will foster more targeted investment and alignment across institutions.

Maddie: Health care policy debates are occurring in city legislatures and state legislatures all over the country, and they should not be viewed as separate discussions from prevention. The Massachusetts Public Health Association's goal is to make sure that prevention is included in these discussions about health care reform.

4. One of the challenges in promoting investment in community prevention is that in moving "upstream" the impacts of interventions become harder capture (e.g., improving neighborhood air quality has multiple health benefits and cost savings potentially accrue to different health payers and other non-health sectors). How does the approach you discussed deal with this challenge?

Janine: To address these issues, we have been working through the ACC toward collective impact. Moving beyond collaboration to sustained, across institution and stakeholders, to all be accountable for the health of all residents of our community.

Rick: A fundamental and sustainable shift in health will only come about if we take on the big issues: the social, environmental and economic systems that influence our health, health behaviors and health choices. Changes at this level will require collective action -- and generate collective benefits -- across many stakeholders (i.e., all of us). It will require patient

capital; long-term investment and a larger pool of investors to spread risk and return. In our white paper referenced in the PI report, we considered a Health Capital Market, where multiple Health Impact Bonds and other investment vehicles would connect a broader set of investors and public and private payers to finance community-wide health improvement and prevention efforts.

Kevin: We're still in the early stages in this process, but as referenced by Janine, the collective impact model offers a vision that should drive our work towards the identification of a limited set of metrics that are relevant to the broad spectrum of stakeholders

Maddie: With the Wellness Trust, we are tied to a four-year timeline and a cost containment policy that requires us to demonstrate strong cost savings and improved health outcomes. Because many upstream strategies take more than four years to show cost and health benefits, we will have to focus on certain interventions that show quicker turn around for cost savings and health improvements, such as chronic disease management activities with populations that already have significant health conditions. However, we will push the Administration and the Department of Public Health to look at different metrics beyond just cost savings and improved health outcomes within four years. Part of the plan may include looking at strategies that achieve changes in health outcomes within the four years, but whose savings will be realized later down the road. Additionally, we may push for strategies that lead to changes in health behaviors within four years, but that won't necessarily demonstrate health outcomes or cost savings within that time frame. We might have to extrapolate out to convince stakeholders that there will be improved health outcomes and cost savings in the future. This will require finding middle ground between more upstream and more downstream approaches.