Institute for Healthcare Improvement

Innovation Project Final Report:
Sustainable Financing for the Triple Aim in a Community
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Intent & Aim: The goal for this work is to help a community develop a set of options that they can use to develop a sustainable flow of financial support for population health /TA in that community. The aim is to create an overall framework as well as to develop resources for communities at different levels of readiness to help them develop sustainable business models for their work on improving population health for their community.

Background:
For many years we have been working with geographic communities at IHI around the Triple Aim. We have developed an overall approach that includes: governance, population selection, high level measures and the development of a portfolio of work to support the project. A big challenge that remains within a geographic community is building a model for the long-term financial support that can sustain this work over time. While not a new idea, implementation of a sustainable financing model for community health work has lagged behind other efforts, with many communities relying on grants and other short-term funding sources.

Description of the Work:
There are hundreds of coalitions across the US that are actively focused on improving some aspect of the health in their community. To maintain their work they need resources, either through in-kind donation or money. The purpose of this work is to provide a framework for resources that can be used to sustain this work. There are some underlying assumptions that we hold that will influence this discussion.

1. Most communities there are a large amount of resources that are already present in the community for improving health.
2. These resources are not being used as well as possible in a coordinated fashion.
3. There are few to no population health outcome measures attached to the present money flow, whether for health care, public health, social services, or community redevelopment, etc.

Listed below are some key ideas about building a sustainable financial model for community health improvement. Much of the material for this document is based on the work of the IOM

committee on Population Health[1] [2] and specifically David Kindig, George Isham [3], Jim Hester and Paul Stange [4]

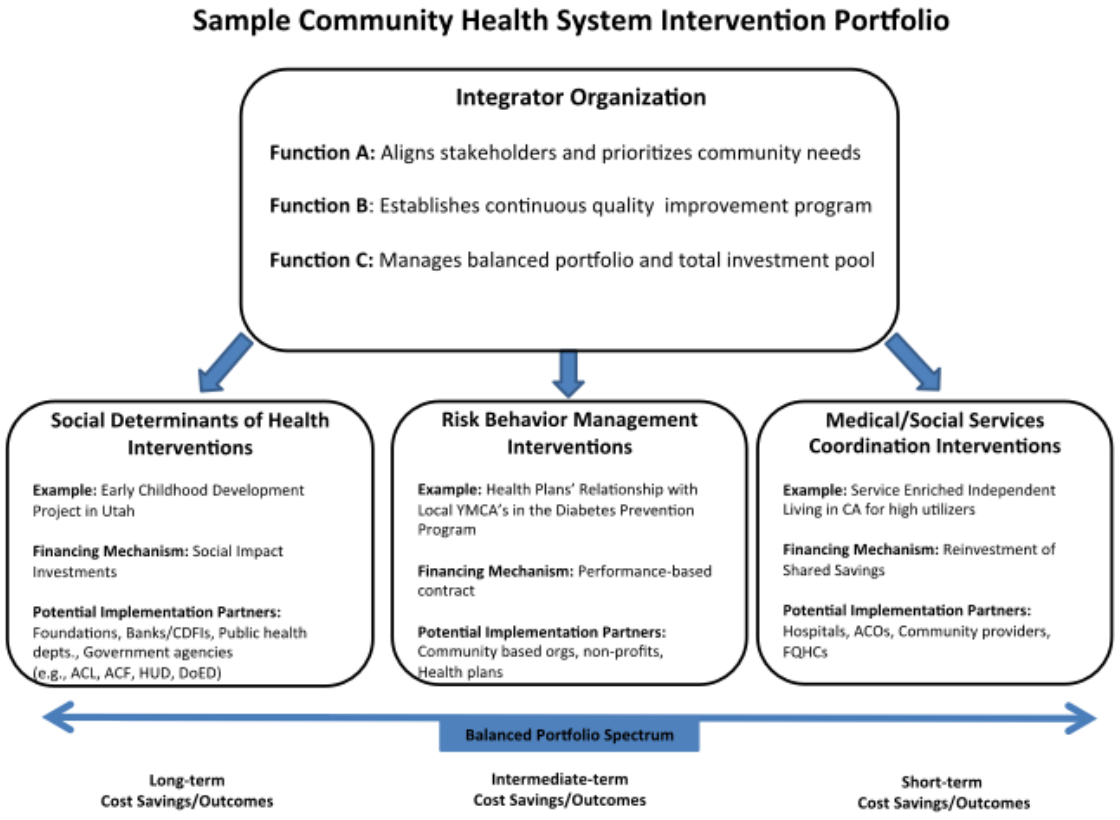
Community Health Improvement System

Before we discuss resources, we should talk briefly about a few of the roles for a community health improvement system.

We need leadership that can convene a group that recognizes that the community has a population or populations that need support. Some of the roles for this group would be:

a. Reconcile diverse perspectives by crafting a clear purpose for the group.
b. Assess community population needs.
c. Coordinate activities among different organizations in the community that impact the at-risk populations. Manage a portfolio of short, intermediate, and long-term programs that impact population health and community vitality. Figure 1 is an example of this.
d. Manage small budgets for backbone organizations and identify the much larger financial resources for each of the major community initiatives in the portfolio.
e. Create a learning system to accelerate the work. This will include key measures for this work along with quality improvement capability.
f. This committee must demonstrate value over time to attract funds.

Figure 1 Sample Portfolio [5]



Building a sustainable financial model for community health improvement.

To support the work of a community health improvement system, you need money and in-kind resources to do two things. One is a relatively small amount to support core infrastructure for the committee itself, "the backbone organization," [6] and two is a larger amount of money to fund the portfolio of projects it supports.

As stated earlier, in most communities there are already a lot of resources and in some there may already exist a 'backbone support organization' that can serve as the integrator organization. Many of these resources are being applied in an uncoordinated manner and producing suboptimal results. No community will be able to perfectly optimize its resources, but most

communities have an opportunity to do better. Based on that, let's discuss some potential financial resources for a community.

1. Identify present financial opportunities. The list below represents current activity/opportunity in most communities:

a. Community Reinvestment Act opportunities - Banks use intermediaries - Community Development Financial Institutions (CDFI). Multi-stakeholder collaboratives need to work with these institutions.

b. Public Financing from federal ,state and county programs. The following is sample of federal programs:

Housing and community development
-Mainly HUD (about $30 billion)
-Includes Community Development Block Grants, HOME Investment Partnership grants, Housing Choice Voucher program, Choice Neighborhoods

Public safety
DOJ ($630 million) in state, local, and tribal law enforcement
Community-Oriented Policing Services (COPS), Byrne Criminal Justice Innovation Program, Community-based violence prevention initiatives, substance abuse programs

Transportation
DOT and EPA (more than $20 billion)
Sustainable Communities Grants, Brownfields, Federal Transit Administration, Surface Transportation program, Metropolitan Planning Grants, MAP-21, TOD planning

Capital and finance
Treasury and others (more than $10 billion)
Low-income housing tax credit

Education
Department of Education, USDA, VA, HHS (about $30 billion)
School meals programs, Head Start, Race to the Top, Veterans education

c. Health Care related financial opportunities

Section 1115 Medicaid waivers at the State level
ACA related community assessment - community benefit dollars
Prevention and Wellness Trust
ACO - Right now any savings are captured by the ACO and not shared with the community. Should they be?
CMMI- CMS grants

Comment. It is known that there is waste in health care. The thought is that if we reduce health care spending we can capture that money to work in the community on other issues. However, you would need a mechanism to capture those dollars for the community.

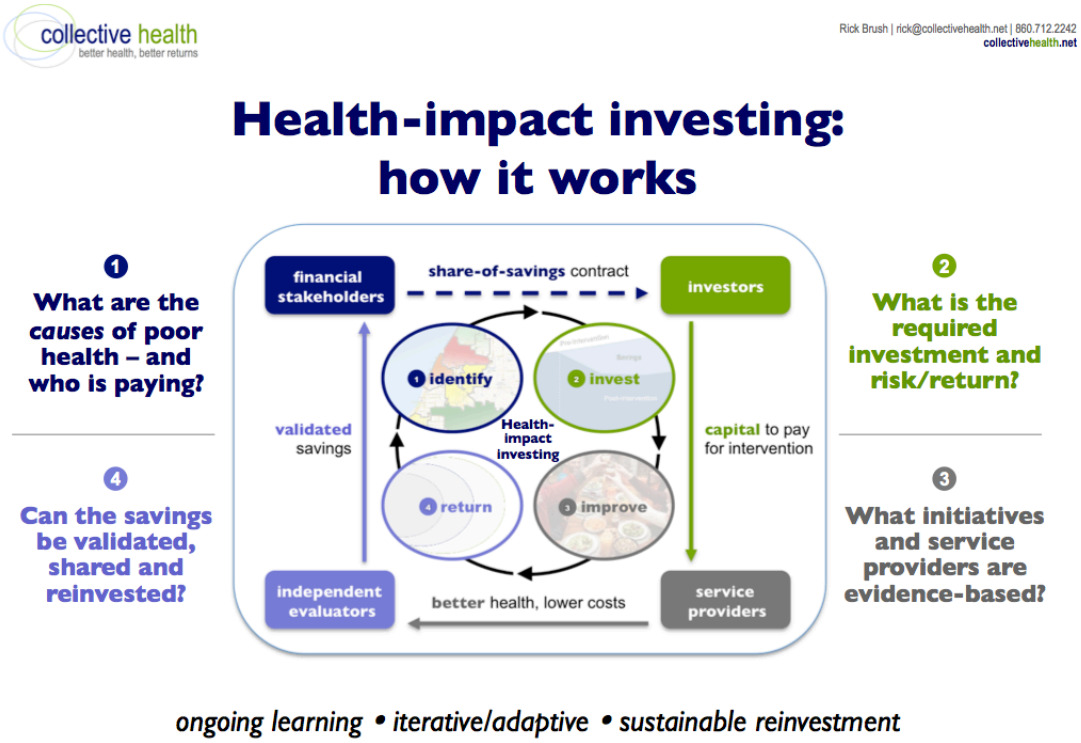
d. Philanthropic organizations: national, state and community foundations as well as sources like United Way

e. Other banking and business opportunities that lead to re-development of a community. As an example, downtown areas of communities where transformation occurs to revitalize the local business opportunities.

f. Membership model. This is basically the idea that the member organizations that make up the community health improvement organization self-fund the work through a membership fee which is adequate to maintain at least the core functions of the organization.

2. Future approach for community health improvement resources:

a. Pay for success financing (another term used for social bonds). This is a mechanism to turn health improvement opportunities into financial opportunities. The idea is that you identify an opportunity where there is a significant gap in health or social outcome that has a known solution. You determine who is paying for this poor health or social outcome. If the payer is willing, you develop a performance contract based on what improvement can be achieved with the known intervention. You apply the intervention and determine over time how successful the actions are. The chart below is an illustration of this idea.



Comment: We need to start to think of money in a community as a "capital stack." The stack might include outside investment, money already being spent on broken processes that can then be returned to investors along with philanthropic money that can be used as part of the return to entice investment. A little bit of money can be used to help produce a better financial return. That financial return attracts the much larger capital that is needed for community transformation.

b. Community Health Trust Fund. An example of a health trust fund is the Massachusetts Prevention and Wellness fund. It has $60 million that is used to make community grants. It is funded through a tax on insurers and large health systems. This same idea might be applied at a local community level. In the Michigan Blueprint for Health Innovation,[7] "*A community trust fund is created by a pre-payment by the relevant stakeholders (such as payers, health systems, business) for improving community health and reducing community health risk factors that increase health care cost and impact the quality of life and productivity of Michiganders. The community trust, funded based on the number of covered beneficiaries that live in a region, is accountable for public reporting of spending and outcomes achieved. If Michigan were to adopt Medical Loss Ratio requirements for Medicaid contracted health plans, payments to the community trust by those plans would be considered medical costs rather than administrative expenses".*

Table 1 is an example from Hester and Stange on a balanced portfolio for a community. [8]It describes both the idea of building a portfolio and the funding stream to support the portfolio of projects.

TABLE 1 Sample Balanced Portfolio for Community Health System

Intervention	Target population	Implementation partners	Financing vehicle	Time frame	Risk/evidence	Savings sharing vehicle
Intensive care coordination	Dual eligible high utilizers	Accountable care organizations	Shared savings	Short	Low risk	Community benefit
Integrated housing–based services	Medicaid eligible, multiple chronic illness	Medicaid managed care plan, housing corporation	Capitation	Short	Low risk	Performance contract
Innovative use of remote monitoring	Medicare eligible, multiple chronic illness	Medicare Advantage Plan, private foundation	Grant	Short	High risk	None
YMCA diabetes prevention program	Commercial insured and self insured	Commercial health plan, self-insured employers	Shared savings	Medium	Medium	Performance contact
Asthma medical management	School-aged children	Commercial and Medicaid health plan	Shared savings	Medium	Medium	Performance contract
Asthma environmental hot spots	Children with asthma	Public health agency	1115 Medicaid waiver	Medium	Medium	Savings sharing
Expand early childhood education	Reduce adverse childhood events	Preschool educators	Pay for Success, Social Impact Bonds	Long	Medium	Investing in Social Impact Bond
Community walking trails	Community	Nonprofit hospital	Community benefit	Long	Medium	
New grocery store	Residents of U.S. Department of Agriculture food deserts	Community Development Financial Institution	Community reinvestment	Long	Medium	None

As you review table one, you will note that there is a shared saving column. For some investments that are successful, money will flow back to the investors along with a return to the community health improvement system. The money that goes back to the community can be used to help fund the backbone organization and some could be used for future portfolio work. Of course this is dependent on the creation of shared savings.

Underlying Mechanisms for a Sustainable Flow of financing for TA in the Community
Our analysis of the situation has suggested that there are three current approaches to building a sustainable money flow to support community health improvement activities: community health trust funds, shared savings and pay for success In some communities there may be the will to create a "tax" of health care payers and providers to pay for a trust fund for health improvement activities. However, this may not work for all or for even a minority of communities. Therefore it is important to consider alternatives. With shared savings, a per capita payment amount is established for a specific population and issued to a provider to deliver a social service to individuals. Built into the payment amount is an average cost of complications and defects across the whole population. If the service can be provided (and outcome achieved) for less than the payment amount, the provider keeps all or part of the savings. Shared savings is being used widely at this point in time through a variety of specific financial instruments and vehicles.

Another approach is incentive-based programs that 'pay-for-success' or pay for outcome. In these models, the financer establishes performance targets for beneficiaries of social services and organizations provide services to meet those outcome-based targets. In some instances, a tiered reward is then paid based on the level of health or social achievement that is attained. An example of a financial vehicle that is using this mechanism is social impact bonds described above that are leveraging private investment to cover innovative social programs that may reduce prisoner recidivism, hospital readmissions, and school absenteeism.

Shared savings and pay for success are good and useful resources. It is unclear whether either can be sustainable funding for the future. The problem with shared savings is that, over time, the agency 'paying' the savings will start to recognize that the capitated amount can be reduced, therefore shrinking the savings that can be captured. The problem with pay-for-success is that there is an additional premium that needs to be paid to a neutral third party to verify that the promised result has been achieved in order for payment to flow. Funding for these, often costly, evaluations that are key to the whole pay-for-success mechanism are not themselves sustainable.

An alternative to these two might be what we are calling "shared profit" or "shared benefit" approaches. These approaches, rather than sharing the fixed and dwindling pie of unused capitation payments, start with the idea that when everyone wins (financially) the cycle will continue to churn sustainably into the future. Shared profit financing vehicles might pool community resources (investments) from various stakeholders and then loan those funds to businesses and service providers to provide services that generate a financial return for the original investor. Such "shared profit" mechanisms require "conversion" of the benefit (which may be a social or health benefit) back into a financial gain.

Take for example, home solar installation in the US. In this example, homeowners in many parts of the US were initially incented by state and local government tax breaks to install solar panels on their roofs. The remaining capital was provided by the homeowner, but the benefit of reduced energy costs allowed homeowners to recoup their investment amount within 3-7 years (on average). Energy surpluses were then sold back to the state at a profit to the homeowner, but at a discounted price to the state—a price differential that ultimately saves the government money and pays off the lost revenue from the tax breaks originally afforded to the homeowners. In this cycle, both sides profit—homeowners ultimately from sales of power and government from reduced prices on power downstream.

Importantly, in "shared profit" examples, unlike shared savings, there's no need for a mechanism to "capture" the profit or savings and then distribute it to the responsible party. Profits either accrue to the parties involved or they don't. And unlike pay-for-success, there is no 3rd party evaluator or other intermediary creating other administrative costs. This is much more of a traditional business model. Some business models work and many do not. We predict the same will occur in shared profit systems.

Social programs may also combine features of these models: use investment to kick off a hybrid shared savings and shared profit program. For example, a local hospital entered into a risk sharing agreement to manage the health of its highest ER utilizers who were also homeless. The hospital used some of the resources made available through a capitation program to provide funding to several apartment building owners with vacant apartments. By providing housing to these homeless and vulnerable citizens, a percentage were stabilized and were able to find and secure jobs. These citizens were now able to pay their own rent—sharing profits (patient making money, landlords making money). The process was catalyzed by an investment from a shared savings program but ended up in a shared profit scenario. Now stably housed, these citizens also came to the ER less providing financial benefit to the hospital under the original shared savings scheme. The challenge we now face is to extend examples like this to other population segments and perhaps to chronic disease states.

Next steps for a community

1. What value does the "integrator" organization bringing to the community? Is anyone willing to pay for this value?
2. How is the "integrator" organization funded and how are projects funded? Should there be two streams of money, one for the integrator and one for projects or should it just be one stream?

3. Have you thought about the idea of creating a community health trust fund? Do you have a mechanism at the county or city level to create one? (some states have mechanism to create this at the county level)
4. Is there value in completing the portfolio guide for each project?
    Intervention
    Target population
    Implementation partners
    Financing Vehicle
    Time frame
    Risk/evidence
    Shared Profit Vehicle
5. Look at your portfolio of work and decide where money could come from. How could you create a business model for this work? Who are the investors for your work: government, business community, private citizens, healthcare, philanthropy, or private citizens? What mechanisms, alone or in combination, might support the various initiatives that you are proposing?
6. Is there value in following the flow of money for project? As stated earlier a lot of money flows to organizations without outcome or even process measures tied to it. Is there any way to improve that.
7. What resources (orgs, initiatives etc) are available in the community already that can be leveraged to align existing activities to the portfolio of projects that are chosen.Talk with an organization like United Way to see if you can require organizations that are supported to help in some way with your portfolio of work. Require at least process level measures from them.
8. Take an inventory of existing projects that may be related to community reinvestment and public financing. Have a conversation with bankers who are responsible for the community reinvestment act. See where there is synergy between that and the expected portfolio of projects that would meet the community's needs.
9. What changes are occurring in your state that can positively impact this work?

Conclusions and Recommendations:

1. Existing community coalitions need to create sustainable funding mechanisms. We have outlined a set of "next steps" that we think will be helpful to them.

2. IHI could use this set of "next steps" as a means to assess community coalitions from a financial sustainability perspective.

3. We are potentially at the beginning of a larger community collaborative movement around health. The ACA required not-for-profit health systems to do a community assessment. At the same time both United Way and public health departments have been doing community assessment. If they link their work together this should lead to more collaboration and hence a need for sustainable funding to implement the plans that will come from the collective assessment.

4.We proposed in this paper a shared profit model. More work and testing needs to be done with this model at some future date.

Open Questions:

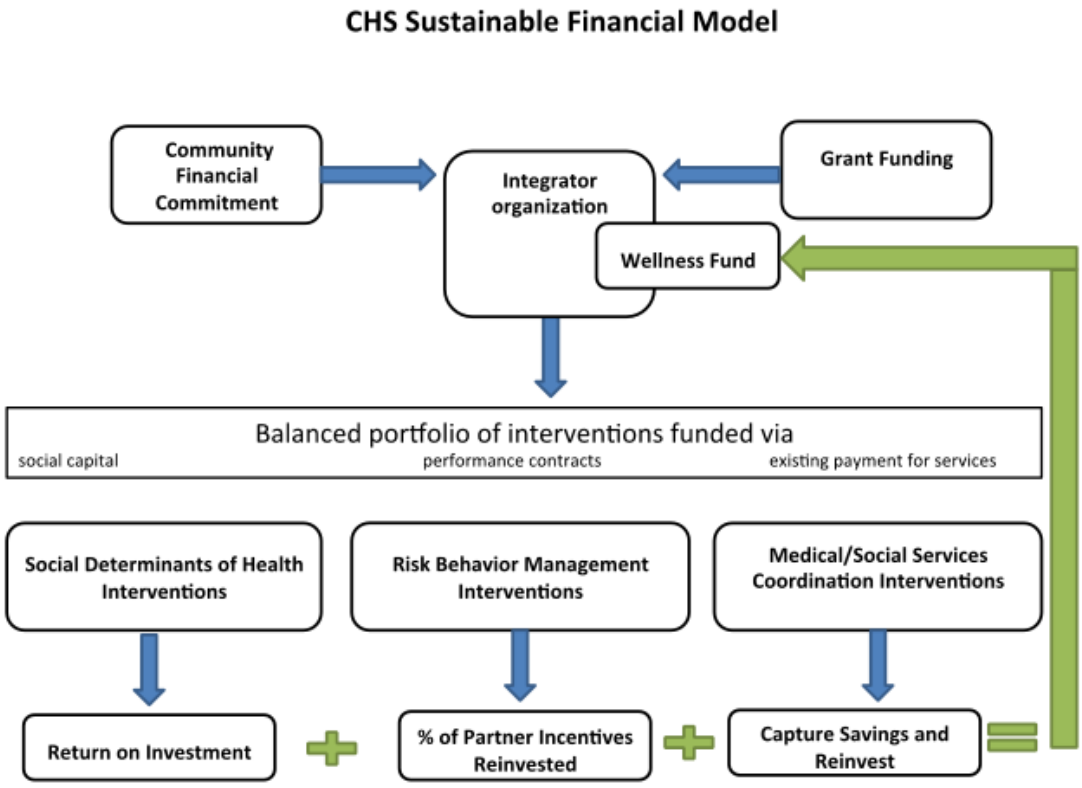
1. Is there enough money already flowing to a community for the work of community health improvement? Should we start to look at budgets that already exist and what we are getting from them: public health, social services, etc.?

2.For most major community concerns, is there someone already working on it in the community? Is there money flowing to them? Do they measure anything? What outcomes do we expect from them? How was the choice made to support this community organization?

3. Should more place-based work be carried out? What if we focused on a small area that is "poor" and figured out how much money is actually being spent in this area on services, health and otherwise?

4. Since this approach is focused on funding community health improvement, are there other models or countries that we should look to for good examples?

Appendix A
Jim Hester Model of Money flow [9]



Appendix B *Michigan's Blueprint for Health Innovation* [10]

These are excerpts taken straight from the Michigan's Blueprint for Health Innovation submission to CMMI that were thought to be relevant to this paper

Michigan's Blueprint for Health Innovation proposes a transformation that includes the following structural elements: Patient Centered Medical Homes, Accountable Systems of Care, Community Health Innovation Regions, Payment models and Statewide infrastructure

Patient Centered Medical Homes put the individual in charge of their health care: clinicians are more accessible, care teams engage patients with complex needs, and providers monitor their patient population to assure that everyone is getting the care they need.

In Accountable Systems of Care, providers are organized to communicate efficiently, coordinate patient care across multiple settings, and make joint investments in data analytics and technology. Through clinical integration – supported by formal governance and contractual relationships – providers co-create tools, workflows, protocols, and systematic processes to provide care that is

accessible to patients and families, supports self-management, is coordinated, and incorporates evidence-based guidelines. As the capacities of an Accountable System of Care grow, the system can be held responsible for performance in terms of quality of care and the health outcomes of their assigned population. Health plans will continue to fulfill their current role in managing insurance risk, while contracting with Accountable Systems of Care to take on performance risk. Plans will
collaborate with Accountable Systems of Care to provide wrap-around services and benefits; beneficiary outreach, engagement, education, and other member services; data analytics; and information on utilization outside of the Accountable System of Care.

In Community Health Innovation Regions, partners act cohesively with a broad-based vision for region-wide impact, to make the environment healthier and to connect health services with relevant community services. The process begins with a collaborative community health needs assessment that identifies key health concerns, illuminates root causes of poor health outcomes, and sets
strategic priorities. Action plans are developed to organize and align contributions from all partners for collective impact. Payment models are designed to incentivize value over volume – aligning the interests of patients, communities, primary care providers, specialists, hospitals, payers, and policy makers toward the aims of better population health, high quality health care, and lower cost. To do this, a staged approach to payment reform is proposed in which Patient Centered Medical Homes and Accountable Systems of Care are supported in moving away from fee-for-service and adding capacity for coordinated care and responsibility for outcomes.

A statewide infrastructure will be put in place to provide governance for the implementation of Michigan's Blueprint and to respond to the needs of patients, providers, communities, and payers. State government must align policy, payment, and programming to reinforce the Blueprint elements and incentivize the desired outcomes. The State is a major purchaser of health care services for Medicaid beneficiaries and for its own employees. The State has an important role in guiding
investment in shared infrastructure and promoting practice transformation through statewide data monitoring, evaluation and dissemination. It establishes systems to monitor and reward performance, and to disseminate information, including recognition of top performers.

Community Health Innovation Regions will perform the following functions:
I. Act as a convener of cross-sector stakeholders, including facilitating partnerships among stakeholders that are competing in a market-based health system
- *a. Governed by a Board of Directors and by-laws*
- *b. Convene diverse stakeholders*
- *c. Engage and sustain the commitment of leadership from local government, purchasers, payers, providers, community, and public health*

d. Facilitate a process to develop and define a common agenda and community health improvement goals

e. Facilitate a process to develop and define how to measure improvements

f. Assure accountability to improvement goals

II. Provide backbone organizational body for governance and a staff that carries out the day-to-day organizational and administrative functions

III. Coordinate activities with state and local public health

IV. Develop a systematic approach to community-wide public engagement, education, and mobilization for ongoing input into improvements in the health care delivery system and community-centered population level strategies, with special emphasis on vulnerable populations

V. Develop a core set of community performance measures with input from community members, collaborating with the state-level Performance and Recognition Committee

VI. Maintain a public community dashboard that provides community specific measures, target performance, and compares level of improvement against target performance goals

VII. Ensure a community needs assessment is completed including development of strategic priorities for health improvement in the community

VIII. Develop and effectively champion strategic interventions to drive improvements in health and health care; examples of strategic interventions include:

a. Coordination of health care services with human services (e.g., implement Pathways Hub model or leverage Pathways to Potential Family Resource Centers, as described in chapter B)

b. Integration of medicine, public health, and community resources in addressing health priorities (e.g., a community-wide approach to childhood obesity)

c. Public reporting of performance measures in health care delivery and at the community level

d. Local approaches or policies that create healthy environments

e. Develop community-level, culturally appropriate health literacy and consumer engagement strategies

IX. Champion the need to achieve greater balance in investments in health care and other social determinants of health and marshal available resources within the community (financial, knowledge/skills, leadership, manpower, etc.) to achieve collective impact in community-based strategies that improve health and health care, including:

a. Community benefit dollars (as required by IRS)
b. Community investment/development funds (as required by the Community Reinvestment Act)
c. Philanthropic funding
d. Federal, state and local funding (e.g., Metropolitan Planning Organizations investing transportation dollars in a healthy built environment)
e. Community trust funds
f. Funding streams that represent a shared savings from a high-performance health system
g. Expanding billing for services by local public health departments
h. Comprehensive payment reform that pays for value

Sustainable Funding for the Community Health Innovation Region
The Community Health Innovation Region requires sustainable funding to support its essential functions including ongoing funding for the backbone infrastructure, community engagement, community assessment, strategic planning, and execution of strategic priorities. To assure sustainability and demonstrate that local stakeholders are committed, Community Health Innovation Regions must secure
financial support from a broad base of local funding sources, for example, Community Benefit funding, health plans, business, and philanthropy. The Community Health Innovation Regions must also demonstrate an ability to leverage public and private funding streams to support ongoing operations and
population strategies. With a demonstrated return on investment, Community Health Innovation Regions could secure other sustainable funding sources. New payment mechanisms will be tested including community health trusts and social impact bonds.

[1] Financing Population Health Improvement Workshop Summary Joe Alper and Alina Baciu, Rapporteurs IOM Roundtable on Population Health Improvement

http://www.iom.edu/Reports/2014/Financing-Population-Health-Improvement.aspx?utm_medium=etmail&utm_source=Institute%20of%20Medicine&utm_campaign=07.28.14+New+Report-+Financing+Population+Health+Improvement&utm_content=&utm_term=

[2] Financing Population Health Improvement Workshop

http://www.iom.edu/Activities/PublicHealth/PopulationHealthImprovementRT/2014-FEB-06.aspx

[3] DAVID A. KINDIG AND GEORGE ISHAM Population Health Improvement: A Community Health Business Model That Engages Partners in All Sectors Frontiers of Health Services Management V30 Number 4 Summer 20140

[4] James A. Hester, Paul V. Stange* A Sustainable Financial Model for Community Health Systems March 6, 2014 Copyright 2014 by the National Academy of Sciences.

http://www.iom.edu/Home/Global/Perspectives/2014/SustainableFinancialModel.aspx

http://www.iom.edu/Reports/2014/Financing-Population-Health-Improvement.aspx?utm_medium=etmail&utm_source=Institute%20of%20Medicine&utm_campaign=07.28.14+New+Report-+Financing+Population+Health+Improvement&utm_content=&utm_term=

[5] Financing Population Health Improvement Workshop

[7] Department of Community Health State Innovation Model Design Proposal http://www.michigan.gov/documents/mdch/Michigan_Blueprint_APPENDICES_REMOVED_454499_7.pdf

[8] James A. Hester, Paul V. Stange* A Sustainable Financial Model for Community Health Systems March 6, 2014 Copyright 2014 by the National Academy of Sciences. http://www.iom.edu/Home/Global/Perspectives/2014/SustainableFinancialModel.asp

[9] IOM Financing Population Health Improvement Workshop

[10] Department of Community Health State Innovation Model Design Proposal
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Michigan_Blueprint_APPENDICES_REMOVED_454499_7.pdf
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