

# Opportunity Knocks: Population Health in State Innovation Models

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*\*Participants in the activities of the IOM Roundtable on Population Health Improvement*

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# **Opportunity Knocks: Population Health in State Innovation Models**

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These are historic times for health care and health. The Affordable Care Act (ACA) has unleashed novel initiatives such as the Health Care Innovation Awards and State Innovation Models (SIMs), and we applaud Congress and the Center for Medicare and Medicaid Innovation (CMMI) for their foresight in creating such learning opportunities. Our country's National Quality Strategy focuses our efforts on the Triple Aim<sup>2</sup> of improving population health, improving the experience of care and lowering per capita costs of care. And this is matched with growing on-the-ground experience striving to achieve the laudable goals of the Triple Aim, spurred in part by CMMI's funding in this area.

Nevertheless, our current health care payment system rewards medical care for individuals, neglecting rewards for changing the factors that make people healthy, e.g., the places outside the doctor's office where people live, learn, play, and work. One clear need is to develop models that reward making the population healthy. We believe that the SIMs developed by states provide a unique opportunity to test new alignments, payments, and incentives that focus our current delivery system on achieving health for all. Unless we start now to develop such tools and models and accelerate their use, an orientation toward population health will always be underrepresented and underresourced. Furthermore, we are unlikely to achieve the goal of health care reform until we address the underlying drivers of increased prevalence of chronic disease such as tobacco use and obesity.

The major models currently being tested are focused primarily on the aims of controlling total costs of care delivery and improving the patient experience and do not significantly reward improvements in population health. They include measures of population health that focus on clinical preventive services but do not track "upstream" or higher-level determinants of health, such as school days missed, patient-reported health statuses, or health outcomes for a community as defined by a geographic region. Although clinical care contributes to population health, we have learned that other factors, such as healthy behaviors and the local built environment, are much more important. Another issue with the current payment models is that the time horizon for improvements is determined by the annual cycle of changes in medical spending, which precludes interventions with longer-term impacts and a wider range of benefits, such as interventions in the realms of employment and education. The unfortunate reality is that we have a relatively poor understanding of how to pay for population health in a sustainable way.

This creates the opportunity, no, the imperative, that the states receiving Centers for Medicare & Medicaid Services (CMS) funding to test and implement SIMs dedicate a portion of their resources to pilots and experiments that are focused on the third aim of improving population health. With input from and ownership by the community and providers, we believe these pilots should be structured with goals and actions at the community level and integrate

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<sup>1</sup> Participants in the activities of the IOM Roundtable on Population Health Improvement.

<sup>2</sup> A concept developed by the Institute for Healthcare Improvement in 2006 (see Berwick et al., 2008) and forming the basis for the Three-Part Aim described in CMS and other Department of Health and Human Services programs.

clinical services, public health programs, and community-based initiatives targeting the upstream determinants of health. They should include the implementation of a core set of metrics for tracking changes in population health for both program improvement and accountability (see, for example, the recommendations in the 2013 IOM report *Toward Quality Measures for Population Health and the Leading Health Indicators*). They should also include aligned payment models for key stakeholders that reward and incentivize demonstrated improvements in the health of the community.

Where could these models start? An optimal approach would involve a portfolio of measures paired with financial incentives that are balanced in the following dimensions:

- substantively balanced to meet the prioritized needs of the community;
- designed to capture and link both clinical and community-wide measures for process and outcome; and
- intended to produce both short- and long-term impacts.

For example, a balanced portfolio might include both practice- and community-wide measures and intentionally seek ones with relatively quick positive and measurable health benefits and/or cost-saving outcomes, such as effective prevention interventions (e.g., influenza vaccinations, alcohol screening/brief counseling), asthma intervention measures (which decrease emergency room visits and hospitalizations), and behaviors responsive to city- or state-wide interventions (e.g., tobacco use levels). Mental health measures could be included (e.g., Patient Health Questionnaire-9 for depression, which can be used for screening and follow-up). Alternatively, there might be complementary metrics for which significant benefits may be seen over a longer period of time, such as the prevalence of risk factors (e.g., obesity) and illness (e.g., diabetes, HIV), and/or summary measures of population health (e.g., Centers for Disease Control and Prevention healthy days or health-adjusted life-years [see, for example, IOM, 2011]).

In addition, a balanced approach might incentivize proven or promising process measure goals best achieved by large provider systems such as accountable care organizations. Examples of process measures that could be constructed to focus on population health outcomes include (1) evidence of meaningful partnerships between health care organizations and state and local public health departments, (2) systematic use of community-based health workers in underserved communities and among racial and ethnic minority populations to assist in care transitions and reduce environmental risk factors, and (3) active participation in community-wide efforts to improve conditions affecting health.

We encourage states and CMMI to take advantage of this historic opportunity to fully realize the Triple Aim. Both should push the limits of innovation, recognizing that population health initiatives are unlikely to achieve the understandably aggressive cost-saving goals being pursued in health care over a 6-month, 12-month, or even 3-year period. *Intentionality* is the operative word for states and CMMI. States will need to be intentional about including population health community partners and agencies and focusing their grants in this area, even though the perceived financial payoff seems uncertain. The complexities of improving the health care system alone often result in population health being treated as a last-step add-on or being addressed only superficially or not at all. Similarly, CMMI will need to be intentional and realistic about population health outcomes and the costs-saving goals that can be achieved. CMMI will need to consider different criteria for success in evaluating interventions that include population health, including allowing for longer time frames for achieving results. Finally, let us

not let the risk of failure and the difficulty of achieving cost savings and improved outcomes in the short term discourage states and CMMI from taking advantage of this opportunity to focus on population health.

We believe that there is no better time for innovation in population health than now. CMMI opportunities, supplemented by complementary initiatives supported by other sponsors, have the potential to accelerate the growth of innovative approaches. Harnessing the lessons learned through state collaborative networks offers the potential for further acceleration and advancement in the field, but first we need to build strong proposals, together with continued support and flexibility from CMMI. Current investment by states and CMMI in this area have the potential to reap even greater rewards in the future as CMMI focuses on dissemination and spread.

We urge states and CMMI to open the door and step through quickly as opportunity knocks for population health.

#### **Thoughts on Potential Next Steps Toward a Balanced Portfolio of Measures in the SIMs and Beyond**

Although the specific parameters of the ideal balanced portfolio are not currently known, the SIMs and Innovation Awards offer opportunities to contribute to the knowledge base. However, even though these CMS initiatives are an important resource, they will not be sufficient by themselves to develop the tools and models needed to pay for improvements in population health, as many of the “population health” initiatives being proposed are focused targeted high utilizers (super-utilizers) to achieve medical cost savings in the short term as CMS requires. Commercial payers and large self-insured employers have greater flexibility to test models and have advanced payment reform in the past through the development of innovations such as the Alternative Quality Contract designed by Blue Cross of Massachusetts. Private foundations also have a role, as exemplified by the social impact bond for asthma that was sponsored by The California Endowment (Social Finance, 2013) and the exploration of the role of Community Development Financial Institutions sponsored jointly by the Federal Reserve, the Kresge Foundation, and the Robert Wood Johnson Foundation (see, for example, Erickson, 2013). Ideally, potential sponsors will look to the SIM states as fertile ground for testing and spreading new approaches to creating a sustainable balanced portfolio for improving population health. Ultimately, public- and private-sector collaboratives deploying innovative approaches with a focus on shared learning and harnessing and spreading what works would help to move the field even further.

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<http://nam.edu/wp-content/uploads/2015/06/OpportunityKnocks>.

#### **REFERENCES**

- Erickson, D. 2013. *Linking community development and health*. Testimony Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America, June 2013. Available at <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf406408> (accessed August 16, 2013).
- Berwick, D.M., T.W. Nolan, and J. Whittington. 2008. The triple aim: care, health, and cost. *Health Aff* (Millwood) 27(3):759-69.
- IOM (Institute of Medicine). 2013. [\*Toward quality measures for population health and the Leading Health Indicators\*](#). Washington, DC: The National Academies Press.
- IOM. 2011. [\*For the public's health: The role of measurement in action and accountability\*](#). Washington, DC: The National Academies Press.

Social Finance. 2013, March 25. *The California Endowment awards grant to social finance and collective health.* News release, March 25. Available at [http://payforsuccess.org/sites/default/files/fresno\\_asthma\\_demonstration\\_project\\_press\\_release.pdf](http://payforsuccess.org/sites/default/files/fresno_asthma_demonstration_project_press_release.pdf) (accessed August 16, 2013).