Clarifying Feasible Procedures for Reinvesting Health Care Cost Savings

ISSUE BRIEF

September 18, 2014
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Preface and Acknowledgements

This project was initiated as a partnership between Altarum Institute’s Center for Sustainable Health Spending (CSHS) and ReThink Health (RTH), under a contract from the Fannie E. Rippel Foundation. Evoking the collaborative spirit that is essential for successful multi-sector reinvestment initiatives, we enjoyed an extremely complementary working relationship with the RTH team of Bobby Milstein, Laurie Stillman and Ernest Cawvey.

We thank the experts who generously shared their time to relate specific experiences of community partnerships or other aspects of reinvestment feasibility (the individuals we contacted about this project are listed in Appendix B). We were truly inspired by the vision and determination exhibited by these leaders, who face complex challenges to the realization of their project goals. It was also uplifting to obtain quite positive reactions about the reinvestment concept from health policy or prevention experts who are not currently engaged in related endeavors. We would especially like to thank Matt Guy, David Ford, and Amy Schultz for providing valuable comments on earlier drafts of this brief.

The authors are, or course, soley responsible for its final content.

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# Table of Contents

1.0 The Concept and Imperative of Reinvesting in Health .................................................. 1

2.0 Overview of the Process for Establishing a Reinvestment Mechanism .......................... 2

3.0 Issues in Establishing a Reinvestment Mechanism ....................................................... 3
   3.1 Assess Community Readiness ....................................................................................... 3
   3.2 Establish Objectives, Structure, and Governance ......................................................... 10
   3.3 Develop Approach for Characterizing Savings ............................................................. 14
   3.4 Develop Vehicles for Securing Gains ............................................................................ 17
   3.5 Develop Approach for Allocating Gains ....................................................................... 18
   3.6 High-level Implementation Checklist ............................................................................ 21

4.0 Summary of Findings and Reflections on Possibilities ................................................... 23

Appendix A: Synopses of Select Innovative Programs ............................................................ 26
   A.1 Akron, Ohio Accountable Care Community ................................................................. 26
   A.2 Atlanta Regional Collaborative for Health Improvement ............................................. 27
   A.3 CareOregon .................................................................................................................. 27
   A.4 Collective Health – Fresno, California Health Impact Bond ......................................... 28
   A.5 Dignity Health .............................................................................................................. 29
   A.6 Health Improvement Organization, Jackson, Michigan ................................................. 30
   A.7 Hennepin County, Minnesota Accountable Care Organization .................................... 31
   A.8 MediCaring: Reinvestment with Elder Focus ............................................................... 31
   A.9 New York State Medicaid Redesign ............................................................................ 33
   A.10 PeaceHealth, Whatcom County, Washington ............................................................. 34
   A.11 Pueblo Triple Aim Corporation .................................................................................. 35

Appendix B: Key Informants ..................................................................................................... 36

Appendix C: Strategies for Contract Negotiations ..................................................................... 39

Bibliography ............................................................................................................................. 41

Glossary .................................................................................................................................. 46
1.0 The Concept and Imperative of Reinvesting in Health

Efforts to promote significant change in the U.S. health system are underway in a variety of settings and along multiple dimensions. The goals of these efforts can be categorized according to the Institute for Healthcare Improvement’s Triple Aim: to improve the experience of care, improve population health, and reduce the per capita cost of care.

Innovative efforts may be funded internally by care providers or supported through government or philanthropic grants, issuance of bonds, or other sources that generally focus on the initial investment needed to create change. Yet the challenge of sustainable financing beyond this initial investment can undermine even the most ambitious endeavors, and, as a result, innovators may produce short-term effects but rarely achieve sustained, long-term influence. Most innovations are not yet implemented at the scale, intensity, or duration needed to alter long-term health system performance.

Many approaches have surfaced to escape this cycle of “reform and rebound.” Some of the most promising efforts feature novel schemes to alter provider payment, pool resources, or share savings generated through improved health care delivery between payers and providers. However, few programs include mechanisms to reinvest these savings upstream in some of the most powerful determinants of health, including the exposures and choices that people encounter in their homes, workplaces, schools, and neighborhoods.

By reinvesting a portion of the health care cost savings into determinants of health, innovators can create a “community reinforcing loop” – a financially sustainable cycle of health improvement leading to health care savings, leading to further health improvement.

Moving from concept to implementation, there are pressing questions about who decides how resources are used and how diverse stakeholders in a community can work together as stewards of their common health system. Who makes the initial investment? Which policies are prioritized? How are initiatives aligned around those priorities? Who captures the proceeds? Where does the money go? What alternative arrangements are possible? Who decides?
This brief provides structure and discussion around these and other questions to clarify feasible procedures for reinvesting health care cost savings into improving health. We highlight potential barriers and suggest strategies for addressing them. We identify important steps and substeps in an implementation checklist, recognizing that specific approaches will vary greatly and will likely evolve over time. We share possibilities and challenges observed by individuals who have already begun this process in communities around the country. Finally, we provide summaries of example initiatives and a bibliography of relevant research, tools, and examples for further reference.

While the reinvestment concept is new, and significant development work lies ahead, there are programs underway from which proponents can learn. Our focus is on encouraging the innovators to take action, rather than persuading the skeptics. The time is right. Rising demand for services from an aging population and payment reforms that reward better health over volume are poised to soften the negative financial impact on providers of investing in health. The challenges in establishing and maintaining a reinvestment strategy are great, but so are the opportunities and potential gains to health and fiscal sustainability.

### 2.0 Overview of the Process for Establishing a Reinvestment Mechanism

An overview of the process for establishing a reinvestment mechanism is shown in Exhibit 1.

**Exhibit 1: High-Level Process for Establishing a Reinvestment Mechanism**

- **1. Assess Community Readiness**
- **2. Establish Objectives, Structure, and Governance**
- **3. Develop Approach for Characterizing Savings**
- **4. Develop Vehicles for Securing Gains**
- **5. Develop Approach for Allocating Gains**
- **Not Ready**
- **Address Barriers to Community Readiness**

Begin Reinvestment Process
For each step in this process, there is a range of alternative approaches that will depend on the goals and characteristics of the local community and the participating stakeholders.

Step 1 is to assess community readiness for reinvestment, since the chance of success will be greatly enhanced by the preexistence of an integrated, appropriately directed group of stakeholders (such as providers, insurers, health departments, and community organizations) in a region. Addressing existing barriers to readiness before a community moves forward with reinvestment will help ensure successful pursuit of a robust reinvestment process.

For communities that are ready to move forward, step 2 is to establish an organizational structure and an associated governance process for coordinating reinvestment activities (of course, this structure might support a range of other goals besides reinvestment per se). Overall reinvestment objectives should be identified early in this step to ensure that all stakeholders are pursuing consistent goals. (Details of these objectives can subsequently be developed as part of step 5). This step in the process provides a foundation for developing approaches for securing gains (step 4) and allocating these gains to improving the health of the community (step 5). These approaches might suggest the need for adjustments to the details of structure and governance. A separate, more technical step (step 3) involves developing methods for identifying and measuring the magnitude of savings in health care costs that provide the gains to be used in reinvestment.

Chapter 3.0 discusses each of these major steps in some detail, and concludes with a summary checklist of substeps within each of the major steps.

3.0 Issues in Establishing a Reinvestment Mechanism

This chapter provides a discussion of underlying issues, important considerations, and alternative solutions for each of the five major steps in the process outlined in Chapter 2.0.

3.1 Assess Community Readiness

There are many phases of readiness along multiple dimensions, and progress will likely be iterative. There is no single metric that designates a community as ready. Nevertheless, the further along a group or community is in a number of important ways, the better position they will be in to tackle the specific steps around setting priorities, establishing metrics and methods, and managing resources that are needed to implement a reinvestment strategy.

ReThink Health has produced a developmental assessment instrument to help a community evaluate its readiness for creating and sustaining a “healthy health system” (ReThink Health, 2014). Shortell et al. (2012) have also developed a readiness assessment tool for Accountable Care Organizations (ACOs) that has some relevance to community readiness for reinvestment. These tools can assist communities in both assessing their state of readiness and in determining areas on which to focus to improve readiness.
ReThink Health’s developmental assessment tool identifies eleven areas that are important for success, and asks respondents to characterize their community according to five possible phases of readiness in each area. In this tool, a community best positioned for success will have the following characteristics:

1. **Multi-sector champions**: Well-positioned leaders in the stakeholders across sectors have committed themselves publicly to aims that will benefit not just their institution, but the whole health system.

2. **Aspirations**: A key leadership group has articulated audacious goals about transforming the whole health system for all regional participants.

3. **Regional system view**: Many well positioned leaders across sectors have invested in developing the ability to understand the health system as a complex system, including how upstream factors influence health, how key institutions influence each other’s actions and incentives, and how a long-term view should shape action in the short term.

4. **Multi-stakeholder leadership team**: A key leadership group of the health system is composed of all relevant stakeholders, operates as a real leadership team, and makes decisions together that affect the whole health system (they exercise legitimate authority).

5. **Stewardship of a system strategy**: A key leadership group has formulated a high leverage strategy that proposes a coherent set of initiatives to be undertaken in a coordinated way among stakeholders of the whole health system of a region.

6. **Engaged Citizens**: The general population, individually and collectively, exercise responsibility and ownership for their own health system.

7. **Economic Incentives**: Positive financial consequences accrue to individuals, groups and institutions contingent on system-level performance outcomes, and do not reward undesired behavior.

8. **Sustainable Financing**: The health system change strategy is supported by a financing strategy that is designed to be self-sustaining and its survival is not dependent on any one main funding stream or outside grants.

9. **Collective Power**: Groups implementing innovations are coordinating with each other and combining resources where possible in a way that builds toward critical mass for change to take hold.

10. **Measurement and Learning**: A coordinated effort exists to collect and use data that measure impact across a range of key outcomes, for testing hypotheses about the impact of initiatives, and for altering course based on findings.

11. **Cultural Movement**: Different stakeholders pervasively express similar strong values about the characteristics of a healthy health system in the region, and their norms of behavior and organizational priorities support action toward those values.
Although it is not necessary (nor is it likely) for a community to be in the final phase of readiness along every dimension in order to move forward, as communities assess their local environment with respect to each of these dimensions, they will be able to identify areas where additional progress would improve the likelihood for success.

In assessing readiness, it will be important to identify and consider the role of a number of key stakeholders. While all stakeholders in a potential reinvestment initiative share a common interest in overall community health, they are challenged by having different spheres of influence and different concerns and incentives.

In the context of barriers to readiness, we provide some discussion of the major types of stakeholders and their potential concerns. We also discuss potential difficulties in defining the measures of success and preparing the participants for the types of legal arrangements that will be necessary.

**Stakeholders and their potential concerns**

In addition to the population served, we identify five core stakeholder groups: health care executives; health care providers; health insurers (public and private); health departments (which may link to other governmental organizations and municipal leaders); and community organizations (which may include local business or coalitions, and various grant makers/foundations, e.g., the United Way). Effective implementation of a savings reinvestment initiative requires close cooperation among health departments, provider organizations, and community organizations to identify and measure community health outcomes.

We start our discussion with health care executives, because reinvestment of savings generated by lower health care spending is dependent on provider CEO buy-in of the concept. The Affordable Care Act’s (ACA) Community Health Needs Assessment (CHNA) process and pressures to improve community benefit requirements for non-profit status are good motivators for non-profit CEO engagement. And health care executives are clearly cognizant of the pressures to change from volume to value.

Based on our preliminary discussions with selected health care executives, there is substantial recognition that the status quo is untenable and that the future lies with a balanced investment strategy that has a significant and sustained focus on community health as well as the delivery of high-value care. In concept, therefore, leading health care executives are ready for change (as one business leader put it, they fully accept the “logic model”). But there is considerable uncertainty as to what they should be doing. For example, one executive said that his health care system knows how to generate revenue under the current system, knows that the system needs to migrate to population health, and believes that insurers will follow, but has no clarity on how to generate revenue during the transition.

Several policy and practice trends suggest that health systems and hospitals will be under pressure to improve the health outcomes of the communities they serve, not just their attributed patient populations. Allocating health care cost savings to improve the
community’s health can assist non-profit facilities in meeting their community benefit obligations and ACA provisions. Through CHNA requirements, non-profit health care facilities must assess community health needs at least every three years and implement the findings. Over time, given the ACA’s access expansions, facilities will need to find alternatives to the cost of uncompensated care in fulfilling the community benefit investment requirement. Thus, allocating health care cost savings to improving the community’s health could be a double win for non-profit health systems. First, it could be used to fulfill the CHNA process. Second, nonprofits still need to meet their community benefit requirements to retain their tax-exempt status for both federal income and state property taxes.

Under any circumstances, provider engagement will be an essential component of a community-based population health strategy. Accountable Care Organizations (ACOs), which are one structure under which a reinvestment strategy may be implemented, are arrangements between providers and health systems or hospitals, with financial support from insurers. Providers, especially those who deliver expensive specialty care or hospital services whose needs might decline with improved community health, will need to be convinced that investing the savings to improve the community’s health is in their long-term interests. Better coordination of care for their patients through community-based organizations might be an adequate non-financial inducement.

Health insurers should be interested in participating because improvements in population health could help reduce cost and ultimately premiums, reducing the political pressures continually faced by the industry. And, although insurers may not be directly involved in ACO operations, they have an interest in ACO outcomes. As is the case for many other reinvestment-related issues, there is a clear divide between insurers who are devoting all of their energies to cutting short-term costs and thus bringing down their premiums to be more competitive on new health insurance exchanges, and innovators who are exploring reinvestment opportunities. Thus, while America’s Health Insurance Plans (AHIP) has not explicitly advanced reinvestment, examples of companies that have made strides include Wellmark Blue Cross/Blue Shield of Iowa, Blue Cross/Blue Shield of Massachusetts and various insurers in Vermont.

On the public insurance side, many Medicaid managed care plans have exhibited strong interest in this strategy. Indeed, despite the immense pressures faced by the Centers for Medicare and Medicaid Services (CMS), the organization has been vocal in urging action on population health. Also, the second round of the Center for Medicare and Medicaid Innovation (CMMI) grants explicitly calls for, “Models that improve the health of populations – defined geographically (health of a community), clinically (health of those with specific diseases), or by socioeconomic class – through activities focused on engaging beneficiaries, prevention (for example, a diabetes prevention program or a hypertension prevention program), wellness, and comprehensive care that extend beyond the clinical service delivery setting.” These are indications that the government is interested in exploring public insurer engagement with population health.
Although health departments may face considerable constraints, many of them are likely to be active partners in a reinvestment initiative. For one thing, their mission is to improve population health. Some, for instance, are helping health systems comply with their ACA CHNAs. For another, they are already participating in public-private partnerships with health systems on a range of issues. Beyond that, there are certainly entrepreneurial and risk-taking health officials who would welcome the opportunity to be involved in innovative population health initiatives. The experience with the Washtenaw Health Initiative (Washtenaw County, Michigan), where the county health department has been an active and engaged participant from the beginning, suggests as much. (This initiative is described further in Section 3.2.)

Community organizations will need to play a key role in this process. First, better coordination of care requires the ability of health providers to work with community organizations, including social service organizations. Second, improved health literacy among patients also requires services largely found in community-based organizations. Many community-based organizations will be willing partners in attempts to improve population health, since they are often the beneficiaries of investments in community health and the social determinants. However, as those who conduct community-based participatory research would note, it is important to assure community leaders that their involvement in such research will lead to lasting benefits, and not simply impose on their time and resources – building trust in this context and elsewhere is essential.

Challenges in defining measures of success.

This question is pivotal for understanding whether any reinvested savings would generate a reasonable return on investment (defined in either financial or non-financial units). How will success be measured? Despite David Kindig’s groundbreaking work, including his influential County Health Rankings, there are still open questions about the ability to measure population health improvements, at least in the short-term. For instance, Jacobson and Neumann (2009) found that there was no consensus in the field on how to measure the value of public health services. Developing and evaluating a robust set of measureable outcomes will be an important component of a reinvestment initiative. Because there are few useful short-term measures already in place, one suggestion has been to involve a set of affected persons (patients and caregivers) to guide measure development, even during implementation.

Unfamiliarity with the Legal Arrangements.

New legal arrangements may be needed to implement the reinvestment initiative so that it is managed properly. These arrangements could involve the creation of new structures, an array of contractual arrangements, or establishing governance issues to be negotiated among multiple stakeholders. As we describe below, informal arrangements may work, but the possibility that legal issues will arise should be anticipated. At least some of the stakeholders will be unfamiliar with the anticipated legal arrangements, and hence might be reluctant to move forward. This could limit the number of participants, potentially reducing
both the ability of the program to achieve specific outcome measures and the ability to achieve the scale and scope needed to be transformative.

With respect to the core groups mentioned above (health care executives, providers, health insurers, health departments, and community organizations), the relative unfamiliarity with legal issues will vary, as will the degree to which this is likely to be problematic. Health care executives and insurers should be relatively more comfortable, since they deal with attorneys and legal issues on a daily basis. Similarly, physicians and other providers who are already participating in an ACO have undoubtedly signed contracts with health systems, and contracts with each other to form provider organizations.

Health departments will likely be mixed in their familiarity with contractual and other legal arrangements. Health officials from larger health departments may have an attorney who assists them with public-private contracts and with the regulatory process. Those in smaller health departments may have less access to counsel.

Some community-based organizations will be very sophisticated with regard to legal issues and will have no trouble representing their own interests. Others, however, will have limited experience with complex legal arrangements and will often only have access to pro bono legal assistance.

Proof of concept may overcome any lingering concerns. After all, health care executives, insurers, and providers are quite accustomed to long-term arrangements that need time to develop. And community groups have potentially a lot to gain from the savings reinvestment arrangement.

**Overall considerations in setting the stage for implementation**

Three broad elements should be considered in improving readiness and in setting the stage for early organization and implementation. The first is **aligning the incentives for participation**. How can participants be assured that their investment of time and resources will generate a favorable return both economically and in the form of community health improvements?

As the stakeholder discussion suggests, each participant group will have different incentives for either entering into or eschewing the arrangement. Is there a common rationale for reinvestment that addresses these varying incentives? For health care executives, insurers, and health departments, that should not be difficult to address. Health care executives are under pressure to move from volume to value, insurers should be willing to invest in programs that could lead to improved community health (and hence lower health care costs), and the arrangement would take maximum advantage of health departments’ population health expertise.

But that leaves two other groups where the incentives are less clear. Thus, the second element deals with **outreach to, and engagement with, providers and community groups**. In particular, what are the incentives for health care providers? They could legitimately object that any savings should be reinvested in patient care as opposed to the goal of

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8
improving community health, which may be perceived as too broad and less direct. Yet, as suggested earlier, two incentives for participation might be effective. One is the need for better coordination of care across multiple providers, and with community-based organizations. The other is that providers are also subject to policy pressures moving toward population health improvements. For physicians in particular, there is the growing trend of physicians being employed by hospitals, and thus, by extension, reflecting the incentives of the hospital system. And there are many progressive physician organizations, with growing multi-specialty rosters, which promote community health as part of their missions.

If the core reinvestment objective is to improve the community’s health, then community-based organizations are an essential strategic partner. The incentives for community groups are likely to be strong, since their mission is to improve the healthy lives of their members, a goal that all of the stakeholders share. At the same time, there may be skepticism about the long term commitment of all stakeholders to the community’s health. Indeed, entrepreneurs are establishing businesses to re-direct Medicare savings from more efficient post-acute care services to investors, rather than providing additional needed services to frail elders (Lynn, 2014). To overcome potential skepticism by community groups, it will be important to stress the population health mission and how savings reinvestment will be of direct benefit to the organizations and the community served.

Active participation and input by community groups will greatly benefit the design of programs to improve the population’s health. It will be important that community representatives are part of the governance structure. Depending on the organizational form that is adopted (discussed further in Section 3.2), this could include community representation on the organization’s board or an executive management team.

It should also be made clear that there are considerable opportunities for collateral gains flowing from such multi-sector, collaborative, community partnerships. In the South Carolina Birth Outcomes Initiative, begun with a targeted goal of reducing the number of low birth weight babies, three years of monthly meetings with excellent participation (aided by six workgroups) has led to several effective initiatives involving long acting birth control and a mothers’ milk bank. Similarly, the Health Improvement Organization begun in Jackson, Michigan roughly 15 years ago, is now associated with education and financial stability components and can claim multiple successes in its goal to build lasting infrastructure.

The third element in setting the stage for implementation is the strength, transparency, and comprehensiveness of the pre-contracting negotiating process. An important contributor to a successful program will be the upfront negotiations among the various stakeholders. Some potential participants may not have experience with complex program development and delivery, and may be especially wary of the legal obligations participation would entail. This could result in either limited participation or in scaling back the program to entice community groups to participate. Either way, being transparent and comprehensive in explaining both the program and the legal structure that supports it will be a time-consuming but critical part of the start-up process.
3.2 Establish Objectives, Structure, and Governance

The many activities involved in establishing the initiative’s objectives, structure, and governance include the following:

1. Identify participating groups;
2. Identify the initiative’s specific, measurable objectives;
3. Identify the organizational structure;
4. Define all terms to ensure mutual understanding among participants;
5. Address financial considerations;
6. Develop a governance structure;
7. Ensure compliance with applicable state laws and regulations;
8. Identify nature and degree of commitment among partners;
9. Identify data and other information requirements and related data processing and analysis needs;
10. Develop processes for renewal of agreements, dissolution of the arrangement, opting in/out by participants, and exclusion of a participant from the program; and
11. Develop an evaluation plan, if needed, to determine if the program is working, evaluate strengths and weaknesses and strive for continuous improvement, and revisit governance structure to confront and reconcile problems.

We discuss noteworthy aspects of several of these activities in the remainder of this section.

Even before the organizational details of structure and governance are established, it will be important for the participants to set priorities for reinvestment of gains at the outset. Identifying investment objectives early in the process, well before the group develops the details of its approach for allocating gains (Section 3.5), can help ensure the pursuit of a set of common goals during the process of establishing its structure and details of governance. This practice also minimizes complications that may arise if priorities are negotiated after savings begin to be generated and actual funds are already in play.

Related to the structure of the operation, a question often faced by a health system is whether to operate independently or to participate in jointly designing community-based investments with other health care providers in a given geographical area. One advantage to the latter would be to create a larger pool of money for developing, implementing, and evaluating strategies to improve community health. But a clear disadvantage is that any individual provider loses control of how the funding is invested, monitored, and measured. As an alternative, the cost savings could be invested in community partnerships to leverage the ACA’s prevention fund and the community transformation grant mechanism. Although these ACA-funded programs are politically vulnerable, they present opportunities to enhance community health.

Whether independently or jointly with other providers in the area, there would appear to be two complementary structural strategies that motivated health systems could pursue: (1) integration of clinical care and population health management; and (2) direct contributions
to community-based organizations to develop better ways of keeping people healthy (which the Robert Wood Johnson Foundation is now calling the Culture of Health).

The integration of clinical care and population health is a topic receiving significant current attention. For example, the Commonwealth Fund released a report titled, “A State Policy Framework for Integrating Health and Social Services” (McGinnis et al., 2014). Earlier this year, the Kaiser Commission on Medicaid and the Uninsured issued a statement titled, “Integrating Physical and Behavioral Health Care: Promising Medicaid Models” (Nardone et al., 2014). Both reports contain solid general frameworks for how to go about integrating health care delivery and population health, but neither report provides insights or guidance on how individual health systems or hospitals should be engaged in the process.

These two reports represent the state of the art as reflected in the literature and in policy pronouncements. There is a clear recognition that the future of health care lies with integration, but little sense of how to achieve the goal. A reflection of that reality is the recent Institute for Healthcare Improvement blog, “Easier Said than Done: Improving Health for People with Complex Needs” (Gauthier, 2014). In sum, there is no shortage of commentary on the need for integration, and some exciting ideas about how to integrate, but moving from that general goal to its implementation appears challenging.

ReThink Health’s (RTH) ideas for an accountable health community fit squarely within the current consideration of the savings reinvestment program. RTH’s conceptual work on the evolving concept of an accountable health community appropriately cites David Kindig’s pioneering work for enhancing population health as the progenitor for the accountable health community. But how much has actually changed in the nearly 20 years since Kindig’s initial framing? Why, since the need is so palpable, has there been so little progress?

Despite the apparent desirability of an integrated system, there are few examples of how to integrate successfully, and published evaluations are similarly sparse (IOM, 2012 is an important exception). For instance, Denver Health has received considerable attention as an integrated system. But interviews suggest it is less fully integrated than generally understood (Jacobson and Wasserman, 2011). Another model, community care networks, contains some aspects of population health and clinical medicine, but does not appear to be a fully integrated approach (Conrad et al., 2003). A third strategy is the Institute for Healthcare Improvement’s (IHI) Triple Aim strategy, which focuses on redesigning primary care and linking it to population health and disease management. Specifically, Triple Aim comprises three critical objectives: improving the health of the population; enhancing the patient experience of care (including quality, access, and reliability); and reducing, or controlling, the costs of care.

The ideas contained in the above reports provide some guidance for how to invest the savings from various demonstration projects now underway in US health care delivery. Perhaps the most prominent and promising demonstration projects are the Medicare Shared Savings Program through ACOs and the patient-centered medical home (PCMH) concept. Effective reinvestment of savings would have the potential to encourage the
expansion of the ACO and PCMH models. In theory, these models, along with Medicaid expansion, will have positive effects on community health because of expanded access to health care. Even if successful, the population health effects from these programs will be limited without greater investment in programs more directly designed to address the problems influencing poor health outcomes at the population level, often termed the social determinants of health.

A number of legal issues will be important to consider in developing the structure and governance of a reinvestment initiative. The central question that will shape the legal issues is the structure that will be used to reinvest the savings. This structure will be a function of the overall savings reinvestment goals. A full range of legal forms is available. The entity could be a for-profit or non-profit corporation, a partnership among stakeholders, a series of contractual arrangements, or a trust. Each form carries legal advantages and disadvantages.

Contracts are extraordinarily flexible legal instruments that are limited only by the parties’ imagination (as long as they meet basic contract law principles). One clear advantage of contractual arrangements is that they can be implemented without the need for a formal legal structure. An important function that contracting serves in this context is to obtain agreement on, and understanding of, key terms that will guide the savings reinvestment program and relationships among the various stakeholders. Aside from setting forth the core program objectives, a contract would define all of the terms needed to make the venture successful. Viewed this way, the signed contract represents the end stage of a series of interactions and negotiations designed to inform all parties and obtain agreement on all definitions and terms. In short, the negotiation process provides an opportunity for stakeholders to develop a shared vocabulary, an understanding of how the venture will operate, and identify each party’s responsibilities.

To the extent that a community partnership is a potential arrangement, it should probably be organized as a non-profit arrangement such as a limited liability corporation or a partnership. (Since form follows function, it could certainly be organized as a for-profit enterprise if stakeholders agree that generating revenue is important to achieving the program’s objectives.) In any event, the governance issues should be addressed up front. In particular, deciding on the balance of stakeholder representatives as executives and board members will be a delicate issue, especially since the initial funding is likely to be from the health systems and hospitals through the cost savings. (Initial funding is discussed further in Section 3.4.) At a minimum, any multi-party agreement will require a series of contracts to specify the nature of the arrangement, its governing structure, financing arrangements, data collection and retention, dissolution, etc., as shown in the negotiations framework presented in Appendix C. It is possible, of course, that reinvestment is pursued by an already-existing multi-stakeholder stewardship group with existing governance and associated legal procedures and agreements. However, those procedures and agreements may need to be revisited if substantial investments are to be made.
Another model is a more informal arrangement along the lines of the Washtenaw Health Initiative (WHI) (http://washtenawhealthinitiative.org/). WHI is a voluntary collaboration among representatives from health care and community-based organizations to improve access to health care for low income, uninsured, and Medicaid populations within Washtenaw County, Michigan. What makes this interesting, and a potential model for the savings reinvestment program, is that it functions as a collaborative without a formal legal structure. Funding initially came from the county’s two largest health systems, but several county agencies and local organizations have provided additional financial support. Participating members simply sign a form outlining expected membership responsibilities and whether they can provide financial support.

WHI’s governance structure evolved informally and sequentially. WHI started as an idea from three retirees with prior connections to health care delivery and community service. Along with the University of Michigan’s Center for Healthcare Research & Transformation (CHRT), they convened a steering group comprised of representatives from key stakeholder organizations. To obtain buy-in and input from community-based and governmental organizations, WHI convened a larger planning group, comprised of many community-based organizations, that meets quarterly. The planning group comments on steering group recommendations and helps shape WHI’s future directions and initiatives. CHRT provides staffing and overall leadership for WHI. Without that, the effort could not be successful, suggesting that even an informal arrangement needs a defined structure to operate.

Thus, any similar effort will need to have a central organizing capability to manage the reinvestment process and offer strategic direction. The same would apply to a partnership or a more formal contractual set of arrangements. As part of the contracting or partnership process, the parties should establish a governance structure that clearly sets forth the roles and responsibilities of each participant or partner. Who will have overall responsibility for developing, implementing, and monitoring the reinvestment strategy? How will disputes be resolved? How will the partnership or contractual arrangement be dissolved? How will any remaining assets be distributed? Each of these (as well as other related questions) can be resolved through careful pre-contractual negotiations and drafting of the partnership agreement or contractual arrangement.

An alternative arrangement, consistent with the WHI model, would be to establish a separate fiscal sponsor responsible for managing the reinvested savings program. Fiscal sponsors, for instance, currently provide back office support for health departments or specific services for other non-profit organizations. Through a simple contractual arrangement (see, e.g., http://www.adlercolvin.com/pdf/forms/Fiscal_Sponsorship_Model_A_agreement_2011.pdf), the fiscal sponsor would be subject to fiduciary duties to use due diligence in meeting its management responsibilities. The contract would specify exactly what services the fiscal sponsor would provide.

If, instead, a corporate form is used, state law will largely determine the governance arrangements, including a board of directors and corporate officers. A model for using the
corporate form might be a regional quality of care collaborative (e.g., NHRI, Michigan collaboration, North Colorado Health Alliance). If the goal is reinvesting savings to improve a community’s health, the most appropriate form would probably be a non-profit corporation. An advantage of the non-profit form would be the ability to aggregate diverse funding sources into a cohesive, community health, improvement strategy. In most communities, many funding agencies focus on specific areas, such as housing, early childhood initiatives, the elderly, etc., but lack a coordinating mechanism for leveraging the reinvested savings to achieve broader community health objectives. A non-profit entity could be a perfect vehicle for a coordinated funding approach across a county or region that would be more effective than the sum of its parts. This would be especially attractive to ACOs that are already organized as non-profits. Stated differently, the non-profit form would be the best opportunity to generate a significant market share that would involve a substantial community presence for the reinvestment to be transformative and innovative.

To be sure, a for-profit entity would be feasible if the participating ACOs feel that a more entrepreneurial strategy is needed to achieve community health improvements. The IRS now allows non-profits to combine with for-profits to form joint ventures, as long as any revenue generated is reinvested to achieve the non-profit (i.e., charitable) mission. One argument favoring a for-profit approach is to manage the reinvestment strategy as a business venture. Against that, however, community groups might not view a for-profit management firm as having the community’s best interests in managing the joint venture.

An additional legal issue will be protection of any data collected and analyzed to meet HIPAA requirements. HIPAA compliance is unlikely to be a particularly serious concern, as much as something that must be observed when deciding what data to collect and how to report it. Still, an important consideration will be data collection, storage, analysis, and sharing. Most importantly, data privacy and confidentiality must be maintained. The program should develop policies and procedures for how the data will be collected and stored, who will have access to the data, and how the data will be redacted or de-identified when shared or reported with program participants.

3.3 Develop Approach for Characterizing Savings

Characterizing actual and projected cost savings that will generate excess cash flow for reinvestment has three major components:

1. The development of agreed upon quality (i.e., patient outcomes, safety and satisfaction) and performance improvement (clinical, operational, and financial) metrics that will serve as benchmarks to measure achievement;

2. An objective and consistently applied methodology and approach for measuring quality and performance improvement within a health care system, including financial gains resulting from quality and performance improvements; and

3. The creation of a quality assessment and performance improvement measurement system that will facilitate the collection, analysis and application of historical
operational/financial performance data to project savings from proposed initiatives to improve quality or efficiency.

There are many ways to measure quality and efficiency in health care. Vigen et al. (2013) provides both an overview of these methods and an inventory of specific approaches taken by more than 100 organizations and programs. The inventory summarizes the metrics and procedures used as well as results achieved, and includes references to many publications describing the measurement initiatives in greater detail. Vigen distinguishes between micro and macro approaches to measuring cost, efficiency, utilization and resource use. Micro approaches examine whether care to an individual patient was provided at the right time in accordance with best-practice treatment guidelines for the specific diagnosis and severity of that patient. Macro approaches (which are the focus of Vigen’s analysis) evaluate a provider’s quality and efficiency at a population level by examining cost, efficiency, utilization and resource use, adjusted, if needed, for relative risk or severity.

A significant barrier to characterizing cost savings is a lack of understanding of the costs of delivering care. Indeed, it is noteworthy that many states are investigating or currently developing all-payer claims databases, e.g., Massachusetts, New Hampshire, Maryland, Vermont, and New York. Kaplan and Porter (2011) describe ongoing pilot projects that address this issue by measuring costs at the level of the individual patient over the full cycle of care for a specific medical condition. Such initiatives, if adopted more widely, could have a major impact on alleviating this barrier.

After estimating expected future costs for a health condition and affected population segment, the need to project savings is driven by the requirement to establish targets that can serve as metrics to subsequently establish whether such savings have been (or are being) achieved. Projections also provide up-front estimates of the gains that can be expected to be available both to compensate the participants in the savings program and for use in reinvestment. Such evidence of savings potential is particularly important because many interventions with intuitive appeal have turned out in practice to have disappointing results. Projecting savings requires an ability to estimate the impact of an initiative on disease burden or treatment efficiency, and associated cost savings. It is most easily accomplished for conditions and initiatives whose impacts can be easily measured and that have been studied extensively to create a compelling evidence base (total hip replacement is an example). This suggests that early attempts to identify future savings should focus on well-studied and well-documented initiatives, for which existing evidence can provide a starting point for the projection. Targets for savings should be realistic, balancing past performance with high standards for future performance.

Given the ability to measure and project the impact of an initiative, the approach to tracking progress is conceptually straightforward, but must be supported with comprehensive data from multiple sources such as past claims, electronic medical records, and disease registries. Technical details such as data collection and analysis methods are summarized by Vigen et al. (2013) for numerous specific programs.
Another barrier to characterizing savings is that many initiatives to reduce disease burden do not produce realized savings for several years after initiation of the program. Yet, participating stakeholders, and the reinvestment process itself, require early and continuous returns to sustain the process. The following approach to characterizing savings, summarized by Austen BioInnovation Institute in Akron (2012), addresses this issue:

1. Identify a metric associated with a savings initiative that can be measured in the near term and that is linked in a known way to improved health outcomes and associated savings. An example for diabetes management is a patient’s HbA1C level.

2. Estimate an achievable impact on the metric (and the associated impact on savings) as a target for the initiative.

3. Measure the change in the metric resulting from implementation of the initiative and use that change to update the target. (From a technical perspective, Bayesian methods can be used to perform the update.)

4. Distribute savings in accordance with the updated target.

5. Subsequently measure the actual savings accrued, and reconcile the distribution of savings to match the gains actually realized. This may require additional distribution of gains (if the updated target is surpassed) or drawing funds from a reserve maintained for this purpose (to make up any shortfall in gains).

This process operates in much the same way as income tax collections, where collections during the year based on estimated tax obligations are adjusted at year’s end with either a refund or a requirement for an additional payment. Prospective payment systems in health care operate in a similar way. This approach, of course, requires an initial investment in the reserve to provide for possible shortfalls in meeting the target. There are other requirements to mediate risk to investment stakeholders.

Another potential challenge in characterizing savings is that improvements in care delivery eventually become the “new norm.” Determining when to stop (or reduce) attribution of savings to these improvements is a difficult issue. On the one hand, continuing to count new standards of care as generating savings produces an artificially low standard. On the other hand, curtailing savings prematurely can threaten the sustainability of a reinvestment program. Further research is needed to address this problem.

An additional challenge in estimating savings is the handling of confounding factors that may either raise or lower costs for reasons outside of the initiative. For example, over the course of the intervention did the baseline health of the relevant population change (become more ill or healthier)? Did exogenous factors change the health spending environment? Are results merely an extension of trends that began before the initiative and that were likely to continue regardless? While it may not be feasible to entirely separate causality, it is wise to anticipate these types of methodological challenges and exogenous changes in defining how savings are to be measured.
3.4 Develop Vehicles for Securing Gains

We discuss these two major activities related to funding:

1. Identify sources for initial funding; and
2. Establish mechanisms for holding and managing gains for subsequent reinvestment.

Because many savings initiatives require upfront investment, vehicles for initial funding can be an important feature of a reinvestment program. As noted in Section 3.3, a reserve of funds to be used for adjusting the distribution of gains might also be an important component of some reinvestment initiatives. Possible sources for these funds could be social impact bonds, funds from non-profit hospitals used to meet their community benefit requirement, local taxes, or philanthropy. An obvious and underused source of funds is “sin taxes,” a tax specifically levied on certain generally socially proscribed goods and services, e.g., alcohol and tobacco, soft drinks, and gambling. Ideally, public policy should strive to “close the loop” whereby a large portion of the sin tax receipts are devoted towards decreasing the relevant behavior (Cohen and Iton, 2014).

After the initial investment, sustaining funding of a successful program would then come from savings associated with reinvestment of the gains. Securing these gains for reinvestment requires establishing mechanisms for holding such gains for subsequent reinvestment.

Specific vehicles for securing gains can include a community/health/ wellness trust, a nonprofit insurance company, or a new organization established with a new bank account, or the (potentially cooperative) utilization of another existing institution as a fiduciary. A financial management firm could be used to ensure that the gains being held for subsequent reinvestment are invested wisely and that returns are maximized while principal is protected. Whatever entity is selected for securing gains would need operational autonomy from the stakeholders involved in the initiative as an objective determiner of the savings achieved. Transparency of the process is critically important.

A major challenge in securing financial gains for reinvestment is the fact that, for many savings initiatives, one stakeholder’s savings (e.g., the payer) is another’s loss (e.g., the provider). Any methodology and approach for incenting, measuring and distributing financial gains, therefore, must reflect the need for all stakeholders to clearly understand and agree upon the financial risks and rewards – and the basis upon which those will be determined.

As payment systems evolve, elimination of the “zero-sum” nature of financial gains may become more feasible. Miller (2014) illustrates how savings can result in improved margins (even with lower revenue) for physicians and hospitals as well as payers. Such a scenario could reduce the resistance of stakeholders to share savings for reinvestment, but will be difficult to achieve without major payment reform.

A growing population can also mitigate the challenges of securing gains for reinvestment. In some situations, reducing per-capita costs will not reduce any provider’s income, which can
be made up in the growth of the population affected. (For example, the number of frail elderly people in the U.S. is expected to triple in the next 20 years.)

### 3.5 Develop Approach for Allocating Gains

There are at least two activities closely related to developing an approach to allocating the cost savings generated by the reinvestment initiative:

1. Assess community needs to be addressed and community strengths to be exploited that will meet the stated objectives; and
2. Identify specific recipients of gains consistent with these needs and strengths.

An approach to reinvesting gains requires a decision making process and authority to determine how savings are to be invested, including the levels and frequency of investment. Many of the decisions regarding this process and authority will be established during the development of the investment initiative’s structure and governance, as discussed in Section 3.1. In addition, overall objectives and priorities for reinvestment should be established early in the process of designing the structure and governance, as discussed earlier.

Identifying specific areas for reinvestment requires information regarding community needs that have high leverage to improve health and ultimately serve to further reduce health care costs. Ensuring adequate representation of community organizations with knowledge of such needs can help address this issue. Community Needs Assessments provide one source of information for identifying targets for reinvestment, though their utility would be improved if they were better coordinated among non-profit systems within a geographic area. Tracking of ongoing population health initiatives, modeling of the potential benefits of proposed initiatives, and research into successful initiatives in other communities can also provide needed input to this process.

Again, as noted in Section 3.1, it is important to establish at least broad targets for allocating gains early in the process of establishing a reinvestment initiative to help ensure the pursuit of agreed-upon common goals once savings begin to be realized. There are numerous such targets that could be pursued. For example, the following classes of reinvestment targets are among the initiatives that have been analyzed using the ReThink Health simulation model (for detailed descriptions of these classes of interventions, see [http://rippelfoundation.org/docs/Interventions.pdf](http://rippelfoundation.org/docs/Interventions.pdf)).

1. Enable healthier behaviors
2. Reduce environmental hazards
3. Reduce crime
4. Create student pathways to advantage
5. Create family pathways to advantage
6. Improve routine preventive and chronic physical illness care
7. Improve care for chronic mental illness
8. Support self-care
9. Prevent hospital-acquired infections
10. Redesign primary care practices for efficiency  
11. Recruit primary care providers for general (non-FQHC) offices and clinics  
12. Recruit primary care providers for FQHC clinics  
13. Improve hospital efficiency  
14. Offer pre-visit consultation for non-urgent episodes  
15. Create medical homes  
16. Coordinate health care  
17. Implement shared decision making  
18. Expand use of generic drugs  
19. Improve post-discharge care to reduce hospital readmissions  
20. Expand the use of hospice care  

Any investment strategy must assess potential barriers to implementation. Based on our preliminary review of the literature and conversations with selected health care executives, there appear to be several barriers to reinvesting savings to improve population health. Potential barriers include capacity constraints, legal and policy considerations, administrative concerns (e.g., communications across stakeholders), and data collection and analysis limitations. We discuss four specific barriers below.

**Limited Empirical Evidence.** There may be limited empirical evidence to support which investments would derive the best population health outcomes. The CHNA process has not yet provided a critical mass of data that could be used to estimate the most effective outcomes. Nor has the public health system provided sufficient data to estimate the value of specific public health services (Jacobson and Neumann, 2009). Second, as widely recognized, the community benefit requirements for non-profit health care facilities are ill-defined and inadequately monitored. This means that the community benefit process has also been inadequate to guide potential investments.

On the other hand, there is an emerging body of evidence from policy and intervention research that has identified investments that are likely to support better health over time. This includes the work of the Community Preventive Services Task Force, the Commission to Build a Healthier America, the Partnership for Prevention, the National Prevention Council, the Centers for Disease Control and Prevention through its Vital Signs initiative, and the Federal Reserve Bank of San Francisco and the Low Income Investment Fund through their Investing in What Works for America’s Communities project, among others. These sources provide a good beginning for identifying investments with high leverage for improving population health. This is an extremely important context to prevent the perfect being the enemy of the good.

**Workforce Capacity.** Even with good ideas for re-investment, workforce capacity is a potential barrier across many stakeholders that will affect the speed of an initiative to achieve its full potential. As noted above, the emphasis within ACOs/health systems has been on its attributed population, and there is some doubt that these organizations have the in-house population health capacity needed to devise and evaluate community investment strategies. As a result, they will be relying on collaboration with health
Departments and community organizations. Yet only a few health departments and community organizations have the requisite management capacity to undertake complex, multi-stakeholder initiatives. As community-based researchers know, managing community collaborations requires patience and recognition of different goals and strategies to achieve those goals. In reality, many community organizations will have a steep learning curve regarding population health and health literacy.

Nonetheless, several innovations worth examining include the Detroit-Wayne County Health Authority’s experiment to train and place preventive medicine residents in the community, and the way in which DenverHealth has integrated clinical care and public health responsibilities. Increasingly, entrepreneurial competitors to traditional health departments are emerging in certain markets that warrant attention for their potential successes (Jacobson et al., 2014). For example, health authorities, public health institutes, and fiscal sponsors are potential partners with health systems. These organizations are more politically independent, entrepreneurial, and fill gaps in activities that health departments may not be able to offer. They can avoid the bureaucracy associated with government hiring and firing of employees, and hence are able to act quickly.

**Fraud and Abuse and Antitrust.** Depending on the nature of the investment approach, fraud and abuse or antitrust considerations may or may not become a barrier. Under the fraud and abuse laws, the government is concerned about increasing patient referrals from financial incentives to physicians. Would the DHHS Office of the Inspector General (OIG) view the allocation of savings to community health as an inducement for referrals, particularly if physicians are involved in plan implementation? While it seems unlikely that this would amount to a serious concern, the arrangement would need to be structured to avoid the problem. The reason is that the OIG has narrowly interpreted the fraud and abuse laws to prevent arrangements that appear to be efficient and patient-friendly. As an example, the OIG has prohibited providers from waiving certain co-pays, and some have suggested that direct payments to patients would implicate the fraud and abuse laws.

Likewise, antitrust would not appear to be a problem. Under the antitrust laws, the enforcement agencies are concerned that, for instance, ACOs could control the market and hence raise prices. It seems unlikely that any savings reinvestment arrangement would restrain trade, but it is an issue to think about in structuring the program.

**Community Benefit Obligations.** The savings reinvestment program arguably would help non-profit health care facilities meet their community benefit obligations. However, the IRS has not yet ruled on whether population health improvements, absent a reasonable amount of uncompensated care, would meet their current requirements (which are, as Senator Grassley has noted, notoriously ambiguous). The same goes for state property tax exemptions. Although there is a strong argument favoring population health, it has not yet been tested.
3.6 High-level Implementation Checklist

The following checklist identifies the major activities to be undertaken under the basic steps illustrated in Exhibit 1 for establishing a reinvestment program. It is a high level summary of material addressed in this chapter, and the reader should refer to the corresponding section of the chapter for more discussion on the items in the checklist. This list will likely evolve as these processes are better understood, and may vary depending on the specific circumstances of a particular community.

1. **Assess Community Readiness**
   a. Identify major stakeholders and leaders for local reinvestment effort.
   b. Apply a developmental assessment tool.
   c. Evaluate the tool results to establish degree of readiness.
   d. If necessary, address barriers to improve readiness before proceeding.

2. **Establish Objectives, Structure, and Governance**
   a. Identify participating groups.
   b. Identify the initiative’s specific, measurable objectives (e.g., regarding population health improvement).
   c. Identify an organizational structure. This “structure” could take many forms, including those listed below, and can clearly evolve as the initiative is developed:
      - a for-profit or non-profit corporation;
      - a partnership among stakeholders;
      - a series of contractual arrangements;
      - an informal consortium; or
      - a trust.
   d. Define all terms to ensure mutual understanding among participants.
   e. Address financial considerations:
      - sources of savings or other funds;
      - anticipated savings over time;
      - sustainability of savings and alternatives if savings goals are not achieved;
      - funding needed to achieve objectives;
      - the reinvestment approach; and
      - strategies for increasing available resources.
   f. Develop governance structure. Depending on the nature of the investing entity, this might include:
      - composition of board of directors and advisers;
      - identification of CEO or program manager;
      - policies and procedures for distributing resources;
      - decision-making process;
Clarify feasible procedures for reinvesting health care cost savings

Altarum Institute

- mechanisms for resolving disagreements;
- roles of providers and community organizations; and
- compensation – if any – for board members and executives.

g. Ensure compliance with applicable state laws and regulations.

h. Identify nature and degree of commitment among participating groups.

i. Identify data and other information requirements and related data processing and analysis needs, including:
   - process for community input;
   - data collection strategy;
   - data protection policies and practices;
   - approaches for data analysis;
   - process for distributing data and analysis results; and
   - methods for program evaluation and monitoring.

j. Develop processes for renewal of agreements, dissolution of the arrangement, opting in/out by participants, and exclusion of a participant from the program.

k. Develop an evaluation plan, if needed, to determine if the program is working, evaluate strengths and weaknesses and strive for continuous improvement, and revisit governance structure to confront and reconcile problems.

3. Develop Approach for Characterizing Savings

a. Develop agreed-upon quality and performance improvement metrics as benchmarks to measure achievements.

b. Develop methodology to measure quality and performance improvements, including associated financial gains.

c. Develop a quality assessment and performance improvement measurement system for collection, analysis, and application of historical operational and financial performance data to:
   - forecast costs in the absence of improvement initiatives;
   - project the impact of improvement initiatives on costs (and associated savings); and
   - track savings as they occur.

4. Develop Vehicles for Securing Gains

a. Identify and sources for initial funding.

b. Establish mechanisms for holding and managing gains for subsequent reinvestment.

5. Develop Approach for Allocating Gains

a. Assess community needs to be addressed and community strengths to be exploited that will meet the objectives established in step 2b. above.
b. Identify specific recipients of gains consistent with these needs and strengths.

4.0 Summary of Findings and Reflections on Possibilities

We conclude with a summary of findings and observations on possibilities and challenges.

1. **Patience is required at every phase.** Progress is usually much slower than expected. This is a time intensive undertaking that needs to facilitate entrepreneurial efforts to take root and grow.

2. **It is essential to build trust.** Trust must be in place for the community to be successful in any kind of reinvestment effort. Ideally, trust should span the dimensions of multi-sector collaborations, socio-economic status/geographic divides, and all leadership levels (formal and informal). Experiments with wider forms of reinvestment can comprise successful approaches to develop and test partnerships that are trustworthy, i.e., investments can be leveraged to build trust and strengthen inter-organizational relationships.

3. **Collaborations evolve in many different ways.** Success in some cases arises because of longstanding groups that change in accordance with a new mission. Composition of the governance structure plays an essential role, especially to co-opt potential opposition. No matter what structure the collaboration ends up taking, there must be leadership buy-in to the governance structure to push a community reinvestment initiative forward. The governance structure should have some level of independence to avoid becoming "just another program" of a particular agency or group. The collaborative decision-making process must be driven by relevant, local data as available. It is best if the data are collected and analyzed by the collaborative leadership as a whole, with assistance as needed.

4. **Closed systems make the entire reinvestment strategy easier to execute.** This is best seen in various Medicaid initiatives where funds freed by efficiency interventions can somewhat straightforwardly be reinvested into the program, e.g., the New York State Medicaid redesign (see below). However, it should also be noted that closed systems can discourage innovation because the impact to the major player(s) in a closed system may not seem to be of benefit to those in charge of the system, and once that shift occurs the entire effort may be in jeopardy. Open systems are more complex to organize, but a neutral convener can be a good driving force in an open system.

5. **Reinvestment is dramatically facilitated in conjunction with large-scale payment reform.** The greater the penetration of reimbursement modes beyond fee-for-service, the easier it will be to carve out funds for reinvestment (see Section 3.4).

6. **A growing population of health care needs aids reinvestment strategies.** In situations where the affected populations are large and rapidly growing, e.g., frail elders for a host of medical conditions, or diabetics stemming from the obesity epidemic, it will be easier
to push revenue requirements of the providers to the back seat and thus elevate the discussion of generating savings for reinvestment.

7. **The difficulty in generalizing should not preclude getting started.** Beyond the unique circumstances that people face in every community, there are several common goals, strategies and functions that leaders can successfully confront. Many of these are fundamental, such as strong, inspired leadership working within a community that has a base level of social cohesion. See Sections 3.1 and 3.6.

8. **Successful, sustainable innovation requires a change in leadership thinking regarding resource allocation.** We heartily endorse the perspective from this McKinsey report (Buescher and Viguerie, 2014): Senior executives should also be willing to make significant changes in how and where resources are allocated. After all, a strategy is only a theory until resources are allocated to it. In making the allocation, the executives should take care to ensure that they are not underresourcing the new strategy. There is also a second danger the executives should guard against: at many companies, budget processes favor existing businesses over new ventures. Our research into more than 1,600 US companies shows, for example, that about 90 percent of all capital-expenditure allocations can be explained by the previous year’s capital-expenditure allocations. Although all of the companies had detailed planning and capital-expenditure-allocation processes, those processes were inadvertently reinforcing the status quo.

9. **Failure must be an option.** Failure must be allowed in efforts with a quality improvement mindset for the community, to provide “backbone support” and to instill leadership. If failure is not an option, there will be a lack of incentive for innovative changes, a major requirement for any reinvestment initiative. An iterative, learning orientation is critical as a strategy that can both build trust and overcome the initial inertia of entrenched interests.

10. **Creative incentives and appreciation of provider cost structures can spur reinvestment.** In re-directing shared savings to upstream (or downstream) investments, a critical challenge is the need for the providers to receive their allocation, which will be pivotal to the success of some of these attempts. Many current shared savings programs include less than adequate returns to mitigate the losses by the health system and cover the infrastructure costs of the clinically integrated networks (not to mention the upfront ‘sunk costs’ and investments). Thus, there are two important needs for a system engaging in reinvestment efforts. First is the ability to negotiate contracts that address these issues and include creative ways to fund health systems in order to cover fixed costs while reducing variable costs, such as described in some of the work by Harold Miller. Second is the need to ensure that providers or health systems have a viable strategy for ‘right sizing’ to prepare for reduced volumes. The latter is not a given since systems may not have an effective way to do this given a lack of prior experience.

11. **Risk sharing and system-wide saving opportunities deserve investigation.** To the extent that health systems or ACOs bear some downside risk in the success of a health
improvement initiative, if the risk were also shared with the community, this could go a long way toward encouraging sharing of the reward by the community. Also, it would be interesting to investigate the possibility of quantifying the savings generated in other sectors beyond health as a result of collaborative efforts, and to explore ways of capturing at least a portion of those savings for the reinvestment pool, further driving buy-in from the health sector in sharing savings.

12. **Carving out funds for reinvestment is difficult, but justifiable and worthwhile.**

Everyone is in line for efficiency savings, and payers and providers may sincerely believe they are entitled to these gains. However, when family caregivers, social service organizations, public health agencies, employers, elected officials, and scores of other contributors have a hand in reducing health care costs, it is fair to ask, “Whose money is that?” and to question, “Who ought to decide where it can be best invested?” Nevertheless, carving out a slice for investments in social determinants of health, to rev up the reinvestment engine, is intrinsically difficult. Moreover, allocation of this slice may be highly contested over community needs. One innovator implored, “I would go so far as suggesting that social determinants of health may need to be equal to that of payers and providers to get solid footing at the reinvestment table.” RTH modeling and other analyses convincingly show that social determinants of health are important to the short and long-term success of community health improvement and reinvestment efforts.
Appendix A: Synopses of Select Innovative Programs

This appendix provides summary information about example reinvestment programs in various stages of implementation.

A.1 Akron, Ohio Accountable Care Community

Austen BioInnovation Institute in Akron (ABIA) launched the first Accountable Care Community (ACC) in Akron, Ohio in 2011. ABIA is a biomedical innovation institute, founded in 2008 by Akron Children’s Hospital, Akron General Health System, Northeast Ohio Medical University, Summa Health System, The University of Akron and the John S. and James L. Knight Foundation. The ACC is made up of more than 70 public and private partners. It integrates area assets into a shared responsibility framework among regional institutions to enable improvement in population health, to close gaps in healthcare delivery, and to measure impact as innovative health strategies are implemented. The Accountable Care Community initiative is focusing its efforts on chronic conditions, such as diabetes, obesity, asthma, and hypertension (first focusing on type 2 diabetes).

As stated by ABIA, they are “taking the concept of ACOs a few steps farther by expanding it into the entire community by linking to and leveraging the joint ABIA-Wellness Council of Summit County. The council was created in 2010 as a way to unite multiple community sectors around a shared vision of optimum wellness for Summit County, Ohio, residents. By mobilizing diverse partners in coordinated and collaborative efforts, the Wellness Council, as a component of the Accountable Care Community, aims to improve the physical, social, intellectual, emotional, and spiritual health of the community.”

The overall goal of the Accountable Care Community is to effect changes across the range of determinants of health (for example, income and social status, genetics, physical environment, and social support mechanisms) and to make community efforts more efficient by strengthening links between existing programs, capitalizing on resources, and building novel solutions to chronic health issues. Success is measured by factors including the improved health of the whole community, cost effectiveness and cost savings in the health care system, improved patient experience for those using the health care system and job creation in Akron. NB: Following hospital system consolidation, ABIA has lost executive health care leadership and its progressive momentum. Also, Janine Janosky has moved to an academic position in Michigan. It is unclear what will become of this initiative.

Links:

A.2 Atlanta Regional Collaborative for Health Improvement

The Atlanta Regional Collaborative for Health Improvement (ARCHI) is an interdisciplinary coalition working to improve the region’s health through a collaborative approach to community health assessments and improvement strategies. It is a partnership of hospital, public health, regional planning, academic, non-profit and philanthropic organizations and experts who have a stake in a comprehensive assessment of health priorities and a commitment to ensuring local investments in health are crafted in a way that improves health in Metro Atlanta. ARCHI has produced a collaborative, regional health assessment and short- and long-term improvement plans that allow different partners to invest according to their interests and needs. The Collaborative has also worked with ReThink Health to develop a model calibrated specifically for Atlanta, incorporating extensive data on residents’ health and the area’s healthcare system, which now forms the basis of ARCHI’s common agenda.

Using the ReThink Health model, ARCHI members have examined and tested several scenarios. The scenario that received the most support was titled Atlanta Transformation, which included seven items: Encouraging Healthy Behaviors, Family Pathways, Coordinated Care, Global Payment, Capture and Reinvest, Expand Insurance, and Innovation Fund. The vast majority of the diverse group of ARCHI members (almost 90%) said they would be proud to enact the Atlanta Transformation scenario, and everyone indicated where their organization might have the most to contribute. People are getting on board and finding consensus about how to drive this initiative. Workgroups have already been formed to work on each of the seven items in the Atlanta Transformation initiative.

In addition to in-kind contributions from the three leadership organizations, crucial support for the creation of ARCHI came from the Centers for Disease Control and Prevention, Kaiser Permanente, Grady Health System, and St. Joseph’s Health System.

Links:
http://www.archicollaborative.org/
http://www.archicollaborative.org/archi_playbook.pdf

A.3 CareOregon

In 2012 the Oregon Legislature passed health care reform laws authorizing the creation of Coordinated Care Organizations to cut medical costs incurred by members of the Oregon Health Plan. From the Oregon Health Plan website: “Coordinated Care Organizations (CCOs) are a new way for the Oregon Health Plan. They will be the umbrella organizations that govern and administer care for OHP members in their local communities.

CCOs are local health entities that will deliver health care and coverage for people eligible for the Oregon Health Plan (Medicaid), including those also covered by Medicare. CCOs
must be accountable for health outcomes of the population they serve. They will have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs will bring forward new models of care that are patient-centered and team-focused. They will have flexibility within the budget to deliver defined outcomes. They will be governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk...The potential cost savings for Oregon are substantial -- more than $3 billion over the next five years -- and will ensure that our most vulnerable citizens maintain coverage, while freeing limited resources for other public priorities.”

The state is tracking 17 CCO incentive metrics and 16 additional state performance metrics. It is also tracking financial data, displayed both by cost and by utilization. By using quality, access and financial metrics together, the state can determine whether CCOs are effectively and adequately improving care, making quality care accessible, eliminating health disparities, and controlling costs for the populations that they serve. Their first “report card” has been published (http://www.oregon.gov/oha/metrics/Pages/index.aspx).

Links:
http://www.careoregon.org/
https://cco.health.oregon.gov/Pages/Home.aspx

Of note, CareOregon, has also been involved in an IHI Triple Aim Initiative, having developed two innovative programs to help optimize care for its enrollees: a patient-centered medical home initiative in safety-net clinics and a multidisciplinary case management program for members at high risk of poor health outcomes:

A.4 Collective Health – Fresno, California Health Impact Bond

Collective Health is a “health impact investing firm” launched with research support from UC Berkeley School of Public Health and grant funding from the California Endowment (TCE). The firm is overseeing the first “health impact bond” to reduce emergency department visits and hospital stays related to asthma among low-income children in Fresno, California. As described by Collective Health, health impact bonds “redirect capital where it can do the most good. Investors finance community-based prevention in exchange for a share of future health care cost savings. A portion of savings is then re-invested in additional community improvements, creating an ongoing system of better health and lower costs.”

The pilot phase of the Fresno project began in 2013, with likely launch of the bond in 2014 (NB: a press release states the bond will actually launch after the two-year pilot—see below). The two-year pilot aims to reduce asthma-related emergencies through home-
based educators and indoor air quality improvement. Collective health forecasts $6 million in savings (a 5:1 ROI). A press release from the California Endowment states that Collective Health and Social Finance, Inc. were awarded $660,000 in grant funding to launch this demonstration project. According to TCE, “Central California Asthma Collaborative and Clinica Sierra Vista, which both have proven track records in managing this disease, will design and execute the comprehensive asthma management program, and Regional Asthma Management and Prevention will provide technical assistance. The partners will engage with the families of 200 low-income children with asthma to provide home care, education, and support in reducing environmental triggers ranging from cigarette smoke to dust mites and other indoor air contaminants.” Collective Health will use insurance claims data to measure health care cost reductions among program participants and calculate net savings from the project, while Social Finance, a nonprofit financial intermediary, will act as a strategic advisor and will assist with project management and implementation. Together, Collective Health and Social Finance will create an advisory group to begin planning for a Social Impact Bond to launch after the two-year demonstration. The Social Impact Bond will attract up-front capital from investors to scale up the asthma prevention and management program to serve up to 3,500 additional children. The investors will have the potential to recoup their principal and earn a rate of interest if agreed-upon health outcomes are achieved.

Collective Health’s website also mentions other projects, including one in Phoenix, AZ, for which they forecast $17 million in savings (2.4:1 ROI) through “integrated health coordinator and community approach to reducing emergency and hospital services among individuals with chronic mental and physical illnesses.”

Links:

Collective Health website: http://www.collectivehealth.net/new/home.html

Information on Fresno project:
http://ehp.niehs.nih.gov/121-a45/
http://www.collectivehealth.net/new/about_files/CH_fresno%20asthma%20value%20mode l.pdf


### A.5 Dignity Health

Dignity Health is the fifth largest hospital provider in the nation and the largest hospital system in California. They recognize that health cannot be defined simply as the absence of disease. Mental, spiritual and environmental well-being all play a part in the overall health of an individual or a community. For this reason, they go beyond their hospital walls to help improve the long-term health of the communities they serve, and this is reflected in their
community benefits strategy. In addition to making grant funds available to their community partners, they also work to establish larger pools of capital for those who have been historically underserved. Their Community Investments are providing below-market interest rate loans to nonprofit organizations that are working to improve the health and quality of life in their communities. Dignity Health borrowers develop community facilities such as child care and community clinics, affordable housing for low-income families and seniors, job training for the unemployed or underemployed, and health care services for low-income and minority neighborhoods. Since 1992 they have invested more than $88.1 million in 185 nonprofit organizations. (From Sprong and Stillman, 2014).

In addition to their Community Investments, in 2005 Dignity Health also developed the nation’s first Community Need Index, which maps the level of community need for every zip code in the United States, allowing them to pinpoint communities with more barriers to access and take strategic, informed steps to meet those needs. They are “now applying the same level of scientific rigor we demand in the practice of medicine to the practice of Community Benefits. And with better tools for measurement we are better able to design the programs and services that will have a real impact on the health of the communities we serve.” They also have a Community Grants program to increase access to quality care. Organizations that receive grant funds are working to improve access to jobs, housing, food, education, and health care for people in low-income and minority communities. Since this program began in 1990 they have made grant awards to nearly 3,006 projects totaling $51.3 million.

Link:
http://www.dignityhealth.org/Who_We_Are/Community_Health/index.htm

A.6 Health Improvement Organization, Jackson, Michigan

The Health Improvement Organization (HIO) was founded by Allegiance Health in 2000 to improve the health status of the community through a compact among patients, physicians, employers, the health system and the health plan. In 2006, the Health Improvement Organization adopted a new governance structure, vision and principles based on a year-long re-visioning process. This led to the creation of our HIO Coordinating Council.

The HIO Coordinating Council is a multi-disciplinary stakeholder’s group led by Allegiance Health with representation from local government, public health, health care, health and human service agencies and nonprofits, school districts, health plans, mental health, employers and the faith community. The HIO CC now functions as the community stakeholder planning committee of Allegiance Health’s Health Improvement Organization Board Committee, Jackson County’s Health Communities strategic plan, the United Way of Jackson’s Health Community Solutions Team and the Health Strand of the Jackson 2020 initiative. This coordination of efforts across community leaders in health allows for unprecedented alignment of goals and resources, as well as the creation of a strong community platform for advocacy.
A.7  Hennepin County, Minnesota Accountable Care Organization

In 2012, Hennepin Health was formed as a capitated Medicaid demonstration project by four organizations: Hennepin County Medical Center, NorthPoint Health and Wellness (a Federally Qualified Health Center), Metropolitan Health Plan and the county’s Human Services and Public Health Department (including Health Care for the Homeless, the county’s Mental Health Center and other social services). The providers bill the plan on a fee for service basis and split the gain (or loss) at the end of the year. An assigned care coordinator works to ensure that each enrollee receives appropriate services based on his or her medical, behavioral health, and social service needs. Partners share data electronically to allow for complete information on each enrollee, and jointly implement initiatives to improve care and promote appropriate utilization. Hennepin Health serves single, nondisabled adults ages 21 to 64 years who do not have dependents. With the expansion of Medicaid eligibility under the Affordable Care Act, Hennepin Health now serves individuals who are earning up to 133 percent of the Federal poverty guideline, effective January 1, 2014. The ACO has enrolled an increasing number of clients over time and has reduced admissions, readmissions, ED visits, and the costs of caring for enrollees with historically high use. The program has generated high enrollee satisfaction.

Links:
AHRQ Innovation Profile: http://www.innovations.ahrq.gov/content.aspx?id=3835

Commonwealth Fund case study:

A.8  MediCaring: Reinvestment with Elder Focus

Most of us will live into old age, and most of us will have a phase of life when we are unable to manage daily life on our own due to a combination of illnesses and disabilities that are associated with aging. Preventive steps earlier in life will not evade this phase – indeed, good health in most of life probably increases the likelihood of living long enough to have frailty in old age as one’s course to death. This phase of life accounts for roughly half of our lifetime health care costs, yet does not buy us the services we truly need. Instead, medical errors, over-medicalization, shortages of direct care, burdens on family, and other calamities
are so commonplace that people who escape them consider themselves lucky, while those who encounter problems take it as expectable if not inevitable.

The serious and costly shortcomings of service delivery in old age present a remarkable opportunity to apply many of the principles and insights embodied in reinvestment strategies. Frail elderly people routinely need medical care, housing and nutrition access, caregiver support, and social interaction – all as an integrated package that makes sense and is trustworthy. At present, the pieces are variably available, hard to identify or coordinate, and costly. The major locus of overspending is in Medicare-covered hospital care, though unnecessarily quick use of nursing homes likely runs up avoidable costs in the same ballpark. Moreover, the services for frail elders are quite tied to where they live – moving around is difficult and many services must come to the person where he lives, rather than the elder travelling to the service. Several projects have shown how to make the care reliable and less costly, but they have been very difficult to scale up for many reasons, not the least of which is that they do not easily qualify for the current shared savings models.

These and other considerations make it quite appealing to see whether some communities could generate a comprehensive and redesigned care system for frail elders that deliberately saved money on the Medicare side and reinvested most of it in the underfunded social supports, and in the management of the system. Estimates vary, of course, but one commercial company is routinely avoiding 45% of the 23% of Medicare expenditures that fall in the 90 days after hospitalization, i.e., about 10% of all Medicare expenditures. Assuming that it takes a few percent to manage the system (the company provides no services except decision guidance), that would still be about 8% of all of Medicare expenditures made available. In our much more conservative estimates in four diverse communities, savings would amount to $5-10 million each by the third year of operation. That is enough to start making a real difference in access to Meals on Wheels or housing adaptations, etc.

A dozen communities are moving along in some way toward implementing this MediCaring Communities model. Since they cannot yet anticipate a mechanism to harvest the shared savings, they are doing what they can using an array of strategies – building coalitions, implementing better care planning, better managing transitions, identifying the frail elders, and so on. Most are thinking of a non-profit trust or a government-linked entity that would eventually manage the system. It is likely that when harvesting the savings becomes possible, they will not be fully ready, they will not have a fully workable structure or governance, and they will not have good metrics or dashboards. They will be in the process of building these elements, but their system won’t be polished or smooth – and there will be substantial risks.

Nevertheless, those involved have confidence that start-up funds can be found via social impact bonds or pay for success strategies, in local taxes, or in local philanthropy. Medical care is mostly covered by Medicare, and since the community’s eldercare coordinating entity will be working in the public interest, we anticipate having little trouble with anti-trust. Generating care plans for frail elders and then having them available across settings
and time (and evaluated with working feedback loops) is still a challenge, but one that the Program of All-Inclusive Care for the Elderly (PACE), and other innovative programs, are working out.

Advocates are thinking of generating health care cost savings in relatively healthy populations, in large part by tackling the social determinants of health. The model is parallel, though the language is different, when considering how to manage serious disability and illness over multiple years in old age. The social determinants of well-being are underfunded, and the lack of housing, nutrition, transportation, and caregiving run up remarkable costs in the open-ended medical care system. If communities could turn that around – implement strategies that elders and families need and want, and that cost a great deal less, and the communities could garner the savings – the communities could also invest those savings in the very social supports that make the system work. Sustainability would increase from the shift from medical expenditures to social supports (and to managing the local system). People living with serious disabilities in old age could have better lives, unnecessary medical interventions would be avoided, and supportive services would become more reliable. Also, the rapidity of the return on investment is stunning, since the costs to be avoided are being incurred every day – there is no built in lag! The lives of those affected with serious chronic conditions are not remote – someday, it will be you or someone you love!

Link:
http://altarum.org/research-centers/center-for-elder-care-and-advanced-illness

A.9 New York State Medicaid Redesign

On April 14, 2014, Governor Andrew M. Cuomo announced that New York has finalized terms and conditions with the federal government for a groundbreaking waiver that will allow the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. The MRT waiver amendment will transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members.

The Medicaid 1115 waiver amendment will enable New York to fully implement the MRT action plan, facilitate innovation, lower health care costs over the long term, and save scores of essential safety net providers from financial ruin. The waiver allows the state to reinvest over a five-year period $8 billion of the $17.1 billion in federal savings generated by MRT reforms.

The waiver amendment dollars will address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health...
improvement. Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

Links:

https://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

A.10 PeaceHealth, Whatcom County, Washington

Whatcom County has worked with ReThink Health to configure the ReThink model for the specific circumstances of the county. ReThink reports that “a general blueprint for health reform in Whatcom has been articulated, centering on the idea of an ‘Accountable Care Community’ (Whatcom Alliance for Healthcare Access, 2011). They regard this community-wide emphasis as an important extension beyond the conventional limits of an accountable care organization. Equipped with the ReThink Health model, Whatcom leaders believe that they will be positioned to reinforce that population perspective and also sharpen their focus on enacting a package of high leverage interventions.” The Whatcom Alliance for Healthcare Access’ Transforming Healthcare project aims to increase access, improve outcomes and lower costs through development of a local community Accountable Care Organization. Whatcom appears to have a long history of local collaboration for the purpose of improving health and health care. For example, Whatcom received a grant from IHI for their “Pursuing Perfection” project, to increase its focus on patient-centered care (see link to case study below), utilizing the Community Health Improvement Consortium (CHIC) of Whatcom County, an alliance of public and private health care providers, payers, and purchasers that has been working together for nearly ten years to increase safety and efficiency, reduce costs, and eliminate barriers — especially for patients with chronic conditions — across the entire system of care.

Links:

http://www.systemdynamics.org/conferences/2012/proceed/papers/P1430.pdf
“Pursuing Perfection” Case Study: http://www.ihi.org/resources/Pages/ImprovementStories/PursuingPerfectionReportfromWhatcomCountyWashingtononPatientCenteredCare.aspx
A.11 Pueblo Triple Aim Corporation

According to the Rippel Foundation, Pueblo was the first pilot region to work with the ReThink Health Dynamics project. As a member of the Institute for Healthcare Improvement’s Triple Aim in a Region program, key stakeholders in Pueblo are committed to pursuing the three simultaneous goals of better health, better care, and lower costs. When they first convened in November 2010, local leaders sought to understand how they might address all three goals, without sacrificing progress in one area to achieve improvements elsewhere. They worked with the ReThink Health Dynamics team to gather data and build a formal model that simulates the behavior of Pueblo’s health system. As a result, members of the Pueblo Triple Aim Coalition (PTAC), including the health department, community health center, hospitals, mental health center, Kaiser Permanente, schools, business leaders, elected officials, philanthropies, and more, now have a better understanding of their health system and how it may change over time. They have gained actionable insights not only about where the leverage lies to influence the Triple Aim, but also how to finance and sustain those initiatives.

Using the ReThink Health Dynamics model, calibrated with Pueblo’s own data, team members studied scores of scenarios and eventually identified a compelling suite of initiatives that could significantly strengthen most aspects of their health system. The PTAC plan now centers on a mix of cost-saving initiatives, like care coordination and post-discharge planning, along with support for self-care, greater safety net capacity, and investments in upstream social, economic, and behavioral initiatives. Just as importantly, PTAC planners determined that it may be possible to sustain all of these activities over decades by capturing and reinvesting a portion of health care cost savings. This financing strategy is similar to one that Sanne Magnan and colleagues have proposed in their essay on Accountable Health Communities.

Links:

http://rippelfoundation.org/rethink-health/dynamics/regions/pueblo-colorado/ (includes link to Pueblo ReThink model).


http://www.improvingpopulationhealth.org/Pueblo%20Triple%20Aim%20Case%20Statement.pdf

http://www.pueblotripleaim.org/#
Appendix B: Key Informants

From April 2014 through August 2014, members of the Altarum Center for Sustainable Health Spending spoke with over 30 individuals involved in community health collaborations or nascent reinvestment projects, as well as selected national health policy and prevention experts. Besides the typical 30-minute call (some were in-person meetings), there were opportunities for follow-up communications in some cases. In addition, a small set of these experts reviewed drafts of this brief. Below we list the individuals in alphabetical order. Contact information is available from the authors of this brief.

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Virginia Commonwealth University

Pano Yeracaris
Co-Director
Rhode Island Chronic Care Sustainability Initiative, Former VP & CMO, Network Health
Appendix C: Strategies for Contract Negotiations

The following outline presents a framework for negotiating contracts as part of establishing governance for a reinvestment initiative. Many of these steps are also necessary for initiatives that employ structures other than a set of contracts.

1. Establish initiative goals and objectives
2. Define all terms
   a. Ensure that participants understand the nature of the contracting process
   b. Ensure that participants understand the structure and process of entering into long-term legal agreements
   c. Ensure that participants understand the expectations and obligations of the savings reinvestment initiative
3. Contract as the end point of negotiations
4. Pre-contract activities
   a. Due diligence assessment
      (1) Financial information
         i. Sources of cost savings/other funds
         ii. Anticipated savings over time
         iii. Sustainability of savings and alternatives if savings goals are not achieved
         iv. Funding needed to achieve objectives
         v. The reinvestment approach
         vi. Strategy for increasing available resources
      (2) Governance structure
         i. Board of directors/advisers composition
         ii. CEO or program manager
         iii. Policies and procedures for distributing resources
         iv. Process for making decisions
         v. Mechanisms for resolving grievances/disagreements (i.e., dispute resolution processes)
         vi. Role of physicians and community-based organizations
         vii. Compensation (if any) for board members/executives
      (3) Other providers/groups who will participate
      (4) Applicable state laws/regulations
      (5) The initiative’s specific, measurable objectives
      (6) Strategic commitment among partners
      (7) Expected commitment in time and resources
      (8) Process for expansion to other communities
      (9) Process for bringing in new participants
      (10) Documents incorporated by reference
   b. Collect and analyze documentation/data
      (1) Process for achieving community input
(2) Data collection strategy
(3) Data protection policies/practices (i.e., privacy and confidentiality)
(4) Analysis/distribution of data
(5) Program evaluation and monitoring

c. Anticipate potential problem areas
d. Length (i.e. year-to-year) of the contract and renewal terms (i.e., automatic or asking members to rejoin at specified intervals)
e. Dissolution process
   (1) Process for terminating the arrangement (i.e., arbitration)
   (2) Process for any participant to opt out
   (3) Specific reasons for excluding a participant from the initiative
   (4) Distribution of remaining assets upon termination
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1. The Evolving Concept of an Accountable Health Community: Options for Funding a Population Health Trust
2. Investment Opportunity: Federal and State Community Benefit Requirements for Non-Profit Hospitals
3. A Sustainable Health Investment Strategy: The Role of Health Care Payment Reform
4. Investment and Collaboration Opportunity: Community Development Financial Institutions
5. Snapshot: Health Insurance Market and Provider Payment Programs: New Hampshire and Vermont
7. Prevention Opportunity: Prevention and Wellness Trusts
8. Financial Guide: Chapters 1 – 4 {3 documents}


Clarifying Feasible Procedures for Reinvesting Health Care Cost Savings

Altarum Institute • 44


Premier Letter to CMS on the Medicare Shared Savings Program (2014). April 28, 23 pp. Available at: [https://www.premierinc.com/wps/wcm/connect/034b7a42-1df6-4dba-bf1d-343f5b76e47a/MSSP-Pre-reg-comment-letter_FINAL.pdf?MOD=AJPERES](https://www.premierinc.com/wps/wcm/connect/034b7a42-1df6-4dba-bf1d-343f5b76e47a/MSSP-Pre-reg-comment-letter_FINAL.pdf?MOD=AJPERES)


[Blog links to conference materials and readiness assessment survey instrument.]


## Glossary

| Accountable Care Organization | Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO) |
| Affordable Care Act | The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or "Obamacare", is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. [http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act](http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act) |
| Community Health Needs Assessments | The Affordable Care Act creates an opportunity for hospital organizations, numerous governmental public health agencies, and other stakeholders to accelerate community health improvement by conducting triennial community health needs assessments (CHNA) and adopting related implementation strategies that address priority health needs. Under the Affordable Care Act, hospital organizations satisfy their annual community benefit obligations by meeting those new requirements which are described in section 501(r)(3). In addition, hospital organizations have new requirements for reporting and for paying taxes. [http://www.cdc.gov/policy/chna/](http://www.cdc.gov/policy/chna/) |
| MediCaring | MediCaring is a comprehensive approach to providing medical care, long-term care, and social support services for older adults who are living with worsening disabilities and fragile health associated with aging. MediCaring4LIFE is a proposed test of MediCaring’s potential to improve lives and reduce costs of the period of frailty. |
| **Reinvestment** | A financing mechanism to support programs, policies, practices, and initiatives via dedicating a portion of savings from innovative health care interventions to the upstream and powerful drivers of system performance, i.e., the social determinants of health. These include the exposures and choices that people encounter in their homes, workplaces, schools and neighborhoods. [http://hria.org/resources/reports/community-development/leveraging-multi-sector-investments-new-opportunities-to-improve-the-health-and-vitality-of-communities.html](http://hria.org/resources/reports/community-development/leveraging-multi-sector-investments-new-opportunities-to-improve-the-health-and-vitality-of-communities.html) Re: investing and reinvesting, see: [http://www.iom.edu/~media/Files/Perspectives-Files/2014/Discussion-Papers/closingtheloop.pdf](http://www.iom.edu/~media/Files/Perspectives-Files/2014/Discussion-Papers/closingtheloop.pdf) |
| **Sustainable Financial Models** | The diverse set of new financial vehicles for financing population health interventions and infrastructure that have been emerging in recent years including: new payment models for clinical services that reward Triple Aim outcomes instead of volume; breaking down funding silos to create multi-sector programs that blend resources in to a common pool, e.g., through a Medicaid Section 1115 waiver; and a diverse set of innovative funding models that tap into new and existing pools of public and private capital. [http://iom.edu/~media/Files/Perspectives-Files/2014/Discussion-Papers/BPH-SustainableFinancialModel.pdf](http://iom.edu/~media/Files/Perspectives-Files/2014/Discussion-Papers/BPH-SustainableFinancialModel.pdf) |
| **Triple Aim** | Institute for Healthcare Improvement’s construct to depict health system betterment into three categories: Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of health care. |