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Academy of Medicine**

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**POPULATION HEALTH SUMMIT II**

*October 28, 2014*

# **BRIDGING HEALTH CARE AND POPULATION HEALTH: PAYMENT AND FINANCING MODELS**

**JANUARY 2015**



**The New York  
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## BACKGROUND

On October 28, 2014, The New York State Health Foundation, in partnership with The New York Academy of Medicine and New York University School of Medicine, Department of Population Health, convened its second Population Health Summit, Bridging Health Care and Population Health – Payment and Financing Models. (Attachment 1 contains the summit’s agenda; the New York State Health Foundation’s [web site](#) has additional meeting materials.)

Building on the first summit, held in 2013, the organizers designed this meeting as a forum to explore how current and planned changes in New York State’s health care payment systems and other financing mechanisms might best support efforts to improve population health, i.e., the health of entire communities. Building healthy communities is a community-wide responsibility and requires attention not only to the availability of personal health care services, but also to the range of what have come to be known as the social determinants of health: the way that health is affected by the places and ways in which people live, learn, work, and play. A major barrier to improving population health on a broad scale in the United States lies in how improving health by targeting social determinants is (and is not) paid for, by both the public and the private sectors.

The purpose of this paper is to highlight the discussion at the summit and, from this, to frame additional opportunities that New York State might pursue to sustain the investment needed to make New York the healthiest state.

## THE HEALTH CARE DELIVERY SYSTEM AND POPULATION HEALTH

In the United States, most economic investment in the health and social sectors takes the form of investment in medical care (\$2.3 trillion in 2011, according to the National Center for Health Statistics<sup>1</sup>). While researchers such as Elizabeth Bradley and her colleagues have shown that European countries invest more in social services than in medical care, the ratio in the United States is reversed.<sup>2</sup> At 13.3 percent of GDP, however, the U.S. investment in social services is nonetheless massive.<sup>3</sup> The first question for the summit then became, as asked by James R. Knickman, president and CEO of the New York State Health Foundation, “how do we better leverage that investment to the benefit of population health?”

Work to improve population health needs long-term, dependable revenue streams (beyond grants and other short-term, project-based funding), and rebalancing the investments now made in

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<sup>1</sup> National Center for Health Statistics. Health, United States, 2013. Available at [www.cdc.gov/nchs/hus/at\\_a\\_glance.htm](http://www.cdc.gov/nchs/hus/at_a_glance.htm), accessed November 12, 2014.

<sup>2</sup> *BMJ Qual Saf* 2011;**20**:826-831

<sup>3</sup> *Ibid.*

health care systems can play a role in helping to provide these. Summit keynote speaker David A. Kindig<sup>4</sup> cautioned that, while an approach that solely relies on funneling the savings from reduced waste and improved efficiency into efforts focused on population health is an important start, it will not be sufficient. We need, Kindig said, to identify the “sweet spots” where health care investments can align with those in other sectors to increase the investment in “the critical non-medical determinants of health.”

In suggesting where these sweet spots might lie, Kindig referenced the model that underlies the [County Health Rankings](#), a Robert Wood Johnson Foundation-funded program that measures the health of each county in the United States. This model attributes about 20 percent of health outcomes to actual clinical care; the remaining 80 percent derive from factors such as the physical environment (housing, transit, safe water, air quality); social and economic factors such as jobs, income, community safety, family and social support; and personal health behaviors.

The challenge for health care organizations committed to the broad goal of improving population health is to recognize that their lack of direct control over many key factors that drive this mission need not prevent them from acting to establish the robust partnerships with public health and with other organizations in their communities to build the infrastructure and assure the sustainable financing needed to achieve it. These other organizations must include the business community, and attention should be paid to demonstrating the business case for community health improvement. The leadership of HealthPartners, a large non-profit integrated health system in Minnesota, proposes a community health business model to guide this work.<sup>5</sup> This model involves the following:

- A broad set of stakeholders
- Reliable data on community health status and transparency as to progress
- A defined leadership structure with clear goals
- Evidence-based interventions with appropriate incentives across economic sectors
- The ability to learn from actions taken.

In some cases, the health care organizations in a given community can be the logical conveners of this work. In other communities, discussion of sustainable financing for community health will start outside of the medical care system.

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<sup>4</sup> Emeritus Professor of Population Health Sciences, University of Wisconsin Madison School of Medicine and Public Health, Population Health Institute.

<sup>5</sup> For more information, see Kindig and Isham, “Population Health Improvement: A Community Health Business Model that Engages Partners in all Sectors,” *Frontiers of Health Services Management*, 30 (4) Summer, 2014.

## NEW YORK STATE'S HEALTH SECTOR REFORM INITIATIVES AND THE PROMOTION OF POPULATION HEALTH

The four major initiatives being used by the New York State Department of Health to integrate a population health focus into its health care system are the:

- [Prevention Agenda](#), which sets public health priorities across the state.
- [Delivery System Reform Incentive Payment Program](#) (DSRIP), designed to channel Medicaid dollars towards restructuring the health care delivery system, to provide better-coordinated, collaborative care.
- [State Health Innovation Plan](#) (SHIP), strengthening primary care and integrating it into behavioral, specialty, and long-term care and community support services, and further supporting the Prevention Agenda in communities state-wide.
- [Population Health Improvement Program](#) (PHIP), providing for regional convenings and overall support for the other three initiatives.

New York State's goal for each and all of these programs, explained Courtney Burke, New York State's deputy secretary for health, is to support the achievement of the [Triple Aim](#): to improve population health, enhance the experience and outcomes of patients in the health care delivery system, and reduce the per-capita cost of care for the benefit of the community. By their very nature, however, each intervention is based in the State's structures for the payment and delivery of health care services; the primary focus of these programs therefore starts within the health care delivery system.

In its DSRIP initiative, for example, New York State will use payment for Medicaid patients as its vehicle to provide financial incentives for the ongoing support of what it calls "performing provider systems." The state's goal is that DSRIP will reduce unnecessary hospitalizations by 25 percent—a target clearly related to the goal of keeping populations healthier—through projects sponsored by collaborations of health providers in a given community. By the end of the fifth year of the program, New York State intends that 90 percent of its Medicaid payments will be based on value rather than volume.

One key theme of New York State's payment reform work is that actions be planned and carried out at the local level (while coordinated statewide): in the Prevention Agenda, for example, individual counties throughout the state select the specific health priorities relevant to their situation. Proposed DSRIP projects will be based on community health needs assessments, and the very purpose of PHIP is to make sure each region can rely on a neutral, experienced entity able to guide that region's improvement efforts. These initiatives also seek to strengthen the integration of medical care and behavioral health care. A priority of the Prevention Agenda, the

integration of primary care and behavioral health services, is also highlighted as one of the clinical improvement projects supported by both the SHIP and DSRIP.

Across these initiatives, New York State is stressing the importance of accountability, established through performance measurement and driven by payment reform that includes financial incentives for care integration and quality. Communities undertaking projects funded through DSRIP will report regularly on their progress on formal project plans. As noted above, payment to providers will be based on outcomes. The SHIP also incorporates value-based payment with the goal of implementing common measures of success across all payers, public and private; more data leading to greater transparency around actions and outcomes is a long-term objective. The importance of measurement and accountability in all its payment reform initiatives is underscored by the state's requirement that its PHIP contractors devote substantial resources to the management of performance information.

## **CHANGING THE PAYMENT SYSTEM TO HELP DRIVE POPULATION HEALTH**

How strong a force for aligning population health and health care might the health care payment system actually prove to be? The Affordable Care Act, through its provisions for accountable care organizations (ACOs), lays the groundwork for a major change in payment incentives. The Medicare ACOs—now numbering more than 330 in 47 states—are groups of doctors, hospitals, and other providers that come together to accept accountability for both the quality and costs of care for groups of Medicare patients that they serve. Similarly, there are private payer initiatives that create the same incentives for population health through shared savings and/or capitation programs. There are, additionally, other types of payment changes that have been tested on smaller stages. Might any also prove to be an effective “incentive for alignment,” as New York University's Marc Gourevitch<sup>6</sup> asked in introducing one panel at the summit?

One model comes in the form of Federally-Qualified Health Centers (FQHCs), operating with support from the federal government and focused on providing primary care in a manner reflective of the needs of their surrounding (usually disadvantaged) communities. Urban Health Plan, an FQHC operating in the South Bronx and Queens, NY, has successfully augmented its federal funding and state-sponsored support with grants focused both on improving its delivery of health care services and on enabling the Center to affect the social determinants of health in the communities in which it operates. Actions to improve health care described by Urban Health

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<sup>6</sup> Gourevitch is the Muriel G. and George W. Singer Professor and founding Chair of the Department of Population Health, NYU School of Medicine.

Plan's President and CEO Paloma Izquierdo-Hernandez included better coordination and ongoing support for patients in care, the use of community health workers to improve access to care, and a focus on patient activation to improve the health of patients with chronic illness. The Plan also has undertaken strategies for direct investment in broad determinants of health, e.g., hiring within its community; providing job training through youth employment programs; advocating with both local stores and national food distributors to improve the availability of healthy foods in its neighborhoods; and providing safe places for children to play and for young people to gather.

Even with all it has been able to accomplish, however, Izquierdo-Hernandez described an organization under pressure to reduce the cost of its health care services (and limited in its efforts to reduce costs by the difficulty of tracking patients' use of care across time and providers), and lacking stable funding for its work on the social determinants of health. New York State understands the need for better health care coordination and outreach, Izquierdo-Hernandez said: "If they didn't, funding wouldn't be available." But without a payment system focused on aligning health care and population health, organizations like Urban Health Plan currently serve as a model for, at most, an intermediate step for providers seeking to improve the health of their communities.

A more sustainable strategy for building a payment system supportive of both health and health care may come from payers joining together to coordinate their requirements and incentives, engaging providers in the same goals. The P2 Collaborative of Western New York provides one example of how this might work (and, in its community-wide approach, also provides a model for DSRIP communities going forward). Initially convened by the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative (and later supported by a federal Beacon Grant), the P2 Collaborative consisted of providers and payers identifying quality measures on which the region's performance was poor—diabetes, in this case—and committing to improving this performance. A key agreement among participating payers to agree on the same quality standards meant that, first, the payers would work with each other and second, that providers also were willing to participate. From this mutual trust, the Collaborative was able to build and share patient data registries as well as a range of tools to improve diabetes care across participating practices and systems. And as the Collaborative's work on diabetes was informed by the Chronic Care Model<sup>7</sup>, many of these tools involved both support for greater patient self-management as well as changes relating to community resources and policies. Ultimately, explained Kate Ebersole, a former executive of the P2 Collaborative, participating practices in Chautauqua County were able to leverage their experience into a Medicare Shared Savings Pilot ACO.

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<sup>7</sup> Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving Chronic Illness Care: translating evidence into action. *Health Affairs*. 20(6) 64-78. Nov-Dec 2001.

A third model involves augmenting traditional payment for medical services with funds raised through partnerships with other economic sectors. Monica Peek, Assistant Professor in the Division of General Internal Medicine at University of Chicago, described the collaboration between Chicago's South Side Diabetes Project (SSDP), a six-clinic "learning collaborative" for improvement in diabetes care also anchored in the Chronic Care Model, and the Walgreens chain of drug stores. SSDP staff contacted Walgreens to take advantage of what Peek described as the company's trying "to see itself in a different space," re-branding itself as a health entity ready and able to play a role in a health care system potentially dominated by accountable care organizations—and also interested in forming an affiliation with a prestigious university.

In Walgreens, SSDP has found a long-term partner, and many of the actions resulting from this partnership affect the health of the community as well as of SSDP's patients. Walgreens stores in the area now offer more fresh food, and prescriptions for healthy food can be filled at Walgreens, with the resulting information incorporated into SSDP's electronic medical records. Walgreens also provides direct support to diabetes patients in the form of discount coupons for supplies for diabetes care self-management. The store's pharmacists serve as resources for health education and Walgreens makes space in its stores available for community health education. The partnership also benefits the academic medical center with which SSDP is affiliated: Walgreens' robust data systems support the program's research agenda while the strength of the program helps meet the medical center's community benefit requirement. Stressing the need to "approach this work as though it is a PDSA cycle," with ongoing testing and evaluating of ways to strengthen the partnership, Peek highlighted the importance of communication, accountability, and transparency to the partnership's success.

Ultimately, however, shifting the goal of the health system to the improvement of population health will require transitioning from traditional fee-for-service payment to a system that provides a true financial incentive for keeping people healthy: the "incentive for alignment," as Marc Gourevitch described it. New York's plan for DSRIP aims to reduce unnecessary hospitalizations, to base payment on value, and to make health systems responsible for health within a geographic area. The scale of its impact, however, will depend in part on whether, as the State hopes, this shift away from fee-for-service in the Medicaid payment system will spread to other payers. (The New York SHIP, in contrast, does seek directly to accelerate multi-payer models as it promotes integrated care delivery to achieve the community-wide population health goals of the Prevention Agenda.) Even more likely to restrict impact is the limited ability of any system of payment for health care services to affect health on a larger stage.

## OTHER FINANCING MECHANISMS TO SUPPORT POPULATION HEALTH

As New York State proceeds with its payment reform initiatives, policy-makers should also pursue additional financial approaches that could be used to further advance the agenda of population health. Introduced at the summit by New York Academy of Medicine Executive Vice President Anthony Shih, these include the following:

- Fully leveraging the community benefit requirement of the Internal Revenue code
- Community development financial institutions
- Public health trust funds
- Social impact bonds.

All not-for-profit hospitals in the United States must quantify the benefit they provide to their communities in order to retain their tax-exempt status. The Affordable Care Act has put this requirement “on steroids,” noted George Washington University’s Sara Rosenbaum<sup>8</sup>, moving from what was previously a requirement met mostly through the provision of free or discounted care to one that now specifically requires each hospital formally to assess the health needs of its community and annually to update an implementation plan, what Rosenbaum called a “blueprint of how its community health investment is going to happen.” Under the Affordable Care Act provisions, development of the assessment and the implementation plan must be a public process: Rosenbaum reminded the summit audience that the community benefit requirement led to the University of Chicago’s support of the SSDP. And the funds involved are “not inconsiderable”: 7.5 percent of overall U.S. hospital expenditures in 2009, with 5.3 percent linked more specifically to community health improvement activities. With numbers of uninsured falling due to the Affordable Care Act, Rosenbaum posited that hospitals may need to increase their investment in community health improvement. The best models, she added, lie in specific communities where local health entities have developed community-wide plans and health providers are collaborating on carrying these out.

A second community-based force for health comes from the field of community development. Specifically, explained Amy Gillman of the Local Initiatives Support Corporation, Community Development Financial Institutions (CDFIs)—institutions that aggregate resources from wide variety of sources funnel these to neighborhoods for community development activities—are increasingly seeing their role as “building viable places to live, work and raise a family.” As this role has become more broadly understood among CDFIs, they are becoming more intentional

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<sup>8</sup> Professor of Health Law and Policy and Founding Chair of the Department of Health Policy, George Washington University School of Public Health and Health Services.



about pursuing it, planning projects so they include, for example, energy efficient housing built with healthy building materials, commercial development that will provide jobs, safe places to play, healthy food source, and health facilities oriented to primary care and community needs. The CDFIs, in addition to assembling the necessary financing (public, private, grant funding, and tax credits)—and liaising with a banking sector that has its own requirements to demonstrate community benefit—also coordinate many tasks similar to those undertaken by hospitals to meet their community benefit requirements. CDFIs make sure the resources in a neighborhood are accurately inventoried so needs can be determined, they ensure technical assistance is brought in when required, and they engage community-based organizations so changes in neighborhoods are properly supported over time. Gillman stressed the importance of “bring(ing) people together in person in the neighborhoods.” Different people from different economic sectors need to learn how to speak with each other, she observed, but—in her experience—building a personal connection among key players is what makes this learning occur.

As for statewide actions, Massachusetts’ Prevention and Wellness Trust Fund provides one example. The Fund was established by the Massachusetts state legislature in 2012, part of a larger law primarily focused on reducing health care costs, a subsequent step to the state’s major health reform enacted in 2006. The Fund’s \$60 million, four-year appropriation is funded via assessments on insurers and large providers and is administered through the Massachusetts Department of Public Health.

As a legislative product, the Fund by definition resulted from compromise. John Auerbach, currently at the Centers for Disease Control and Prevention and Commissioner of Public Health in Massachusetts at the time the law was developed, described “mixed intentions on the part of the people who were strongly supporting the trust,” as one of the biggest challenges in its implementation. The primary focus of the legislature was that the Fund more than pay for itself: the law requires the Fund have a positive return on investment after only three years (with the fourth year of funding intended to support planning for long-term sustainability). The Fund’s target areas, therefore, are those most likely to generate the greatest return—high-risk populations and secondary interventions: childhood asthma, tobacco use, falls in the elderly, and hypertension. Workplace-based wellness programs also are a major focus. Many of those lobbying for the legislation, however, had hoped for a more broadly-construed set of targets (“with a wider population and primary interventions,” as Auerbach put it), and the narrower result dampened some enthusiasm for implementation.

Still, the Fund prescribes an approach to these issues with a population health orientation. One goal for the Fund is to build an evidence base for effective state-sponsored prevention strategies. Entities applying for grants from the Fund must include clinical providers, community-based

organizations, health plans, municipalities, regional planning agencies, and (where relevant) work sites. Reducing health disparities is a focus, as is better coordination and tracking of how patients move from community-based to health care services. Auerbach noted both the importance and the difficulty of achieving the latter goal: the Fund’s evaluation will include an assessment of its success at linking high-risk patients with community services, and both federal and state funding will be needed for the establishment of an adequate information technology infrastructure to support this. In December 2013, Massachusetts funded nine projects: “It’s early in the game but so far, so good,” Auerbach said.

A final, and highly innovative, financing mechanism presented at the summit was the social impact bond (also known as Pay for Success)<sup>9</sup>. Megan Golden of the Institute for Child Success described the components of Pay for Success projects and also their rarity: only five have been established in the United States, including one in New York City seeking to reduce teen offender recidivism rates. Key components include investors who provide capital to support evidence-based interventions and bear the associated risk that expected outcomes will not be achieved; governments that repay these investors for pre-established measurable results; an independent evaluator who assesses program results; and an intermediary organization that manages the process. Golden observed that the focus on measurable results and the transfer of risk to the investing sector have generated political support for the Pay for Success concept, but cautioned that the approach comes with high transaction costs. Health outcomes, with their long time frame and complicated origins, also may not prove viable as measurable results. “Our aspiration is that after we learn more about these, they will be easier to do,” Golden said. “Getting the investors is not the problem; it’s getting the government to do the contract.”

## **EXPERIENCE WORKING TOWARDS THE TRIPLE AIM**

Given that New York State intends for its payment reform initiatives to support the achievement of the Triple Aim, the summit also explored the experience of communities that have made a long-term commitment to this goal. John Whittington, one of the initial designers of the Triple Aim concept and faculty at the Institute for Healthcare Improvement (IHI), summarized what the IHI has learned about the Triple Aim in the decade since it was first proposed.

The critical foundational activity for achieving the Triple Aim, Whittington said, involves identifying a target population (often a patient population attributed to a provider system or specific sub-populations within such a group; the definition increasingly, however, seeks to encompass

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<sup>9</sup> Golden recommended the [Social Innovation Fund](#) for more information about social impact bonds.

populations living in a specific geographic area served by the provider system or health plan) and determining its health needs. Populations, not delivery systems, are the focus of the work. Specific implementation steps begin with clarifying the business model—determining how the Triple Aim will come to make economic sense for the identified population so the work will be sustainable. Then comes defining the governance structure: Whittington and his colleagues have found that, as he said, “Health really is regional and we have to think about it that way,” so in most cases the leadership has to be regional in scope. And as the appropriate governance structure becomes established, so must the key purpose of the effort—Whittington warned, “You have to think seriously about the why,” and communicate it clearly, and ensure it is clearly understood by all who will be involved.

With the economic model, the leadership, and the purpose in place, then comes the time to develop a portfolio of activities: activities that, again, derive from the needs of the defined population. “Go talk to people,” Whittington urged. “Think about your population segment, their specific (health) needs and the assets they have available,” and conduct an accurate inventory of what already is in place.

The final essential element of this approach is what Whittington called a “robust learning system”: system-level measures, theories to guide actions, a way of learning through testing, a way to harvest individual examples for key concepts that can be tested more broadly, a plan for spreading proven good ideas, and the people who will make sure that these measures, theories, tests, and plans are properly used.

## **RECOMMENDATIONS TO ADVANCE POPULATION HEALTH IN NEW YORK STATE HEALTH REFORM INITIATIVES**

With the construct of the Triple Aim as background and with the discussion at the summit as context, the summit’s sponsors<sup>10</sup> subsequently identified four main areas requiring ongoing attention in the effort to improve population health in New York State:

- Influencing the evolution of the state’s payment reform initiatives
- Ensuring a voice for population health in the governance of health reform
- Developing additional resources that can be invested in population health
- Creating and maintaining a “robust learning system” for population health.

Within each of these areas, the sponsors then developed specific recommendations.

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<sup>10</sup> The New York State Health Foundation, the New York Academy of Medicine, and the New York University School of Medicine’s Department of Population Health.

## PAYMENT REFORM

New York State should continue to accelerate the progress away from the current predominantly fee-for-service payment system towards payment systems that reward improving population health:

- In addition to using Medicaid as a lever, the state should pursue multi-payer initiatives in order to give consistent signals to the provider community that population health is important.
  - One possible approach, for example, could involve demonstration “Accountable Care Communities,” involving multiple payers and other key stakeholders in efforts to improve health broadly in a given geographic area.<sup>11</sup>
  - The state may also use leverage from both the New York State health plan marketplace, the New York State of Health, as well as its health insurance regulatory authority to promote alignment among payers.

## GOVERNANCE

It is important that the population health perspective be represented in all oversight, advisory, and working groups that are addressing health and health care in New York State. Specifically:

- The New York State Department of Health will be developing a series of working groups addressing different aspects of health reform; seeding population health into each group’s charge and agenda as well as in its overall governance and coordinating structure will help ensure the ongoing place of population health in the conversation about policy and policy change. Additional specific actions should include the following:
  - Developing the New York State Public Health and Health Planning Council role in implementation of the SHIP grant to ensure a population health agenda is addressed
  - Encouraging the governance structure of the “performing provider systems” being funded through DSRIP to include representatives with a population health perspective.
- In addition, New York State should consider convening a “Prevention Council” (similar to the [one established at the federal level under the ACA](#)) at the highest level of state government with representation from all key sectors that can have a positive or negative impact on health (housing, transportation, education, business, etc.), to align their efforts to improve the health of New Yorkers.

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<sup>11</sup> Healthier by Design: Creating Accountable Care Communities, a Framework for Engagement and Sustainability. Available at [www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf](http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf). Accessed December 19, 2014.

## RESOURCES

New York State should leverage existing resources for a focused effort on improving population health, and actively seek new resources. These may include the following:

- Existing hospital community benefit dollars. At the summit, for example, Sara Rosenbaum highlighted that using local health entities to coordinate how the community benefit dollars from individual hospitals and health systems are spent is a successful model. In New York State, aligning community-based Prevention Agenda goals and those identified in DSRIP with hospital community benefit investments could significantly increase the impact of these investments over time.
- A population health trust fund established by the legislature, similar to that in place in Massachusetts. While John Auerbach noted the complexity of Massachusetts' legislative process, the bottom line is \$60 million available to advance population health.
- Greater implementation of Health in All policies, to raise both awareness and resources. This tool was not discussed in detail at the summit, but was mentioned by David Kindig as a way to get “more health from what we are already spending in other sectors.” The National Prevention Council's use of its National Prevention Strategy to support Health in All policies<sup>12</sup> could serve as a model for implementation, both statewide and locally (see Governance recommendation above).
- Other economic development investments. As Amy Gillman described, interest in using health as an anchor for economic development is growing; the health sector should actively support this and engage with CDFIs and communities in such efforts. Governor Cuomo's Economic Development Councils could become vehicles for such activities.

## LEARNING SYSTEM

New York State should encourage a statewide learning culture so that best practices and models for promoting population health are spread more rapidly. Many specific actions to build and support such a learning system emerged from the discussions at the summit:

- Any initiative to support population health needs to come with clear measures of success: both the aim and the metric require definition. These form the foundation of the Triple Aim's “robust learning system.” While the Prevention Agenda has developed some such metrics, adaptations would be needed for these to drive the effort to improve population health in New York State across all reform initiatives.

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<sup>12</sup> See [www.astho.org/Programs/Prevention/Implementing-the-National-Prevention-Strategy/HiAP-Toolkit/](http://www.astho.org/Programs/Prevention/Implementing-the-National-Prevention-Strategy/HiAP-Toolkit/) for more information.

- David Kindig, in his keynote address, identified the need for what he called “local investment benchmarks,” a target for what the right level of per-capita investment in population health should be, given a particular community’s profile. New York State’s current County Health Rankings show what has been achieved at current levels of investment; these also could be used as a first step in determining what such investment optimally should look like. The gap between what the investment is and what is needed could then serve as both an impetus to action and the first step in developing an action plan.
- John Whittington, citing the example of Memphis, TN, with 41 uncoordinated organizations working on the issue of infant mortality, stressed the importance of having a clear picture of all the current actions and activities supportive of population health in a given community or region. Beginning initiatives without such clear inventories of resources is ultimately wasteful. The State’s Population Health Improvement Program might tackle such fragmentation at the regional or local level.
- There is a need to disseminate—widely—information about initiatives that have been successful in improving even small aspects of the health of communities, so that learnings can be captured and shared. New York State has examples of improvement coalitions and collaborations of many sorts, with participants who may be invested in what has taken place locally and who can serve as advocates for their work with others from their economic sector and across economic sectors—and across communities and regions. In this way, current experience can be harnessed towards the larger purpose of population health.

## CONCLUSION

It will be challenging to build a fully-realized focus on population health throughout New York State. First, the state is large and its regions vary greatly from each other. Second, the health care delivery system in the state traditionally has been dominated by hospitals and their financing (and, in the state’s largest city, by academic medicine), with a focus very much on patients under treatment rather than on “those who are not yet our patients,” as one summit speaker said. Population health needs vary: from downstate urban counties that are home to people from multiple races, ethnicities and cultures to upstate rural counties under deep economic strain. And different parts of the state have had differing experiences with collaboration in general and health improvement collaboratives in particular: in some counties they form an established way of doing business, while in others they are completely foreign. This variation in history and experience has led also to variation in the effectiveness of efforts to match investment to population need.

Into this challenging environment, New York State has brought a set of models of health care payment mechanisms and regulations designed to drive progress towards the Triple Aim. To

reach their full potential, they must be aligned to achieve the population health goal of making New York the healthiest state. As this summit has shown, achieving this goal means moving away from the currently dominant fee-for-service system of reimbursement for all payers. A number of financing mechanisms—involving both the public and the private sector (as the responsibility is not government’s alone)—have successfully supported community health improvement in a range of settings and ways; these should be tried in New York State, with their impact closely assessed.

Momentum is building for population health, including momentum coming from payment mechanisms oriented towards holding an entity responsible for the health of the patients entrusted to its care. IHI’s Whittington referred to this as “population medicine,” a perhaps necessary first step, as even this outlook remains a stretch for many health delivery and payment systems today. “Be patient,” Whittington urged summit attendees. “We will get more in tune as time goes on.” Not without close attention, however, to creating financing and payment mechanisms that assure the needs of a geographic population are addressed over time. As noted above, New York State’s payment reform initiatives represent an opportunity to be taken advantage of: part of a range of possibilities to be exploited and that led Whittington to observe, “It’s a good time to be alive when it comes to population health in the United States.”

#### **AUTHOR & DISCLAIMER:**

Katherine E. Garrett, writing on behalf of the New York Academy of Medicine Primary Care and Population Health Working Group. Although this work was informed by the deliberations of the Working Group, the views expressed do not necessarily reflect those of every individual member of the Working Group.

#### **FUNDING AND ACKNOWLEDGEMENTS:**

The Population Health Summit II and this paper were made possible by the generous support of the New York State Health Foundation. The author would like to thank the New York Academy of Medicine Primary Care and Population Health Working Group for their input into early drafts of this paper, and to Dr. Jo Ivey Boufford, Dr. Marc Gourevitch, Dr. James R. Knickman, Jacqueline Martinez Garcel, Hope Plavin, Anna Pomykala, and Dr. Anthony Shih for their detailed review and comments.

# POPULATION HEALTH SUMMIT II

## BRIDGING HEALTH CARE AND POPULATION HEALTH: PAYMENT AND FINANCING MODELS

Tuesday, October 28, 2014

<b>9:00 am - 9:15 am</b>	<p><b>Welcome &amp; Introduction</b>  Welcome: <a href="#">Jo Ivey Boufford, MD</a>, President, New York Academy of Medicine  Introduction: <a href="#">James R. Knickman, PhD</a> President and CEO, New York State Health Foundation</p>
<b>9:15 am - 9:45 am</b>	<p><b>Keynote Address - “Providing National Context for Attention to Population Health”</b>  <a href="#">David A. Kindig, MD, PhD</a>, Emeritus Professor of Population Health Sciences, University of Wisconsin Madison School of Medicine and Public Health, Population Health Institute</p>
<b>9:45 am - 10:15 am</b>	<p><b>Opening Plenary - New York State’s Commitment to Population Health</b>  <a href="#">Courtney Burke, MS</a>, Deputy Secretary for Health, New York State</p>
<b>10:15 am - 11:45 am</b>	<p><b>Panel 1 - Bridging Healthcare and Geographic Boundaries in Population Health: Examples Facilitated By Provider/Payer Alignment (National and NY State)</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Marc Gourevitch, MD</a>, <i>Moderator</i></li> <li>• <a href="#">Greg Allen, MSW</a> Director, Division of Financial Planning and Policy, New York State Department of Health</li> <li>• <a href="#">Kate Ebersole</a>, KEE Concepts Consulting, formerly Director of Community Health Improvement and Care Transformation, P2 Collaborative of Western New York</li> <li>• <a href="#">Paloma Hernandez, MS, MPH</a>, President and CEO, Urban Health Plan</li> <li>• <a href="#">Monica Peek, MD, MPH, FACP</a>, Assistant Professor, Division of General Internal Medicine, University of Chicago</li> </ul>
<b>11:45 am - 12:05 pm</b>	<p><b>Break and transition to Lunch</b> - Room 20 (2nd floor) and Reading Room (3rd floor)</p>
<b>12:05 pm - 1:15 pm</b>	<p><b>Lunch Session</b>  Welcome: <a href="#">Jacqueline Martinez Garcel, MPH</a>, Vice President, New York State Health Foundation  Speaker: <a href="#">John Whittington, MD</a>, Institute for Healthcare Improvement</p>
<b>1:15 pm - 1:30 pm</b>	<p><b>Break and transition to Panel 2</b> - Auditorium (1st floor)</p>
<b>1:30 pm - 3:00 pm</b>	<p><b>Panel 2 - Alternative Financing Mechanisms: Bridging Health Care And Geographic Boundaries in Population Health: Community Trusts (e.g., Massachusetts Prevention and Wellness Fund), Social Impact Bonds, Community Development Organizations</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Anthony Shih, MD</a>, <i>Moderator</i> Executive Vice President, New York Academy of Medicine</li> <li>• <a href="#">John Auerbach, MBA</a>, Senior Policy Advisor to the Director at the Centers for Disease Control and Prevention (CDC)</li> <li>• <a href="#">Sara Rosenbaum, JD</a>, Professor of Health Law and Policy and Founding Chair, Department of Health Policy, George Washington University School of Public Health and Health Services</li> <li>• <a href="#">Megan Golden, JD</a>, Senior Fellow, Institute for Child Success and Fellow, NYU Wagner Graduate School of Public Service</li> <li>• <a href="#">Amy Gillman, MBA</a> National Program Director, Local Initiatives Support Corporation</li> </ul>
<b>3:00 pm – 4:00 pm</b>	<p><b>Next Steps in New York State - The role of providers, payers, and policy-makers in investing in and promoting population health in New York State.</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Howard Zucker, MD, JD</a>, Acting Commissioner of Health, New York State</li> </ul>

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