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Population Health NEWS

Measuring Total Investments in Health

by Robin Arnold-Williams and Laura Summers

Research has shown a positive relationship between spending on social services and improved health.[1] As researchers, policymakers and the general public begin to better recognize the many factors influencing individual and population health beyond direct clinical care, some localities, states, federal agencies and research organizations have shown interest and engaged in efforts to measure the total investments being made to produce health. The overall goal is to develop a broader and more encompassing definition of health and health spending.

An assessment, focusing on aggregating and reporting on total spend on health (or expenditures that extend beyond traditional clinical care costs or total cost of care measures, including costs related to the social determinants of health), describes these efforts. The assessment includes a literature review, interviews and convening thought leaders engaged in this work.[2]

Research related to total spend on health is growing due to the value it provides end users. When considering why this research is occurring and the potential value of measuring total spend on health, several key themes emerge:

- Total spend on health analyses help reframe the issue of what produces health and prompts consideration of more than just medical spend.
- Total spend on health analyses aid policymakers and other stakeholders in understanding the synergy between various sectors and multiple determinants of health.
- Having a more complete and clearer picture of current health spending assists in weighing decisions regarding resource allocation—specifically whether more resources are needed or if existing resources should be expended differently to address identified needs.
- Total spend on health analyses can also be used to help inform the design, implementation and evaluation of emerging healthcare delivery and payment models, such as accountable care and global budget models.

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In This Issue

Meeting Consumers' Demands in Safety Net Health Systems

by Cindy Ehnes, Esq.

Fee-for-service medicine is often tagged as the culprit in fostering a fragmented, inconvenient, costly health system. These costs of inconvenience, poor system quality and high hidden expense impact every individual patient and healthcare consumer. In addition, many commentators believe that the healthcare system revolves around what's most convenient for physicians and other caregivers, as opposed to the actual healthcare consumer.

Consumers well understand what they want and expect from their interactions with the health system—low-cost, high-touch and convenient, community-based care. While well-heeled health systems are better equipped to deliver on these increasing consumer expectations, safety net systems are greatly challenged in accessing needed capital and risk-based contracts from payors to reward strategies that reduce inpatient revenue and require large-scale, infrastructure build.

Under the current administration, the Centers for Medicare and Medicaid Services (CMS) and other policymakers have been making macro moves to push health systems to improve quality, enhance the patient experience and lower healthcare costs. CMS has advocated that health systems move into risk-bearing relationships with payors to incent higher quality, less costly care. Given continued cost pressures, the federal push for enhanced quality and patient experience, with costs controlled under capitation or a similar value-based, payment framework, is likely to continue under the new administration.

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Advancing the concept of total spend on health. Moving forward, the following steps have been recommended for advancing the measurement of total investments being made to produce health:

- **Determine appropriate timing for moving toward consensus.** There is a divergence of views on how best to define, measure and calculate total spend on health; however, this is not inherently a negative point. It shows that thought leaders involved in these efforts are committed to their individual initiatives and projects and to getting the total spend on health definition and measurement "right." Given this outcome, the first step in advancing the concept of total spend on health is to determine whether it makes sense to seek establishment of a national or consistent definition.

  Because total spend on health analyses are so specific to the end user, it may not be advantageous to force a consistent definition or methodology; instead, it might be more beneficial to allow initiatives to differ—particularly at the local vs. national level.

- **Make sure all relevant voices are included.** There may be critical voices that have had limited involvement in total spend on health efforts to date who need to be included in order to gain greater consensus. These voices include, but are not limited to, public health, social services, education, transportation, economic development, housing, behavioral health, consumers, community stakeholders, policymakers, budget/fiscal staff and other individuals, who are ultimately responsible for making and tracking expenditure decisions using the total spend on health calculations.

- **Determine a strategy for establishing guiding principles or a national framework for total spend on health calculations and gain adoption of these principles.** This should happen if and when it is determined that the time is right and the appropriate stakeholders have been engaged. This includes achieving greater consistency in total spend on health methodologies.

- **Move from theory to action.** The final step is moving from theory to action and learning from those who are already engaged in these initiatives. The total spend on health movement is active and continuing to gain traction among researchers and policymakers. The need for guiding principles or a framework for total spend on health calculations should not slow the research and individual initiatives currently taking place. Meaningful work is being accomplished that can inform and provide lessons learned for the development of guiding principles.

Thought leaders and researchers engaged in measuring total investments in health have accomplished meaningful work. As they continue this work, they should look for opportunities to enable greater consistency through increased collaboration. This in turn provides an opportunity to drive more widespread acceptance of total spend on health and increase its use in policy decisions.

[1] "Measuring Total Investments in Health: Promoting Dialogue and Carving a Path Forward." Leavitt Partners and the Robert Wood Johnson Foundation. Oct. 17, 2016.
[2] *Ibid.*

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A similar push for change is coming from consumers—both as patients and as payors for health services. Consumers have enough financial "skin in the game" to rightly question why health insurance and health services often lack basic service standards that govern most of their retail experiences.

Here are the top five things that healthcare consumers want clinicians and health systems to deliver besides good care:

1. **Treat me as an individual, not as data**. Patients want adequate time with clinicians to get at the heart of physical and emotional issues. When patients come to a visit with a binder full of information about their anticipated diagnosis, they hope to be seen as engaged partners with their health professionals. Comprehensive care management is a team sport, and consumers want to be a part of a team.

2. **Don't surprise me with poor coverage and balance bills.** Consumers want their private or public coverage to provide predictable and affordable costs of care. This necessitates comprehensive health coverage because unlike auto coverage, in which risks of an accident and severity are statistically well-grounded, it is virtually impossible to predict one's health needs down the road. The majority of Americans are not financially prepared for the devastating monetary impact of chronic conditions, major accidents, disabilities or major medical events. That is why the Affordable Care Act's standardization of essential benefits coverage is vital from the standpoint of most insurance regulators. Consumers want reasonable bills and don't want surprises, such as balance billing by non-contracted personnel when they access an emergency room.

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3. **Envision care from my eyes.** Consumers want innovation and ease of doing business, including use of mobile technology to personalize care. This includes extended hours for urgent care services, walk-in access for routine care and scheduled appointments. They want virtual visits and the ability to get lab results and order pharmacy services online. Consumers want clinical integration with system reminders at the point of care. They do not want to see a physician who is still using paper charts, requiring patients to carry photocopies of their medical records to a specialist.
4. **Don't fence me in.** Consumers want all the benefits of an integrated system without actually being in a closed network. Consumers instinctively love the word "choice" even though it has largely brought them disconnected, fragmented health services. Integrated delivery systems meet those expectations, comprised of robust panels of primary and specialty physicians, including behavioral health, linked organizationally and electronically to quality hospitals, clinics and community care.
5. **Help coordinate this bewildering healthcare cosmos.** Disconnected care puts the onus on the patient to figure out how to link providers, understand differing diagnoses and reconcile multiple medications. A care delivery system that focuses on and coordinates the care of the highest risk patients should be a reasonable expectation of consumers.

It's easy to rattle off the above list of an empowered consumer's demands. What many, if not most, of these "wants" have in common is patient centeredness and a very clear expectation of a more seamless healthcare experience. While often at odds on many issues, consumers and health plans share an abiding belief that high-quality, high-performance care should be a core capability of a system, not an expensive add-on.

But as experience has shown, health systems differ widely in their capabilities to transform the healthcare experience. All systems are facing reduction in hospital patient revenue, the staple component of hospital system budgets; however, many safety net systems serve the sickest and most means-challenged patients.

For many safety net hospitals, a majority of their patient population is covered by Medicaid, has been uninsured and/or homeless, is comprised of racial and ethnic minorities and tends to have more complex health and behavioral health issues. A quality consumer experience in this unique context takes on an enhanced scope that extends well into the community through ties with community-based organizations meeting social, behavioral, housing and economic needs.

To maintain or increase bottom line, financial performance while also improving quality and patient experience, many safety net health systems flirt with a risk-based, contracting strategy, in which payors will hopefully financially reward cost reductions and improved patient experience. These health systems often take some steps to build an appropriate supporting infrastructure toward population health management; however, the same systems generally maintain their clearest footprint on a discounted fee-for-service path, which relies on inpatient revenue.

This muddled strategy is both understandable and likely inescapable without a clear roadmap. Often it is based on magical thinking, "If we build it, they (payors) will come and reward our efforts." However, if the contracts with payors are not in place from the outset, the upfront costs of building a data or care management infrastructure are not supported by a payment stream and potentially reduce traditional sources of revenue. If health systems are not rewarded for these "big-build" projects in a formal contract negotiation with a payor, these efforts may prove unsustainable.

What is needed in its place is an articulated strategy that gradually builds the elements of an integrated delivery system that consumers anticipate. These phased innovations should address discrete problems and should have immediate impact on patient care. For example, improvement in standardization of care management is an absolute key to quality improvement and accountability in a system. Expansion of primary care services, including patient-centered medical homes (PCMH), is another baseline strategy. Integration of clinical services and best practices should then be jointly developed with PCMH and key specialty leaders in targeted therapeutic areas.

From this foundation, staff could dedicate itself to care management and case coordination, with particular attention to care transitions and individuals with highest utilization. Both centralized (telephone or virtual) and field-based, care management are vital. Information systems must support care management through clear care team roles, development of a single care plan and IT support of workflow. In addition, higher levels of analytic capabilities are also necessary to succeed under financial, risk-bearing arrangements.

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To be clear, these clinical improvements are essential linchpins to improved consumer experiences. But sustainable success over the long haul will ultimately hinge on safety net health systems negotiating profitable, risk-based financial contracts with payors. Retrospective value payment and shared savings are a good starting place. However, prospective payment streams are essential, starting with risk-adjusted care coordination fees for the sickest patients and then moving into broader risk payments, such as capitation, as capabilities and confidence build.

Consumers want a high-quality, high-touch, seamless experience whenever and wherever they touch the healthcare system. Safety net systems face many competing demands and tight margins. They must be focused and deliberate to achieve these consumer expectations and remain in service to their communities.

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