

Q: By "population," do you mean the population of patients in a health system, or a community population in the public health sense of the term?

Jim Hester: The latter. Making the transition from viewing accountability as applying to patients to instead being responsible for a community population is a key indicator of a 3.0 system.

Q: As devil's advocate, it appears that most ACOs are looking at their patient panel. Without a "single payer" system, it seems another system is needed to have the "health care system" agree to support population level interventions. How to solve this?

JH: A single payer system would not change an ACO's mindset. It would be more likely that the ACO would focus on its patient population while the health system embedded in the ACO made the transition to accountability for population level interventions as part of its community benefit.

Q: How are the hydraulics of reallocation of funding complicated by the length of the time horizon over which the effects of population health interventions are experienced?

JH: The intent of the balanced portfolio is to have a blend of interventions with different timeframes, in order to smooth out the flow of funds.

Q: Once one of these model saves the health system real money, how do you convince them to give some of that up back to the community rather than merely reinvest it internally or return it to share holders?

JH: The exact rationale depends upon the nature of the intervention and the way in which the CHS adds value. It could be an investor in a social impact bond and share in savings by earning a return on that investment. A hospital included in an ACO could return part of its savings as a community benefit contribution.

Q: What are the parameters for a "population"? City, county, neighborhood? Or does it all depend on scale for financial sustainability?

JH: Existing examples range in size from small neighborhoods with a few thousand people to large counties with million of residents. We need to learn what the minimum size is to support a backbone organization – my guess is that it is in the range of 150,000 to 250,000

Q: So many interventions are looking at treating problems in adults. What about investing in kids and true primary prevention. Do you have recommendations for best models?

JH: The Nemours system as been doing excellent work in Delaware in obesity and asthma; New York Presbyterian has a long standing effort in Washington Heights; and Cincinnati Children's Hospital has a strong community based program.

Q: Can you talk about the role that state and local public health agencies have played and should play in developing sustainable population/community based financing and programs?

JH: I addressed that in the last part of the presentation (slides 44-45)

Q: In the examples you gave, which entities play the role of the systems backbone and intermediary? What are the pros and cons of that role residing in a government entity (e.g. County Public Health Dept.), healthcare, existing nonprofit, new nonprofit, etc.? I am specifically interested in the relative pros and cons of different sectoral entities taking the lead.

JH: The pros and cons vary with the community and depend on history, the relative strength and credibility of different sectors, etc. The backbone organization role has been played by a wide range of entities and I believe that will continue to be the case.

Q: How do you see the relationship with the Collective Impact approach? Are there strategies and practices from CI that can be applied in building an integrated community health system?

JH: Collective Impact is very compatible and has been integrated into a number of example such as ARCHI in Atlanta.