Spotlight on Action Interview Full Transcript: Frederick Isasi, Families USA

Aparna Higgins, LAN (00:00:)

Hello and welcome to Spotlight on Action produced by the Healthcare Payment Learning and Action Network, commonly known as the LAN. I'm your host today, Aparna Higgins, a Senior Advisor to the LAN and a Senior Policy Fellow at the Duke Margolis Center for Health Policy. The LAN spotlight on action highlights LAN members' work on the ground to effect positive change in our healthcare system. Through alternative payment models, also known as APMs from leading APM adoption to focusing on APM design elements, that address health equity and break down barriers that stand in the way of people being their healthiest selves. LAN members are on the frontline of the healthcare transformation that is currently underway. We are very fortunate to have Frederick Isasi with us today.

Mr. Isasi is the executive director of Families USA, one of the nation's leading nonpartisan nonprofit healthcare advocacy organizations. The mission of Families USA is to ensure that all people receive high quality, affordable consumer-centered care. He's a national thought leader and subject matter expert on the social issues and solutions related to driving value and equity into healthcare and providing high quality coverage drawing on decades of experience in the healthcare industry, public policy and law. He previously founded Family USA's National Center for Coverage Innovation to help state and federal policy makers and consumer leaders develop and implement pragmatic non-partisan approaches to expand and improve healthcare coverage. He also founded and still directs his organization's Center on Health Equity Action for System Transformation, the only national entity exclusively dedicated to developing and advancing patient-centered health system transformation policies designed to reduce racial, ethnic, and geographic inequities. Frederick, I'm very pleased to welcome you to this conversation today.

Frederick Isasi, Families USA (02:11):

Thank you so much Aparna. It's a true joy to be here.

Aparna Higgins (02:14):

Well, I wanted to start us off today by, focusing on three of the four focus areas or pillars as you call it. And as described on your website and specifically the three of them are healthcare value, healthcare equity and consumer experience. So, I was hoping you could elaborate further on each of these areas, including why you selected these areas as your areas of focus, but also what specific goals you seek to achieve.

Frederick Isasi, Families USA (02:45):

Terrific question. Thanks so much Aparna. So, as you mentioned, Families USA, we've been around for over 40 years and our mission really is to ensure the very best health and healthcare equally accessible and affordable to every living soul in our country. And these are three of the key pillars that we work in. So, the first - as you mentioned, was, is healthcare value. And for us at the heart of what value is really about is first and foremost, making sure that the healthcare system, all of the resources that we have in this country directed towards healthcare really do result in improved health for all. So, it really is at its heart about reorienting the system all the way towards health, not just simply units of healthcare, and then making sure that in seeking care, and, and trying to take care of oneself, one's family, it really is affordable, that it's something that isn't creating economic instability for families, and that's allowing families to really thrive and live to their full potential in our society. When it comes to health equity, it's

really acknowledgment that we have some very deep and pervasive inequities in our health, in our society and in our healthcare system that resulted in some pretty terrible outcomes, for different populations of country, folks who live in rural America, but in particular for communities of color. And so, a lot of our work is focused on trying to surface where those inequities look like. You know, things like for example, that in this country right now, the African American babies who are being born are twice as likely to die during childbirth, then their white counterparts, right? That's this is a country that was really built on the premise of fairness. There's something so fundamentally unfair about that. So, it's about surfacing those kinds of inequities and then developing solutions that really can drive the entire system to allow for the, for these populations to thrive, alongside of their, say white or, or urban dwelling counterparts. And then the last area you said, you mentioned was consumer experience. That's really important to us. You know, we are at our heart, we are trying to bring forward the interest of all families in this country and in particular, some of the most vulnerable and what we've learned through our experiences, we are constantly working with policy makers, either in the U S Congress or in the federal administration. And then we also do a lot of work in state capitals around the country and with governors and in all of that work, what we've learned is that some of these issues can become incredibly partisan, incredibly politicized. There's nothing at all that can cut through all of that rhetoric, all of that partisanship better than the experiences of individuals and families trying to seek help, right. When those, when we can bring people forward and they can talk about, for example, you know, a history in their family of, right now we know in this country that if you're, African American, you're 50% more likely to die prematurely from cardiovascular disease, right. Just another example of kind of inequities we have in this country. And, when somebody comes forward actually tells that story, what it's like in their family to watch the older folks in their family dying early, that cuts through a lot of the rhetoric, a lot of the partisanship, and really speaks to our values as a nation where we really believe every single family, every person should have a shot at their best life possible.

Aparna Higgins (6:08):

Great. Well thank you for that great overview. Obviously, there's a lot of work that you're involved with. So, I want to, you know, sort of even zero in further on the health equity issue, and you gave some examples of the stark differences between communities of color and the white population and mentioned some of the solutions you think that could help address that issue. So, could you talk a little bit more about Family USA's efforts to help advance health equity and reduce disparities in this country?

Frederick Isasi, Families USA (6:40):

You bet. So, this is, one of our most important focus areas. We're very, very busy. We've got a lot of work going on. You mentioned, you know, myself along with really terrific staff at Families, we created the National Center for Health Equity and Value. That is a really important effort. And it's one of the things I think that is, often most misunderstood about the value, effort. You know, we are true believers that, this country, we're not suffering from a lack of resources where we're suffering from a healthcare system that is responding to the wrong incentives, that isn't being given the tools that it needs economically to really ensure that it can drive towards, the health of its, make sure that patients are healthy, and families are healthy. And a lot of times when I've, when I'm in these conversations around value, folks will ask me, well, don't you think for example, that if we're improving the quality of care for all people, that that's going to be really beneficial to some of the most vulnerable folks and particularly communities of color and what I want to say. I've had a lot of experience in this working with say in previous lives, working with directly with health system executives or working with governors. And what's very, what's very evident to me is that a lot of the effort around values about finding standard population of risk and deescalating that risk, and really creating better health outcomes for those folks and reducing the cost or the spend for those populations, right. That's kind of the overarching

philosophy on value reforms. The problem is that a lot of the populations we're talking about the most vulnerable folks out there, they may not fit a standard population. They may have dimensions in their life that are very different than a traditional middle-class families, for example. And for that very reason, what I watched was a lot of leaders in the value space working pretty hard to figure out how to keep them out of their value efforts so that they didn't have to deal with that uncertainty and that variation, they wanted to create the most standardized population possible. We know what that results in, it's not just that we aren't addressing the needs. We actually even making these disparities worse, right. So, the health equity and value center really stands for the notion that we have got to get extremely intentional about addressing health inequities and bring them into the center of the healthcare transmission enterprise. And not just assume that things will get better just simply because we're making it better for everyone. That's one example of, of very deep work we have going on. We also have, a health equity and values academy where we bring together leaders from around the country, particularly leaders on the community level, to teach them about the opportunities in healthcare, to learn from them about what's going on in their communities and help empower them to change the policies in their, either their communities or their states around healthcare value and equity. We also have a big effort going on around early childhood and addressing some of those fundamental early experiences, particular adverse childhood experiences that there's a lot of research shows can really set a trajectory for a human being through their whole life. We have one project going on in the District of Columbia focused on finding sustainable ways to pay for Nurse-Family Partnership, for example, to really give moms and babies and dads, the support of a nurse-family partner in those early years to really get their kids off to an early start. So those are just some of the examples of the deep work we're doing.

Aparna Higgins (10:12):

Okay, great. That's actually really helpful in terms of some of the detail that you provide. Obviously, you're doing incredible work, you and your team, I should say, are doing incredible work in this area. I guess the, as you know, the LAN recently established the health equity advisory team, to help identify and prioritize opportunities to advance health equity through APMs, influence design principles and inform LAN priorities and initiatives, its goal is person-centered. So, I think that aligns with, you know, your own organization's mission, and, to leverage APMs since you were talking about value to help make needed care, more accessible, drive better patient outcomes and reduce disparities. Obviously, you've talked about a lot about your own work. And so would be interested to hear, you know, from you in terms of how you view the alignment between the work that Families USA is doing and the LAN initiatives and goals.

Frederick Isasi, Families USA (11:13):

Well, I'm really proud of where the LAN has been going on this issue and how hard they're working towards raising both on the importance of APMs and the importance of addressing health equity. I think it's really powerful work and it's been a… it's been a real honor to be a part of it. I think a couple of really important concepts. First, I think that as we've talked about, the idea that LAN is trying to make health equity central in the transformational enterprise is really important for the very reasons we just talked about, because if we don't, it's not just that we won't make them better, we're going to make them worse. But the other thing, I think one thing that's most exciting is at its foundation, some of the most bold alternative payment models, APMs out there are really about collecting the resources in a community in a state, that are provided for healthcare, right. That could be through federal Medicaid dollars. It could be through Medicare dollars, it could be through private insurance, state employees, right, collecting those resources, building a community table, which includes insurers, hospitals, physician groups, but it also includes social service agencies, housing supports. We've seen for example, mental health services, behavioral health services, all at that table, right. And they look at their data for

that community. What's really going on here? What, where do we really see the opportunity and the real problems for, for achieving health in this country or in this community? And then they really start to set targets for themselves about how they can change, the way in which the resources are being utilized to achieve the goal of health, not just simply units of healthcare. That's a really, really powerful idea. It's a really transformative idea. And when that happens, you see really tremendous reforms that are very innovative happening. Things like addressing unmet behavioral health needs, addressing housing insecurity, addressing, violence in communities, the impact of systemic racism, things like that can be really powerful. So, I think at its heart APMs and the work the LAN, and the LAN is really pushing hard to say, we have to go much further in reallocating, these resources, nutrition and other parlance by developing much stronger risk-based models. Right. That is really exciting to us and Families, I think is the key, one of the most important keys to addressing health inequities.

Aparna Higgins (13:41):

Okay. So, you talked earlier about, you know, the work that you're doing through the Center in terms of being intentional, intentionally designing, ways in which to address health equity. And as you think about the intersection between APMs and health equity, could you share your perspective on what it means to intentionally address health equity in the context of an APM?

Frederick Isasi, Families USA (14:02):

You bet. So, first and foremost, I think, you got to start and I, I did a lot of this work, previously with the National Governors Association in states and state Medicaid programs where a lot of the most exciting stuff is happening. You got to start with data, right. So first you've got to get into a community and really surface the best data sources and understand what's really happening. And what we've seen in many different states, and these are red states and blue states, urban states and rural states, it doesn't really matter. Once you start looking at your data, you start finding some really interesting patterns, for example, in one, in one state we're working in they found, that there was a massive over-utilization of ER services in a very vulnerable community, right. So, that became a focal point. Well, how do we address this? Why is this happening? So first start with your data. Second, it is really about bringing together the full community, a set of resources. So not just a hospital, not just a physician group, but really thinking about all of the resources that can address, not just physical health, but the social determinants, behavioral, all those sorts of things. And then third, that using data, you set real accountability targets, how are we going to improve outcomes? How are we going to reduce the wasteful spending? And in the example, I was just giving you in that instance, they determined there had been a clinic that had been operating a primary care clinic in this community. It was shut down about five years before because people weren't really using it, but it turned out people weren't using it because it was only open during work hours. They re-opened the clinic, they provide, after hours and late hours, they reduced spend by about $15 million in one year when this clinic was open and the outcomes went through the roof because people had access to primary care when they weren't at work, when their kids, you know, for example, also on Saturdays and Sundays, when kids, you know, the weekend hits and all of a sudden you realize your kid's got a fever or sick, all those things, you start dealing with those problems and these vulnerable communities, health really starts to improve. So that's an example of using data, bringing the community together, and then really monitoring with accountability metrics, the improvement of outcomes and reduction in wasteful spending.

Aparna Higgins (16:05):

Okay, great. Well, that almost sounds like a nice playbook for people to follow in terms of some of these goals. So, we've talked a lot about health equity, the intersection of health equity and APMs, and the importance of having these alternative ways of paying for health and healthcare, as you said. So, I was curious if you could actually elaborate, you know, even more on efforts that you're undertaking to

advance APMs, you know, Families USA, obviously you focus a lot on consumer experience and some of the other pillars you talked about, but could you talk more about your efforts to advance these kinds of alternative payment models?

Frederick Isasi, Families USA (16:42):

You bet. So let me give you two examples, one on the federal level and then one of the state level. So, we do a lot of work with Congress and the federal administration of whatever party to really think about how do we continue to evolve APMs so they really have impact. And I think one of our biggest pushes in that regard is focused on trying to achieve much better alignment across multiple payers, so that the models themselves hold much more economic power, meaning much more of the book of business of a hospital or a physician group is aligned around population health, and they can really go for it. And I think we've been big advocates, both on the hill and in the federal administration to find ways to really, unleash the power of APMs is by providing a lot more risk, a lot more of a book of business associated with the global payment, right. That's an important principle to us. We are doing a lot of work. I think, you know, this is, maybe not super sexy, for a lot of folks, but actually maybe to our viewers, it would be. And that is, we've got to do a much better job of collecting race and ethnicity and gender, sexual orientation, geography in our healthcare data, and then reporting it because one of the things we know, as the COVID pandemic has certainly taught us that, when stressors are encountered by our system, the people who pay the price more than anyone else are people of color in this country. And so, but we only know that because we can look at the data and find the places where the system may be failing and we are right now, you know, I would say we're probably 20% there in terms of really collecting and making those data available for us to understand where the problems are. I think that's, it's foundational, we're working really hard on that as well. And then on the state level, we do a lot of work with state Medicaid programs. We just had a very deep project for several years, working with state partners in California, to really think about as they go, you know, states go back to CMS to request a, a new, Medicaid waiver, 1115 waiver, or series of waivers. How can they build equity into their waiver design? And, you know, it's, it's everything from ensuring that there's culturally competent care. They're really thinking about the workforce. How are they developing a diverse workforce? We know that's really important to get getting to, to better health for diverse communities. We've also did a lot of work around community health workers and thinking about how do you build much stronger linkages between community members and the folks who are delivering care to them? So, so we, we do a lot of work on the state level to think through what are the Medicaid policies that can be adopted that can result in much more equitable distribution of health.

Aparna Higgins (19:23):

Okay. So maybe building on the theme of connecting, you know, the providers of care with the people that they're serving, would be interested if you could talk more about, how do we ensure going forward that as we design APMs, they truly embrace the consumer or the beneficiary. We all talk a lot about person-centered care, right. But how do we ensure that we're truly placing the beneficiary or the consumer at the center of design and, and meeting their needs? So we'd be interested in hearing your perspective on that.

Frederick Isasi, Families USA (19:55):

You know, we have a lot of perspectives on this, so, and we couldn't agree more that at the heart of this, what we're really talking about fundamentally is intelligent design, right? It's the lessons of intelligent design. When you are trying to redesign a system, we have to put the end user into the center of the design enterprise or else we end up designing something that doesn't, you know, often you hear things like, you know, you built a car, there's no steering wheel. You sort of, you miss really important things when you don't have that end user right in the center. So that's such a foundational principle. But I also

think it's interesting because I've been a part of a lot of policy efforts to try to change, for example, the statutory or regulatory framework around, healthcare payments. And there's often a drive to bring consumers into that effort. Can be really powerful, but let's be really clear, sitting down, putting a Medicaid recipient down next to a hospital CEO is not going to result in a really fruitful exercise, right. There has to be really a lot of intention and thought put into how do we empower consumers needs and interests to come forward. And how do we provide technical assistance to policy makers so that the consumer's needs are coming all the way into the regulatory or statutory process, meaning it's not just simply a conversation, right. It's surfacing the needs of the community, talking to the community about this, finding out where their interests are, identifying priorities that align with the community's priorities, not the governor's priorities or the president's priorities, but the actual community's priorities. But then doing the hard work of finding out well, okay, let's say in this community it's unmet behavioral health needs, right. They've identified, well, we have so many folks in our community who either have substance use disorder or severe and persistent mental illness and their needs aren't being met. Well, at that point, you got to start doing a lot of hard work to explore around the country. Well, how has this been solved before, right? That's not asking the consumer to solve the problem. It's about really providing the technical assistance to find the solutions and bring them into that new state, that new regulatory framework. So that's a really important distinction. I think sometimes you see people say, well, the Medicaid beneficiary didn't tell me how to solve that problem. I, I throw my hands up, right. And that's a, that's a pretty, fruitless exercise, but then, you know, once you really set up the regulatory framework, and say the payment structure, then it really is about intelligent design. It's about, as you're thinking, for example, about behavioral health integration. Have you brought the patients who you're trying to reach into the design enterprise, right? Have you talked to the, the behavioral health providers in that community, who are working in the community mental health center and working the primary care setting about how integration should occur, right? So, it really is. That is a place I think, where deep involvement with community members with the direct service providers can really transform what the payment delivery form looks like.

Aparna Higgins (22:51):

Okay. So, speaking of, you know, bringing solutions that have maybe worked in, in one community to another community, could you talk a little bit about, and we hear a lot in healthcare about, success stories, right. And those are very important. But I'd be interested in getting your perspective in terms of how do we scale those success stories, because as you talked about, you know, bringing learning from one community to another, you know, what is your perspective and what efforts are you taking to help sort of scale some of these successes?

Frederick Isasi, Families USA (23:23):

Yeah. And I would say, you know, there are some really powerful success stories, particularly around health equity and trying to address these in our most vulnerable populations. And it's not a long list, right. It's a really powerful, and it's a pretty short list. So, one of the things we know for sure, is really important is, addressing unmet behavioral health needs. It's an incredibly powerful set of interventions, and those come in a few different flavors. I can talk about that more if you want. The second is, really thinking about the role of primary care and empowering primary care to both coordinate the needs of the vulnerable populations, and also help direct patients to the highest value care providers. Those are two of the most important flavors you see there. The third is addressing over-utilization of emergency room services, which of course is really expensive, really wasteful and doesn't really often result in any improvements in the outcomes. And that can often be about working hard, to understand access problems where people cannot, can, and can't get care. And, you know, for example, the example I was giving you, in, in, in one community in the, in the north, it was about realizing that what this community

needed was a primary care clinic that was open late, after hours, things like that. Another instance, there was a wonderful effort in Washington state, ER utilization really ended up focusing on unmet substance use disorder and all of the utilization that stems from that. So there, you know, that's another example. And then finally, transitions in care are really important. So, for vulnerable populations, making sure they're going back to their follow up appointments, making sure that they are, they're being, there's a lot of…there's wraparound services to make sure they can go through the process of recovery and end up coming out with good outcomes. And then the very last example I always point to is housing insecurity and housing first and using housing as a healthcare intervention, incredibly powerful. And we know there's millions of examples of very vulnerable folks who are accessing a lot of healthcare, but because they're housing insecure, their health just gets worse and worse and worse. And by bringing those two things together, their health needs and their housing needs, you can really transform their lives and you can actually reduce the overall spend for those people. So these are examples of the actual interventions that can really make a difference in the lives of the most vulnerable and really address health inequity.

Aparna Higgins (25:39):

Okay. So, building on that, social determinants of health, you talked about housing insecurity, for example, as one, you know, one of those determinants, and could you share your perspective on how APMs could be structured to help meet some of those, you know, social determinants of health? You mentioned earlier about how currently the APMs are maybe more designed for standardized populations, but you have a lot of vulnerable people that are getting left out and these vulnerable people have social risk factors and have social determinants that need to be addressed. So, could you share how APMs could be more intentional in terms of, you know, melding health and social services together?

Frederick Isasi, Families USA (26:22):

Absolutely. And, you know, that's, I think, you know, going back to our earlier conversation, that really is focused on allowing for the resources, the dollars flung into a community to become together, and to be examined as, as sort of one resource available for the whole community. One of the best models that I've seen in that is the Oregon Coordinated Care Organization model, a CCO model where literally the healthcare dollars flowing in for Medicaid are provided to this community table, right? Both hospitals, providers, but all of the other social service agencies and with data, they can figure out what are the social determinants that are being unmet, and then they can start allocating healthcare dollars towards those social determinants, in a way that really truly they're measuring impact and can say, you know, we have reduced overall costs and our outcomes are, are getting better and better. So that fundamental model that CCO accountable care accountable community model is really powerful. I think the most important social determinant interventions that we're seeing are things that are aimed at unmet behavioral health needs. There's no question we have a crisis in this country, you know, we know for example that, right now, if you're African American this country, you're 50% less likely and, and, and you have mental health illness, you're 50% less likely to get it than your white counterparts, right. It's an example of, it's very hard for all people to get access to behavioral health in this country, but then when you're African American and, and if you're a person of color living in rural America, it's even worse, right. So, unmet behavioral health needs are really, really important. Housing insecurity really, really important, a lot of issues around substance use disorder that could, that we could do a lot better with. And then I think that there's even deeper questions about environment, things like, the impact of clean air and clear water, the impact of systemic racism and violence, and then go all the way as we were talking about earlier to the very first experiences of little children, of little babies as they're born the world they come into, the amount of care they have in just the first couple of years can be

transformative, right. So, these are all examples of the ways in which if we can reallocate resources to address social determinants, we can really change the life trajectory of an individual.

Aparna Higgins (28:40):

So, we've talked about a lot of very important issues, and it's been great to hear your perspective and, and thank you for sharing a lot of your learnings. So, as we look ahead in terms of the evolution of APMs, as you called it, earlier, as well as, you know, the importance of intentionally addressing health equity, could you maybe summarize some of the key learnings as you know, policy makers and others are thinking about these issues and payers and providers are thinking about these issues? Could you share some of the key learnings that would be important to keep in mind as we look to advance APMs, but those, especially those that are intentional about, about addressing health equity?

Frederick Isasi, Families USA (29:24):

Sure. I'd say the first one is one I know that the LAN has been working on very hard, which is underneath all of this, what we have to recognize is that economic incentives drive the, the behavior of providers. There's no way around it. And we have to be really honest with ourselves about that. And I've worked a lot and, with hospital CEOs and CFOs and Chief Medical Officers and, behind the curtain, no one's confused, right? Everybody knows that this is a volume game for high-cost or high-margin procedures, and that's what we're going for. Right. And so underneath all of this, the number one thing I would say is policy makers have got to understand that honestly, policy makers created the incentives inadvertently for fee-for-service, sort of treadmill economics and policy makers have got to unwind those, and really drive towards a model that aligns the financial interests of people with the providers that are serving. Cause I would say right now that in many instances, providers are trying to do their best, despite the way we pay them. Right. We pay them one way and they're just working really hard to try to do what's right for their patients, even though they could be losing money by doing that. So it's a, we've got to align those two things that's most important. And to get there, we have got to give providers a much larger percentage of their book of business, focused on the APM. It's got to be 80% or more of their book of business and real risk-based payments because when you, when you get into that kind of environment, you see unbelievable change. And one of the things that really inspires me about that is when you talk to the individual providers in these health systems or physician groups and this, health centers, they are incredibly excited about this. This is why they went into the practice of medicine they want to do what's right for their patients. They're tired of that treadmill, you know, patient, patient, patient, procedure, procedure procedure. So, there's a lot of within the community of providers is a huge, I think, there's excitement and there's a lot of enthusiasm for this, that's one. Two, I would say that, remember that as we talked about earlier, inequity will not be addressed by passively just improving the system for all. We really have to be intentional about equity and understand what are the interventions that are going to most affect the vulnerable communities of color that are being left behind right now. And the third thing I would say is, and to me, this is a really helpful thing. I have done this work in the most rural states, the most urban states, the bluest of states, and the reddest of states. And the truth is so much of this work is really about reallocating resources to meet the needs of a community and to empower a community, to come forward and identify and work on their needs. That is wildly popular in all of these different environments. You know, like we did this work in Wyoming, we did this work in California. It was wildly popular in both because at the end of the day, when you devolve to a community level, it resonates with people from all kinds of different perspectives. So I think there's also a real political future here. This could really happen because it isn't partisan. It isn't, you know, it isn't about, you know, where your starting point, if you're Democrat or Republican, it really is about, I want my community's needs to be met, which is a very, very powerful, very American kind of perspective.

Aparna Higgins (32:43):

Great. Well, Frederick, thank you so much for sharing your perspectives with us today. It has been extremely illuminating. I've learned a lot and I'm sure our listeners will learn a lot too. And I really enjoyed speaking with you.

Frederick Isasi, Families USA (32:57):

Thank you so much, Aparna. It's been an honor to be here and to you and to the LAN, thanks for all the hard work to all the folks who are watching this. You guys are out there working really hard with a vision and we at Families USA are there to support you.

Aparna Higgins (33:10):

Thank you all for joining us. If you enjoyed this conversation, please keep checking the LAN website for more on our Spotlight on Action series that will highlight the work of our members. This and future spotlights will also be posted on our social media. So be sure to follow us on Twitter at payment underscore network and on LinkedIn, by searching for Healthcare Payment Learning and Action Network.