Building Shared Ownership for Community Health Improvement

All Hands on Deck:

Navigating Partnerships in Population Health Planning

Health Policy Institute of Ohio

Mid-Ohio Foodbank

April 29, 2015

Kevin Barnett, DrPH, MCP

Senior Investigator

Public Health Institute

PUBLIC HEALTH INSTITUTE

Overview

- **Community assessments and the larger CHI process**
  - Focus on assessments: erosion of community trust
  - Federal regulations as a starting point

- **Moving from compliance to transformation**
  - The limits of public policy
  - Coming to grips - the larger purpose of CHI

- **CHI with a quality improvement orientation**
  - Internal alignment
  - Transparency, accountability, and community engagement

- **Moving beyond the usual suspects**
  - Health improvement and community development

Compliance – IRS Final Regulations

- **CHNA cycles** – "…these final regulations require the *solicitation and consideration of input* from persons representing the broad interests of the community *anew with each CHNA*, even if the CHNA builds upon a previously conducted CHNA."

- **Setting priorities** – "…the final regulations clarify that the requirement to take into account input in assessing the health needs of the community *includes taking into account input in identifying and prioritizing significant health needs*, as well as identifying resources potentially available to address those health needs."

- **Documentation of input** – "..these final regulations respond to commenters' requests to require public input on the implementation strategy by requiring a hospital facility to *take into account comments received on the previously adopted implementation strategy* when the hospital facility is conducting the subsequent CHNA."

IRS Final Regulations, Cont'd.

- **Focus on disparities** – "…a joint CHNA conducted for a larger area *could identify as a significant health need a need that is highly localized* in nature or occurs within only a small portion of that larger area."

- **Social determinants of health** – "…the final regulations expand the examples of health needs that a hospital facility may consider in its CHNA to include not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or *to address social, behavioral, and environmental factors* that influence health in the community."

- **Evaluation** – "…the final regulations replace the proposed requirement that the implementation strategy describe a plan to evaluate its impact with a *requirement that the CHNA report include an evaluation of the impact of any actions that were taken* since the hospital facility finished conducting its immediately preceding CHNA."

CHIDSS Development

- **How**
  - Community is defined
  - Community stakeholders are engaged
  - Priorities are set
  - Implementation strategies are designed

- **Select specific geographic regions to allow for comparative analysis**

- **Sources of data are public reports from**
  - Hospitals
  - Public health agencies
  - United Ways
  - Community Action Agencies

PUBLIC HEALTH INSTITUTE

Sample Totals

15 Pilot Sites; each with geo sub-county area with concentration of disparities

10 States representing the 4 US Census Bureau Regional Divisions

51 total hospitals located in target sites

44 total hospital CHNAs and **27** implementation strategies reviewed
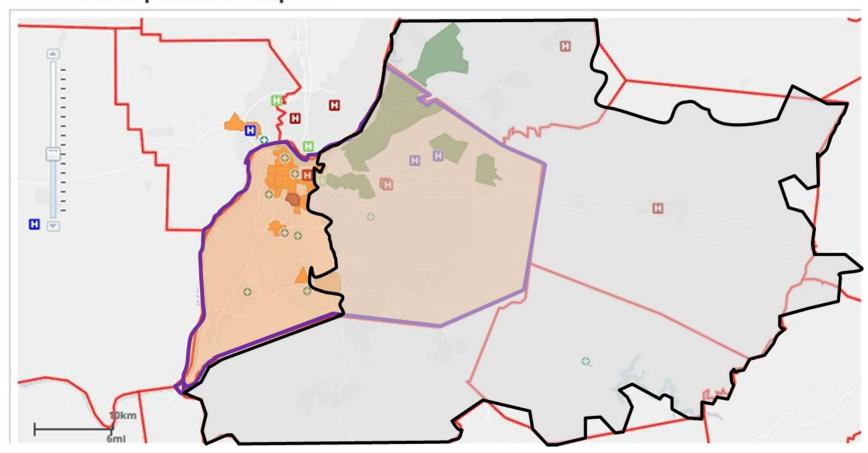
Preliminary Totals, continued

- All **44** hospitals defined community as patient service area.

- **16** of **44 (36%)** used zip codes to define their service area.

- **23** of **44 (52%)** did not provide a specific method to calculate their service area.

- **13** of **44 (30%)** defined their community as multi-county/ regional service area.

- **Only 10** of **44 (23%)** hospitals identified the geographic concentration of disparities in their community.
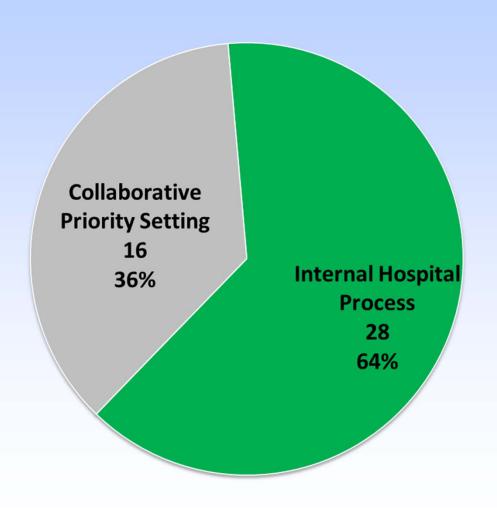
PUBLIC HEALTH INSTITUTE

Service Area Exclusion of Geo Areas with Concentrated Poverty

Vulnerable Populations Footprint
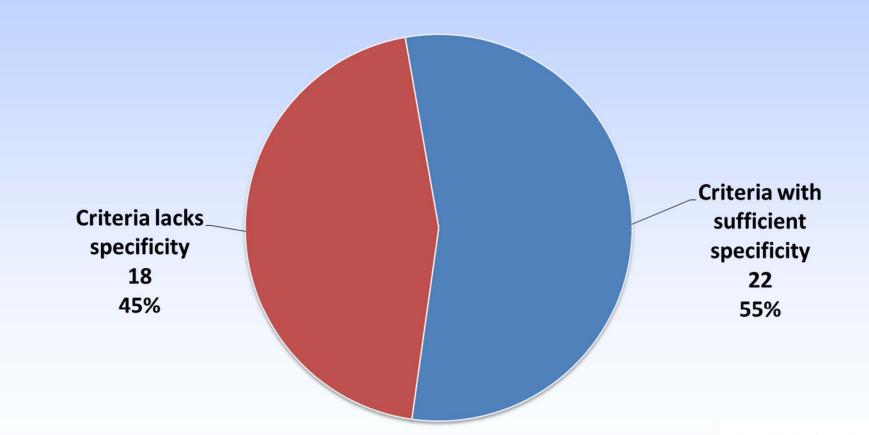
Priority Setting
Collaborative and Internal Hospital Priority Setting

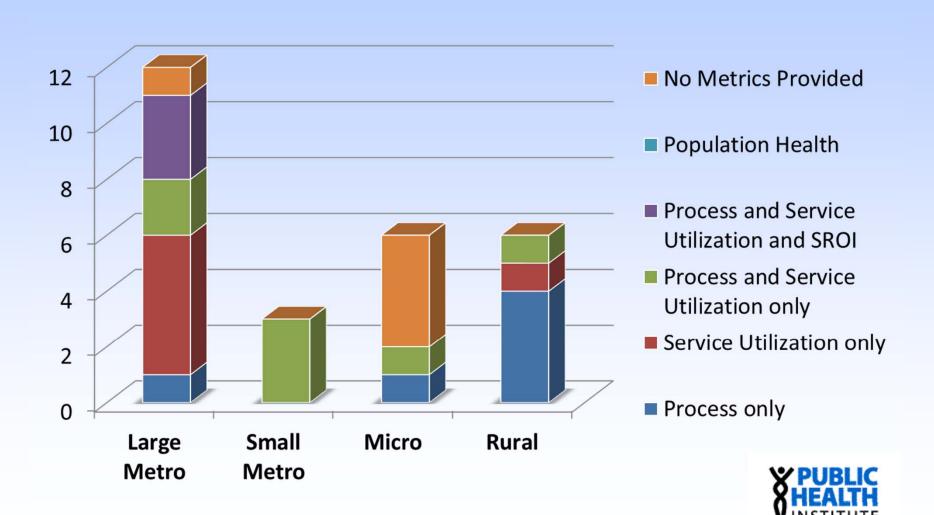# Priority Setting Criteria
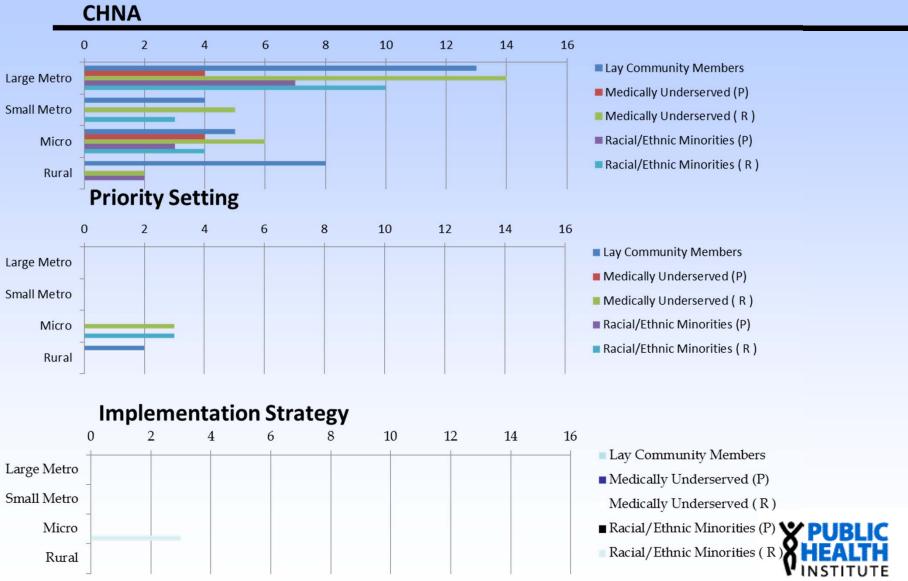## Sufficient Specificity to Inform Decision Making

Criteria lacks specificity
18
45%

Criteria with sufficient specificity
22
55%

Program Metrics by Region

Community Engagement Drop off

Selected Recommendations

- Take steps to **harmonize** disparate, but similar CHI practices among community stakeholders.

  - Encourage LHDs, CAAs, UWs, CHCs, and other institutions to **post assessment findings** on websites.

  - Encourage stakeholders to develop proactive strategies to **align schedules** for assessment and planning processes

- Increase focus of CHI **resource allocations** in communities **where health disparities are concentrated**.

- Hospitals use tools to implement a **QI approach** consistent with a commitment to **transformation**.

- **Clarify roles of stakeholders** in setting priorities, planning, implementation, evaluation, and oversight of CHI practices.

http://www.phi.org/uploads/application/files/07f7jf5f38j3huiot3cnkjf471lnbswemugyfrqkiu7x2f6x1s.pdf

PUBLIC HEALTH INSTITUTE

Opportunities for Alignment

Issue-Specific Assessments (Health Impact Assessment)	Local Health Departments (CHAs/CHIPs)	Tax-exempt Hospitals (CHNAs/ISs)	Community Health Centers (Section 330 Application)	United Ways (CHAs)	Community Action Agencies (Community Services Block Grant Application)	Financial Institutions (CRA Performance Context Review)
When available, HIAs provide an **additional layer of information, most often relating to broader environmental impacts,** in the design of strategies to improve health.	Given reduced public funding,, ongoing collaboration with diverse stakeholders provides an **opportunity to leverage expertise and secure political support** for LHD leadership in monitoring and advancement of **policies that reinforce and sustain improvements in health status and quality of life**.	**IRS allows hospitals to develop ISs in collaboration with other hospitals and State and local agencie**s, such as public health departments. Expanded enrollment and **movement towards global budgeting will require work with others who can help address the determinants of health and** reduce health disparities.	CHCS are **encouraged to link with other providers such as LHDs and hospitals** to provide better-coordinated, higher quality, and more cost-effective services.	UWs have an **established history of collaborating with other stakeholders** in conducting assessments and addressing unmet health needs.	Standard 2.1 **emphasizes partnerships across the community, CAAs can often "serve as a backbone organization of community effort**s to address poverty and community revitalization: leveraging funds, convening key partners…""	Targeted CRA investments in housing, retail, education, and job creation in targeted low-income census tracts that are aligned with parallel interventions and investments of health care and public health stakeholders provide an **opportunity to address social determinants of health and help reduce health care costs**.

Community Health Improvement:
A Framework to Promote Best Practices in Assessment, Planning and Implementation

Accountability Mechanisms

Accreditation Requirements

State and Community-based Analyses of CHNA/Implementation Strategy Public Reports

T R A N S P A R E N C Y

Hospital, LPHAs, United Way & Others COLLABORATING → **CHNA/ CHA** → **Implementation Strategy/ CHIP** → **Implementation** → **Improved Community Health Outcomes?**

Data and Analytic Support Platform

Monitoring & Evaluation

§ 501(r) Requirements, Form 990 Schedule H

Community Benefit 26 USC § 501(c)(3), IRS Ruling 69-545

Reports

Assuring Shared Ownership of the Process among Stakeholders (e.g., formal agreements)?
Assuring Ongoing Involvement of Community Members

Key Issues to Address to Promote Alignment between Accreditation, NP Hospital CB, and Other Community-Oriented Processes

-Arranging Assessments that Span Jurisdictions

-Using Small Area Analysis to Identify Communities with Health Disparities

-Collecting and Using Information on Social Determinants of Health

-Collecting Information on Community Assets

-Using Explicit Criteria and Processes to Set Priorities (use of evidence to guide decision-making)

-Assuring Shared Investment and Commitments of Diverse Stakeholders

-Collaborating Across Sectors to Implement Comprehensive Strategies

-Participatory Monitoring and Evaluation of Community Heath Improvement Efforts

Compliance and Transformation

Compliance

Transformation

Shared Ownership

Co-finance consultant to conduct CHNA
Hold meetings to discuss design
Return to hospital to set priorities

⟷

Ongoing stakeholder engagement to build
common vision and shared commitments
Set shared priorities & take coordinated action

Diverse Community Engagement

Solicit input through surveys, focus groups, town halls
on health care needs – no action required
Meet with local or state PH officials

⟷

Engage diverse community stakeholders as
ongoing partners with shared accountability
Identify shared priorities to improve community health

Broad Definition of Community

Define community as hospital service area
Identify underserved pops w/in service area
Design programs at service area level

⟷

ID **concentrations of health inequities** w/in larger
region that includes hospital service area
Select geo focus where needs are greatest

Maximum Transparency

Post CHNA report on hospital website
Attach Implementation Strategy (IS) to Schedule H
submittal or post on website

⟷

Post CHNA & shared priorities in multiple settings
Develop and post IS in multiple settings with **defined
roles for diverse community stakeholders**

PUBLIC HEALTH INSTITUTE

Compliance and Transformation, cont'd.

Compliance   Transformation

Innovative & Evidence-Informed Investments

Describe how hospital will address priority
unmet needs

⟷

Survey best practices to ID strategies with **evidence** of
effectiveness or that offer considerable promise
Establish **shared metrics** that will document ROI at
multiple levels

Incorporate Continuous Improvement

⟷

Establish indicators of progress (e.g., systems
reforms)that validate progress towards outcomes
Establish monitoring strategy that **integrates
adjustments based upon emerging findings**

Pooling and Sharing of Data

⟷

Sharing of utilization data across hospitals, PH, CHCs to
assess total cost of care
Proactive determination of ROI at institutional and
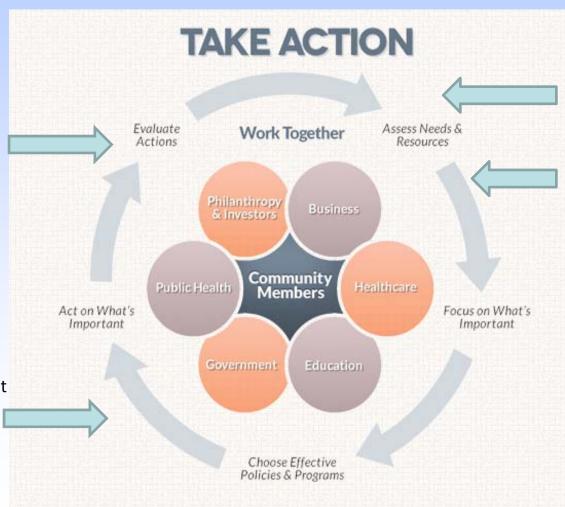community level

PUBLIC HEALTH INSTITUTE

Beyond a "Check the Box" Approach

Quality Improvement
Summative and *ongoing* formative analyses

Synergy
Explicit alignment of programs, services, and investments

Initial Assessment
ID geo inequities
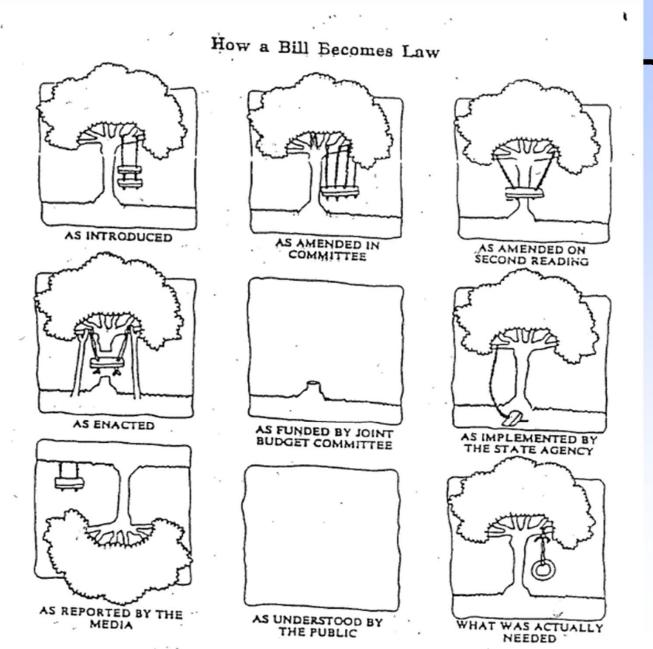Drill down
Set baseline
Build shared ownership

Next Round(s)
Deepen analysis
Expand scope/scale

The Limits of Public Policy

How a Bill Becomes Law

AS INTRODUCED

AS AMENDED IN COMMITTEE

AS AMENDED ON SECOND READING

AS ENACTED

AS FUNDED BY JOINT BUDGET COMMITTEE

AS IMPLEMENTED BY THE STATE AGENCY

AS REPORTED BY THE MEDIA

AS UNDERSTOOD BY THE PUBLIC
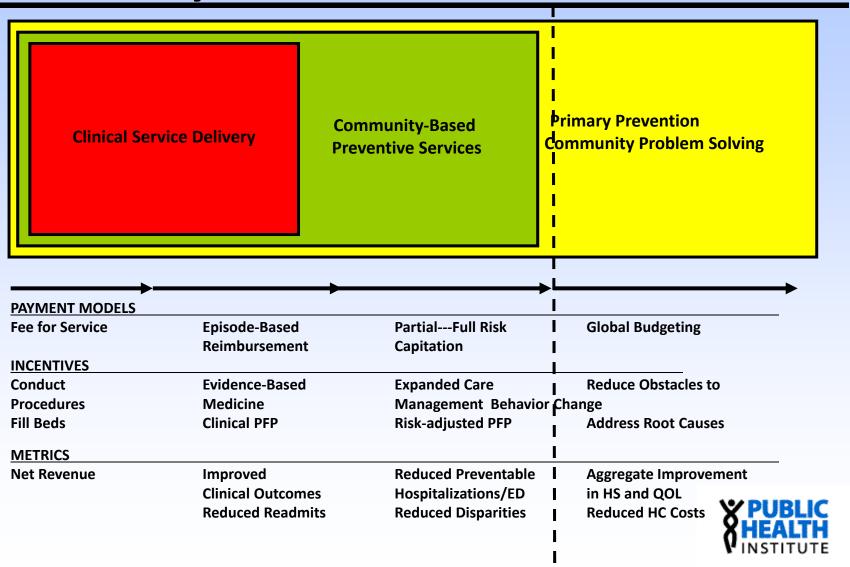
WHAT WAS ACTUALLY NEEDED

Taking Advantage of Transparency:
Key Questions at the Local/Regional Level

- Does the assessment identify and provide insights into geographic sub-county areas with concentrations of health disparities?

- Are diverse community stakeholders engaged in a manner that acknowledges their shared ownership for improving health in local communities?

- Does the priority setting process reflect a commitment to make optimal use of limited resources through a thoughtful deliberation of options and implications?

- Does the implementation strategy give focus to geographic sub-county areas with concentrations of health disparities?

- Does the implementation strategy reflect an understanding of the need to address both the symptoms and underlying causes of health problems?
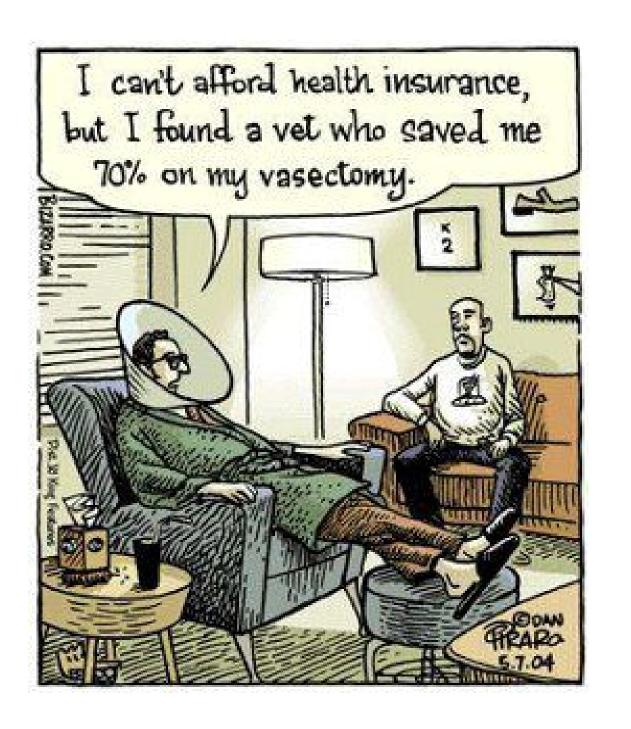
PUBLIC HEALTH INSTITUTE

Community Benefit and Health Reform

Clinical Service Delivery

Community-Based Preventive Services

Primary Prevention Community Problem Solving

PAYMENT MODELS			
Fee for Service	Episode-Based Reimbursement	Partial---Full Risk Capitation	Global Budgeting
INCENTIVES			
Conduct Procedures Fill Beds	Evidence-Based Medicine Clinical PFP	Expanded Care Management Behavior Change Risk-adjusted PFP	Reduce Obstacles to Address Root Causes
METRICS			
Net Revenue	Improved Clinical Outcomes Reduced Readmits	Reduced Preventable Hospitalizations/ED Reduced Disparities	Aggregate Improvement in HS and QOL Reduced HC Costs

PUBLIC HEALTH INSTITUTE

Health Reform Progress and Pace

- Some states (e.g., Oregon, Vermont, Massachusetts, Minnesota) are taking definitive steps towards global budgeting.

- Others taking advantage of SIM and CMMI funding to test and scale innovations.

- Some state leaders appear to be working against their own interests, rejecting Medicaid expansion funding, while safety net institutions close and innovation is impeded by fiscal constraints…

- The bottom line is an inexorable move towards financing that incentivizes keeping people healthy and out of hospitals.

- In the meantime, patients will need to be creative…

PUBLIC HEALTH INSTITUTE

Coming to Terms with Health Inequities

- Unhealthy housing

- Exposure to array of environmental hazards

- Limited access to healthy food sources & basic services

- Unsafe neighborhoods

- Lack of public space, sites for exercise

- Limited public transportation options

- Inflexible and/or poor working conditions

- Health impacts (e.g., allostatic load) of chronic stress

Emptiness amongst the Crowd
Wojciech Dziadosz

PUBLIC HEALTH INSTITUTE

Population Health

Medical Model Population Health	Place-Based Population Health
Assess patient health status	Assess patient health status, **social and environmental risk factors**
Ensure timely access to clinical services and medications	Ensure access to clinical services **& link to social support systems**
Clinical case management through team-based care	Case management through clinical and **community-based teams**
Patient education	**Community-based** education, **problem solving, and advocacy**
Use EMR to ID and group risk populations, monitor service utilization and patient outcomes	Use **EHR** and **GIS** to identify geo conc. of **health disparities, target interventions,** & monitor population health outcomes
Lament persistent patient noncompliance	Leverage HC resources through **strategic engagement** of diverse stakeholders

PUBLIC HEALTH INSTITUTE

Key Steps for Hospitals

- Organizational commitment to transparency, evidence-informed practice, and quality improvement

- **Integrate** care redesign and community health
  - Timely data analysis and sharing with finance
  - Coordination and expanded intervention design with strategy

- Build **internal** population health capacity
  - Assess competencies, reporting relationships, local oversight, senior leadership accountability

- Build ethic of shared ownership for health **with diverse community stakeholders** (and other health care providers!)

PUBLIC HEALTH INSTITUTE

Internal Alignment – ASACB Principles

- **Assess staffing population health capacity**
  - Competencies, FTE level, job descriptions

- **Assess reporting relationships**
  - Align priorities of managers and supervisors
  - Expectations of departments
  - Dedicated time for quality improvement
  - Accountability metrics

- **Establish formal oversight body**
  - Develop formal charter with explicit QI role
  - Competency-based membership
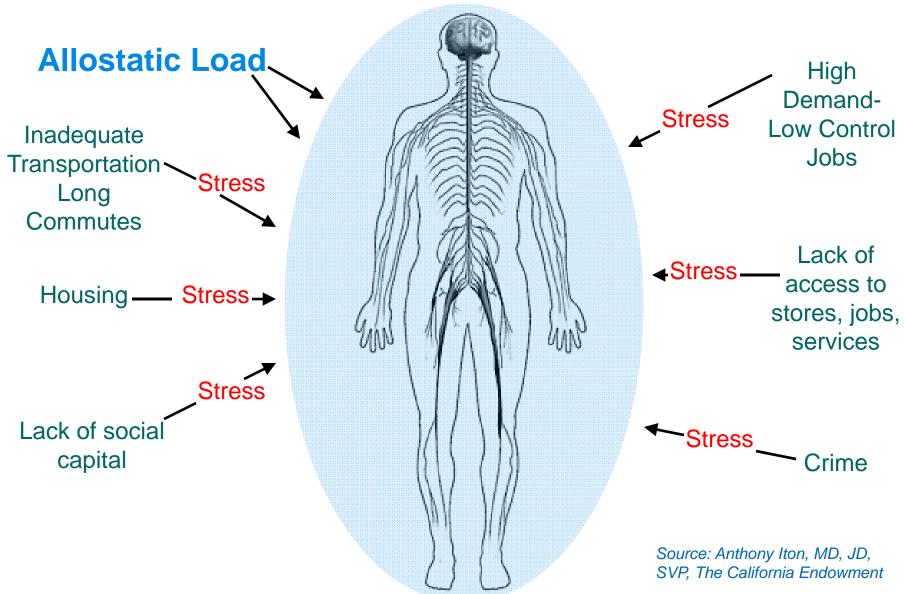 - Predominantly external membership

PUBLIC HEALTH INSTITUTE

Working Anything but 9 to 5

Scheduling Technology Leaves Low-Income Parents With Hours of Chaos
By Jodi Kantor, Photographs by Sam Hodgson
AUGUST 13, 2014

When the external becomes internal: How we internalize our environment

Allostatic Load

Inadequate Transportation Long Commutes

Stress

Housing — *Stress* →

Stress

Lack of social capital

High Demand- Low Control Jobs

Stress

Stress — Lack of access to stores, jobs, services

Stress — Crime

Stakeholder Health

- **Formed in 2011 as Health Systems Learning Group**
  - Over 40 health systems, representing over 400 hospitals
  - Commitment to voluntary leadership

- **Imperative** - Shared ownership for health w/diverse community stakeholders

- Coordinate with HHS Office of Faith-Based and Neighborhood Partnerships

- **Core objectives**
  - Proactive care management – reducing preventable utilization
  - Building transformational partnerships
  - Addressing determinants of health

- Monograph at http://www.methodisthealth.org/files/faith-and-health/HSLGembargoedmonographApril42013.pdf

- Website at http://stakeholderhealth.org/

100 Million Healthier Lives Campaign

- Launched by IHI in October 2014

- "Distributive Leadership Model" – IHI as "backbone" with "hub" organizations across country

- Shift from HC-centric focus to broader systems change

- Innovators from organizations & communities to develop

  – **Shared learning system** to ID and disseminate innovations

  – **Social movement** and communications strategy

  – Logic model, metrics and evaluation plan for diverse local efforts to connect to a **common goal**

  – and **remove barriers** in critical areas such as payment reform, technology, etc.

http://www.ihi.org/Engage/Initiatives/100MillionHealthierLives/Pages/default.aspx
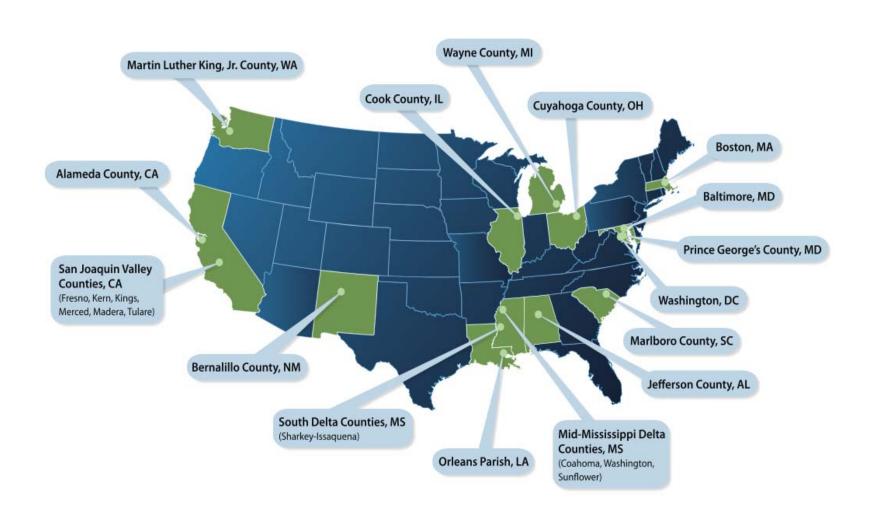
National Collaborative for Health Equity
The PLACE MATTERS Initiative

Objectives:

- **Build the capacity of local leaders** to address the social and economic conditions that shape health;

- Engage communities to increase collective capacity to **identify and advocate for community-based strategies** to address health disparities;

- Support and inform efforts to establish **data-driven strategies** and outcomes **to measure progress**; and

- Establish a **national learning community** of practice to accelerate applications of successful strategies

PUBLIC HEALTH INSTITUTE

Moving from Science to Practice – The Joint Center PLACE MATTERS Initiative

Place Matters Team Locations

Martin Luther King, Jr. County, WA

Wayne County, MI

Cook County, IL

Cuyahoga County, OH

Boston, MA

Alameda County, CA

Baltimore, MD

Prince George's County, MD

San Joaquin Valley Counties, CA
(Fresno, Kern, Kings, Merced, Madera, Tulare)

Washington, DC

Bernalillo County, NM

Marlboro County, SC

Jefferson County, AL

South Delta Counties, MS
(Sharkey-Issaquena)

Mid-Mississippi Delta Counties, MS
(Coahoma, Washington, Sunflower)

Orleans Parish, LA

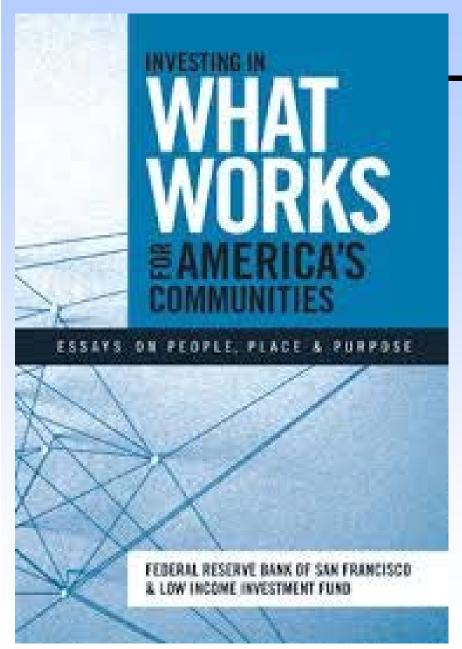# CRA – Impetus for Financial Institutions

- Passed in 1977; not effectively enforced until early-mid 80s, based on advocacy from groups such as ACORN.

- Purpose is to redress decades of disinvestment in urban inner city communities driven by financial institutional "red-lining"

- Defines any of the following as lawful investments **in geo areas that meet CRA criteria**:

  - **Equity investment** in a small business venture capital company or community development corporation

  - Investment in **bonds** with a primary purpose consistent with **community development**

  - **Deposit or membership share** in a community development financial institution **(CDFI)**

- Estimates of annual investments are in the range of tens of billions per year

Potential Areas of Investment with Health Impacts

- Housing development – renovation (link to health services)

- Healthy food (grocery stores, enhanced corner stores)

- CHC development / expansion in scope of services

- Child care / development

- Small business / job development

INVESTING IN WHAT WORKS FOR AMERICA'S COMMUNITIES

ESSAYS ON PEOPLE, PLACE & PURPOSE

FEDERAL RESERVE BANK OF SAN FRANCISCO
& LOW INCOME INVESTMENT FUND

National dialogue initiated by the Federal Reserve Bank of San Francisco in support from the Robert Wood Johnson Foundation.

Released series of essays entitled *Investing in What Works for America*

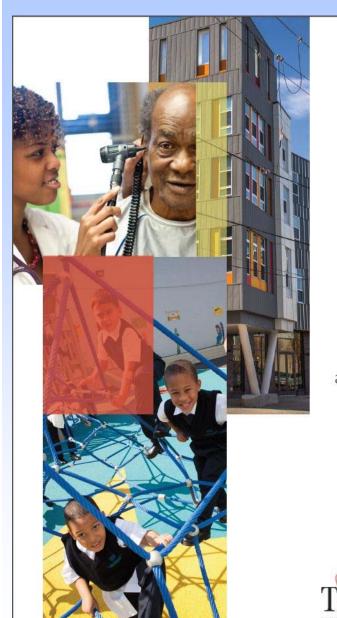2014 launch of Building Healthy Places Network to share emerging research and best practices at (http://www.buildhealthyplaces.org/)

PUBLIC HEALTH INSTITUTE

Build Healthy Places Network

VISION: Communities where all people live healthy and rewarding lives

MISSION: To catalyze and support collaboration across the health and community development sectors, together working to improve low-income communities and the lives of people living in them.

AHEAD
Alignment for Health Equity and Development

An Initiative by the Public Health Institute and The Reinvestment Fund

2014 launch of *Alignment for Health Equity and Development* to support alignment of community health and community development programs and investments.

Generous funding from the Kresge Foundation, with matching support from local stakeholders

Five pilot sites, including:
- Atlanta
- Boston
- Dallas
- Detroit
- Portland

Larger cohort of learning communities across the country to participate in webinars, dialogue.

AHEAD Criteria

Shared Ownership

- **Ongoing engagement** of diverse community stakeholders *beyond CHNA*

- Commitment to **data sharing, alignment of programs**, and **shared metrics** across institutions and sectors

Strategic Targeting

ID **neighborhoods**, census tracts, or zip codes **with concentrated health, social, and economic inequities** as the focus for shared investment
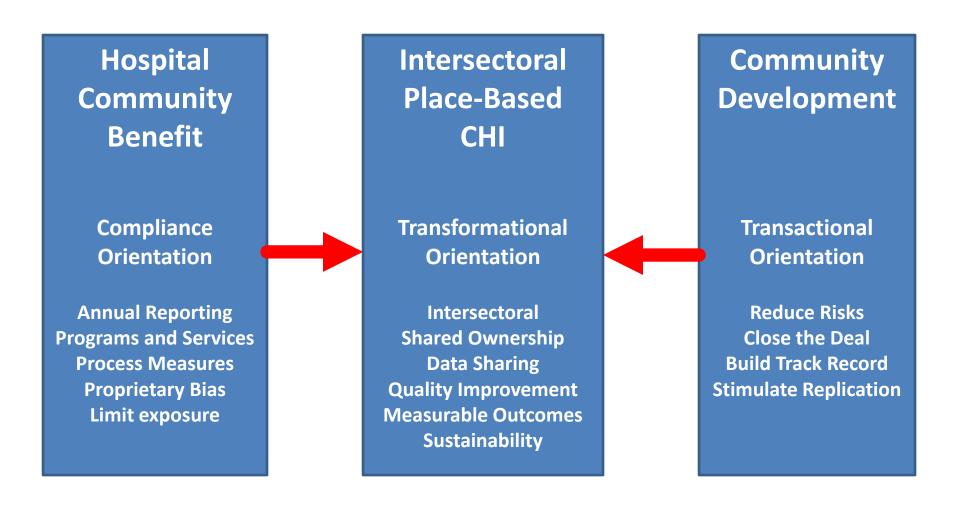
Backbone Infrastructure

Entities with **expertise *and* objectivity** to manage the process (e.g., convening, facilitation, monitoring and evaluation, and intersectoral knowledge).

PUBLIC HEALTH INSTITUTE

Obesity-Focused Convergence Strategy

Convergence at the Center

Hospital Community Benefit

Compliance Orientation

Annual Reporting
Programs and Services
Process Measures
Proprietary Bias
Limit exposure

Intersectoral Place-Based CHI

Transformational Orientation

Intersectoral
Shared Ownership
Data Sharing
Quality Improvement
Measurable Outcomes
Sustainability

Community Development

Transactional Orientation

Reduce Risks
Close the Deal
Build Track Record
Stimulate Replication

Hospital Advocacy for Shared Ownership

- Hospitals one of the largest employers in communities

- Hospital leaders have unusual access to and influence with public officials

- Hospitals assuming increasing financial risk for poor health

- More than 80% of what improves health is outside of medical care delivery

- Health inequities concentrated in urban and rural communities with high poverty, limited access to healthy food, poor quality housing, dysfunctional schools

- Advocacy is cost-effective – Low cost/high returns

PUBLIC HEALTH INSTITUTE

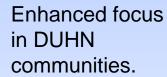# Doing Good and Doing Well
Community Benefit and the Business Model

CB 1.0

Imperative for program and services alignment with the needs/location of commercially insured populations.

Proprietary model.

Random acts of kindness.

CB 2.0

Enhanced focus in DUHN communities.

Increased emphasis on social determinants.

Limited relevance to clinical services.

Lack of financial incentives.

Collaboration with community stakeholders.

CB 3.0

Evidence-based seamless continuum of care.

Comprehensive, intersectoral approach to programs.

Institutional financial incentives aligned.

One player in a balanced portfolio of investments.

Collaboration with all Stakeholders.

PUBLIC HEALTH INSTITUTE

The Case for Investment

- It's not about bleeding hearts, but making good societal investments
    - Child development or incarceration?

    - Healthy food access/policies or medical bankruptcy and reduced life expectancy?

    - Affordable housing and support services or homelessness and full emergency rooms?

    - Job opportunities and living wage or despair and delinquency?

PUBLIC HEALTH INSTITUTE

At the end of the day….