The Evolution of Community Benefit and Population Health

Catholic Health Association
Orlando
2016

Community Health Solutions

- Cloud-based System to improve Community Health
- Health Dashboards and Maps with 100+ indicators Continuously Updated and Curated
- Over 2000 Promising Practices of Successful Programs and Policies
- Evaluation Resources and Trackers
- Work in 38 States, 140 active engagements, over 350 partner organizations
- National Knowledge Base and Peer-Learning Network of Population Health Solutions
- Offer Professional Services
- Award Winning Technology (HHS)
- Expert and Credentialed Public Health Team
- Formerly Healthy Communities Institute

U.S. Health Care: By Far The Most Expensive Health Care "System" On Earth
And Yet…

But Health Care and Social Services totals are not so different…

Determinants of Health
History of Community Benefit

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1894</td>
<td>Wilson-Gorham Tariff Act – Tax-exempted organizations solely for charitable or religious purposes</td>
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<tr>
<td>1946</td>
<td>Hill-Burton Act – in exchange for infrastructure grants of public and nonprofit hospitals obligated to provide free or discounted care for those who could not pay</td>
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<tr>
<td>1969</td>
<td>IRS ruling shifted qualifying activity from just charity care to include community benefits (public health and health promotion)</td>
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<tr>
<td>2000–2008</td>
<td>IRS released Form 990 and Schedule H derived from CHA community benefit reporting standards – not clearly defined level and forms of activity</td>
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<tr>
<td>2000–2015</td>
<td>IRS adequacy of community benefit activities under congressional scrutiny and reports (large variance in definition and activities by state)</td>
</tr>
<tr>
<td>2010</td>
<td>ACA – New provisions require working with others (like public health) to determine community health needs and take action to meet those needs</td>
</tr>
<tr>
<td>Today</td>
<td>IRS recognizing importance of addressing the social determinants of health, saying “…some housing improvements and other spending on social determinants of health that meet a documented community need may qualify as community benefit for the purposes of meeting the community benefit standard.”</td>
</tr>
</tbody>
</table>

History of Population Health

Today: Community benefit now becoming accepted as a core element of the clinical and financial population health strategy with its focus on addressing the social determinants of health.

The Number of ACOs

[Graph showing the increase in the number of ACOs from Q4 2010 to Q4 2015]
ACOs Are Growing – What Are They Learning?

- Building networks of facilities and providers
- Signing risk-based contracts
- Gathering, aggregating, and analyzing data
- Identifying high cost patients who represent large financial risk
- Discerning gaps in care
- Intervening with case management tools

... These are “Inside Out” Activities - and what are they finding?

Leading ACOs are recognizing that social workers may be as or more important than care managers for “high risk” patients

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Population Health – Thomas Jefferson University

Population health is a systematic approach to health care that aims to prevent and cure diseases by keeping people healthy.

- Connecting prevention, wellness and behavioral health science with health care delivery, quality and safety; disease prevention/management and economic issues of value and risk – all in the service of a specific population ... provider’s practice, employee group, hospital’s primary service areas ...
- Identifying socio-economic and cultural factors that determine the health of populations and developing policies that address the impact of these determinants.
- Applying epidemiology and biostatistics in new ways to model disease states, map their incidence and predict their impact.
- Using data analysis to design social and community interventions and new models of healthcare delivery that stress care coordination and ease of accessibility.

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What Is Population Health?
Geography Matters!

"... a person's zip may be a more important indicator of health than their genetic code."


Community Health - Stakeholders

Leaders
Schools
Payers
Health Systems
United Way
Foundations
Churches
Community Organizations
Health Departments
Community Health Solutions

Collective Impact

• Shared vision of the problem and a joint approach to solving the problem through agreed upon actions
• Ways success will be measured and reported with key indicators for each participating organization
• Coordinating a set of differentiated activities through a mutually reinforcing plan of action
• Frequent communications to build trust and inform ongoing learning and adaptation of strategy
• Staff dedicated to: Guide Strategy; Support Activity; Report Shared Measurement; Advance Public Use and Policy; and Mobilize Funding.

Approach to Improve Community Health/Population Health

Example of Community Health Dashboard

Looking At Health More Broadly

- Traditional Health Diseases:
  - Access to Health Services
  - Cancer
  - Diabetes
  - Disabilities
  - Exercise, Nutrition, Weight
  - Family Planning
  - Heart Disease/Stroke
  - Immunizations/Infectious Disease
  - Maternal, Neonatal/Infant
  - Mental Health
  - Oral Health
  - Prevention/Safety
  - Respiratory Diseases
  - Substance Abuse, etc.

- Other Determinants of Health:
  - Built Environment
  - Economy
  - Education
  - Public Safety
  - Social Environment
  - Transportation
**SocioNeeds Index**

* Using all Kansas zip codes, the SDI calculates and maps where there are high levels of socio-economic need, which is correlated with higher rates of preventable hospitalization and premature death.

* Zip codes with higher calculated need appear in deeper shades of red.

**Data Scoring**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Scoring</th>
</tr>
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<tbody>
<tr>
<td>Women's Health</td>
<td>5</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>6</td>
</tr>
<tr>
<td>Transportation</td>
<td>6</td>
</tr>
<tr>
<td>Cancer</td>
<td>15</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
</tr>
<tr>
<td>Children &amp; Youth</td>
<td>11</td>
</tr>
<tr>
<td>Older Adults &amp; Aging</td>
<td>18</td>
</tr>
<tr>
<td>Teen &amp; Young Adult Health</td>
<td>5</td>
</tr>
<tr>
<td>Access to Health Services</td>
<td>11</td>
</tr>
<tr>
<td>Nutrition &amp; Physical Activity</td>
<td>11</td>
</tr>
<tr>
<td>Respiratory Diseases</td>
<td>11</td>
</tr>
<tr>
<td>Environmental &amp; Occupational Health</td>
<td>5</td>
</tr>
<tr>
<td>Child Health</td>
<td>7</td>
</tr>
<tr>
<td>Mental Health &amp; Mental Disorders</td>
<td>7</td>
</tr>
<tr>
<td>Immunizations &amp; Infectious Diseases</td>
<td>8</td>
</tr>
<tr>
<td>Prevention &amp; Safety</td>
<td>12</td>
</tr>
<tr>
<td>Social Determinants</td>
<td>13</td>
</tr>
<tr>
<td>Prevention &amp; Safety</td>
<td>12</td>
</tr>
<tr>
<td>Maternal, Fetal &amp; Infant Health</td>
<td>6</td>
</tr>
<tr>
<td>Family Planning</td>
<td>1</td>
</tr>
<tr>
<td>Food Safety</td>
<td>1</td>
</tr>
<tr>
<td>Government &amp; Politics</td>
<td>1</td>
</tr>
<tr>
<td>Men's Health</td>
<td>2</td>
</tr>
<tr>
<td>Immunizations &amp; Infectious Diseases</td>
<td>8</td>
</tr>
<tr>
<td>Prevention &amp; Safety</td>
<td>12</td>
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<tr>
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<td>2</td>
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**Community Health Profiles**
Example of Working Groups and Tracking to Goals

Hawaii: Two Community Case Studies
Case Study 1: Hawaii Medical Respite Building for Homeless Patients

Problem
① Urban homeless patients with frequent and lengthy hospitalizations for infections and open wounds
② Unable to discharge homeless patients for home recovery – lack of sanitary housing
③ Placement in local hotels expensive and challenging

Oahu’s Growing Homeless Population

<table>
<thead>
<tr>
<th>Year</th>
<th>Sheltered</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2,304</td>
<td>60%</td>
<td>3,833</td>
</tr>
<tr>
<td>2014</td>
<td>3,079</td>
<td>65%</td>
<td>4,712</td>
</tr>
<tr>
<td>2015</td>
<td>3,015</td>
<td>70%</td>
<td>4,355</td>
</tr>
<tr>
<td>2016</td>
<td>3,015</td>
<td>66%</td>
<td>4,355</td>
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Health Impact Pyramid
Hawaii Medical Respite Solution

- Hawaii Pacific Health partners with local recovery housing organization to develop new medical respite
- Part of Community Benefit programming
- Reinforces population health outcomes goals for health system
- Recognizes the need to address the social determinants of patients

Value: Meeting Socio-Economic Needs

Medical Respite = Cost Savings

Demonstrated cost avoidance for hospitals partnering with medical respite programs

- Los Angeles, CA: $3 million total cost avoidance in the first year
- Portland, OR: $5 million total cost avoidance due to 90% reduction in readmissions
- Cincinnati, OH: $9 million total cost avoidance due to 60% reduction in readmissions
- San Diego, CA: $11 million total cost avoidance due to 90% reduction in readmissions
- Atlanta, GA: $10 million total cost avoidance due to 90% reduction in readmissions
- Sacramento, CA: $12 million total cost avoidance due to 90% reduction in readmissions
- Richmond, VA: $11 million total cost avoidance due to 90% reduction in readmissions
- Salt Lake City, UT: $10 million total cost avoidance due to 90% reduction in readmissions
Case Study 2: Hawaii Bacterial Pneumonia Hospitalizations

**Problem**
- Analysis of statewide historical utilization data revealed high rates of preventable hospitalizations due to bacterial pneumonia AND
- Dashboard indicator data showed low community pneumonia vaccination rates for adults 65+ years, and especially low for Filipinos and men.

**Solution**
1. Studying geographic hospitalization utilization data, Hawaii hospitals identified neighborhoods with highest bacterial pneumonia hospitalization rates, and largest Filipino populations across the island.
2. Initiated a plan to increase vaccination among Filipino male populations through:
   - Targeted Community Benefit activities to include pneumonia vaccinations
   - Reminders and increased efforts to vaccinate managed care population

**Outcome**
1. Cost avoidance approximately $10,500 per hospitalized case
2. Pneumonia vaccinations for 65+ age group have a positive ROI
3. Estimated potential hospitalization cost avoidance for hospital service area: $1.8M
4. Estimated potential hospitalization cost avoidance for Oahu: $5.3M

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3. Assumptions: 209,904 pop.65+, vaccination rate increases 20% , proportional reduction in bacterial pneumonia in-patient rate change from 205/100,000 to 147/100,000 @ $10,800 per in-patient case
Evolution of Community Benefit

- Narrow focus → Broader focus, moving upstream
- Alone → Collaborate (use a methodology: e.g., Collective Impact)
- Mission driven → Data driven
- Do the right thing → and Evidence-based
- Work hard → Evaluate and Measure Impact
- Disconnected → Integrate with clinical initiatives
- Incremental Change → Re-engineering and improved outcomes and ROI

Reorganizing for Resilience ... Ranjay Gulati, Harvard

Coordination—Alignment of activities, processes, and information across units within an organization
- Cooperation—Alignment of goals, attitudes, and behaviors across units within an organization
- Clout—Assignment of power to customer-facing individuals and those responsible for integration within the organization
- Capabilities—Development of customer-facing generalists along with product specialists
- Connections—Expand the source of inputs and also complementary offerings beyond internal production units to external strategic partners.

A Strategic Approach to Community Health Improvement for Hospitals and Health Systems

- Align activities in “defined population” and “geographic population” approach
- Improve core quality metrics linked to financial incentives
- Communication Tools for Leadership and Community Service Area Strategy Development
- A strategic plan for your service area - estimate and evaluate impact of interventions
- CHNA and Implementation Strategy
- Data-driven and evidence-based CHNA and IS (from assessment to impact evaluation)
- Consistent, standardized analytic approach to summarizing data
- Capacity building to implement programs with measurable outcomes
- Technology is the foundation to grow collaboratives – shared understanding of need and interventions
- Work across stakeholder groups and community resources for greater, collective impact
Discussion

Thank You!
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Community Health Improvement Cycle

ADOPT A NEED:
- Identify community needs
- Set health priorities
- Collaborate with community partners
- Develop an action plan
- Monitor progress

DEVELOP A STRATEGY:
- Identify key stakeholders
- Develop realistic timelines
- Integrate existing resources
- Implement needed interventions

IMPLEMENT A SOLUTION:
- Integrate with other initiatives
- Evaluate progress
- Communicate successes

MONITOR:
- Track progress
- Adjust as needed
- Evaluate outcomes
- Renovate cycle as needed