The Evolution of Community Benefit and Population Health

Catholic Health Association
Orlando
2016

Community Health Solutions

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 500 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…

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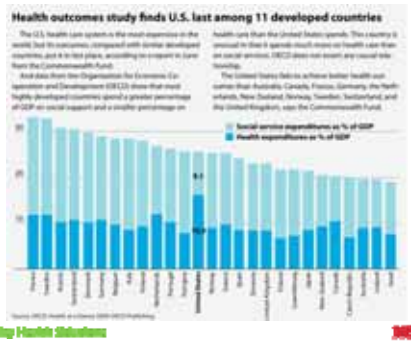
K. Davis, K. Stremikis, D. Squires, and C. Schoen, Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally, The Commonwealth Fund, June 2014

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



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OECD, Health at a Glance 2009: OECD Publishing

Determinants of Health

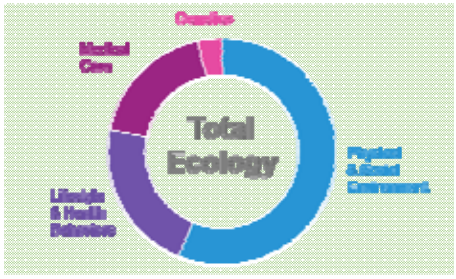

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Figure: Estimates of how each of the five major determinants influence population health (US CDC Social Determinants of Health: http://www.cdc.gov/socialdeterminants/faq.html

History of Community Benefit

Year	Event
1894	Wilson-Gorham Tariff Act – Tax-exempted organizations solely for charitable or religious purposes
1946	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
1956	IRS requires nonprofits maintaining tax exemption to provide as much charity care as they could afford
1969	IRS ruling shifted qualifying activity from just charity care to include community benefits (public health and health promotion)
2000 – 2008	IRS releases Form 990 and Schedule H derived from CHAs community benefit reporting standards – not clearly defined level and forms of activity
2000 – 2015	IRS adequacy of community benefit activities under congressional scrutiny and reports (large variance in definition and activities by state)
2010	ACA – New provisions require working with others (like public health) to determine community health needs and take action to meet those needs
Today	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."

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

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

Kim D. Sibcum, President KDS Consulting, LLC. "Financial Realities and the Future of US Health Care." Presentation, October 9, 2014

Population Health – Thomas Jefferson University

... Population health is a systematic approach to health care that aims to prevent and cure disease 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 area …
- 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.

--The Jefferson School of Population Health

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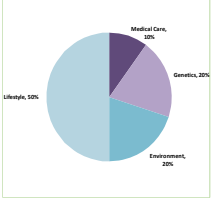
What is Population Health? *Jefferson School of Population Health*, Thomas Jefferson University. Website: http://www.jefferson.edu/university/population-health/about.html 2015

Population Health - Moving Beyond "Defined Populations"

Geographic Population	Determinants of Health	Defined Population
Data Public Health and Demographic Data Evidence-base Community Health Interventions Implementation/Evaluation Stakeholder Collaboration, Community Programs, Population Health Tracking		Data Claims and EHR Evidence-base Clinical Quality AHRQ/NCG, ACP, NIH, IOM Implementation/Evaluation Care Mgt. and Coordination, Readmission Rates, Quality Metrics, Meaningful Use
"Outside-In"		"Inside-Out"

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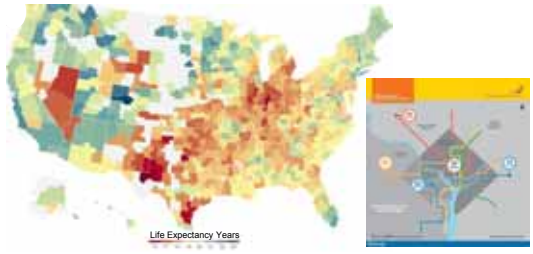
Geography Matters!



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

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Irwin, Nel, Bui, Quoctrung. *The Rich Live Longer Everywhere, For the Poor, Geography Matters.* New York Times. The Upshot.. Hassmiller, RN, PHD. *Culture of Health: Why Your Patient's Home Environment Matters.* MedScape

Community Health - Stakeholders

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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.

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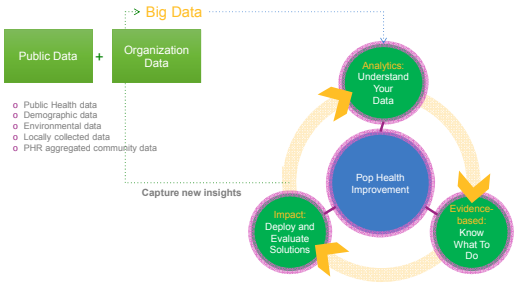
United Way

Kania, John; Kramer, Mark. Collective Impact. Stanford SOCIAL INNOVATION Review. Winter 2011. See: http://www.ssireview.org/articles/entry/collective_impact;
Cincinnati. *Collective Impact, The "New Normal" in the Greater Cincinnati Region.* Sep 2012. See: http://www.slideshare.net/gcfdn/collective-impact-the-new-normal-in-the-greater-cincinnati-region

Approach to Improve Community Health/Population Health



Example of Community Health Dashboard

Looking At Health More Broadly

Traditional Health Measures

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

Other Determinants of Health Factors - Social and Physical

- 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

Topic Area	Indicators	
Women's Health	5	Most Concern >1.5
Substance Abuse	6	
Transportation	6	
Cancer	15	
Diabetes	5	
Oral Health	5	
Heart Disease & Stroke	11	
Older Adults & Aging	19	
Teen & Adolescent Health	5	
Access to Health Services	11	
Environment	13	Some Concern 1.25–1.5
Exercise, Nutrition, & Weight	17	
Respiratory Diseases	11	
Environmental & Occupational Health	5	
Children's Health	7	
Mental Health & Mental Disorders	7	
Public Safety	5	
Wellness & Lifestyle	6	
Education	8	Least Concern <1.25
Immunizations & Infectious Diseases	8	
Prevention & Safety	4	
Social Environment	4	
Economy	20	
Maternal, Fetal & Infant Health	6	
Family Planning	1	Not Enough Data
Food Safety	1	
Government & Politics	1	
Men's Health	2	

Community Health Profiles

Example of Working Groups and Tracking to Goals

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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 3: Oahu Summary 2011-2015

	Sheltered		Unsheltered		Oahu Total
	#	%	#	%	#
2015	2,964	60%	1,939	40%	4,903
2014	3,079	65%	1,633	35%	4,712
2013	3,091	68%	1,465	32%	4,556
2012	3,035	70%	1,318	30%	4,353
2011	2,912	69%	1,322	31%	4,234

State of Hawaii, Point in Time Homeless Count 2015 Report

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

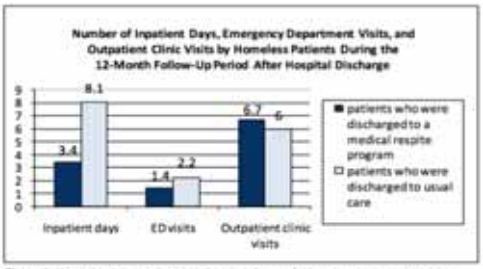

Figure 1: Hospital and clinic utilization before and after medical respite program participation

Medical Respite = Cost Savings

Demonstrated cost avoidance for hospitals partnering with medical respite programs

- Los Angeles, CA
- Portland, OR
- Cincinnati, OH
- San Diego, CA
- Atlanta, GA
- Sacramento, CA
- Richmond, VA
- Salt Lake City, UT

Case Study 2: Hawaii Bacterial Pneumonia Hospitalizations

Problem

- Analysis of statewide historical utilization data revealed high rates 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

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Hawaii Bacterial Pneumonia Hospitalizations

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

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Hawaii Bacterial Pneumonia Hospitalizations

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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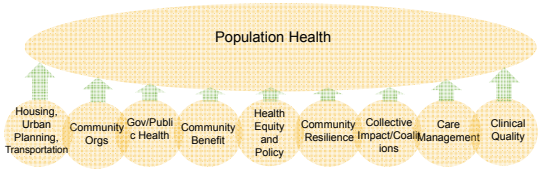
1. Nichol, K.L., K.L. Margolis, J. Wuorenma, and T. Von Sternberg. "The Efficacy and Cost Effectiveness of Vaccination against Influenza among Elderly Persons Living in the Community." New England Journal of Medicine 1994; 331: 778-784. 10.1056/NEJM199409223311206. 2. Berg, G.D., E. Thomas, S. Silverstein, C.L. Neel, and M. Mireles."Reducing medical service utilization by encouraging vaccines: Randomized controlled trial." American Journal of Preventive Medicine November 2004; 27(4): 295-300. doi: 10.1016/j.amepre.2004.07.001. 3. Assumptions: 209,954 pop 65+, vaccination rate increases 25%, proportional reduction in bacterial pneumonia in-patient rate change from 295/100,000 to 247/200,000 @ $10,500 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 → *and* 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. "

"…. the point where the greatest resilience is achieved, is **connection**: shrinking the core and expanding the periphery to join seamlessly with external partners to identify and solve customer problems … Only when that is completed … do firms achieve the shape-shifting holy grail of "outside-in" actions. In achieving that, they achieve the responsiveness and nimbleness that enable survival in the roughest of oceans."

Gulati, Ranjay. Reorganize for Resilience: Putting Customers at the Center of Your Business. Harvard Business School Publishing Corporation, 2009.

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

Population Health
- Align activities in "defined population" and "geographic population" approach
- Improve core quality metrics linked to financial incentives
  (Example Core Measure: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- 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

Collaboratives and Collective Impact
- 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