Health Care Investments in Population
Health Improvement:
Opportunities, Challenges, and Priorities

Presentation
Institute of Medicine
Roundtable on Population Health Improvement
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Public Health Institute
Overview

- **Emerging Opportunities in the Community Benefit Arena**
  - CB and Health Reform
    - Transparency
    - Policy Tools
    - Compliance versus transformation
  - Potential for Intersectoral Alignment

- **Challenges to be Addressed**
  - Climate of Crisis Management
  - Filling the Knowledge Gaps
  - Managing Competitive Dynamics

- **Priorities Moving Forward**
  - Building Critical Mass: Focus in *Places* with Health Inequities
  - Role of Institutional Leadership in Policy Advocacy
Transparency

· **Pricing**
  - Billing for procedures, equipment, pharmaceuticals
  - Comparative analysis of reimbursements, reported shortfalls, other CBs

· **Outcomes**
  - Public “ROI” for care

· **Location**
  - Payer mix
  - Jurisdiction
  - SDH

· **Public expectations**
  - IRS reporting requirements opens the door to a broad set of questions
Defining Community

- IRS encourages hospitals to use service area to define community.

- Service areas based primarily on voluntary selection and driven by concentration of commercially insured patients.
  - May be inconsistency between defined communities for CB purposes and geo concentrations of health disparities.
  - Geo concentrations of health disparities in proximal areas may be in different jurisdictions.

- Lack of knowledge, insular tendencies contribute to view that geo concentrations of disparities are not major concerns of hospitals.

- Hospitals with limited resources (e.g., CAH) conduct independent CHNAs.

- LPHAs with limited resources conducting single county CHAs and CHIPs when health concerns and resources transcend jurisdictions.
It’s all about Place
ID Health Disparities in CHNA
Large and Small Metropolitan Regions
ID Health Disparities in CHNA
Micropolitan and Rural Regions
Community Engagement

- IRS guidance to hospitals limited to call to “consider input” from community stakeholders in CHNA process. No call for
  - Information on how input informed CHNA process
  - Community engagement in priority setting
  - Community engagement in planning or implementation
Priority Setting and Implementation

- Poorly designed and implemented priority setting processes
  - Assessment of criteria; whether is level of specificity, objectivity, issues outside of institutional concerns
  - Content focus broad and focused on access to clinical services

- Disconnect between priorities and focus of programs
  - Framing is broad, allowing for perpetuation of existing programs

- Lack of focus in geo concentrations with health disparities
  - Whether interventions are targeted for populations or communities with disparities

- Lack of measurable objectives
  - Documentation of different forms of metrics
Public Policy Tools

- Payment in Lieu of Taxes (PILOTs)
  - E.g., Pennsylvania CB law
- Determination of Needs (MA)
- Community Benefits Agreements (CBAs)
  - E.g., CA Pacific Medical Center, SF
- Informal “requests” from local political leaders
  - E.g., Boston
- Local Ordinances
  - Los Angeles Wellness Trust
- Voluntary Pooling with local foundations
  - Northwest Health Foundation
Compliance and Transformation

**Compliance**

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

**Transformation**

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

**Shared Ownership**

**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
**Compliance and Transformation, cont’d.**

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<thead>
<tr>
<th>Compliance</th>
<th>Transformation</th>
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<tbody>
<tr>
<td><strong>Innovative &amp; Evidence-Informed Investments</strong></td>
<td>Survey best practices to ID strategies with evidence of effectiveness or that offer considerable promise</td>
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<td>Describe how hospital will address priority unmet needs</td>
<td>Establish shared metrics that will document ROI at multiple levels</td>
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<td><strong>Incorporate Continuous Improvement</strong></td>
<td>Establish indicators of progress (e.g., systems reforms) that validate progress towards outcomes</td>
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<td>Establish monitoring strategy that integrates adjustments based upon emerging findings</td>
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<td><strong>Pooling and Sharing of Data</strong></td>
<td>Sharing of utilization data across hospitals, PH, CHCs to assess total cost of care</td>
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<td>Proactive determination of ROI at institutional and community level</td>
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*Public Health Institute*
Opportunities for Alignment
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<tr>
<th>Issue-Specific Assessments (Health Impact Assessment)</th>
<th>Local Health Departments (CHAs/CHIPs)</th>
<th>Tax-exempt Hospitals (CHNAs/ISs)</th>
<th>Community Health Centers (Section 330 Application)</th>
<th>United Ways (CHAs)</th>
<th>Community Action Agencies (Community Services Block Grant Application)</th>
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<td>Generally varies, one element of an HIA includes Scoping, which establishes the population affected by the proposed policy, plan or program.</td>
<td>Jurisdictions that determine the service populations of LHDs vary, including: county, districts, city, and combined city-county areas.</td>
<td>Regulations allow flexible framing in geographic service area, with consideration of principal functions and target populations. Cannot define community in a way that excludes medically underserved, low income, minority groups, &amp; groups with chronic disease needs.</td>
<td>Located in or serve a high need community such as MUAs (designated Medically Underserved Area or Population).</td>
<td>UW jurisdictions typically include county/ and multi county/regional areas.</td>
<td>Established in 1964 as part of the War on Poverty, the 1100 CAAs define their communities as broad geographic areas, ranging from multi-county regions and MSAs to more targeted municipalities or inner city areas. The central focus in low-income communities.</td>
<td>CRA “assessment areas” include one or more MSAs or one or more contiguous political subdivision, such as counties, cities or towns. Attention is given to the location of main offices, branches, ATMs, and loan origin geo locations. Areas may not arbitrarily exclude low- or moderate-income geographies.</td>
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<td>Core Expectations</td>
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| **Issue-Specific Assessments**  
(Health Impact Assessment)                                                                 |
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(CHAs/CHIPs)                                                                 |
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| **Community Health Centers**  
(Section 330 Application)                                                             |
| **United Ways**  
(CHAs)                                                                 |
| **Community Action Agencies**  
(Community Services Block Grant Application)                                           |
| **Financial Institutions**  
(CRA Performance Context Review)                                                      |
| HIAs use data, research and stakeholder input to **determine a policy or project’s impact** on the health of a population. HIAs also provide recommendations to address these impacts. |
| LHDs **connect people with personal health services**, including preventive and health promotion services. They also **advocate for programs and services and monitor the quality and accessibility** of public health services. |
| Relieve **government burden** by serving poor populations & communities. Economic value of tax exemption is a common metric. **Historical focus is free and discounted medical services. Increasing focus on proactive services and activities** that reduce the need for medical care. |
| CHCs provide comprehensive primary health care and support services  
(education, translation and transportation, etc.)  
for populations with limited access to health care. |
| As a coalition of charitable organizations working with partners to  
address issues surrounding income (i.e. financial stability), health and education |
<p>| Services include community coordination, emergency services, education, food and nutrition, child and family development, training/employment, budget counseling, transportation, housing, economic development, health care. |
| CRS is intended to encourage depository institutions to help meet the credit needs of the communities in which they operate, including low- and moderate-income neighborhoods, consistent with safe and sound operations. |</p>
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<td><strong>The desired outcome is to engage community members to understand impacts on health and how to advocate to improve conditions.</strong></td>
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### Accountability Mechanisms

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<td>No laws explicitly require HIAs as an approach or method in regulatory analysis. Once ordered, there may be a court order or other publicly authorized process that requires action in response to findings.</td>
<td>Accountability mechanisms are typically tied to categorical funding. Some states require LHDs to conduct CHAs/CHIPs. PHAB standards require both a CHA/CHIP for LHDs seeking accreditation (PHAB accreditation is a voluntary process).</td>
<td>Fine of $50,000 and potential loss of tax exemption for failure to submit a CHNA. Penalties for noncompliance with reporting requirements (e.g., adoption of IS in same year as CHNA, exclusion of low income community) are unclear. Notice 2014-2 provides a “safe harbor” for hospitals to correct errors without penalty.”</td>
<td>CHCs are required to conduct periodic needs assessments (time frame not specified). Required to document the needs of target populations in order to inform and improve its delivery of appropriate services.</td>
<td>Annual certification of adherence to standards that include financial reporting, governance, ethics, diversity operations, as well as self-assessments.</td>
<td>Site visits at each CSBG-eligible entity once during 3 year period. Required to “determine whether meet performance goals, administrative standards, financial and management requirements. Terminate or reduce support if deficiencies not corrected.</td>
<td>A bank’s CRA performance record is taken into account in considering an institution’s applications for deposit facilities, mergers, and acquisitions.</td>
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## Opportunities for Alignment

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<td>When available, HIAs provide an additional layer of information, most often relating to broader environmental impacts, in the design of strategies to improve health.</td>
<td>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.</td>
<td>IRS allows hospitals to develop ISs in collaboration with other hospitals and State and local agencies, 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.</td>
<td>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.</td>
<td>Standard 2.1 emphasizes partnerships across the community, CAAs can often &quot;serve as a backbone organization of community efforts&quot; to address poverty and community revitalization: leveraging funds, convening key partners...&quot;</td>
<td>Targeted CRA investments in housing, retail, education, and job creation in low income communities provide an opportunity to address social determinants of health and help reduce health care costs.</td>
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Challenges to be Addressed
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• **Crisis Management**
  - IS development, consolidation, acquisitions
  - Preparing for constraints on reimbursement
  - CB viewed as compliance issue, rather than an engine for transformation

• **Knowledge Gaps**
  - Local leaders don’t know what they don’t know
  - Power used to date by system leaders limited in population health capacity development

• **Competitive Dynamics**
  - Limited focus on clinical care coordination is impeding potential for collaboration on broader issues
Content Focus of CB Priorities among Study Sites
Priorities Moving Forward

- Broad dissemination of
  - Growing volume of exemplary practices
  - Tools to support local accountability and engagement across sectors and institutions – Shared ownership

- Framing Hospital/Health System Engagement

- Focus on PLACE
  - No excuse for continued avoidance of focused investment in census tracts where health disparities and profound “inequities in opportunity” are concentrated
  - Stimulate accelerated models of shared risk among providers and payers will support place-based investment
Hospital/Health System Community Investments

- **Dignity Health**
  - Pre-development loans for affordable housing
  - Capital campaign bridge loan for low income dental care center
  - Revolving loan fund for small business development NP
  - Lending capital for post disaster reconstruction

- **CHE – Trinity Health**
  - Scholarship Loan Programs
  - Loans for child care businesses and other small business development
  - Pre-development loans for affordable housing
  - Financing for neighborhood revitalization
  - Low income housing linked with support services
Place-Based, “Collective Impact” Approach

Community

Backbone Org. - Integrator

Actions

- Expanded Care Management
- Health Education
- Community Mobilization
- Policy Development
- Community Development

Shared Metrics
- Diabetes PQIs
- Food Access
- Options in schools
- Awareness/knowledge
- Physical activity

Hospital 1
Hospital 2
K – 12 Schools
Local Business 1
Local Business 2
Community Development Dept.
Bank (CRA)
Youth Serving CBO
Faith Community
Resident Coalition
Elected Officials
Parks &Rec Dept.
Philanthropy
Higher Ed
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**
- Increased focus in communities with health disparities.
- 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.
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