Health Care Investments in Population Health Improvement:

Opportunities, Challenges, and Priorities

Presentation
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Kevin Barnett, DrPH, MCP
Senior Investigator
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**

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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

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Defining Community

- IRS encourages hospitals use of 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.

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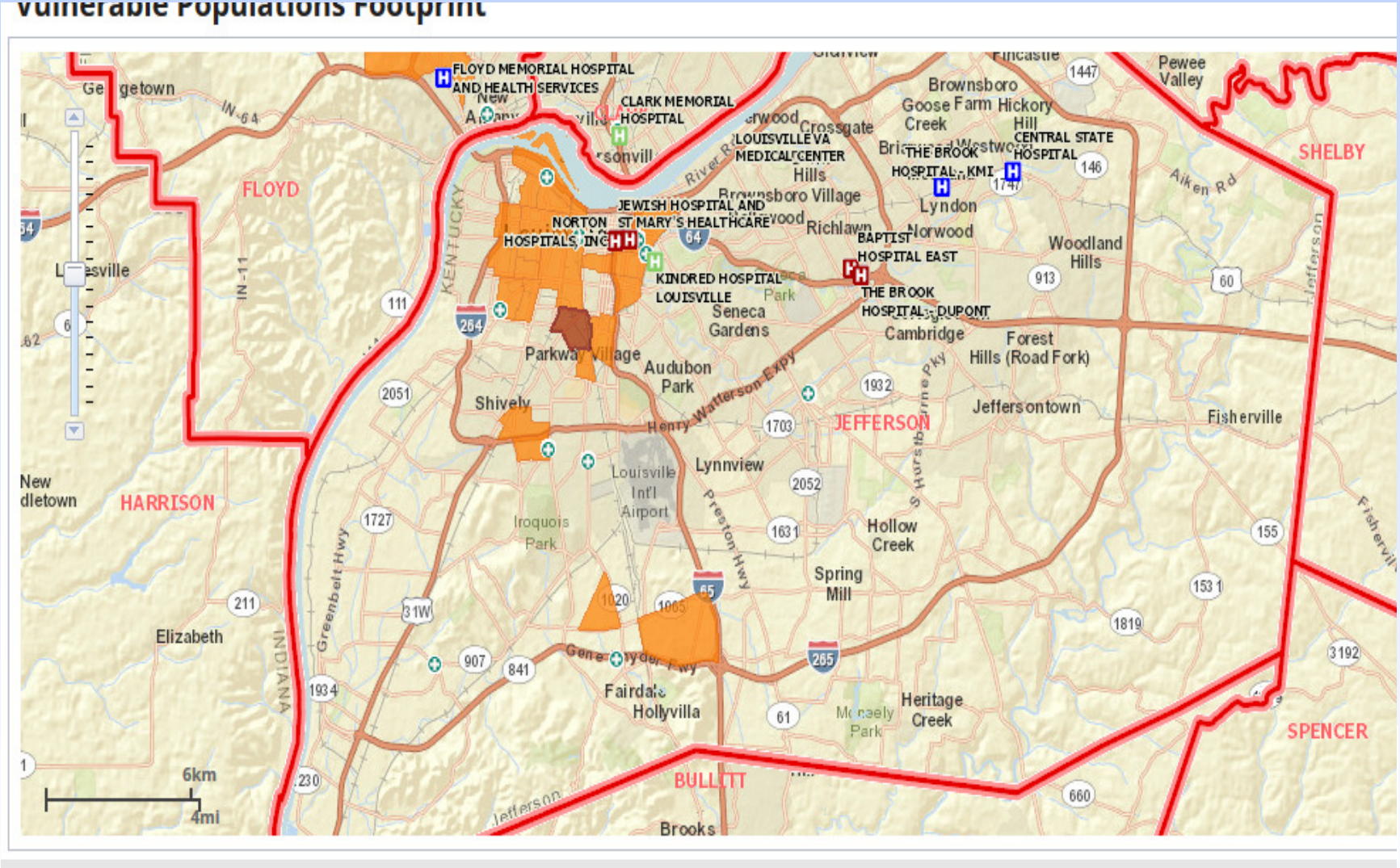
It's all about Place



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

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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 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

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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

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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

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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

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- **Opportunities for Alignment**

Defining Community

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)
Generally varies, one element of an HIA includes Scoping, which **establishes the population affected b**y the proposed policy, plan or program.	Jurisdictions that determine the service populations of LHDs vary, including: **county, districts, city, and combined city-county areas.**	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, & groups with chronic disease needs**.	Located in or serve a **high need community** such as MUAs (designated Medically Underserved Area or Population).	UW jurisdictions typically include **county/ and multi county/ regional areas**.	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.	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**.

Core Expectations						
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)
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**	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.

Community Stakeholder Engagement

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The desired outcome is to **engage community members to understand** impacts on health and how to advocate to improve conditions.	Expected to **engage and mobilize diverse community stakeholders** "in a strategic way" to identify and solve health problems in the jurisdiction.,	Required to "**take into account input** from persons who represent the broad interests of the community" and input from local or state HD **during CHNA process**. The CHNA (including priority setting process) must also be made widely available to the public.	**Strong emphasis on collaboration with other safety net providers** and requirement for 51% consumer membership on board of directors. ,	Strong emphasis on **community mobilization and collaboration** with other organizations in guidance from UW USA.	Call for gathering information from CBOs, faith-based organizations, and private sector, public sector, and education institutions, and **working together** with a joint **problem solving orientation.**	Banks expected to "proactively assess community needs," and "**consult with community stakeholders"** to develop financing options for affordable housing and economic development.

Accountability Mechanisms

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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.	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).	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."	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.	**Annual certification of adherence to standards** that include financial reporting, governance, ethics, diversity operations, as well as self-assessments.	**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.	A bank's CRA performance record is taken into account in **considering an institution's applications for deposit facilities, mergers, and acquisitions**.

Opportunities for Alignment						
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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 low income communities provide an **opportunity to address social determinants of health and help reduce health care cos**ts.

- **Challenges to be Addressed**

Challenges to be Addressed

- **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

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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

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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

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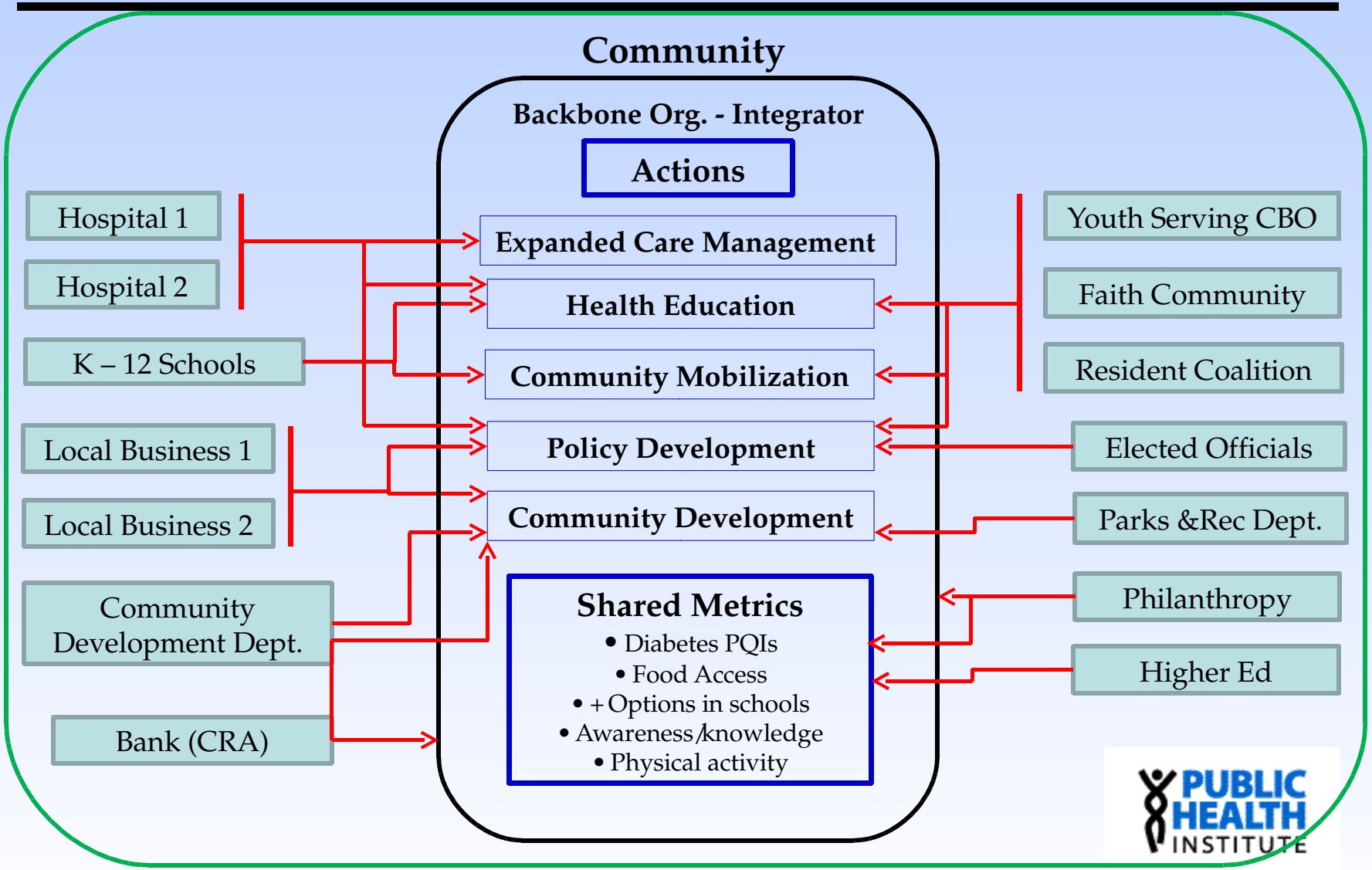
Place-Based, "Collective Impact" Approach



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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Contact Information

- **Kevin Barnett, Dr.P.H., M.C.P.**

  Public Health Institute

  555 12th Street, 10th Floor

  Oakland, CA 94607

  Tel: 10-285-5569 Mobile: 510-917-0820

  Email: kevinpb@pacbell.net