Community Health Improvement: A Holistic Model

Community Centered Health Homes Convening
December 16-17, 2014
The Rizzo Conference Center

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Overview

- Community health improvement as a holistic process.

- Summary findings from recent CDC study, implications for tax exempt hospitals, community health clinics, and other stakeholders.

- Movement from compliance to transformation – the imperative for a focus on the SDH.

- Intersectoral engagement – new models and exemplary practices
The CHI Process:  
Key Steps and Questions to be Addressed

<table>
<thead>
<tr>
<th>Key Steps</th>
<th>Key Questions</th>
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</thead>
<tbody>
<tr>
<td>Engage</td>
<td>Who has a stake in CHI and should be at the table?</td>
</tr>
<tr>
<td>Build Shared Vision</td>
<td>Where do we want to go, and how do we want to get there?</td>
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<tr>
<td>Identify</td>
<td>In what ways should we focus our efforts to justify our investments?</td>
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<tr>
<td>Assess (Inquiry)</td>
<td>What are the most significant challenges, and what assets are available to address them?</td>
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<tr>
<td>Analyze</td>
<td>What is our baseline, and how will we know we are succeeding?</td>
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<tr>
<td>Select</td>
<td>How can we make the best use of available resources? What is shared ownership?</td>
</tr>
<tr>
<td>Design</td>
<td>What mid-course adjustments are needed to better leverage our resources?</td>
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<tr>
<td>Implement (Take Action)</td>
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<tr>
<td>Evaluate</td>
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<tr>
<td>Improve</td>
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</table>
County Health Rankings
Roadmap Take Action Cycle
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
Opportunities for Broader Alignment
<table>
<thead>
<tr>
<th><strong>Defining Community</strong></th>
<th><strong>Issue-Specific Assessments</strong> (Health Impact Assessment)</th>
<th><strong>Local Health Departments</strong> (CHAs/CHIPs)</th>
<th><strong>Tax-exempt Hospitals</strong> (CHNAs/ISs)</th>
<th><strong>Community Health Centers</strong> (Section 330 Application)</th>
<th><strong>United Ways</strong> (CHAs)</th>
<th><strong>Community Action Agencies</strong> (Community Services Block Grant Application)</th>
<th><strong>Financial Institutions</strong> (CRA Performance Context Review)</th>
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<tbody>
<tr>
<td><strong>Generally varies,</strong> 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>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.</td>
<td>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 “serve as a backbone organization of community efforts” to address poverty and community revitalization: leveraging funds, convening key partners...”</td>
<td>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.</td>
<td></td>
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Current Practices: A First Round Snapshot
Focus of 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
Defining Community

- All 44 hospitals defined community as patient service area.

- Only 10 of 44 (23%) hospitals identified the geographic concentration of disparities in their community.
Use of GIS Mapping and Public Data Platforms

- Emerging opportunities to **reduce the cost and time investment** in data collection through use of public data platforms.
- Expanded use of geographic information systems (GIS) puts findings in **user-friendly format** and helps to engage diverse community stakeholders.
- Increased resources to focus on building **shared ownership** for health with diverse stakeholders and **comprehensive approaches** to health improvement with greater potential to produce measurable outcomes.
- A public data platform at [www.chna.org](http://www.chna.org) was launched in December 2012 that is free to users and offers the potential to accelerate the data collection and analysis process.
Service Area Exclusion of Geo Areas with Concentrated Poverty

Vulnerable Populations Footprint
Orphan County in Identified Community
Priority Setting Criteria
Sufficient Specificity to Inform Decision Making

Criteria with sufficient specificity
22
55%

Criteria lacks specificity
18
45%
Community Building

- Category of charitable activities developed in a 1997 monograph\(^1\) that focus on addressing the root causes of health problems in local communities. Examples include:
  - **Physical improvements** (e.g., housing, street lights, graffiti removal)
  - **Economic development** (e.g., job creation, small business development)
  - **Social support** (e.g., child care, youth mentoring, leadership development)
  - **Environmental improvements** (e.g., park renovation, toxic cleanup)
  - Coalition building
  - Community health advocacy

\(^1\) Barnett, K., “The Future of Community Benefit Programming, The Public Health Institute
IRS Adjustment on Community Building

- Initial ruling based upon a **poor understanding** of importance in community health improvement.
- Revised instructions indicate “**some of these activities may also meet the definition of community benefit,**”
  - Hospitals encouraged to document as community health initiative activities
- **Three basic criteria** in instructions justify reporting as a CB:
  - CHNA developed or accessed by the organization;
  - Community need or a **request from a public agency** or community group
  - Involvement of unrelated, collaborative tax-exempt or government organizations as partners.
- Hospitals have supported community building for decades, and are encouraged to report these activities as CB.
Community Engagement
Lessons from History

Ongoing engagement from the outset
Negotiate roles and relationships
Accommodate practical realities
Veto power

Focus Groups
Attitude Surveys
Public Hearings

Citizens Advisory Groups
Neighborhood Advisory Councils

A Geographic Model of CB and CHI: Key Areas of Focus

• Expanded enrollment in low income communities and shift in reimbursement models creates need for a more geographic-based approach to CB with focus on:
  – ID and reduce health disparities
  – Leverage and link resources of diverse stakeholders
  – Advance evidence-based population health improvement
  – Retain broad framework of health to ensure attention to root causes of health problems
  – Pursue a balance of responsibilities consistent with capacity and geographic location
  – Evaluate opportunities to achieve economies of scale through collaboration across geopolitical jurisdictions
Compliance and Transformation

### Compliance

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

**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

**Broad Definition of Community**
- Define community as hospital service area
- Identify underserved pops w/in service area
- Design programs at service area level

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

### Transformation

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

**Diverse Community Engagement**
- Engage diverse community stakeholders as ongoing partners with shared accountability
- Identify shared priorities to improve community health

**Broad Definition of Community**
- 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 & shared priorities in multiple settings
- Develop and post IS in multiple settings with defined roles for diverse community stakeholders
Compliance and Transformation, cont’d.

Compliance

Innovative & Evidence-Informed Investments

Describe how hospital will address priority unmet needs

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

Transformation

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
Dignity Health and the Community Needs Index

- Dignity Health (formerly Catholic Healthcare West), in collaboration with Solucient (now part of Thomson Reuters) developed a tool entitled a **Community Needs Index** (CNI).
  - Uses **demographic metrics** such as poverty rate, unemployment, home ownership, race & ethnicity, insurance coverage, and HS non-completion rate to create a GIS-based tool and composite metric that serves as a proxy for health disparities.

- Mapped PQIs for facilities and overlaid on CNI maps.

- Rates of preventable ED and inpatient utilization for patients from communities with high (negative) CNI rankings were over **twice as high** as other communities.

- Most patients are **uninsured and underinsured**.

- Proactive investment represents good stewardship, freeing **charitable resources for other purposes**.
## CNI Scoring Comparison

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Indicator</th>
<th>Indicator %</th>
<th>Barrier Score</th>
<th>Indicator %</th>
<th>Barrier Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Barrier</td>
<td>Elderly Poverty</td>
<td>10%</td>
<td>5.0</td>
<td>4%</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Child Poverty</td>
<td>28%</td>
<td></td>
<td>2%</td>
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<tr>
<td></td>
<td>Single Parent Poverty</td>
<td>46%</td>
<td></td>
<td>11%</td>
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</tr>
<tr>
<td>Cultural Barrier</td>
<td>Minority Population</td>
<td>98%</td>
<td>5.0</td>
<td>8%</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Limited English</td>
<td>20%</td>
<td></td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Education Barrier</td>
<td>Without HS Diploma</td>
<td>44%</td>
<td>5.0</td>
<td>3%</td>
<td>1.0</td>
</tr>
<tr>
<td>Insurance Barrier</td>
<td>Unemployed</td>
<td>12%</td>
<td>5.0</td>
<td>3%</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Uninsured</td>
<td>32%</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Housing Barrier</td>
<td>Renting %</td>
<td>58%</td>
<td>5.0</td>
<td>13%</td>
<td>1.0</td>
</tr>
<tr>
<td>Final CNI Score</td>
<td></td>
<td>--</td>
<td>5.0 (high need)</td>
<td>--</td>
<td>1.0 (low need)</td>
</tr>
</tbody>
</table>
Community Benefit and Health Reform

PAYMENT MODELS
- Fee for Service
- Episode-Based Reimbursement
- Partial---Full Risk Capitation
- Global Budgeting

INCENTIVES
- Conduct Procedures
  - Evidence-Based Medicine
  - Risk-adjusted PFP
- Expanded Care
- Reduce Obstacles to Fill Beds
- 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
# Towards CCHHs

## Medical Model Population Health
- Assess patient health status
- Ensure timely access to clinical services and medications
- Clinical case management through team-based care
- Patient education
- Use EMR to ID and group risk populations, monitor service utilization and patient outcomes

## Place-Based Population Health
- Assess patient health status, *social and environmental risk factors*
- Ensure access to clinical services & link to *social support systems*
- Case management through clinical and *community-based teams*
- *Community-based* education, *problem solving, and advocacy*
- Use *EHR* and *GIS* to identify geo conc. of *health disparities, target interventions,* & monitor population health outcomes

Lament persistent patient noncompliance

Leverage resources through *strategic engagement* of diverse stakeholders

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**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
Defining the Boundaries
Breaking Down Complex Issues with Problem Analysis

Root Causes
- En vivo smoking
- Indoor triggers
- Poor housing
- External Air
- Poverty
- Genetic Predet.

NT Causes
- 2nd hand Smoke
- Lack of Knowledge
- Poor medical Mgmt
- Helplessness

Immune Distress
- School/Work Absence
- Poor Aca. Performance
- High Svts Utilization

Asthma
- Reduced Productivity
- Low self Esteem
- Medical care dependence

NT Impacts
- High Morbidity
- Reduced Career options

LT Impacts
- High Svts Utilization
- Low self Esteem
- Medical care dependence
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
Housing
Lack of social capital

Stress

High Demand-Low Control Jobs
Lack of access to stores, jobs, services
Crime

Source: Anthony Iton, MD, JD, SVP, The California Endowment
## Strengthen Family and Neighborhood Support Systems

<table>
<thead>
<tr>
<th>Content Focus Area</th>
<th>Indicators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child development center</td>
<td>Improved academic performance</td>
<td>Improved child intellectual and emotional function</td>
</tr>
<tr>
<td>Child care cooperative</td>
<td>Decrease in “latchkey” children</td>
<td>Decreased child abuse</td>
</tr>
<tr>
<td>Leadership development</td>
<td>Decreased parent work absence</td>
<td>Decreased domestic abuse</td>
</tr>
<tr>
<td>After school programs</td>
<td>Decreased suspension/expel</td>
<td>Increased property values</td>
</tr>
<tr>
<td>Neighborhood watch</td>
<td>Decreased juvenile delinquency</td>
<td>Decreased dropout rate</td>
</tr>
<tr>
<td>Community garden</td>
<td>Increased access to fresh produce</td>
<td>Decreased youth violence-related injuries</td>
</tr>
<tr>
<td>Neighborhood skills bank</td>
<td>Increased civic activity</td>
<td>Decreased pre-diabetes/diabetes</td>
</tr>
<tr>
<td></td>
<td>Increase local income generation</td>
<td>Decreased burglary/vandalism</td>
</tr>
<tr>
<td></td>
<td>Decreases purchase of goods and services outside neighborhood (import substitution)</td>
<td>Increased youth employment</td>
</tr>
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Expanding Alignment:
Health and Community Development
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 **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.
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

• Areas of Focus
  – Housing development – renovation
  – Housing – health services – retail (e.g., food)
  – CHC development / expansion in scope of services
  – Child care / development
  – Small business / job development

• Alignment Strategies
  – Geo focus in targeted neighborhoods (rather than regional) aligned with hospital/PH interventions
  – Social capital investments, foundation grants to address pre-development obstacles to focused investment
Bayview/Hunter’s Point
Hunters View
Alice Griffin
Portrero Hill
Visacion Valley
Sunnydale
Tenderloin
Chinatown

Vulnerable Populations Footprint tool at www.chna.org
Tract status for Community Reinvestment Act (CRA) eligibility, as of 2012
COLLECTIVE IMPACT
Collective Impact\textsuperscript{1} – 5 Conditions

- **Common Agenda**
  - “All participants have a shared vision for change, one that includes a common understanding of the problem and a joint approach to solving it through agreed upon actions.”

- **Shared Measurement Systems**
  - “Agreement on a common agenda is illusory without agreement on the ways success will be measured and reported.

- **Mutually Reinforcing**
  - “Encouraging each participant to undertake the specific set of activities at which it excels in a way that supports and is coordinated with the actions of others.”

- **Continuous Communication**
  - “All the collective impact initiatives we have studied held monthly or even biweekly in-person meetings among CEO-level leaders.”

- **Backbone Support Organizations**
  - “The expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails.”

\textsuperscript{1} - John Kania & Mark Kramer, Stanford Social Innovation Review, Winter 2010
Obesity – Collective Impact Approach

**Public Sector**
- Public Health
- Parks and Recreation
- Community Development

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

**Backbone Entity**
- CBOs/Coalitions
- Local Philanthropy

**Shared Metrics**
- ↓ Diabetes PQI
- ↑ Food Access
- ↑ + Options in schools
- ↑ Awareness/knowledge
- ↑ Physical activity

**TOD/Walkability**
- Affordable HSG with support services
- Grocery/Corner store development
- Child care/development
- Façade Renovation
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
- Collaboration with CHCs
- Intersectoral Shared Ownership
- Data Sharing
- Quality Improvement
- Measurable Outcomes
- Sustainability

Community Development

- Transactional Orientation
- Reduce Risks
- Close the Deal
- Build Track Record
- Stimulate Replication