Alignment of Governance & Leadership in Healthcare

Building Momentum for Transformation

Proceedings Report

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THE GOVERNANCE INSTITUTE

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Preface

Held October 29–30, 2016 at the Omni Nashville Hotel in Nashville, TN, *Alignment of Governance & Leadership in Healthcare: Building Momentum for Transformation* brought together a distinguished group of faculty with chief executives, board chairs and directors, and clinical and administrative leaders from healthcare organizations across the country to discuss critical issues related to community benefit and community health. Key questions discussed at the meeting included the following:

- Is the organization directing charitable resources towards proactive strategies that address key drivers of poor health in local communities?
- Is there strategic coordination between community benefit, finance, and population health planning?
- Has the organization built partnerships with external community stakeholders to align and leverage your resources?
- Is addressing social determinants for health a priority for the organization?
- Is the organization working to eliminate the root causes of preventable disease and subsequent health costs?

Supported by the Robert Wood Johnson Foundation (RWJF) and co-sponsored by The Governance Institute, Stakeholder Health, and the Public Health Institute, this conference is part of a larger initiative designed to support non-profit hospitals and health systems in building, managing, and maintaining an effective, tailored population health and community benefit strategy in partnership with local community stakeholders. This proceedings report summarizes the presentations and discussions from the meeting.

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Executive Summary

Held October 29–30, 2016 at the Omni Nashville Hotel in Nashville, TN, *Alignment of Governance & Leadership in Healthcare: Building Momentum for Transformation* brought together a distinguished group of faculty with representatives from not-for-profit hospitals and health systems to discuss critical issues related to community benefits and community health. Supported by the Robert Wood Johnson Foundation (RWJF) and co-sponsored by The Governance Institute, Stakeholder Health, and the Public Health Institute, this conference is part of a larger initiative designed to support non-profit hospitals and health systems in building, managing, and maintaining an effective, tailored population health and community benefit strategy in partnership with local community stakeholders.

This executive summary and the full proceedings report that follows summarize the presentations and discussions that took place at the meeting.

Board and Leadership in a Time of Profound Change: Building the Optimal Partnership

Hospital and health system boards and senior leaders cannot improve community health unless they work effectively together. Key lessons from organizations that have developed effective board-senior leader partnerships include the following:

- **Start the discussion today, being proactive and intentional:** Boards should begin talking about the social determinants of health today. They should think about community health improvement as a strategy for positioning the organization, not as a requirement imposed by the government.
- **Consider bringing in additional outside leaders and board members**: Existing boards and senior administrators may not have the experience, skills, or expertise to lead the transformation on their own. Success requires a totally different mindset and thought process.
- **Pursue risk-based contracts**: Full-risk contracts can give an organization experience in taking responsibility for an entire population and hence a strong financial incentive to begin addressing the social determinants of health.
- **Identify the right partners**: Success depends on collaborating with other community stakeholders, including other hospitals and health systems that may still be viewed as competitors. Success also requires working with unfamiliar partners, such as churches, synagogues, mosques, schools, fire departments, public health departments, developers of affordable housing, transportation companies, and others.
- **Know when to lead (and when not to lead)**: Some initiatives will benefit from hospital leadership while others will do better if the hospital remains in the background, acting as a trusted broker that brings parties together.
- **Review community benefit assessment and reporting processes**: Boards should become more involved in the development, review, and monitoring of community health needs assessments (CHNAs) and related implementation plans, and make sure they are integrated into organization-wide strategic plans. In addition, boards and senior leaders should review and consider revamping community benefit reports.
- **Regularly meet and engage with the community**: Boards and senior leaders need to do a better job of listening to residents and stakeholders. During meetings, purposely avoid looking at the world through the traditional clinical care lens of a hospital or health system, instead opening up to the possibility of addressing housing, food security, and other social determinants of health.
- **Put CEO and senior management compensation at risk**: Payouts should be dependent on performance in transforming the organization and enhancing the focus on community health improvement and the social determinants of health.
- **Allocate human and financial resources to this effort**: Allocations can include both internal funds (e.g., a fixed portion of operating profits) and external sources of capital.
- **Create the right metrics and time frames**: Hospitals and health systems should consider creating a community health dashboard that the board reviews every quarter. Leaders should insist on generating a positive return, but also recognize that success should be measured differently than with traditional interventions, both in terms of measures and time frame.

Making the Journey to Population Health Easier: The Cambridge Health Alliance Story

Background

Cambridge Health Alliance (CHA) is an integrated care delivery system serving 100,000 patients across seven cities. CHA embarked on a journey to transform its system, focusing on five key shifts that needed to take place:

- From a healthcare system to a connected health and well-being system that brings together everything needed to affect social, health, and spiritual well-being.
- From working on equity as a way to "do good" to recognizing that everyone is interconnected and hence cannot afford the price of poverty and inequity in terms of both health outcomes and costs.
- From scarcity to abundance, viewing this challenge as an opportunity to transform the system.
- From pathology to vision and the recognition that change is possible.
- From communities of poverty to communities of solution and untapped potential that can be leveraged to produce better outcomes.

Examples of some of the major changes made include the following:

- **Emergency department (ED) redesign**: CHA sees its ED not as a portal for patients to enter the hospital, but as a vehicle for connecting them with a primary care medical home.
- **Complex care management**: CHA focuses on providing care management support for the most complex patients. The goal is to understand what is going on in their lives and address any issues that may be affecting their health, including social determinants of health. Overall, these and other programs have helped to cut ED visits in half, reduce hospitalizations by 40 percent, cut total costs by 30 percent, and enhance access to primary care doctors.
- **Integrated mental health**: CHA briefly screens all patients for behavioral health issues and refers those who screen positive to an in-house team led by social workers who have support via telemedicine from behavioral health physicians. CHA also has a mental health registry to help in managing patients proactively.
- **Team-based care**: Multidisciplinary teams care for patients, with teams including receptionists and medical assistants who receive training on how to interact with the patient.
- **Cross-sector collaboration**: CHA has many cross-sectoral partnerships. For example, CHA has worked with the schools and the public health department to address childhood asthma, leading to a 90 percent decline in hospitalizations. CHA uses a similar approach with diabetes.

These initiatives and others have helped CHA achieve the following:

- Meaningful improvement in patient experience scores
- Total cost reduction of 10 percent (15 percent compared to others serving Medicaid managed care enrollees), with the savings reinvested to address the social determinants of health
- Improved quality health outcomes to levels above the 90th percentile nationally
- Significantly enhanced joy and deriving meaning for its workforce

Key lessons in CHA's transformation include the following:

- Build patients into the improvement and transformation process, tapping their expertise early. Patients should be more than just advisors, but rather full partners in redesigning direct services, systems, and policies at the institutional and community level.
- Recognize that every population is different, and organizations need to understand—and design programs specifically for—each population.
- Align the financial, clinical, and policy aspects of the transformation.
- Recognize the importance of executing a cultural transformation in what is essentially a human system.
- Eliminate silos in the patient's health continuum, both within and beyond the delivery system.
- Leverage information technology as a critical facilitating factor.

Mission, Faith, and Community: Reawakening Core Values in Tumultuous Times

Large, integrated health systems have embraced investing in the community and community health as a core part of their mission and values, even during tumultuous times. In each case, the founders and leaders view caring for the poor and underserved as a central part of their organization's identity.

- **Providence Health & Services**: In 1859, Mother Joseph started the Sisters of Charity of the House of Providence of the Territory of Washington. She helped to build 30 hospitals, schools, and orphanages. On her deathbed, she reminded her sisters that "whatever concerns the poor is always our affair." Providence Ministries continue to work to improve the health of local communities, living by the mission statement: "As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service."
- **Loma Linda University Health**: Loma Linda University Health has its roots in 1905 when a pastor named John A. Burden started the Loma Linda Sanitarium. While the campus today may look like corporate America with new buildings, the organization remains committed to its roots and its mission of "putting faith and health together to make a difference in people's lives."
- **Baptist Memorial Health Care System**: The leaders of Baptist Memorial Health Care System in Memphis recognize that the vast majority of patients have families and other mediating social structures in their lives. As a result, they have organized and staffed an effort to connect over 600 faith-based organizations with Baptist.
- **Wake Forest Baptist Health**: Since the organization's founding, the healing ministry of the hospital has been directly connected to the healing ministry of churches. In 2016, over 2,000 clergy will visit Wake Forest Baptist Medical Center. The health system partners with these individuals, helping them to be positive, disruptive forces in people's lives, including supporting patients when they return home.

Community Health and Development: New Avenues in Partnership and Financing

Banks, community development financial institutions (CDFIs), public and private payers, and other organizations can be potential partners to hospitals and health systems that commit to improving community health. This section describes two examples of communities that have tapped into these sources and provides more information on one potential source of financing: CDFIs.

Vermont Blueprint for Health

The U.S. healthcare delivery system is in the midst of a transformation. Most of the work has been focused on moving from an acute care delivery system that provides episodic, non-integrated care to a coordinated, seamless system that takes accountability for delivering good outcomes. However, there is another equally—if not more—important step that needs to take place—transformation to a community integrated healthcare system. Vermont's approach to this transition (known as

Blueprint for Health) involves the creation of patient-centered medical homes (PCMHs) with embedded community health teams. It relies on innovative partnerships with public and private payers that agree to make global payments to the PCMHs.

Dignity Health System

Dignity has a wide array of programs designed to enhance the health of the communities it serves, including community grants, social innovation partnership grants, internal efforts to reduce Dignity's carbon footprint, and a $100 million community investments program that provides below-market rate financing to non-profit organizations, including CDFIs.

The Reinvestment Fund (TRF)

TRF and other CDFIs attempt to address the health equity problems found in the low-income neighborhoods that are home to one-fifth of all Americans. TRF has made $1.8 billion in investments since 1985; it has one of the largest loan funds in the country among CDFIs, with $950 million in total capital under management and $318 million in outstanding loans. Through partnerships in communities across the country, TRF channels resources to build affordable homes, quality schools, supermarkets, and health centers, all with an eye toward creating more vibrant neighborhoods. Within the health arena, TRF has a vehicle to finance clinics, community hospitals, specialty sites, and multi-purpose facilities.

Coming to Grips with the Social Determinants of Health: New Forms of Leadership and Advocacy at ProMedica

ProMedica's board adopted the Anchor Institute model to facilitate execution of its transformation. ("Anchor" institutions are large organizations that tend not to move location. As place-based anchors of communities, they naturally focus on the long-term welfare of the communities they serve.) ProMedica is committed to investing substantial sums of money in the local community, agreeing to absorb meaningful losses in the near term to promote long-term benefits, including enhanced health status and a stronger local community. Specifically, ProMedica supported the following kinds of activities: business incubation/innovation, local purchasing, access to education and the arts/culture, affordable housing, financial services, public safety, healthy neighborhoods, and environmental stewardship. To date, efforts have targeted obesity, hunger, infant mortality, mental health/substance abuse, urban revitalization, unemployment, and inadequate housing.

Board Role in Building and Sustaining a Commitment to Community and Transformation: Henry Ford Health System

Henry Ford Health System is a $5.6-billion not-for-profit health system with five acute care hospitals, two psychiatric hospitals, several hundred ambulatory sites, and a 700,000-member health plan. Several years ago, the system board created an *ad hoc* governance review committee that subsequently authorized a benchmark study to compare Henry Ford's governance

structures to those of other similar health systems. The recommendations to come out of this benchmarking study included the following:

- Reduce the size of the system board.
- Lengthen meeting times and eliminate slide presentations to free up more time for discussion.
- Move committee and full board meetings to consecutive days.
- Look for board members with new competencies, including population and community health.
- Encourage community investment by board members.
- Provide updates to board members between meetings.

Going forward, the hope is that the system board will do more to "push" management and the organization as a whole in the areas of population and community health. While the organization has been very active in these areas for a long time, these efforts have been driven primarily by senior leaders and staff, not the board.

Key Takeaways and Next Steps

Board- and Leadership-Related Lessons

- Recognize that success requires changes in how hospitals and communities work together to leverage the limited resources available. No single party can address these issues on its own.
- Engage boards in community health and ensure that they have the right skill sets, competencies, and connections to support senior leaders in taking the bold steps required.
- Adopt governance structures that ease control- and power-related fears among partners.
- Honor one's commitments and model that behavior repeatedly.
- Dedicate board time to discussing these issues.

- Regularly elicit input from patients and communities on how the organization is performing and what it could be doing differently.
- Begin collaborating with competing hospitals and health systems on community health.
- Consider the potential for partnerships with a broad array of community-based organizations.
- Develop the right language to articulate the importance of community health and population health, including how they fit into the organization's mission, vision, and strategic plan.

Operational Lessons

- Align community health and population health functions internally.
- Integrate community and population health into strategic plan development. Board discussions should feed into annual plans, both inside and outside the organization.
- Lengthen the expected timeframes for success.
- Create an enhanced measurement scorecard to monitor ongoing performance.
- Embed community health teams and mental health professionals within primary care practices and EDs, and invest in capacity to promote better oral health in the community.
- Investigate collaborative partnerships to address hunger.
- Take a fresh look at community benefit reporting activities.

Policy-Related Lessons

- Advocate for payment and other public policy reforms.
- Assess the need for institutional policy changes.

Next Steps

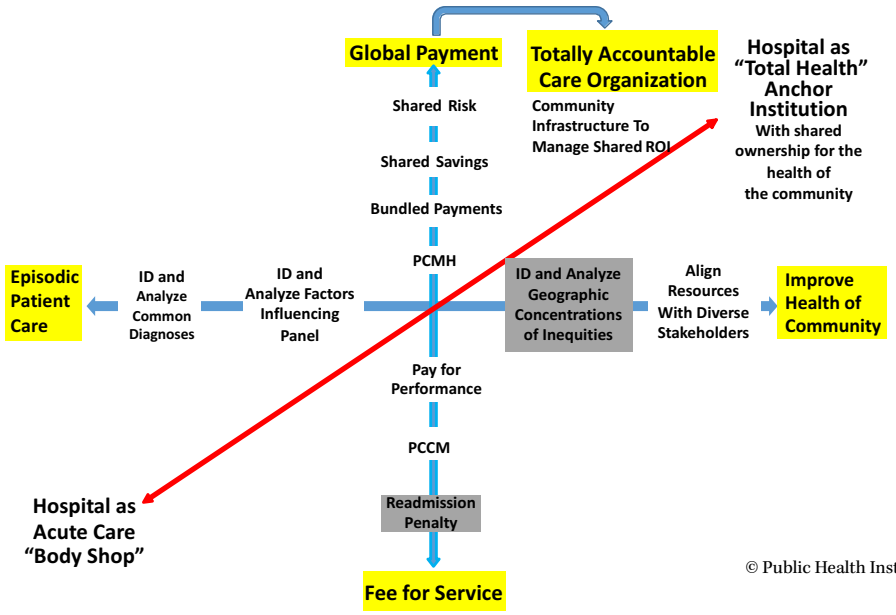
With support from RWJF, The Governance Institute, Public Health Institute, and Stakeholder Health will host conference calls and/or Webinars every other month during which health systems can report on and discuss their current activities, including obstacles, challenges, opportunities, and emerging lessons. These calls will provide an opportunity to continue the dialogue and support each other in moving forward. Future AGLH programs will be held in 2017 and The Governance Institute will follow up with participating organizations in 12 to 18 months to capture progress and lessons learned.

Introduction and Background

Jona Raasch; Kevin Barnett, Dr.P.H., M.C.B.; Gary Gunderson, M.Div., D.Min., D.Div. (Hon); Teresa Cutts, Ph.D.; and Hilary Heishman

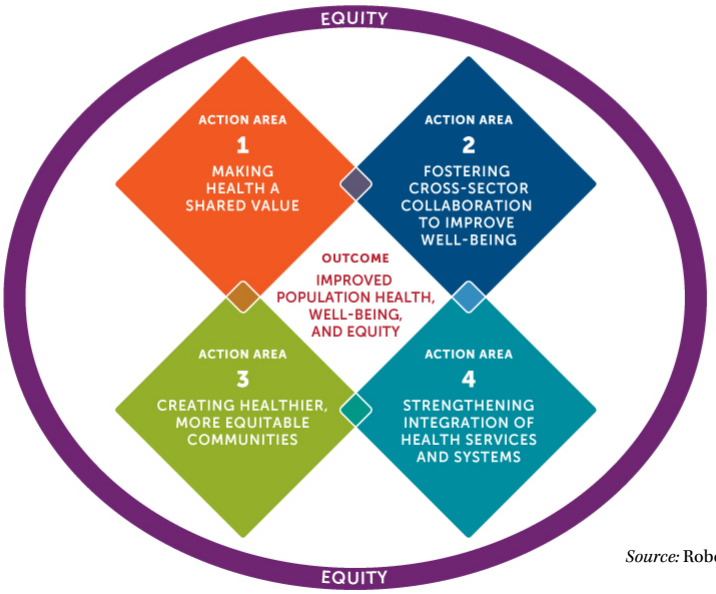
Not-for-profit hospitals and health systems are in the midst of a major transformation, going from being acute care "body shops" to managing "total health." Driven by the movement from fee-for-service (FFS) to global payments (as depicted on the vertical axis in **Exhibit 1**), these organizations are transforming themselves from focusing primarily on episodic care to improving community health (as shown on the horizontal axis).

Exhibit 1: Healthcare Transformation Continuum



As shown in **Exhibit 2**, the goal is to create what Robert Wood Johnson Foundation calls a "culture of health" that results in improved population health, well-being, and equity.

Exhibit 2: Culture of Health Action Framework



Source: Robert Wood Johnson Foundation.

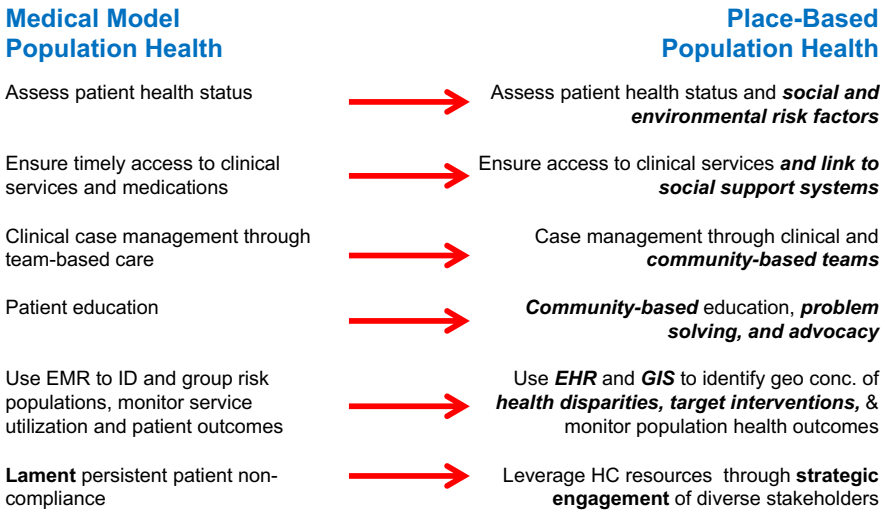
"We must hold institutions accountable for what is possible in the future. The primary job for boards is to look to the future, not the past. Everyone probably has the same idyllic view of the future, but the 'plumbing' for how to get there will be different. The role of boards is to provide the 'plumbers'—that is, the resources and other support required to create that future."

—Gary Gunderson

Not surprisingly, integrated organizations operating under fixed payment systems are at the forefront of this transformation. Kaiser Permanente, for example, is leading the way in prevention of diabetes. Kaiser analyzed its diabetic population, discovering that it routinely lost millions of dollars on its 500,000 members with the disease. Concerned about the potential costs of its 1.2 million pre-diabetic members who might one day develop the disease, Kaiser began investing in a variety of upstream programs—often in partnership with community-based stakeholders—to identify and support these individuals in making the changes necessary to prevent diabetes.

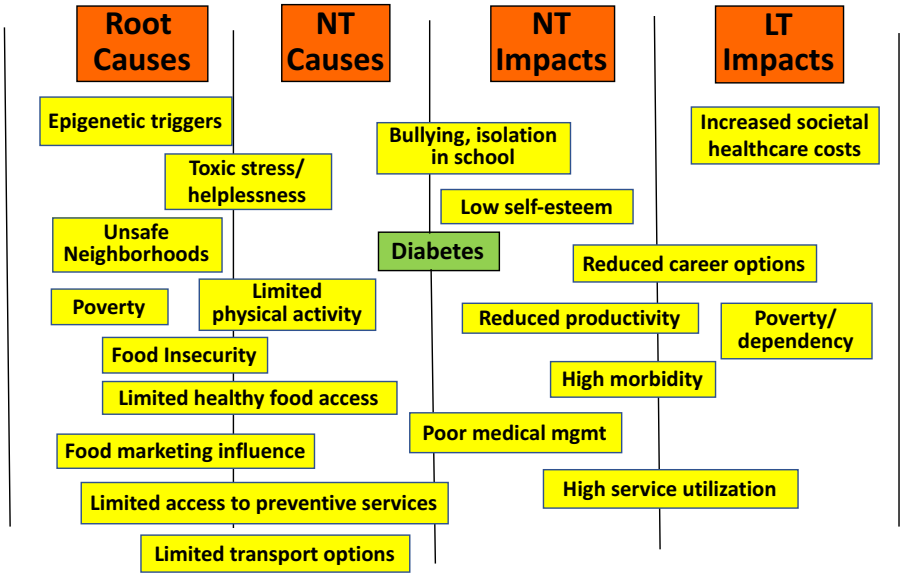
Executing this transformation effectively requires investments in "place-based" population health, which differs from the traditional medical model followed by most hospitals and health systems, as shown in **Exhibit 3**.

Exhibit 3: Population Health



It also requires recognizing and making a commitment to addressing the various inequities that exist outside of the healthcare arena that influence health, including inadequate housing, exposure to environmental hazards, limited access to healthy food sources and basic services, unsafe neighborhoods, lack of public space and sites for exercise, limited public transportation options, inflexible and/or poor working conditions, and chronic stress. Root-cause analyses of health problems such as diabetes often end up identifying these and related issues as the underlying drivers (see **Exhibit 4** on the following page).

Exhibit 4: Problem Analysis



To succeed, hospitals and health systems need adequate internal capacity to address population health, including staffing, financial resources, and internal structures, such as formal job descriptions, appropriate reporting relationships and oversight, and alignment with other departments (e.g., IT, finance). Rather than thinking of community benefit requirements as a compliance exercise, organizations need to integrate these functions with population health management activities, viewing them as drivers of the kinds of changes that need to be made. Working with others, hospitals and health systems need to begin addressing the social determinants of health, such as housing, job creation, and access to healthy food.

> "These are trying times in the healthcare industry, with lots of hard changes happening quickly. But it's also an opportunity to build well-coordinated, patient-centered, community-strengthening systems."
>
> —*Hilary Heishman*

Key arguments to convince the C-suite of the need for these types of investments include the following:

- Building population health capacity is an essential strategic investment that will enable the organization to thrive economically in the future.
- As with other investments, use an evidence-based approach, taking no action without appropriate measures and a realistic time-frame for demonstrating success.
- This strategy represents better stewardship of the limited resources available.
- The strategy brings a quality improvement approach to an area long in need of such discipline. The same approach is used everywhere else in the organization.
- The organization will not be executing this transformation on its own, but rather will reach out to other partners to foster shared ownership for health across sectors.

"A decade ago, quality was the number-one agenda item for the board. Now it's time to get community health and population health to the top of that list…the two largest not-for-profit health systems in the country have the word 'compassion' in their mission statements—specifically, compassion in the delivery of care and compassion for all, particularly the poor and underserved. All systems need to embrace the importance of compassion going forward."

—Jona Raasch

Boards play a critical role in successfully transforming, and organizations need boards with members who understand this role and have the right skills and competencies in these areas. Boards need to serve as a "think tank" that supports senior leaders, raising such questions as the following:

- What is the organization's vision of population health?
- Is there strategic coordination between community benefit, finance, quality, and care coordination?
- What efforts are being taken to build partnerships with other stakeholders to align and leverage resources?
- What is the organization's capacity for population health and community health (e.g., internal staff, competencies, reporting relationships, oversight structures, leadership accountability)?
- Does the organization have measurable objectives for community benefit programs, and are there processes and systems in place to monitor progress toward achieving them?
- What kind of leadership is the organization providing in the public policy arena?

Board and Leadership in a Time of Profound Change: Building the Optimal Partnership

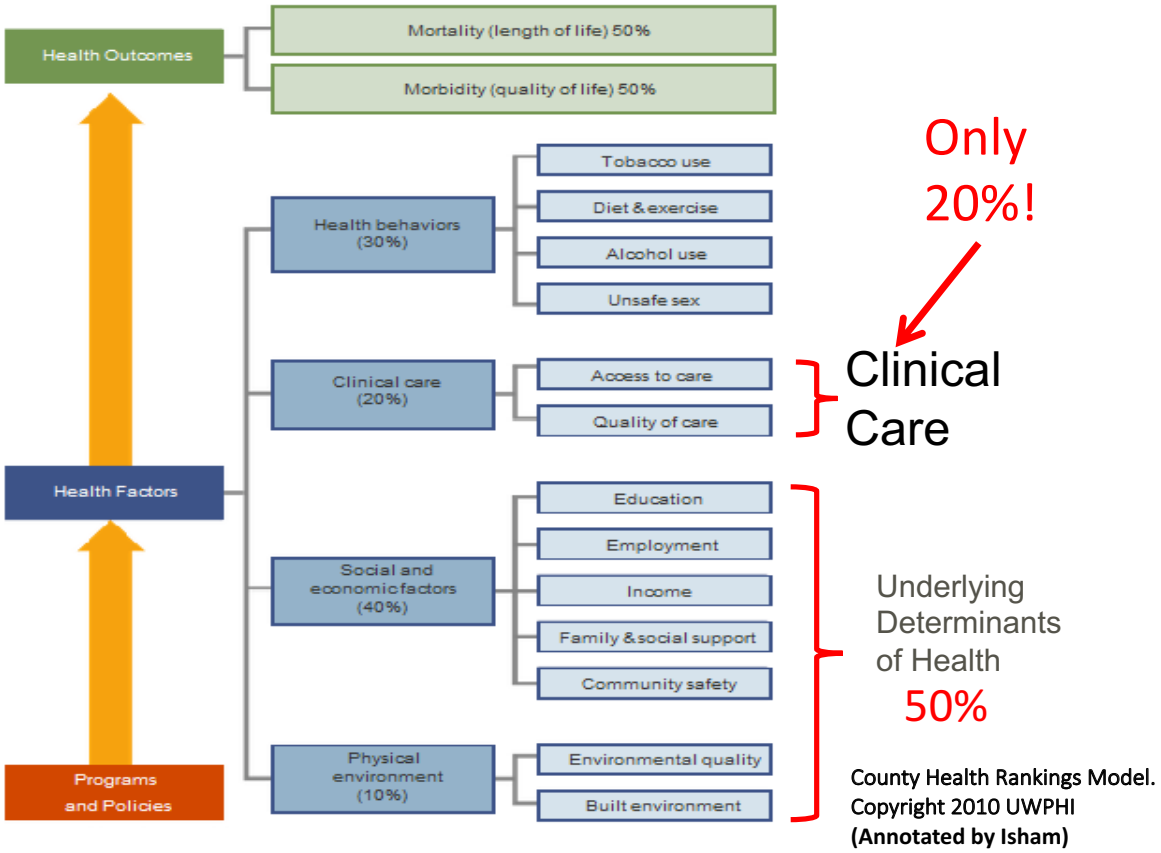
Hospital and health system boards and senior leaders cannot succeed in working with local stakeholders to improve community health unless they themselves work effectively together. This section profiles two organizations that have successfully developed effective board-senior leadership partnerships.

Health Partners

George Isham, M.D., M.S.

Health Partners is a large, integrated system with seven hospitals, a 1.5 million-member health plan, and employed physicians working in clinics throughout the Twin Cities area of Minnesota. Approximately 25 years ago, the organization's board began to recognize the important role the organization should play in improving community health. The board gave Dr. Isham the title of Chief Health Officer, charging him with overseeing Health Partners' role in working with community stakeholders to enhance the health of Twin City residents. Minnesota as a whole and Health Partners in particular already had a reputation for providing high-quality care. With the organization's 30 percent market share locally and 25 percent share throughout the state, the board felt that Health Partners could do more to get outside its walls to address the many non-clinical factors that drive health status. As depicted in **Exhibit 5**, clinical care accounts for only 20 percent of health, while health-related behaviors (30 percent), social and economic factors (40 percent), and the physical environment (10 percent) account for the remainder.

Exhibit 5: Clinical Care—Not The Primary Determinants Of Health



Early on, Health Partners began tackling issues such as tobacco use, which has dropped in Minnesota from 26 percent in the mid-1990s to 11 percent today. During this same period, the proportion of children exposed to secondhand smoke fell from 23 percent to 6 percent. As recently as 2010, however, Health Partners' board still pushed back to some degree about the idea of going beyond the familiar terrain of clinical care. Board members noted that Health Partners was "not the public health department" and hence should not play a role in addressing factors that fall outside of clinical care. To get around this issue, Dr. Isham began sharing data with the board that shows how spending on healthcare crowds out spending on other sectors that actually have a greater impact on health, such as education and housing. In Minnesota, for example, healthcare costs are expected to grow by 8.5 percent a year over the next 25 years. During this same period, state revenues will grow by 3.5 percent a year, meaning that spending on education will only be able to grow by 0.2 percent annually. Since these figures represent nominal dollars, real spending on education will fall significantly. The same story has historically been true in other states—in Massachusetts, for example, inflation-adjusted healthcare spending grew by 81 percent in the past 15 years, effectively forcing a 27 percent cut in education spending during this period.

Seeing this type of information opened board members' eyes to their responsibility to control costs as a *public health* intervention. It led the Health Partners board to adopt a new ethic related to financial management in healthcare, as detailed below:

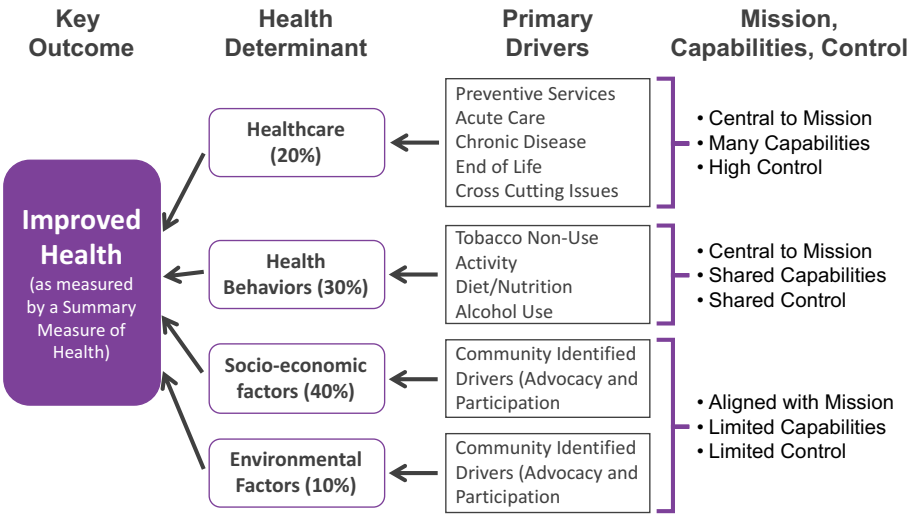
- Be financially responsible through good institutional financial management that generates adequate margins and a stable bond rating.
- Keep institutional cost and price increases under the rate of inflation, so as to do no further harm to society as a whole.
- Support a market dynamic that results in lower total costs of care for the community.
- Be a part of the solution to this pressing social issue by engaging in conversations and collaborative partnerships with other stakeholders.

"We weren't called to this work in order to destroy other people's futures."
—George Isham, M.D., M.S.

To succeed, Health Partners had to figure out its relationship to the broader social determinants of health. As shown in **Exhibit 6** on the following page, the provision of healthcare and the addressing of health-related behaviors are both central to Health Partners' mission. But while Health Partners has strong internal capabilities and control when it comes to providing healthcare, these capabilities and controls are shared with other stakeholders when it comes to addressing health-related behaviors. And while addressing socioeconomic and environmental factors is aligned with the system's mission, the organization has limited capabilities and control when it comes to addressing them. As a result, the Health Partners board and senior leaders decided to join with others to address these factors by becoming part of coalitions. They do this as followers and learners, not leaders.

"Make sure the CEO doesn't have so much of an ego that he or she has to lead everything. We have a lot to learn and need to be humble."
—George Isham, M.D., M.S.

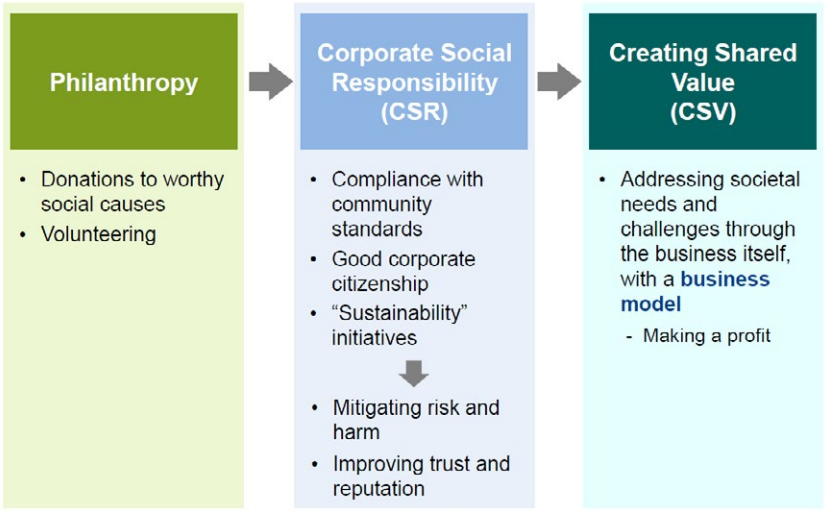
Exhibit 6: Figure Out Your Relationship to the Broader Determinants of Health



Source: Modified from G. Isham and D. Zimmerman, HealthPartners Board of Directors Retreat, October 2010.

Michael Porter of Harvard Business School developed a framework for thinking about the role of businesses in larger societal issues. This model (see **Exhibit 7**) can be useful to not-for-profit health system boards and leaders. While the activities in the philanthropic and corporate social responsibility columns of the chart are generally familiar to most health system boards and leaders, the trick is to migrate to the right side of the chart by creating shared value (i.e., addressing societal needs and challenges through the business itself, with a business model that can turn a profit).

Exhibit 7: Finding Shared Value



Howard University Hospital

James Diegel, M.S.H.S.A., FACHE

Mr. Diegel recently came out of retirement to become the CEO at Howard University Hospital. Founded in 1868 to serve the African-American community that came to Washington, D.C. after the Civil War, the hospital now lies within a rapidly changing community that is still home to many low-income, underserved populations.

Recognizing there is no cookie-cutter approach, Mr. Diegel is working to transform Howard into an organization attuned to the culture and needs of the local community. In doing so, he understands the need for disruption, innovation, and reinvention; for co-creation with local partners; for redeployment of resources; and for a certain amount of courage to lead. The focus needs to be both upstream, on the social determinants that affect health, and downstream, on what happens to patients after they receive care and return home. The key to success is to transform the organizational model. In his 2015 book *Reinventing Organizations*, French management consultant and organizational theorist Frederic LaLoux laid out a continuum of organizational models that have existed throughout history, as detailed below:

- **Reactive**: Beginning roughly 100,000 years ago, people began forming loose confederations.
- **Magic**: Roughly 15,000 years ago, people began to band together in tribes or groups to work with one another. This period marked the start of differentiated roles, such as hunter and gatherer, with people beginning to cooperate and collaborate with each other for the first time.
- **Impulse**: Beginning about 10,000 years ago, power emerged, with some people becoming leaders and directing others. Power often became concentrated in one or a few individuals, with the rest blindly following them. Impulse-based groups still exist today, with gangs and terrorist organizations such as ISIS being prime examples.
- **Conformist**: About 5,000 years ago, the emergence of command-and-control processes and procedures emerged, as seen with the advent of city-states. This period brought structure and stability to the world, with the future largely becoming the logical extension of the past. Many healthcare organizations still follow this model.
- **Achievement**: Approximately 1,000 to 2,000 years ago, profit and growth became formalized as legitimate organizational goals, with people taking accountability and being judged based on merit. Achievement organizations tend to be highly structured, well-oiled "machines" that are predictable and hence relatively easy to govern and manage. Most organizations, including those in healthcare, follow this model today.

> "What worked yesterday is not a prescription for transformation or what will work tomorrow. We must look through a non-linear lens."
>
> *—James Diegel, M.S.H.S.A., FACHE*

- **Pluralistic**: In the last century, culture and values have begun to drive some organizations, with the notion of "servant leaders" also emerging. The leaders of pluralistic organizations have a self-awareness of where they want the organization to go, and they regularly engage their employees in moving in that direction. These organizations tend to be both environmentally and family friendly. It takes a lot of energy to move to this level and stay there over time.
- **Evolutionary**: This new model is just beginning to emerge. It is characterized by constant change, which becomes a normal way of doing business. Evolutionary organizations adapt from within at every level. Power is decentralized, lying within self-organized, self-governing teams that own the functions and the work. People regularly move between teams; job titles and descriptions often do not exist. Teams take accountability for key decisions, such as salary increases. Strategy emerges organically, from the teams, which have an intuitive sense of where the market is going and what customers need. Evolutionary organizations have no formal executive team meetings; instead, senior leaders meet on an *ad hoc* basis only when critical issues arise. Regular interference by senior leaders would fundamentally undermine the evolutionary state of the organization.

The evolutionary model represents a fundamentally different way of running an organization. It is based on wholeness, inclusion, and trust in in-house talent. Success depends on recruiting the very best people and then getting out of their way. Evolutionary organizations are not separate from the communities they serve. In fact, at every level, teams interact with the outside world and interface with markets, products, customers, and vendors.

Going forward, Mr. Diegel is trying to move Howard University Hospital in this direction. Success will depend on the board and his entire C-suite buying into the concept and being willing to let go of traditional roles and approaches.

Key Takeaways

Faculty and conference attendees highlighted the following key lessons from the discussion about board-leadership partnerships:

- **Start the discussion today, being proactive and intentional:** Boards should begin talking about the social determinants of health today, both in the boardroom and with senior leaders. They should think about community health improvement as a strategy for positioning the organization, not as a requirement imposed by the government. If hospitals and health systems do not move in this direction on their own, the government will do it for them. Strategic plans must focus on new models for creating healthier communities. Boards should consider hosting a retreat on this topic that includes physician leaders and representatives from the community.
- **Consider bringing in outside leaders and board members:** Existing hospital and health system boards and senior administrators may not have the experience, skills, or expertise to lead the transformation. Success requires a totally different mindset and thought process. Strong, domineering CEOs may not fare as well as those focused on being a trusted broker within the community. Organizations may also need to focus on increasing diversity at the board and senior management level. Community stakeholders can help with this task.
- **Pursue risk-based contracts:** Full-risk contracts can give an organization experience in taking responsibility for an entire population and hence a strong financial incentive to begin addressing the social determinants of health.
- **Identify the right partners:** Success depends on collaborating with other community stakeholders, including competing hospitals and health systems along with unfamiliar community-based partners, such as churches, synagogues, mosques, schools, fire departments, public health departments, developers of affordable housing, transportation companies, barber shops, and others.
- **Know when to lead (and when not to lead):** Some initiatives will benefit from hospital leadership while others will do better if the hospital remains in the background, acting as a trusted broker that brings parties together.
- **Review community benefit assessment and reporting processes:** Boards should become more involved in the development, review, and monitoring of community health needs assessments (CHNAs) and related implementation plans, and make sure they are integrated into organization-wide strategic plans. In addition, boards and senior leaders should review and consider revamping community benefit reports, which often get put on a shelf never to be seen again.
- **Regularly meet and engage with the community:** Boards and senior leaders need to do a better job of listening to residents and other community stakeholders. During meetings, purposely avoid looking at the world through the traditional clinical care lens of a hospital or health system, instead opening up to the possibility of addressing housing, food security, and other social determinants of health.
- **Put CEO and senior management compensation at risk:** Any payout should depend on performance in transforming the organization and enhancing the focus on community health improvement and the social determinants of health. Mr. Diegel insisted that 25 percent of his compensation be put at risk, with the level of payment tied to his success in transforming the organization.
- **Allocate human and financial resources to this effort:** Allocations can include both internal funds (e.g., a fixed portion of operating profits) and external sources of capital. Health systems should create an "innovation fund" that earmarks 5 percent of the hospital's operating margin toward initiatives designed to advance the structural elements of the evolutionary model and to create a healthier community.
- **Create the right metrics and time frames:** Hospitals and health systems should consider creating a community health dashboard that the board reviews every quarter to get a sense of both current activities and their impact to date, including avoiding downstream costs such as unnecessary emergency department (ED) visits and inpatient admissions. Leaders should insist on generating a positive return, but also recognize that success should be measured differently than with traditional interventions, both in terms of measures and time frame. Efforts that begin now may not pay off for several years.

Making the Journey to Population Health Easier: The Cambridge Health Alliance Story

Soma Stout, M.D., M.S.

Background

Cambridge Health Alliance (CHA) is an integrated delivery system serving 100,000 patients across seven cities. With just under 3,400 employees, the system has 12 community clinics, two hospitals, three EDs, and numerous sites offering specialty care. Half of CHA's patients speak a language other than English and 70 percent have some form of public health insurance. Approximately 20 years ago, CHA faced a crisis that also became an opportunity. Historically reliant upon the state government for FFS payments, CHA received word from the governor that the state could not afford to pay $40 million it owed the system, and that upcoming payments of approximately $100 million were also at risk. Recognizing the inherent problems with reactive FFS medicine, CHA leaders decided to embrace the Institute for Healthcare Improvement (IHI) Triple Aim—simultaneously improving population health, the patient care experience, and per capita costs. CHA leaders decided to add a fourth aim as well—restoring joy and meaning to the CHA workforce. To make this approach work financially, CHA leaders began aggressively transitioning to risk-sharing and global payment arrangements. Over a five-year period, these payments went from 0 percent to 60 percent of total revenues. Going forward, CHA leaders expect this number to increase, as the Centers for Medicare and Medicaid Services (CMS) has set out the goal of having 80 percent of payments in "alternative" (i.e., value-based) payment models by 2020. Other payers are expected to follow suit.

Beyond their own predicament, CHA leaders also recognized the unsustainability of the existing FFS, episode-based model that dominates the industry. If current trends continue, healthcare costs will likely consume 20 percent of gross domestic product by 2020. The average family spends 30 percent of its take-home pay on healthcare expenses, and medical costs account for roughly half of all personal bankruptcies, making them the single largest cause of such bankruptcies in the country.

To succeed, CHA leaders knew they had to change the focus of the organization, away from providing acute, episode-based care to improving the health and well-being of the underserved communities that surround CHA facilities.

> "We had a moment of unprecedented opportunity—to build the health system that we all wanted to create when we entered this field."
>
> *—Soma Stout, M.D., M.S.*

Root Cause: Inequities That Lead to Increased Risk of Chronic Disease

CHA leaders began dissecting the root causes of excess spending and poor health outcomes. They quickly discovered that to really make a difference, the organization had to begin tackling systemic social inequities that lead to greater risk of chronic disease. For example, as shown in **Exhibit 8** on the following page, the U.S. spends $322 billion today caring for diabetes and pre-diabetes. By 2020, that figure will likely reach $550 billion.

Reducing these costs is not just about coaching and other interventions to get people to change health-related behaviors such as diet and physical activity. Rather, it requires addressing underlying social inequities that lead to greater likelihood of acquiring diabetes and other chronic conditions, and that make it much more difficult to manage them. For example, children exposed to toxic stress in early childhood have up to a 40 times greater risk of chronic disease (including diabetes) by age 50.

As shown in the map in **Exhibit 9** on the following page, health and social inequity are inextricably linked, with rates of childhood obesity within geographic areas closely mirroring levels of economic hardship.

Exhibit 8: Cost Of Inequity And Its Impact On Chronic Disease Is Unsustainable

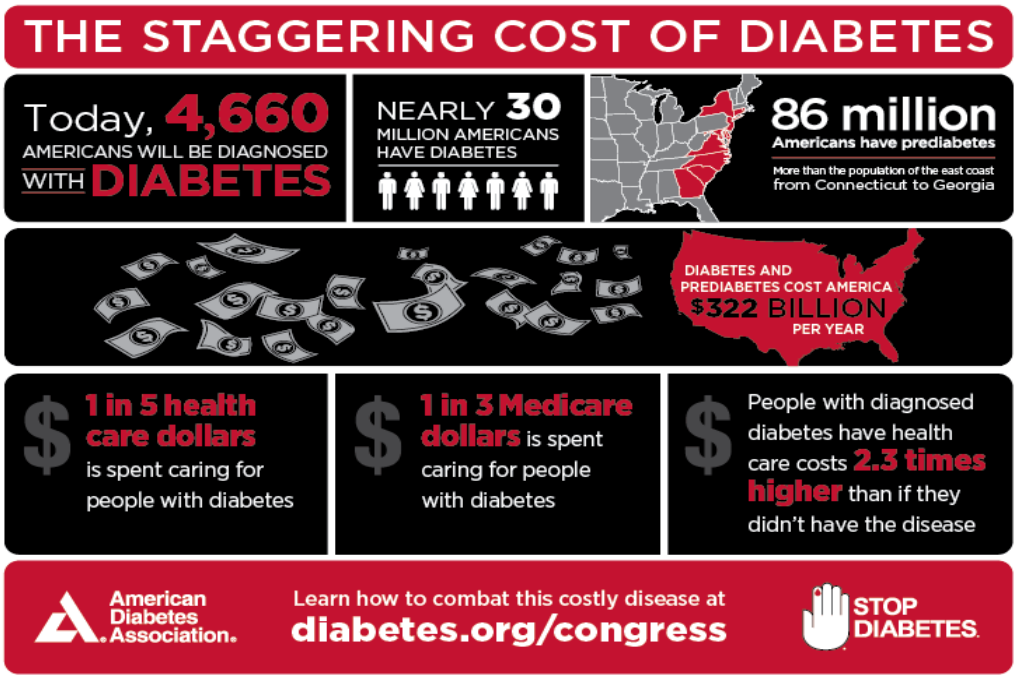
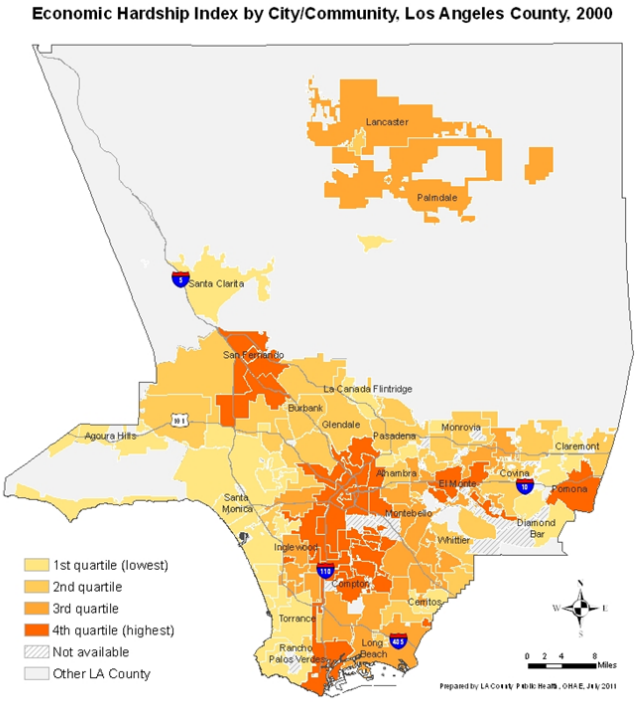
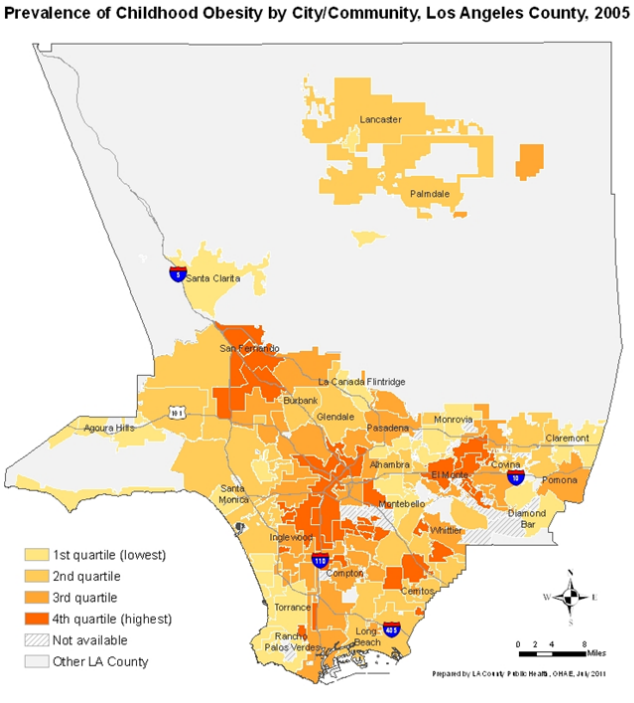


Exhibit 9: Health And Social Inequity Are Interconnected

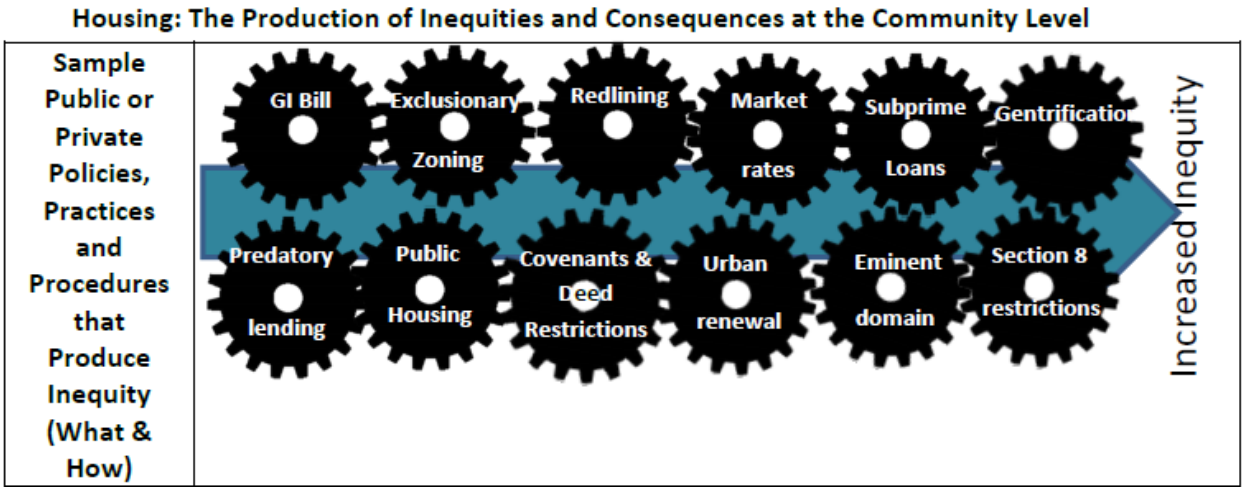




These place-based inequities are not accidental. Rather, the current systems propagate them. Various public and private policies, systems, practices, and procedures produce inequities and poor health outcomes (see **Exhibit 10**). Underlying these are larger societal issues, including racism, poverty, gender bias, and related stigmas. Without recognizing and addressing these issues, all the individual health coaching in the world will not make much of a difference.

Exhibit 10: Chronic Inequities That Are Place-Based Are Not Accidental—There Is a System in Place that Propagates Them

Chronic contributors: Racism, Poverty, Gender, Stigma



Source: "What Happened to You?" Report from the Prevention Institute.

> "We have to recognize the systemic issues. We can do all the individual behavior coaching we want, but unless we address the systemic issues, we are just throwing buckets of water on a fire."
>
> —*Soma Stout, M.D., M.S.*

Transforming the System

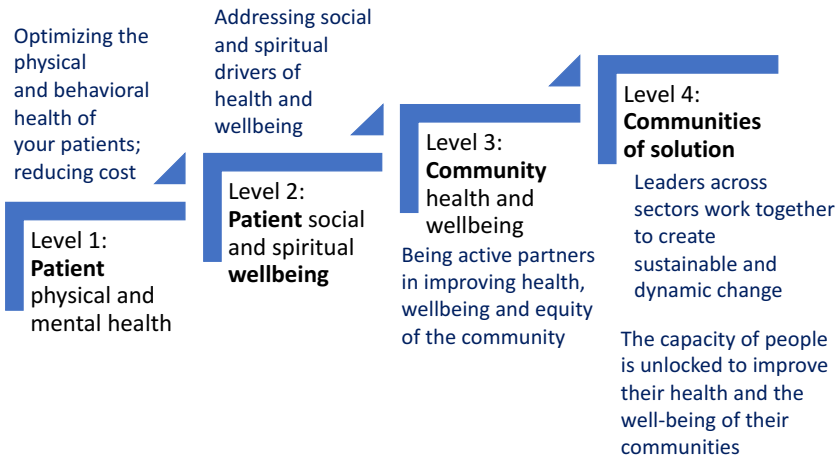
CHA embarked on a journey to transform its system, focusing on five key shifts:

- From a healthcare system to a connected health and well-being system that brings together everything needed to affect social, health, and spiritual well-being
- From working on equity as a way to "do good" to recognizing that everyone is interconnected and hence cannot afford the price of poverty and inequity in terms of both health outcomes and costs
- From scarcity to abundance, viewing this challenge as an opportunity to transform the system
- From pathology to vision and the recognition that change is possible
- From communities of poverty to communities of solution and untapped potential that can be leveraged to produce better outcomes

CHA followed the IHI model developed as part of the *100 Million Healthier Lives* campaign. This model focuses on four levels of change.

- Level 1: The patient's physical and mental health
- Level 2: The patient's social and spiritual well-being
- Level 3: The community's social and spiritual well-being
- Level 4: Communities of solution, where the capacity of the community itself is unlocked to address the problems it faces

Exhibit 11: Shaping The Path: Healthcare



Using this approach, CHA achieved the following:

- Meaningful improvement in patient experience scores
- Total cost reductions of 10 percent (15 percent compared to others serving Medicaid managed care enrollees), with the savings reinvested to address the social determinants of health
- Improved quality health outcomes to levels above the 90th percentile nationally
- Significantly enhanced joy and meaning among its workforce

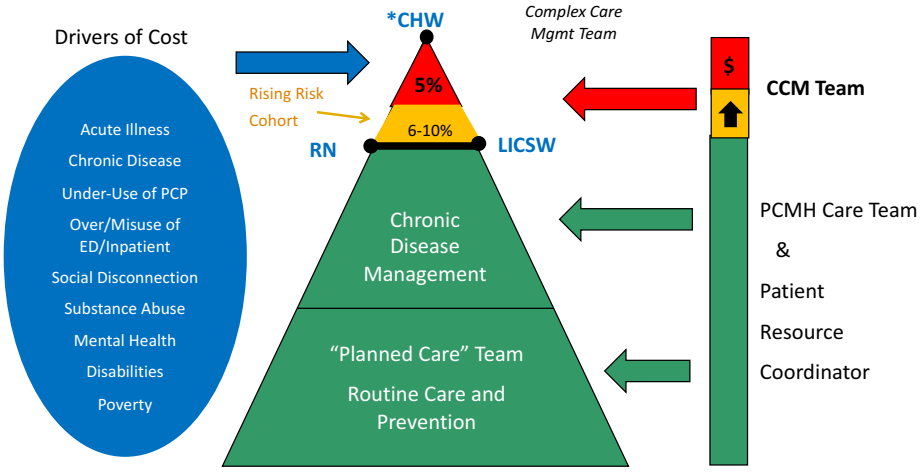
> "Improving health and well-being is our focus, not making money. Money is the fuel to create the impact, not the underlying motivation."
>
> *—Soma Stout, M.D., M.S.*

Examples of some of the major changes made at CHA include the following:

- **ED redesign**: CHA sees its ED not as a portal for patients to enter the hospital, but as a vehicle for connecting them with a primary care medical home (PCMH). To that end, CHA built effective support systems to make those connections. CHA also eliminated the triage nurse, instead using a friendly "greeter" who asks a few screening and triage questions. This change and others led to dramatically decreased wait times, to the point that 94 percent of ED patients see a doctor within 20 minutes of arrival. Even with increases in ED volume, average wait times have never exceeded three minutes in the last five years.
- **Complex care management**: As illustrated in **Exhibit 12** on the following page, CHA focuses on providing care management support for the most complex patients. The goal is to understand what is going on in their lives and address any issues that may be affecting their health, including social determinants of health. Overall, these and other programs have helped to cut ED visits in half and reduce hospitalizations by 40 percent for this population. At the same time, there has been a greater than 100 percent improvement in getting this subset of patients in to see their primary care doctors and a 30 percent reduction in their total costs.
- **Integrated mental health**: Because one in five patients has a mental health issue, CHA briefly screens all patients for mental health issues and refers those who screen positive to an in-house team led by social workers who have support via telemedicine from behavioral/mental health physicians. CHA also has a mental health registry to manage patients proactively, through steps such as the routine screening of patients with diabetes for depression.

- **Team-based care**: Multidisciplinary teams care for patients, with teams including receptionists and medical assistants (MAs) who receive training on how to interact with the patient. Patients often share things with frontline staff and MAs that they may not be comfortable saying to the doctor. The entire team meets each week for 30 minutes to discuss patients, while MAs and doctors have brief five- to 10-minute huddles each day. Teams meet monthly with integrated specialists (e.g., mental health professionals, care coordinators) to review patients on their shared panel.
- **Cross-sector collaboration**: CHA has many cross-sectoral partnerships. For example, it works with school nurses to give them access to the registry of students with asthma so they can identify symptoms early. CHA also works with the public health department to get nurses into the homes of these children to screen for mold and other potential issues. Through these and other efforts, hospitalizations for childhood asthma have fallen by 90 percent. CHA uses a similar approach with diabetes, working with schools to increase consumption of fruits and vegetables and levels of physical activity. CHA also supports collaborative efforts to make it easier for low-incomes students to get a healthy breakfast in school.

Exhibit 12: The CHA Model



Care Management Staff Model – Top 5-10%

*Community Health Worker

"Make health and well-being a community way of life. Don't wait to start working across the community."

—Soma Stout, M.D., M.S.

Lessons Learned

Key lessons in CHA's transformation include the following:

- Build patients into the improvement and transformation process, tapping their expertise early (see **Exhibit 13** on the folowing page). Patients should be more than just advisors, but rather full partners in redesigning direct services, systems, and policies at the institutional and community levels (see **Exhibit 14** on the following page).
- Recognize that every population is different; organizations need to understand—and design programs specifically for—each population.
- Align the financial, clinical, and policy aspects of the transformation.
- Recognize the importance of executing a cultural transformation in what is essentially a human system.
- Eliminate silos in the patient's health continuum, both within and beyond the delivery system.
- Leverage IT as a critical facilitating factor.

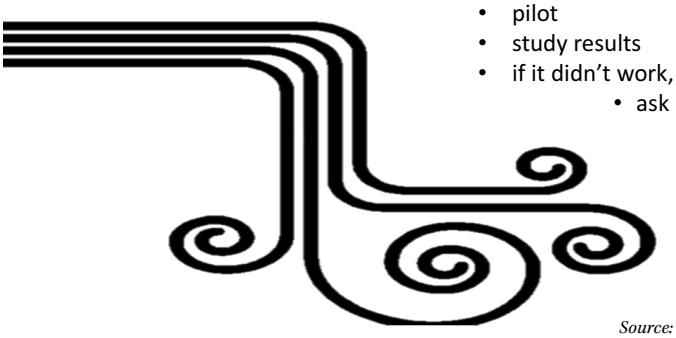
Exhibit 13: Building Patients Into Process Improvement Strategy

Upstream

- define the problem with the patient
- design potential solution together
- pilot
- study results
- If it didn't work, ask team (incl. patient)

Downstream

- Clinic defines problem
- Clinic designs potential solution
- pilot
- study results
- if it didn't work, ask staff
    - ask patient
        - redefine
        - redesign
        - repeat



Source: Cambridge Health Alliance

Exhibit 14: Patients as Full Partners in Redesigning Care

	Consultation	Involvement	Partnership
Direct service or observation	Ask what they would want/ need in a service	Motivational interviewing integrated; health literacy	Peer to peer (CHW, VHA), collaborative planning
Community or system design and governance	Journey-mapping, surveys (before, during, after), focus groups	Advisory board, community members on taskforce and work groups	Community champions as part of leadership team
Policymaking	Community needs assessment, town hall meeting	Community recommendations drive change	Equal representation in decision-making over resources

Mission, Faith, and Community: Reawakening Core Values in Tumultuous Times

Kevin Barnett, Dr.P.H., M.C.P. (moderator); Gerald R. Winslow, Ph.D.; Gary Gunderson, M.Div., D.Min., D.Div. (Hon)

Drs. Winslow and Gunderson discussed how several large, integrated health systems have embraced investing in the community and community health as a core part of their mission and values, even during tumultuous times. In each case, the founders and leaders view caring for the poor and underserved as a central part of their organization's identity.

> "How do you put your heart into healthcare? How do you find the deeper reasons for why you are in this profession?"
>
> *—Gerald R. Winslow, Ph.D.*

Providence Health & Services

After going to the Pacific Northwest at a young age in the 1850s, a young woman later known as Mother Joseph entered the Sisters of Providence. She originally settled in Vancouver, WA, where she lived in the attic of a house with fellow sisters. She subsequently gave her life to caring for people in need. In 1859, she started the Sisters of Charity of the House of Providence of the Territory of Washington. She helped to build 30 hospitals, schools, and orphanages, often playing a direct role in their design and sometimes even helping to lay the bricks. (She was later recognized as the "First Architect of the Pacific Northwest.") On her deathbed, she reminded her sisters that "whatever concerns the poor is always our affair." To this day, the Providence Ministries continue to work to improve the health of local communities, living by the mission statement: "As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service."

Loma Linda University Health

Loma Linda University Health has its roots in 1905 when a pastor named John A. Burden started the Loma Linda Sanitarium after taking over ownership of a failed hotel. The site was later turned into a school of nursing and wellness center. Today, Loma Linda is a regional health system with six hospitals, 15,000 employees, eight health science schools, and several billion dollars in revenues. While the campus may look like corporate America with new, glitzy buildings, the organization remains committed to its roots and its mission of "putting faith and health together to make a difference in people's lives." The system serves a very diverse set of communities, an area where a freeway separates very wealthy neighborhoods from extremely poor ones. In fact, average life expectancy varies by as much as 20 years across these communities.

Over a decade ago, Loma Linda began an initiative known as the Summer Gateway Program. Each summer, this program gives 60 to 70 high school students an introduction to health sciences. The program primarily caters to minority students; it began with African Americans and now also serves many Latinos and Native Americans. Some of its early graduates have gone on to pursue careers as health professionals, including nurses and occupational therapists. For the first time, in 2016, an alumnus of the program graduated from medical school. Program participants are often the first in their families to graduate from college.

Along a similar vein, Loma Linda recently partnered with a local school district to turn a new high school into a health academy. The goal is to get more students to finish high school (half do not in the district) and encourage them to enter the health professions. In September 2016, Loma Linda also opened Gateway College on the same site, in partnership with the local public health department and the Native American community. This college offers entry-level programs in the health sciences. Through these initiatives, Loma Linda has created a single site where high school, college, graduate students, and medical residents all come together. These programs promote better health outcomes by encouraging local youth to stay in school (since education is the best predictor of long-term health outcomes).

Baptist Memorial Health Care System

The leaders of Baptist Memorial Health Care System in Memphis recognize that the vast majority of patients have families and other mediating social structures in their lives. They conducted a survey of the most vulnerable ED patients and found that almost all of them had a "faith home," and 70 percent had attended an event at their faith community within the last 30 days. Based on this finding, health system leaders decided to organize and staff an effort to connect over 600 faith-based organizations with Baptist, including churches of various denominations, mosques, and synagogues. They held conversations with a small group of clergy to discuss how to optimize the relationship between a faith-based health system and a

faith-based community. These meetings occurred at the same time the system was building an electronic medical record (EMR). Local leaders suggested that the EMR have the capacity to note the congregational identity of each patient. IT staff created a drop-down list of all 606 congregations in the area. Each patient is asked if he or she is a member of a congregation and if they would like that congregation involved in this particular health episode. If so, the EMR automatically sends an alert to the chaplain and the individual designated as the liaison to the health system from the congregation. The liaison, in turn, can connect to the social structure of the patient by contacting those who care about the patient to alert them of the episode. Tapping into this type of social structure can dramatically reduce utilization and costs. The key to the program's success is the high levels of trust that Baptist has in the local community. Much of what Baptist does adds to that level of trust. Having this type of relationship with the community (where most people think of Baptist as "their" hospital) gives the system the opportunity to draw on that trust.

Wake Forest Baptist Health

Wake Forest Baptist Health has a legacy relationship with the North Carolina Baptist Convention, which founded its flagship hospital (now called Wake Forest Baptist Medical Center) in 1922. Since the organization's founding, the healing ministry of the hospital has been directly connected to the healing ministry of churches. The founding documents call for every nurse to be assigned to a specific congregation. While the 3,600 congregations of the North Carolina Baptist Convention tend to serve Caucasian congregants, the health system also has relationships with 1,800 other congregations in the state that serve predominantly African-American communities. Beginning in the 1990s, Dr. John Hatch began working to bring these congregations together and to reach out to more than 2,000 other Methodist congregations in North Carolina.

Roughly four years ago, Dr. Gunderson came to Wake Forest Baptist with the goal of connecting in a serious way to the religious health assets in the state. In 2016, over 2,000 clergy will visit Wake Forest Baptist Medical Center, half of them being Baptist and the other half from other religions. These individuals have the potential to be a positive, disruptive force in people's lives, helping patients when they return home by connecting them to social services and other support that can help address various drivers of their health, including non-health issues such as housing, food security, and employment. On an ongoing basis, Wake Forest Baptist organizes and trains these clergy to play this role.

Community Health and Development: New Avenues in Partnership and Financing

Kevin Barnett, Dr.P.H., M.C.P. (Moderator)

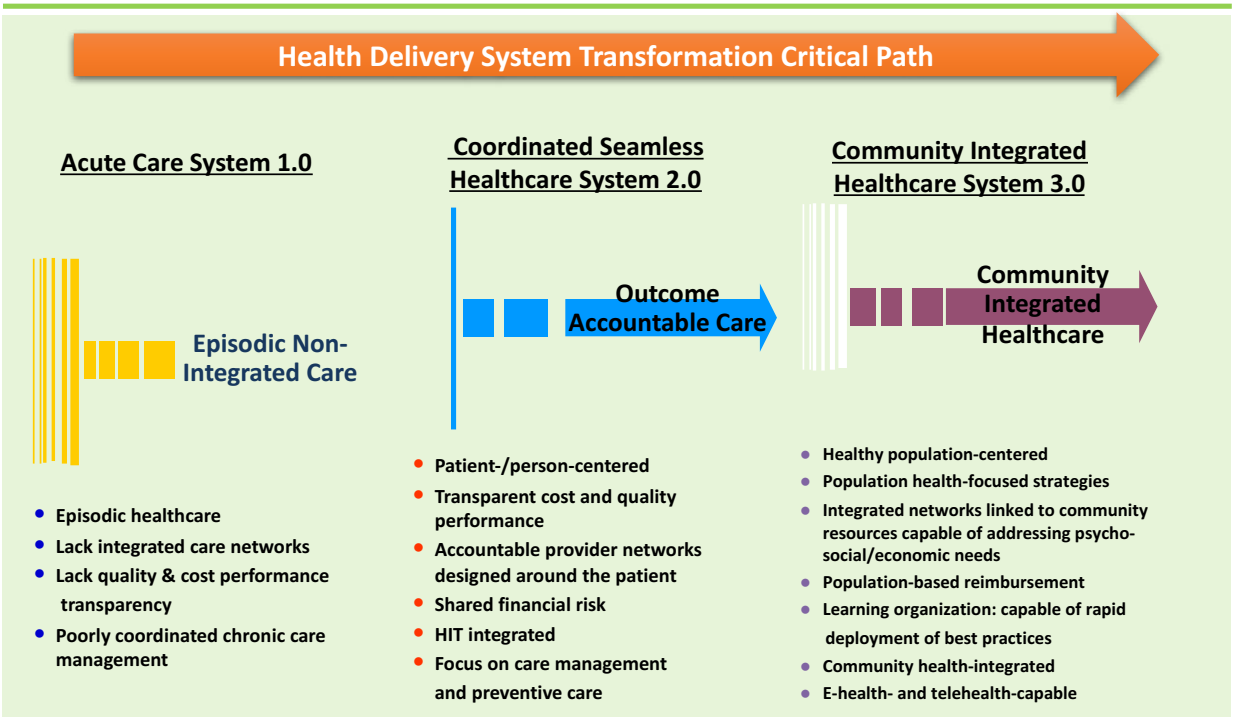
Banks, community development financial institutions (CDFIs), public and private payers, and other organizations can be potential partners to hospitals and health systems that commit to improving community health. Many banks, for example, routinely make investments in affordable housing, grocery stores, schools, and other projects that have important implications for health. Many of these banks and other financial institutions face mandates to direct substantial resources to the same low-income communities served by hospitals and health systems. These financial organizations can be valuable additions to the table during discussions about how to finance programs designed to address the social determinants of health. This section details examples of communities that have tapped into these potential partners and financing sources, and provides more information on one potential source of financing: CDFIs.

A Sustainable Financial Model for Improving Population Health

James Hester, Ph.D.

The U.S. healthcare delivery system is in the midst of a transformation. Most of the work has been focused on moving from an acute care delivery system that provides episodic, non-integrated care to a coordinated, seamless system that takes accountability for delivering good outcomes (from 1.0 to 2.0 on the chart in **Exhibit 15**). However, there is another equally—if not more—important step that needs to take place—transformation to a community integrated healthcare system (3.0).

Exhibit 15: U.S. Healthcare Delivery System Evolution



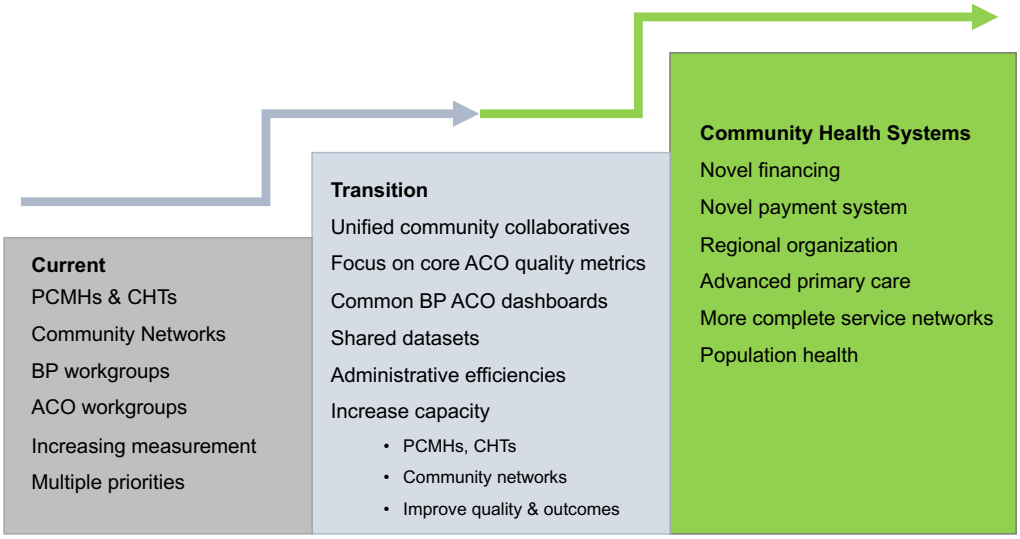
Source: N. Halfon, et al., Health Affairs, November 2014.

In Vermont, efforts to transition from 1.0 to 2.0, and then from 2.0 to 3.0, began roughly a decade ago. Initially launched in three pilot communities testing Wagner's chronic care model, the initiative has evolved and currently attempts to create a community health system featuring enhanced medical homes within primary care practices; accountable health communities (AHCs) at the community level; and state, regional, and national infrastructure and support through health IT and multi-payer payment reform. An AHC is made up of a "backbone" organization that provides the governance structure and key functions, along with partners that implement specific short-, intermediate, and long-term health-related interventions, with financing as necessary for specific transactions.

The "backbone" organization is a community-centered entity that focuses primarily on the convening and planning aspects of the AHC, identifying gaps, and trying to close them whenever possible. This organization takes responsibility for improving the health of a defined population in a geographic area by integrating clinical, public health, and community services. To that end, it convenes diverse stakeholders and creates a common vision among them. It conducts the CHNA, works with partners to prioritize community needs, and then builds and manages a portfolio of interventions to address those needs. On an ongoing basis, it monitors outcomes, implements rapid-cycle improvements, supports the transition to value-based payments and global budgets, and facilitates a coordinated network of community-based services. As part of the Vermont State Innovation Model (SIM) award, the state commissioned a study to look at best practices across the nation and the state when it comes to AHC-like activities, including case studies and community profiles.

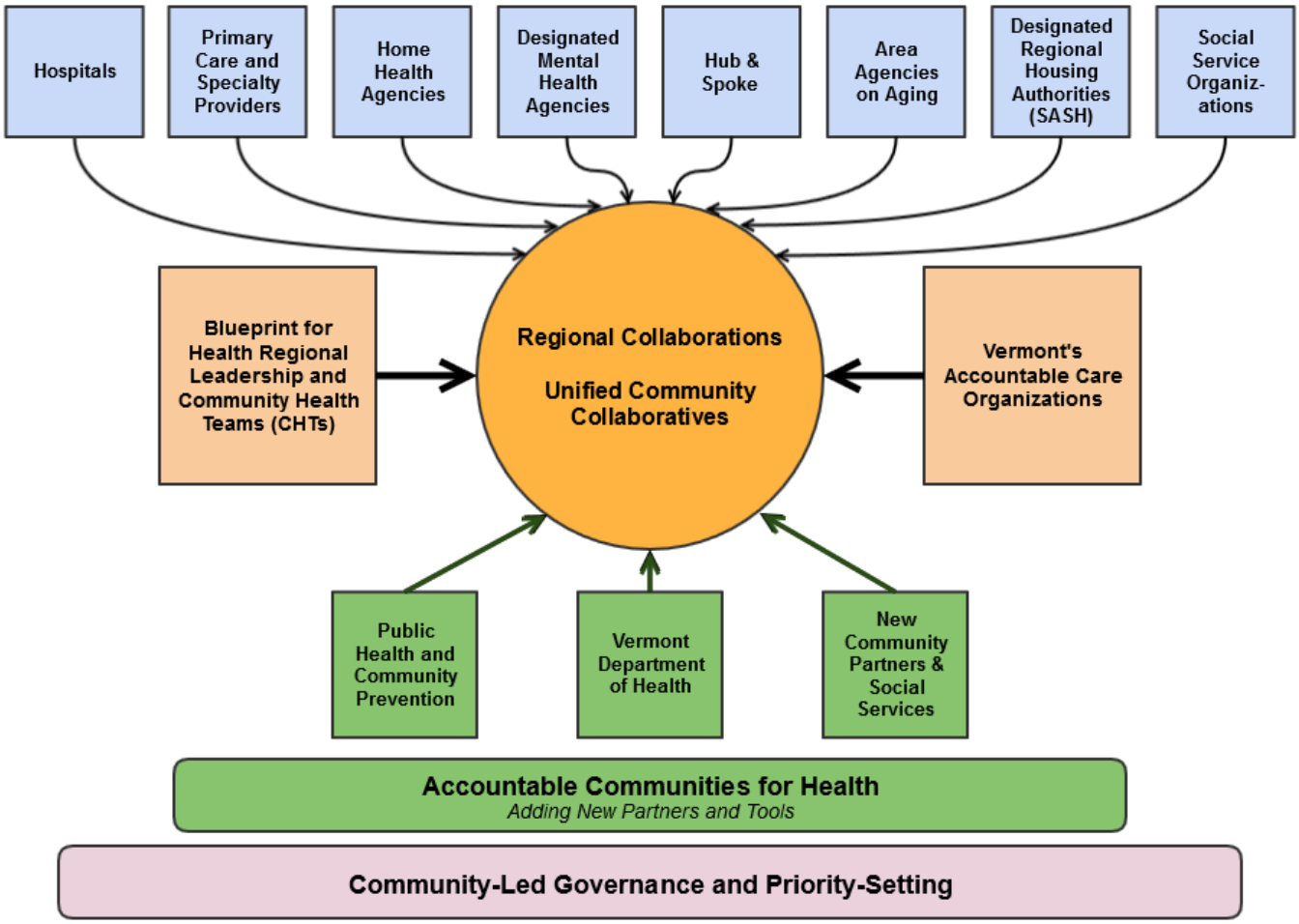
As shown in **Exhibit 16**, Vermont's approach to AHCs builds on the local structures created by the Blueprint for Health, which has created a statewide network of PCMHs with embedded community health teams. Because some overlap and duplication exists between the care management functions of the PCMHs and those of the new ACO (e.g., multiple care coordinators sometimes work with the same patient), a community collaborative was formed to eliminate duplication of effort and coordinate priority-setting and reporting systems. The end result is regional integration and collaboration throughout the state (see **Exhibit 17** on the following page).

Exhibit 16: Transition To A Community Health Focus



Source: Department of Vermont Health Access.

Exhibit 17: Vermont: Regional Integration



The following are key components of a sustainable financial model for improving population health:

- **Theory of action**: There should be multiple levels of action, including at the practice, community, region/state, and federal levels, with integration at the community level between clinical, public health, and community-based interventions. Success requires both an operating revenue stream and capital for infrastructure development, along with a mechanism to capture a portion of the savings and benefits generated from other areas (e.g., criminal justice system) for reinvestment to ensure long-term sustainability.
- **Inventory of financing vehicles**: Funding for clinical services through a global budget and single and multi-sector public financing are necessary but not sufficient building blocks for success. Beginning in 2018, Vermont will operate under a CMS all-payer waiver that creates an aligned global budget payment that covers Medicare, Medicaid, and commercial payers based on next-generation ACO models that organize providers into networks. The payment incorporates explicit incentives to improve population health, with ongoing monitoring and positive and negative consequences based on performance. In addition to these sources, a variety of other innovative funding sources have emerged, including hospitals, community development organizations (e.g., CDFIs), social capital (e.g., social impact bonds), foundations (through program-related investments), employers, and prevention/wellness trusts. The key is to overcome fragmentation and lack of coordination between these entities.
- **Balanced portfolio**: There is no "silver bullet" to this transformation. Rather, success requires a balanced portfolio in terms of the spectrum of time horizons, the level of evidence required, and the scale of investment. Leaders need to build business cases and make decisions on specific transactions, and must aggregate and align various financing streams, managing and leveraging public and private investments to achieve the greatest impact.

The coming period will be one of experimentation, with a number of ongoing collaborations providing opportunities to develop and test new models. In addition, there are working examples of community integrators that have embarked on successful collaboration with innovative financing vehicles. Better tools are needed, including analytic models to project the impact of programs, and measures for monitoring, accountability, and payment. These tools need to allow for assessment of the impact across sectors. Key challenges going forward include:

- **Lengthening the timeframe**: The focus today is too short term in nature. Expectations need to be adjusted as to how quickly positive impacts will occur.
- **Sharing cross-sector savings**: Savings from one sector need to be available for reinvestment by others.
- **Creating community integrators**: These organizations ease the transition to implementation and also plan and develop financing.
- **Avoiding competing models**: Dueling structures both between and within sectors (i.e., health and non-health) must be avoided.

With challenges, however, comes ample opportunity. At present, there is a growing consensus on the ability to develop and implement models that can promote better health for populations, including new payment models that are being tested at scale. There are also signs that payers are aligning in regional markets. Beginning in 2018, Vermont will operate under a CMS all-payer waiver that creates an aligned global budget payment that covers Medicare, Medicaid, and commercial payers based on next-generation ACO models that organize providers into networks. The payment incorporates explicit incentives to improve population health, with ongoing monitoring and positive and negative consequences based on performance. Some early adopting systems are already exploring the path to 3.0. In short, the ability to link health with community development has great promise in this rapidly evolving context.

Exhibit 18: Community Health Initiatives

Dignity Health

Pablo Bravo

Dignity Health has a wide array of initiatives designed to enhance the health of the communities it serves. Many focus simultaneously on community health improvement and population health management (see **Exhibit 18**).

These efforts began in the early 1980s, when Dignity Health (formerly known as Catholic Healthcare West), was formed. As policies and procedures were being formed, leaders felt it was important to insert a section about community investment into the organization's existing investment policy. They also created governance policies and procedures related to community investments, and gave the board-level investment committee responsibility for overseeing such investments. That committee created a subcommittee that would review and recommend community investments to the investment committee. Leaders also laid out staff responsibilities related to community investments and formalized the role of the legal department and of the treasury and finance functions as support structures for community investment activities (which is housed under the community health department). In addition to this system-level support, Dignity has community health directors at all its facilities that are also able to bring potential projects forward. The Vice President of Community Health is responsible for bringing ideas forward to the subcommittee and to the investment committee.

A brief description of key Dignity community health programs follows.

Community Grants Program

Under this program, three or more organizations are required to come together to address health priorities that have been identified by the CHNA. For example, one of the projects funded was to provide diabetes prevention. Three organizations brought different assets to provide prevention education; a local YMCA provided an exercise program; a food bank provided nutrition education and fresh food; and a federally qualified health center (FQHC) provided health-related services.

Social Innovation Partnership Grants
Created in 2015, these grants can be made to organizations in low-income communities that are pursuing "out-of-the-box" strategies to address problems. In most cases, grantees are finding innovative ways to bring services to people outside their own facilities.

Sustainability and Ecology
Within the organization, Dignity Health is working to reduce its carbon footprint.

International Program
This program focuses supporting the efforts of religious women to help individuals in need.

Community and Population Health
Dignity Health recently created a hybrid senior-level position; this role is to align the efforts of community health with the efforts of population health management. The goal is to make sure that the two functions are linked throughout the system.

Community Benefit Reporting
This program focuses on meeting the requirements of government regulators and other external parties with respect to reporting on community health activities and spending.

Community Investments Program
Through this $100 million program, Dignity Health provides below-market rate financing to non-profit organizations that can sustain the debt, including CDFIs. Money for these investments comes out of funded depreciation. Overall, 80 percent of the loans are targeted at Dignity Health's service areas and anywhere that Dignity has a sister sponsor (including developing nations such as South Africa). The maximum amount any one organization can borrow is $5 million (10 percent of the current allocation). Dignity currently has $90 million in total lending capital, with 74 organizations receiving support. Loan volume since the program began totals $166 million. Examples of support provided in 2016 include the following:

- Lending capital to a CDFI making energy improvement loans to low-income residents in Florida who are most vulnerable to the negative impact of climate change.
- Pre-development loans for housing development.
- Capital to refurbish a center for homeless pregnant teens in Sacramento, many of whom are victims of human trafficking.
- Capital to purchase a residence for a homeless youth with HIV/AIDS in San Francisco.
- Capital to a community development enterprise to make loans to health clinics, small businesses, and charter schools in low-income parts of Arizona.

Tapping into a CDFI

Don Hinkle-Brown

A certified CDFI is a specialized financial institution that works in market niches underserved by traditional financial institutions. CDFI certification is a designation conferred by the CDFI Fund and a requirement for accessing financial and technical award assistance from the fund. As a certified CDFI, The Reinvestment Fund (TRF) builds wealth and opportunity for low-income people and places through the promotion of socially and environmentally responsible development. It does so not just by connecting capital, but also by combining information, knowledge, and innovation while working at the intersection of organized people, money, capacity, and data.

Since 1985, TRF has made $1.8 billion in such investments; among CDFIs, it has one of the largest loan funds in the country, with $950 million in total capital under management and $318 million in outstanding loans. TRF has an AA (investment grade) rating from Standard & Poor's and an AAA+1 (the highest) rating from Aeris, the industry rating agency. Most CDFIs, including TRF, have very low loss ratios, typically around 0.1 percent.

Through partnerships in communities across the country, TRF channels resources to build affordable homes, quality schools, supermarkets, and health centers, all with an eye toward creating more vibrant neighborhoods. For example, TRF has been a pioneer in promoting access to healthy foods. The effort began in 2004 in Pennsylvania with the financing of 90 grocery stores. This initiative helped half a million people get out of "food deserts" (areas without access to healthy foods, including fresh fruits and vegetables.). In 2014, TRF launched ReFresh, a national initiative to work with other CDFIs to build their capacity to establish or expand financing efforts to promote access to healthy foods. ReFresh began with four CDFIs working in Ohio, Colorado, Florida, and Northern California. Today the program involves 19 CDFIs working across the country.

Within the health arena, TRF has a vehicle to finance clinics, community hospitals, specialty sites, and multi-purpose facilities. TRF is a part of the Collaborative for Healthy Communities, a national initiative to provide capital for community health centers. Through this collaboration, TRF has funded FQHCs in Pennsylvania, Wisconsin, Washington state, and California. TRF also partnered with the Public Health Institute as part of the AHEAD initiative, which seeks to align health and community development. It is being piloted in five cities: Atlanta, Dallas, Boston, Portland, and Detroit.

In collaboration with RWJF, TRF is also involved in Invest Health, an opportunity for 50 mid-sized cities to transform the way local leaders work together. Using grants of up to $60,000, these cities have each formed cross-sector teams made up of leaders from the public sector (e.g., public health), the community development/finance sector, and an academic or health-related anchor institution. These teams will participate in training and other activities through the end of 2017, including two meetings each in 2016 and 2017.[1]

1 More information is available at www.InvestHealth.org.

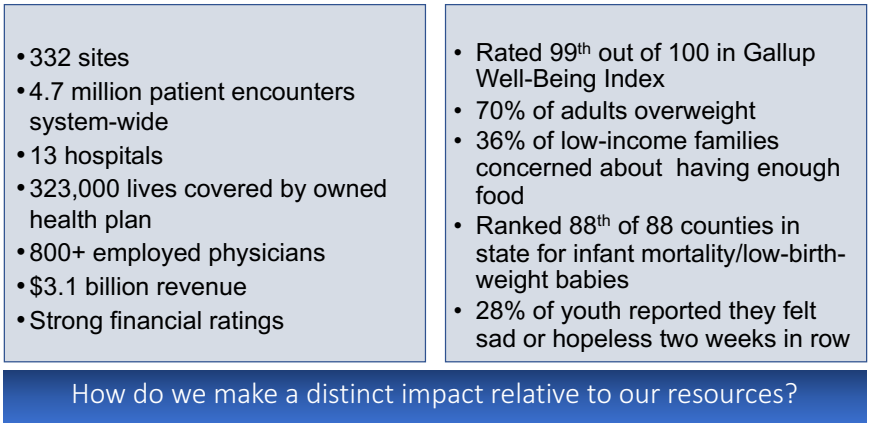
Coming to Grips with the Social Determinants of Health: New Forms of Leadership and Advocacy

Randy Oostra

Defining Success in Healthcare

To help illustrate the need for healthcare systems to consider a different approach to caring for the health and well-being of individuals and communities, ProMedica is an example of a health system that is doing very well by traditional measures of success. However, the state and local community statistics regarding health and well-being are poor. In response to this situation, about a decade ago ProMedica's board of directors became much more interested in applying health system resources to improve the health and well-being of the communities it serves by addressing the social determinants of health (see **Exhibit 19**).

Exhibit 19: What Do You Think Of This Health System Now?



In its survey work exploring the topic of well-being, Gallup has identified five aspects of life that define well-being:

- **Career well-being**: The degree to which someone loves what he/she does every day
- **Social well-being**: The quality of one's relationships
- **Financial well-being**: The security of one's finances
- **Physical well-being**: The vibrancy of one's physical health
- **Community well-being**: What someone contributes to his/her community

Gallup found, moreover, that the difference between a good life and a great life lies in the notion of community well-being.

Hospitals and health systems have a tremendous opportunity to help define and shape the communities they serve. Health systems need to work toward a future in which they provide top-percentile performance in terms of safety, quality, and patient experience by providing integrated, cost-effective care. That said, health systems need to spend as much time on the social determinants of health as they do on clinical excellence. New skills need to be developed and existing ones rebuilt to better engage both staff and the community and hence change people's lives. To succeed, moreover, leaders must balance the needs of today with this future vision.

Redefining Healthcare at ProMedica

ProMedica's board considered several models to facilitate execution of this transformation. The board began looking at very specific social determinants of health, identifying poverty as the root-cause issue. However, "selling" the idea of fighting poverty was seen as a difficult task, as most board members rightly felt that solving poverty was not something the health system could do, even if working with others. However, board members could relate to the idea of addressing specific proxies for poverty, such as the role of hunger, unemployment, and lack of education. More specifically, the board began looking at the Anchor Institute model. "Anchor" institutions are large, often (though not always) non-profit organizations that tend not to move location, such as hospitals, universities, churches,

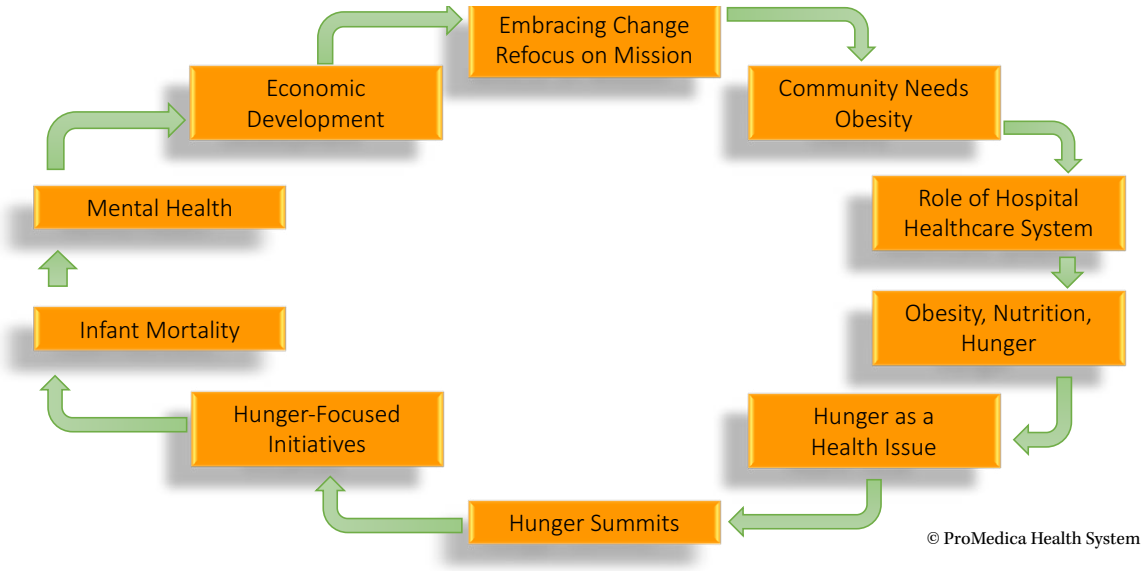
schools, entertainment/sports organizations, arts-based organizations, and in some cases businesses. As place-based anchors of communities, they naturally focus on the long-term welfare of the communities they serve.

The board of ProMedica decided that the organization should adopt the Anchor Institute Model, which commits the organization to being more than the sum of its individual community engagement programs. Rather, it makes community development and improvement an explicit part of its mission, culture, and way of doing business. The board agreed to invest substantial sums of money in the local community, and to absorb significant losses in the near term to promote long-term benefits, including enhanced health status and a stronger local community. Specifically, ProMedica committed to promoting the following kinds of activities:

- Business incubation/innovation
- Local purchasing
- Access to education, financial services, and arts/culture
- Affordable housing
- Public safety
- Healthy neighborhoods
- Environmental stewardship

In particular, ProMedica used its CHNA to identify obesity as a place to get started. After ProMedica hired a company to go into the schools to teach students about healthy eating, it quickly became clear that hunger and lack of access to healthy foods were the real issues. As shown in **Exhibit 20**, this work later led to other initiatives focused on infant mortality (Ohio ranks second-highest in the nation, even though it has some of the best children's hospitals), mental health, unemployment, and inadequate housing.

Exhibit 20: ProMedica's Journey



With respect to hunger, ProMedica's board learned that nearly one in five households (19.5 percent) with children in the U.S. are food insecure (meaning that at least once in the past year they lacked enough money to buy food). In addition, almost a third (31 percent) of seniors cut or skip meals due to a lack of financial resources. Nearly three-quarters of Supplemental Nutrition Assistance Program (SNAP) recipients are seniors, disabled individuals, or working poor. Unfortunately, too often SNAP benefits are exhausted before the end of the month, leaving recipients to buy inexpensive junk food rather than healthy foods like milk, fruits, and vegetables. Overall, the problem of hunger costs the U.S. at least $167.5 billion annually, including healthcare costs related to hunger that total $130.5 billion annually.

> "Many pregnant women are not well-fed. We will put their children in the neonatal intensive care unit after they are born prematurely in poor health. But we won't invest in providing healthy food to the mother."
>
> *—Randy Oostra*

After finding out that more than one in five Toledo families with children are food insecure, ProMedica started a program where all inpatients were screened for food insecurity using two quick questions during intake. For those who screen positive, ProMedica provides food to meet short-term needs, giving patients food donated by employees that has been packed and boxed by a vendor (at no charge to the organization). Those who screen positive also receive a referral to ProMedica's food pharmacy program, where they meet with a dietitian who provides education on what to eat and connects them to community-based resources that can help in accessing healthy food. In 2016, roughly 4 percent of inpatients screened positive (2,243 out of 57,244). Of these, roughly half (1,100) became clients of the food pharmacy. Since its inception, the screening and food pharmacy program has served 4,000 Medicaid patients. Among these individuals, readmissions fell by 53 percent and ED use by 3 percent; at the same time, primary care visits rose by 4 percent. ProMedica invests roughly $100,000 a year in its food pharmacies.

ProMedica is also partnering with local stakeholders to promote other community-based programs directed at hunger, including nutrition maps in schools, food reclamation from local businesses (which collects 300,000 pounds of food each year at a cost of $30,000), employee and community food drives, and employee food assistance programs. ProMedica Children's Hospital serves as a summer feeding site under a United States Department of Agriculture (USDA) program. In addition, the organization promotes a 5K walk/run to benefit local hunger relief organizations and has added survey questions on food security to the CHNA development process.

Thanks in part to a $2 million dollar donation, ProMedica was able to establish an institute addressing the social determinants of health in an inner city location. The first phase of the institute was the opening of a grocery store where there had been previously a food desert, hiring individuals from the local community. The second phase of the institute, which is now open, includes an education center that provides job and career training, financial literacy classes, parenting classes, nutrition counseling, and diabetes education. It promotes community empowerment and improvement on a "block-by-block" basis. The store did not require a major investment by ProMedica, as the empty building already existed in an impoverished part of the city. At present, the board is considering whether to invest with others in the development of affordable housing across the street from the store.

> "Healthcare must address the social determinants with the same passion that we show in meeting acute clinical needs. We must remember that the difference between a good life and a great life is in serving the community. If we take a broader view, we can start to make our communities better."
>
> *—Randy Oostra*

In October 2015, ProMedica expanded its work in the area of hunger as a health issue by founding The Root Cause Coalition (TRRC). The AARP Foundation was a co-founding member. There are currently 20 members of non-profit and for profit organizations focused on promoting a national discussion about hunger as a health issue. TRRC is also partnering with the Centers for Disease Control and Prevention on national research. One goal of TRRC is to get all patients nationally to be routinely screened for food insecurity by 2025. The hope is that Medicare will agree to pay for such screening, causing other payers to follow suit. In addition to focusing on food insecurity, ProMedica is also involved in a number of other areas, as detailed below:

- **Mental health/substance abuse**: ProMedica has a joint venture with Harbor Behavioral Health to manage its inpatient psychiatric units. As part of this venture, Harbor embeds behavioral health specialists in private practices. ProMedica also has grant funding to improve care for pregnant women with substance abuse issues and for patients with persistent mental illness. ProMedica is also proactively collaborating with other health systems and community-based stakeholders to address the opioid crisis.
- **Downtown revitalization**: ProMedica has purchased three downtown buildings and is renovating them to serve as the system's corporate headquarters. This will move over 1,500 employees downtown. In addition to bringing the largest surge of business to the downtown area in decades, ProMedica's interest in downtown revitalization, along with activities of other business and community leaders, has spurred significant momentum and interest in downtown revitalization.
- **Business incubator**: ProMedica's board established an Innovations Committee that works to promote economic development. This committee approved creation of an incubator that invests in local companies that create jobs. Within three years, the incubator expects to be assisting 15 companies that will collectively create 250 jobs outside of the healthcare industry. In fact, ProMedica has outgrown its current space for an incubator, and is in the process of purchasing additional space in the downtown area that would be used not only for ProMedica Innovations, but also for local entrepreneurs and innovators.

Board Role in Building and Sustaining a Commitment to Community and Transformation: Henry Ford Health System

Wright Lassiter, III; Gerald R. Winslow, Ph.D.

This interview of the CEO of Henry Ford Health System focused on the role of the board in building and sustaining a commitment to the community.

Background

Henry Ford Health System is a $5.6-billion not-for-profit health system with five acute care hospitals, two psychiatric hospitals, several hundred ambulatory sites (including clinics, dialysis centers, specialty pharmacies, and vision centers), and a 700,000-member health plan. The system "grew up" as a single-site academic medical center focused on high-intensity medicine, not community or population health. In fact, for its first 60 years in existence, it focused primarily on acute care medicine. The hospital then acquired a city-owned facility roughly 25 miles south of Detroit. For the system's leaders, this acquisition for the first time helped to broaden their thinking beyond academic medicine. The 1970s and 1980s marked a period of rapid growth, with the building of 26 large ambulatory centers that serve most of southeast Michigan. During the same period, Henry Ford began employing most of its physicians, many of whom staff these centers.

Henry Ford leaders faced the challenge of surviving and thriving as a large organization serving a geographic area that generally is not growing. Over time, they realized that they would need to do more than focus on high-end interventions for the sick. They would also need to focus on population and community health.

The Board's Role in Building and Sustaining a Commitment

At Henry Ford, the ideal board member is someone who acknowledges that the purpose of the board is to drive the organization to meet its mission and fulfill its vision. This board member shares his or her skills and talents in a way that challenges, supports, and nurtures management while maintaining objectivity. Collectively, the board needs the wisdom, talent, experience, and knowledge to make good decisions. In some cases, board members may be good individually but not work well together collectively. To ensure a well-functioning board, senior leaders must give the board the right information in a timely manner and educate them proactively and effectively on key issues. When these processes occur, boards can engage in real, meaningful discussions and hence make sound decisions and give good feedback.

Henry Ford's system-level board has 22 members. The organization also has 25 subsidiary boards, a structure that at times can become unwieldy. This unwieldiness stems in part from somewhat inconsistent standards as to which boards are fiduciary and which are advisory in nature. Once a year, members from all the boards come together to talk about the state of the organization and its future.

Several years ago, the system board created an *ad hoc* governance review committee that included the board chairs from all hospital and insurer subsidiary boards, along with members of the system board executive committee. The governance review committee authorized a benchmark study to compare Henry Ford's governance structures to those of other similar health systems, a process that had not been done in roughly a decade. The study coincided with Mr. Lassiter taking over as the new CEO. The goal was to simplify the governance structure, make sure the structure aligns with the overall strategy of driving integrated care and coverage, confirm that Henry Ford was following best practices in governance, and enable growth and the achievement of strategic imperatives. Henry Ford chose to compare itself to regional systems with a large employed medical group structure and owned health plans. The recommendations from this benchmarking study included the following:

- **Smaller system board**: Henry Ford's leaders did not think of the board as being representational in nature, but in reality, 12 out of the 22 members are *ex-officio* representatives of various stakeholders within the organization.
- **Longer meetings:** The traditional practice of two-hour meetings did not leave enough time to engage in strategic discussions. Now meetings last four hours, which still may not be long enough.
- **No formal presentations**: The system board no longer allows formal presentations, but instead limits speakers to reviewing a one-page summary of key points. Board members are expected to have gone through the more detailed presentations in advance of the meeting. This change has freed up 40 percent of meeting time for dynamic discussion.
- **Committee and full board meetings on consecutive days**: Rather than have board committees meet during the second and third weeks of the month and then the full board meet the fourth week of the month, committee and full board meetings now occur between Wednesday and Friday of the same week.
- **New competencies**: No system board members had substantial expertise in population health or community health. While some expertise in these areas came from external members of board committees, these individuals were not on the system board and hence not present during key board discussions. To address this issue, Henry Ford has put in place informal processes to identify specific competencies needed at the system board level and find individuals to fill those gaps. Members of subsidiary boards and outside members of board-level committees often end up being good candidates. Henry Ford will also likely begin looking to bring in board members

from outside the area, a step that may require a more formal search process.

- **More community investment by board members**: Henry Ford will match personal investments by board members in areas related to population and community health, as long as they meet established criteria.
- **Between-meeting updates**: Henry Ford is moving to greater use of between-meeting telephone updates, both within committees and for the system board as a whole. Beginning in 2017, the CEO will regularly provide a between-meeting telephone update to the system board.

With these changes, the hope is that the system board can do more to "push" management and the organization as a whole in the areas of population and community health. While Henry Ford has been very active in these areas for a long time, these efforts have been driven primarily by senior leaders and staff, not the board. The board's public responsibility committee reviews the CHNAs and regularly approves initiatives suggested by senior management. The committee, however, is usually not the driving force behind them, and committee-level discussions do not always make it to the system board meeting agenda. All that said, Henry Ford has well-functioning partnerships in place with a broad array of community-based organizations, such as public schools (including a partnership involving 20 school-based clinics) and congregations. These congregational health partnerships are the perfect place for shared accountability for health and wellness.

To create appropriate accountability, Henry Ford has a senior vice president who oversees community health and reports directly to senior leaders. As noted, a board-level committee has community health as part of its charter, and this committee makes sure that relevant discussions make it to the system board as appropriate.

Henry Ford's CEO also dedicates substantial time to other community-based initiatives. (He typically participates in a few things at a time; to avoid spreading himself too thin, he generally commits to a given initiative for a period of no more than two years.) As part of his work on the mayor's workforce development board, he realized that other organizations, including some health systems, were changing institutional policies related to hiring previously incarcerated individuals. After seeing what Johns Hopkins Medicine had done in this area, Henry Ford decided to no longer ask about previous incarcerations on its employment applications. On a quarterly basis, Henry Ford's CEO also sits down with his counterparts at the two other local systems to talk about opportunities to work together on community health initiatives. For example, at an upcoming meeting, they will share their most recent CHNAs to identify areas of overlap and opportunities to collaborate.

Key Takeaways and Next Steps

Lessons Learned

During various interactive sessions, attendees and faculty shared their experiences with both successful and failed efforts to build capacity and promote improvements related to population and community health. Key takeaways from these experiences include the following.

Board- and Leadership-Related Lessons

- Recognize that success requires changes in how hospitals and communities work together to leverage the limited resources available. No single party can address these issues on its own. Rather, success requires shared ownership for health.
- Engage boards in community health and ensure that they have the right skill sets, competencies, and connections to support senior leaders in taking the bold steps required.
- Adopt governance structures that ease control- and power-related fears among partners. The focus needs to be on influencing and encouraging others to collaborate, not forcing them to do so. To that end, consider adoption of broad governance structures that include equal representation and voting power for all key stakeholders.
- Honor commitments and model that behavior repeatedly. Community-based stakeholders may not initially believe that a health system really has the community's best interests at heart. Convincing them likely takes multiple conversations and a series of actions that demonstrate the commitment.
- Dedicate board time to discussing these issues. At Health Partners, for example, the board dedicates an hour of conversation to health system transformation and related topics at each quarterly meeting.
- Rethink how the organization listens to the communities and the patients it serves, and regularly elicit input on how the organization is performing and what it could be doing differently. These conversations can be a good way to build trust.
- Begin collaborating with competing hospitals and health systems on community health initiatives.
- Consider the potential for partnerships with a broad array of community-based organizations, including school districts, universities, fire departments, police departments, congregations within the faith community, and even non-traditional partners such as barber shops.
- Develop the right language to articulate the importance of community health and population health, both internally and externally, including how they fit into the organization's mission, vision, and strategic plan.

Operational Lessons

- Align community health and population health internally. At Dignity Health, this process required internal education and the hiring of someone to bridge the gap between the two.
- Integrate community and population health into strategic plan development. Board discussions should feed into annual plans, both inside and outside the organization.
- Lengthen the expected timeframes for success. Policymakers and organizational leaders need to end the mindset that investments can be recouped in a year or two. It can take anywhere from three to 10 years to generate positive returns for some of these initiatives. Focus on the total costs of care over time, not the costs of individual components.
- Create an enhanced measurement scorecard with the right metrics and timeframes. The scorecard should provide a detailed look at "hot-spot" neighborhoods, including what percent of such neighborhoods have access to needed services (such as healthy food trucks to address hunger).
- Embed community health teams and mental health professionals within primary care practices and EDs, and invest in capacity to promote better oral health in the community, including use of lower-level providers.
- Investigate collaborative partnerships to address hunger, such as partnerships with local kitchens and vendors that can collect and package unused food. The USDA has matching-fund programs to help support these kinds of activities.
- Take a fresh look at community benefit reporting activities, including opportunities to connect the dots between community needs, how community benefit money is spent, and how staff spend their time. Revamp CHNAs, implementation plans, and related reports so that they are widely read and linked to current strategic plans.

Policy-Related Lessons

- Advocate for payment and other public policy reforms.
- Assess the need for institutional policy changes, such as those related to hiring and the environmental impact of the organization on the community.

Quick Steps to Take Right Away

Meeting attendees highlighted a few things they plan to do right away after returning to the office:

- Share the insights and knowledge gained with the full board at its next meeting.
- Initiate research on best practices in population and community health and plan to distribute the findings widely.
- Conduct an inventory of all current programs and make sure metrics have been developed to evaluate their impact.
- Meet with the local public health manager to understand current activities and what might be needed in terms of resources.
- Convene a board/senior leadership retreat to discuss these issues and to challenge one another to address them. During this meeting, make sure the board and senior leaders understand that investing in population and community health is more important than building another new facility.

Team Self-Assessments and Action Plans

During the meeting, each participating organization began work on the AGLH self-assessment tool, which helps assess where the organization is with respect to seven different aspects of community/population health: board engagement, data systems and measurement, financing/payment models, delivery system redesign, internal activities, external activities (e.g., inter-sectoral collaboration), and policy development (both public and institutional policies). Within each area, teams assessed their organization's current capabilities on a four-level scale, with the first level being early on the path (i.e., limited attention to this issue to date), the second being "toes in the water" (i.e., recognition of the issue as important, but still figuring out how to proceed); the third being fully immersed (i.e., action on multiple fronts, with unclear impact to date), and the fourth being acclimated and learning new strokes (i.e., beginning to see results and ready to take innovations to scale). In addition to completing the self-assessment, teams also began work on a formal action plan designed to capture thoughtful insights to bring back to the organization and start needed conversations.

Next Steps

With support from RWJF, The Governance Institute, Public Health Institute, and Stakeholder Health will host conference calls and/or Webinars every other month during which health systems can report on and discuss their current community health activities, including obstacles, challenges, opportunities, and emerging lessons. These calls will provide a good opportunity to continue the dialogue and support each other in moving forward. Future AGLH programs will be held in 2017 and The Governance Institute will follow up with participating organizations in 12 to 18 months to capture progress and lessons learned.

Appendix:
AGLH Hospital/Health System Self-Assessment Tool

AGLH Hospital/Health System Self-Assessment Tool

This tool is intended to serve as a resource for hospitals and health systems to assess progress to date in healthcare transformation, with attention to building population health capacity. The term "transformation" reflects an acknowledgment that the changes demanded by the shift in financial incentives from volume to value require attention to a broad spectrum of structures, functions, and processes. In determining the optimal actions to be taken, this tool is intended to assist in the identification of entry points that are relevant and offer the best opportunity to build on efforts to date.

Name of organization: _____

Date: _____

My organization is a:

- ☐ **Multi-region health system**
- ☐ **One or more local facilities as a subsidiary region within a larger health system**
- ☐ **Multi-facility regional health system**
- ☐ **Independent, individual facility**
- ☐ **Other (Please describe)** _____

Please review each section and select ONE level (A, B, C, or D) and a numerical value (1, 2, or 3) that best reflects the current status in each area of interest.[1] The four levels and their underlying definitions are as follows:

Level A: Early on the Path
There is limited attention to this issue to date.

Level B: Toes in the Water
There is recognition that this is an important area of focus, but we are still exploring how to proceed.

Level C: Fully Immersed
We are taking action on multiple fronts, but the impacts to date are unclear.

Level D: Acclimated and Learning New Strokes
We are beginning to see some results from efforts to date, and are ready to take innovations to scale.

Within each of these levels, please rate your progress within each level as **1 (low), 2 (moderate), or 3 (high).** A rating of low might indicate that some elements of the statement are true, but progress may be relatively limited at this point. At the other end of the spectrum, a high rating of 3 would indicate that you have fully implemented the letter and spirit of the statement.

[1] *With the exception of Section VII, Policy Development, which is not organized under the four levels of engagement.*

I. Board Engagement in Population Health

This section examines the degree and manner in which strategic conversations are brought to the board that focus on building population health capacity in the organization, both in terms of patient care and addressing health issues in the larger community.

Level A

Our board and senior leadership dialogue focuses primarily on short term business priorities, with occasional discussions about the difficulties of managing the care of selected patient populations.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level B

Population health is a frequent topic of conversation among our board and senior leadership, and we have begun to explore potential areas of focus to strengthen our capacity to manage the care of our patient populations.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level C

Our board provides regular input to senior leadership in the design of systems and care design innovations to enhance our capacity to better manage the care of our patient populations.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level D

Our board serves as a "think tank" for the senior leadership in pushing *beyond* care management for patient populations to address the social determinants of health in the communities we serve.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Section I response explanation:

_____

_____

_____

<u>Choose ONE level</u> and numerical value. Then, provide a brief explanation.

II. Data Systems and Measurement

This section examines progress to date in the development of data systems and the use of metrics that support strategies to improve healthcare quality, reduce healthcare costs, and improve health in the community.

Level A

We compile and analyze data on patient utilization patterns (e.g., readmissions, prevention quality indicators) and discuss findings with our board.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level B

We collect data on social determinants of health (e.g., housing, support services, food insecurity), race and ethnicity, and use geographic information systems-coded data to identify geographic concentrations of health disparities.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level C

We convene clinicians, analysts, community benefit staff, and senior leaders to identify opportunities for alignment of care management and population health strategies and have established a "dashboard" of metrics to document progress.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level D

We share data with other community-based organizations and other healthcare providers to coordinate strategies to address the social determinants of health in geographic communities where health disparities are concentrated.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Section II response explanation:

_____

_____

_____

<u>Choose ONE level</u> and numerical value. Then, provide a brief explanation.

III. Financing/Payment Models

This section focuses on work to date in the redesign of financing mechanisms to support movement towards value-based reimbursement.

Level A

All, or the majority of our care is financed through a fee-for-service system, and we are focusing care coordination efforts on reducing readmissions (and associated penalties).

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level B

We are exploring the formation of an accountable care organization (ACO) to coordinate care for specific cohorts of patients.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level C

We have established an ACO for specific patient cohorts, and are engaged in conversations with external entities to explore increasing risk sharing arrangements.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level D

All, or the majority of our care is financed through a full risk capitated system, or we are sharing risk with one or more payers.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Section III response explanation:

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_____

<u>Choose ONE level</u> and numerical value. Then, provide a brief explanation.

IV. Delivery System Re-Design

This section examines efforts to date to engage, train, and deploy multi-disciplinary teams, and strategies to partner with other stakeholders to improve patient care and broader population health in local communities.

Level A

We are exploring the development of team-based care models to better manage the care of special populations.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level B

We have designed and are piloting one or more team-based care models to better manage the care of special populations.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level C

We are implementing inter-disciplinary team-based care across multiple sites, are exploring referral relationships with external human service organizations, and are establishing metrics to document progress towards achievement of Triple Aim objectives.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Level D

We are implementing inter-disciplinary team-based care on an organization-wide basis, are engaging community health workers in at least one site, have established referral systems with external human service organizations, and have established metrics and a system to monitor progress towards achievement of Triple Aim objectives.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Section IV response explanation:

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_____

_____

<u>Choose ONE level</u> and numerical value. Then, provide a brief explanation.

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Level B

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☐ 2. Moderate
☐ 3. High

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Our board serves as a "think tank" for the senior leadership in pushing *beyond* care management for patient populations to address the social determinants of health in the communities we serve.

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Section I response explanation:

_____

_____

_____

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- ☐ 2. Moderate
- ☐ 3. High

Section II response explanation:

_____

_____

_____

<u>Choose ONE level</u> and numerical value. Then, provide a brief explanation.

VII. Policy Development

This section focuses on institutional policies we are implementing and public policies we are advocating for in order to improve health and well-being among our patient populations and for the broader community.

A. We have ***identified and revised institutional policies to improve working conditions*** for staff and contractors (e.g., livable wages).

☐ 1. Low
☐ 2. Moderate
☐ 3. High

B. We have ***identified and revised institutional policies to increase contracting with local vendors*** to enhance local economic development.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

C. We have ***identified and revised institutional policies and made investments to reduce our negative environmental impacts*** (e.g., waste disposal, energy utilization) at the local and/or global level.

☐ 1. Low
☐ 2. Moderate
☐ 3. High

D. We are ***advocating for public policies at the national level*** to increase attention and funding to address population health issues (e.g., smoking, opioids, obesity).

☐ 1. Low
☐ 2. Moderate
☐ 3. High

E. We are ***working in partnership with external stakeholders to build a common platform for public policy advocacy at the local level*** to address SDH (e.g., improved schools, housing, food access, transportation, youth development).

☐ 1. Low
☐ 2. Moderate
☐ 3. High

Section VII response explanation:

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<u>Check ANY that apply</u> and provide a brief explanation.