Population Health and Health Reform: Hospitals in the Geographic Context

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The current barrage of news reporting on technological impediments to enrollment and the termination of some benefit packages by insurance companies is a disappointment, both to those who desperately need coverage and those who recognize the urgent need for fundamental reform.

For most hospital leaders, however, there is recognition of the need to look beyond the current cacophony and to focus on the larger reality on the horizon.

The first part of this emerging reality is the challenge of providing timely, quality primary care to a large new cohort of previously uninsured and underinsured populations. While the targets of enrollment include younger, healthy populations, many of the new enrollees will be residents of low-income communities with dramatically higher rates of chronic illnesses such as asthma, diabetes, and cardiovascular disease. These new enrollees are faced with an array of social and environmental obstacles to the adoption of health behaviors that are needed to reduce a high demand for costly acute medical care. There are a long list of examples, but a few of particular concern include a lack of access to healthy food, poor quality and unhealthy housing environments, and a lack of safe and/or affordable options for physical activity. As McGinnis and Foege so clearly demonstrated in their landmark research going back two decades,[1] the interaction of behavior and environment plays a far more powerful role in determining health than medical care. In current terms, we know there are clear limits to what even the most advance forms of clinical care management can do to remove these obstacles to improved health.

The Punch Line

That leads us to the most important part of this larger reality. The current system of fee-for-service payment, with its perverse incentives for the provision of ever more high-cost acute care has reached a point where it is undermining the profitability of other sectors, and threatens the economic stability of all but the most affluent members of our society. We are moving towards a more evidence-based system of care that will shift financial incentives towards keeping populations healthy and out of hospitals. As such, the economic viability of hospitals in the coming years will revolve around their ability to move beyond the provision of acute medical care and improve health, with particular focus in communities where health inequities are concentrated. The punch line is that hospitals can't solve these complex problems alone. The imperative and the challenge for hospital leaders is to step definitively outside the four walls and leverage internal resources through engagement and alignment with the full spectrum of external stakeholders. Non-profit hospitals are uniquely positioned, and some would say obligated to lead the charge in this regard.

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Shared Ownership and Geography

The new federal requirements in the ACA for tax-exempt hospitals to conduct community health needs assessments (CHNAs) and develop implementation strategies (ISs) to address priority unmet health needs reflects the imperative to understand and address health in geographic terms. The ACA requirements are reinforced by a set of reporting requirements in the IRS 990, Schedule H that have dramatically increased public access to detailed information on hospital community benefit practices. This, in turn, creates an opportunity for local and regional stakeholders to explore opportunities to enhance practices through better geographic and population targeting, and alignment of interventions and investments across institutions and sectors.

Whether by accident of history or strategic location decision, non-profit hospitals in more affluent locales with more favorable payer mixes will face increased scrutiny. Just as they may justify charitable contributions to developing countries in the wake of natural disasters, non-profit hospitals in more affluent communities will be expected to direct some portion of their charitable resources to communities within their own region where poverty and health inequities are concentrated. Never mind the fact that the communities don't fit into the marketing department-derived calculus for what is defined as the hospital's service area. The fact that there are other, more proximal hospital emergency rooms used by uninsured and underinsured

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1 Michael McGinnis and William Foege, "The Actual Causes of Death in the U.S.," *JAMA,* Vol. 270, No. 18, November 10, 1993, pp. 2207–2212.

populations should lead to calls for balancing alternative charitable investments, rather than justifiable exemptions of shared responsibility. The IRS has guidance in its instructions and notices of proposed rulemaking that encourage attention to populations and communities where health inequities are concentrated, but some language in the most recent notice of proposed rulemaking (NPRM) may contribute to confusion rather than clarity with language that conveys a mixed message:

> "A hospital may not define its community in a way that excludes medically underserved, low-income, or minority populations who are part of its patient populations, live in geographic areas in which its patient populations reside (unless they are not part of the hospital facility's target populations or affected by its principal functions), or otherwise should be included based on the method used by the hospital facility to define its community."[2]

Giving attention to patient populations and service areas is understandable and reflects an appropriate starting point for non-profit hospitals. While service areas offer insights into service seeking patterns of proximal geographic populations, however, they do not provide the complete picture that is needed to identify concentrations of unmet health needs. For most hospitals, the methodology used to define service area is weighted towards insured populations (unless a hospital operates in a locality with a particularly unfavorable payer mix). Voluntary service seeking is not a particularly good mechanism to identify populations with unmet health needs. In other words, unless a particular hospital is the sole provider in a particular region, there are a variety of reasons why medically indigent populations may or may not select one or another hospital facility. More attention is needed at the regional level to identify sub-county areas where health inequities

are concentrated, and to determine how *all* hospitals *and* other stakeholders share responsibility for more targeted investment.

Accountability Is Local

While the IRS can be expected to follow through on its stated intent to broadly enforce the new reporting requirements, it will likely be limited to more egregious failures such as non-completion of CHNAs, not making them publicly available, or not submitting an implementation strategy. The IRS lacks the internal capacity and expertise to closely monitor the degree and manner in which the 3,000 tax-exempt hospitals across the country have complied with the letter and spirit of the new reporting requirements, particularly in terms of the population health dimensions. That having been said, the new reporting requirements have dramatically increased the transparency of tax-exempt hospital community benefit practices. The opportunity is for local and regional stakeholders, ranging from hospitals and local public health agencies to community health centers, community-based organizations, and local advocacy groups, to review the data and inform, refine, and better align the investments of all stakeholders.

In a current study conducted by the Public Health Institute, hospital CHNAs and implementation strategies are being reviewed in 15 urban, suburban, and rural communities across the country. The study focuses on how communities are being defined, how stakeholders are engaged, how priorities are set, and the geographic and content focus of implementation strategies. Preliminary findings point to important areas of focus for the improvement of practices. All 15 regional sites include sub-county areas with high concentrations of poverty and high school non-completion. Of 51 hospitals in the 15 regions, there were 43 hospital CHNAs available. Only eight of the 43 CHNAs identified these geographic areas. Among the 43 hospitals that posted CHNAs on their Web sites, 25 also posted their ISs.[3] Among the 25 ISs, only one hospital indicated an intent to focus all programming where health inequities are concentrated; seven others indicated a focus of one or more specific programs in these areas.

Another issue of concern is the lack of attention by the IRS to the importance of *ongoing* community engagement. Currently, hospitals are only required to "take into account" input from community stakeholders at the CHNA stage of the larger community health improvement (CHI) process. This limitation actually reinforces the view that hospitals bear disproportionate responsibility to solve complex health problems in the community context, and undermines a vision of shared ownership for health with the full spectrum of stakeholders; one where all have something to contribute towards the achievement of shared goals and objectives. In a review of the documentation of the priority-setting process and the implementation strategies, there were only a handful of hospitals in the sample that engaged community stakeholders in those processes. It is important to note that all hospitals in the sample met the IRS standard of compliance; few, however, appeared to grasp the value and benefits of ongoing engagement of diverse community stakeholders.

For many, if not most hospitals across the country, this is their first experience with the CHNA process. As such, they should be afforded the appropriate leniency and understanding by both regulators

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2 Internal Revenue Service, 26 CFR Parts 1 and 53, Notice of Proposed Rulemaking, April 5, 2013, p. 29.

3 The posting of implementation strategies is not currently required by the IRS based upon language in the most recent NPRM; hospitals are only required to submit them as attachments to their completed IRS 990, Schedule H form. As such, most of the hospitals in this sample demonstrated a commitment to transparency that goes beyond current IRS requirements.

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and local stakeholders. The impending release of findings from the current study is intended to inform and encourage, rather than excoriate. As such, sites and hospitals will not be identified. That having been said, one of the products of the study will be a set of tools, templates, and a user's guide that will be available to the full spectrum of local stakeholders for the comparative review of hospital, local public health agency, and other publicly available assessments and health improvement strategies.

The Role of the Board

What is the role of the board of directors, beyond a perfunctory review and approval of a hospital CHNA and IS? First, is to ensure that there is knowledge and expertise of population health among board members. Such expertise is optimally beyond a narrow focus on patient populations with common conditions, or panels, to a more in-depth knowledge of people in the social, cultural, and environmental context of their communities.

Second, as has been undertaken by a growing number of hospitals, the board should consider the formation of a competency-based board committee that can provide ongoing oversight of programs, activities, integration with clinical care functions, and advancement of larger population health goals and objectives. In most cases, boards lack the time and expertise to carry out this important function.

Third, health systems are well advised to assess the current population health capacity of their hospitals, focusing on staff FTE levels, competencies, and reporting relationships. One of the most significant obstacles to the advancement of practices is a lack of knowledge and accountability among local senior leadership. Moving forward, taking definitive action in this area will be essential to ensure a focus on excellence and accountability.

In a recent article,[4] Joint Commission CEO Mark Chassin laments the slow progress in the movement towards increasing patient safety nearly 14 years after the release of the Institute of Medicine's report *To Err Is Human.* In order to move forward in a more definitive manner, Dr. Chassin calls for more effective tools that reflect the complexity of the challenges in improving quality in hospitals and health systems. As hospitals move into the highly complex world of improving health in the community context, a similar level of attention and tools are needed at both the governance and leadership level to ensure an appropriate focus on quality and accountability.

The Governance Institute thanks Kevin Barnett, Dr.P.H., M.C.P., senior investigator, Public Health Institute, for contributing this article. He can be reached at kevinpb@pacbell.net.

4 Mark Chassin, "Improving the Quality of Health Care: What's Taking So Long?," *Health Affairs*, Vol. 32, No. 10 (2013), pp. 1761–1765.