Building Population Health Capacity: Issues and Opportunities for Board Consideration

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Proceeding in an Environment of Uncertainty: Population Health and Health Reform

Population health is a hot topic these days, as hospitals and health systems navigate the expansion in coverage and payment incentives begin to shift from volume to value. The pace of change varies substantially across the country, with states such as Massachusetts, Minnesota, Oregon, and Vermont moving rapidly towards global budgeting. Seventeen states have received funding through the Centers for Medicare and Medicaid Services State Innovation Model (SIM) initiative to support a variety of innovations linking healthcare reform and broader population health improvement. At the same time, a number of states in the Southeast, Midwest, and Mountain states continue to reject the federal Medicaid expansion. Associated financial pressures have contributed in some cases to closure of safety net institutions[1] and limit the ability of other hospitals to make strategic investments necessary to adapt to the changing environment (e.g., information systems development, systems redesign).

In states and regions where healthcare reform is advancing, there is growing imperative to move beyond episodic treatment of symptoms to focus on the whole person—to build an understanding of how people interact with their specific environments, and the positive or negative impacts of those interactions. This, in turn, leads inquiry beyond individual patients to how health and illness is manifested at the population level in the context of communities in which people live.

Coming to grips with these issues creates discomfort, since much of what drives health is outside of what can be done in clinical settings. Moving to a value-based system involves assuming financial risk for actions outside of the direct control of providers. An early step being taken by a growing number of healthcare organizations is to implement models of team-based care that include non-clinical members such as community health workers. These team members serve as important intermediaries between clinical service delivery and broader community health improvement. The redesign of clinical care models is an important part of a complex set of reforms that are needed in a rapidly changing environment. As such, most, if not all, provider organizations are on a steep learning curve.

Defining Population Health

Let's get on the same page about the meaning of "population health." In 1997, David Kindig offered a definition of population health as "the aggregate health outcome of health-adjusted life expectancy (quantity and quality) of a group of individuals, in an economic framework that balances the relative marginal returns from the multiple determinants of health."[2] The use of an economic framework was intended to highlight the fact that there are trade-offs in selecting options to address the multiple determinants of health. Given limited resources, those choices have consequences. Determining the correct choice is driven by how much improvement in a specific health measure is produced by alternative interventions (or sets of interventions). A more stripped-down definition of population health was offered by Kindig in 2003 as *"the health outcomes of a group of individuals, including the distribution of such outcomes within the group."* The qualifying phrase focusing on the distribution of outcomes was intended to encourage inquiry into factors that contribute to disparities. In a recent article, Kindig indicated that his 2003 revision was driven by a desire to give more focused attention to health outcomes in the allocation of resources.[3]

In 2007, the Institute for Healthcare Improvement (IHI) introduced the Triple Aim framework. The Triple Aim established three goals for healthcare: to 1) improve patient experience, 2) improve population health, and 3) reduce per capita expenditures. While the Triple Aim has served as a powerful tool to support a shift in emphasis from volume to value in the delivery and financing of healthcare, there has been a tendency among provider organizations to narrowly interpret the population health dimension of the Triple Aim as clinically defined populations, or panels of patients. Common groupings are patients with chronic diseases, and the focus is on the development of clinical management strategies to reduce the acuity of those conditions. In a recent IHI leadership blog, Ninon Lewis, Director of IHI's Triple Aim for Populations Focus Area, notes that some healthcare organizations have overlooked the

Key Board Takeaways

Board members should work with leadership to ensure there is a quality improvement approach to community benefit that helps to build internal population health capacity. Specific questions to think through include:

- Is programming informed by analysis of utilization data (e.g., the volume of preventable emergency room and inpatient visits among uninsured and underinsured patients)?
- Have we used geographic information systems to identify and focus resources in sub-county areas where health disparities are concentrated?
- Are we directing charitable resources towards proactive strategies that address key drivers of poor health in the communities?
- Are we building partnerships with external community stakeholders to align and leverage our resources?
- Have we set measurable objectives for programming, and are we monitoring progress to determine whether those objectives were achieved?
- Is there strategic coordination between community benefit, finance, and population health planning?
- What are the mechanisms for oversight and accountability for community benefit performance?

1 Nearly 50 rural hospitals have closed in the last four years; See Dionne Searcey, "Hospitals Provide a Pulse in Struggling Rural Towns," *The New York Times,* April 29, 2015.

2 David Kindig, *Purchasing Population Health: Paying for Results,* University of Michigan Press, 1997.

3 David Kindig, "What Are We Talking About When We Talk About Population Health?" *Health Affairs* Blog, April 6, 2015, (available at http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/).

population health dimension altogether, "focusing instead on quality, satisfaction, and costs, often in acute care settings."[4]

This more narrow interpretation (or avoidance) of the population health dimension is driven at least in part by the predominance of the fee-for-service, or "volume-based," payment system. In this context, while effective implementation of population health management may reduce patient suffering (and improve their health), it also contributes to reduced revenue for insured populations.

> Moving to a value-based system involves assuming financial risk for actions outside of the direct control of providers. An early step being taken by a growing number of healthcare organizations is to implement models of team-based care that include non-clinical members such as community health workers. These team members serve as important intermediaries between clinical service delivery and broader community health improvement.

In a recent commentary in *Trustee* magazine,[5] William Jessee called for hospital and health system board members to judiciously monitor investments in population health, demanding that leaders "make the business case" prior to authorization of resource allocations for the design of new delivery models, information systems, hiring non-clinical personnel, and community outreach. He noted that in regional environments where fee-for-service reimbursement is dominant, effective investments could create "a financial disaster" for hospitals in the form of reduced admissions, tests, and procedures.

Jessee acknowledged that many hospitals and health systems already engage in community outreach programs as part of returning benefits to communities in fulfillment of their tax-exempt obligations. It is important to note, however, that while these investments could (and optimally, should) yield some form of measurable outcomes for populations and communities, they are not expected to produce net financial returns for hospitals. On the contrary, hospitals and health systems are expected to make net investments of charitable resources that are at least equal to the financial value of their tax exemption.

At present, community benefit expenditures of most hospitals and health systems are primarily in the form of charity care and public pay shortfalls for Medicaid patients. A small portion of these portfolios include educational events such as health fairs and screenings, and a few strategic investments in community health improvement programs. The historical tendency has been to simply tally up and report these expenditures, giving little attention to whether they represent optimal stewardship of available resources. Rather than evaluating the relative effectiveness of alternative resource allocations, many hospitals have a compliance orientation that focuses primarily on whether the net charitable contribution meets financial targets aligned with their tax-exempt obligations.

A growing number of hospital and health system leaders are taking a closer look at current community benefit resource allocations and asking important questions, including the following:

- Does the current configuration of programs and services represent the most cost-effective use of our limited charitable resources?
- Can we point to measurable outcomes produced by our charitable resource allocations that demonstrate a commitment to improve community health?
- Are we building partnerships with external stakeholders with shared interests in improving community health to leverage our resources?
- In what ways are we aligning our community benefit resource allocations with our core business strategy to build population health capacity?

These leaders are shifting their emphasis away from a compliance orientation to community benefit, and towards a quality improvement approach to community health improvement. Rather than simply tally financial totals, they're asking critical questions about the relative value of alternative options. Of equal importance, they have recognized the opportunity for a more integrated approach that aligns community outreach, workforce development, the design of new care models, and information systems development.

In this context, community benefit portfolios can serve as an "investment pool" to help meet strategic goals such as building internal population health capacity. As addressed later in this article, there are effective strategies to pursue both in markets dominated by fee-for-service reimbursement and those that are shifting more rapidly to value-based payment.

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Internal Alignment and Integration

A key step in the process of alignment and integration of efforts to build hospital population health capacity is to assess existing community benefit structures and functions. An early model for the assessment of internal population health capacity was employed in a multi-state demonstration

4 Ninon Lewis, "A Primer on Defining the Triple Aim," IHI Leadership Blog, October 21, 2014.

5 William Jessee, "Is Your Hospital Ready for Population Health?" *Trustee,* February 9, 2015.

project entitled Advancing the State of the Art in Community Benefit (ASACB).[6] Participating hospitals and health systems focused their assessment in three areas: staffing, reporting relationships/departmental links, and oversight structures.

Staffing

Key areas of focus include full-time equivalent (FTE) levels, scope of required competencies, and job responsibilities. Job descriptions should outline not only population health-related competencies (e.g., expertise in epidemiology, program design, evaluation, community engagement), but also responsibilities that delineate the elements of the larger community health improvement process and integration with internal structures and functions (e.g., finance, care coordination, primary care, strategic planning). Those responsibilities include specific accountability measures and FTE component allocations. A standard job description was developed and adopted by ASACB partners.

Reporting Relationships/ Departmental Links

In reporting relationships, supervisors of community benefit staff should have at least a basic knowledge of community health improvement, and accountability to ensure quality in the portfolio of charitable investments. If the supervisor is a member of the senior leadership team, part of their responsibilities are to ensure that there are

regular briefings on the status of relevant work. If the supervisor is not a member of the senior leadership team, their responsibilities should include regular reporting to that senior leader, with attention to alignment with other relevant department functions.

Other department leaders with relevant responsibilities (e.g., finance, strategic planning, data/information, quality, care coordination, human resources[7]) should also have specific language in their job descriptions and associated accountability to facilitate timely coordination of efforts with the community benefit/population health functions in the hospital. For example, finance and care coordination leaders should work with community benefit staff to link patient utilization data with geographic information system (GIS) coded demographic and related data that highlight common and distinct factors and support more precise targeted programs and resources. In order for this to occur, there needs to be specific expectations and reporting of findings from these analyses at the senior leadership and board level.

Finally, hospitals are beginning to think more about the role of their CEOs in the improvement of community health. In the process, more attention is being given to quality and outcomes, rather than simply financial totals. In the ASACB demonstration, partners developed revised language for the job descriptions of hospital CEOs that explicitly outlined their responsibility for community benefit. The inclusion of such language also ensured that these issues would be addressed in future searches and selections of successors. Some ASACB partners took an additional step, tying annual compensation of CEOs to specific strategic targets such as reducing preventable ED utilization for ambulatory care sensitive conditions.

Oversight Structures

Current IRS regulations call for hospital governing boards to formally approve community health needs assessments (CHNAs) and implementation strategies. In practical terms, however, most boards lack the breadth of competencies and dedicated time to offer more than cursory review and approval. The sheer scale and pace of change in today's environment demands attention of the board to a host of financial and legal issues related to quality, patient satisfaction, infrastructure development, and relationships with providers, vendors, and other healthcare organizations, to name a few examples. As such, the role of the board with CHNAs and implementation strategies is largely to provide legal authorization, rather than substantive review and oversight.

Given these practical realities, many hospitals establish board subcommittees to provide a more in-depth form of oversight. Rather than being presented with a final version of a community health needs assessment or implementation strategy, they have the opportunity to review and provide input at earlier stages of the process. In this way, they can facilitate a more deliberate, quality improvement approach that emphasizes both internal integration and alignment and leveraging resources through strategic alignment with external stakeholders. In the ASACB model, hospitals form committees with board representatives, but with a majority of external stakeholders with relevant competencies. Formal written charters are developed that

6 The Advancing the State of the Art in Community Benefit demonstration was sponsored by a consortium of foundations between 2002 and 2006 and administered by the Public Health Institute, in collaboration with over 70 hospitals and three health systems in four western states.

7 Human resource departments can play an important role in supporting the development of health career pathway programs (e.g., internships and shadowing) for youth in proximal low-income communities who are underrepresented in the health professions.

outline the specific areas of oversight. This specificity signals to staff that they will need to be prepared for a critical review process and signals to committee members that they have substantive roles to ensure optimal quality.

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External Alignment: Hospitals as One Player—a Balanced Portfolio of Investments

As a provider in a value-based payment system in a larger environment where most of what creates health is outside the clinical setting, there is an imperative for hospitals and health systems to align their efforts with a broad spectrum of stakeholders. Hospitals that have taken steps towards the kind of internal alignment described above have a distinct competitive advantage. First and foremost, they have dedicated staff with the competencies, the time and resources, support from leadership, and an oversight structure to ensure a quality improvement approach to community health improvement. In practical terms, they have the space to conduct outreach, build working relationships, assess health-related needs and identify community assets, and work together with diverse stakeholders to design and implement comprehensive strategies that help to effectively address both the symptoms and underlying causes of poor health.

They recognize that "going it alone" practically ensures the perpetuation of the status quo in communities where health disparities are concentrated. The sheer complexity of the interactions between individual behavior, family, culture, and social, physical, and political environments requires intensive focus in targeted geographic areas, alignment of multiple stakeholder investments, agreement on a common set of metrics, and perhaps most importantly, an infrastructure that facilitates, monitors, builds trust, and cultivates an ethic of shared ownership. Stakeholders must move beyond what child psychologists would refer to as "parallel play," delivering services, implementing programs, and taking actions that are not coordinated in a manner in which they can be mutually reinforcing. This includes competing hospitals—while they are expected to compete for patients in providing high-quality clinical services, their long-term viability will be driven in part by their ability to come together and address the drivers of poor health in communities.

Expanding Our Scope

There are a "new" set of players in communities that have not been viewed by most in the healthcare and broader health sector as key partners in improving community health. Truth is, they have been there all along; we just haven't taken advantage of the opportunity to align our respective efforts. Approximately $130 billion dollars in loans are made each year to support community development in low-income communities, a significant proportion of which is provided by financial institutions in fulfillment of their Community Reinvestment Act (CRA) obligations.[8] Another $26 billion are allocated by the federal government in the form of tax credits[9] and community development block grant funding. This funding supports a variety of efforts, including but not limited to affordable housing, grocery stores, child care centers, charter schools, and federally qualified health centers. Four years ago, the Federal Reserve Bank of San Francisco began to convene a series of meetings at district Federal Reserve Bank offices, bringing together representatives of financial institutions and the public health community to discuss the intersection between health and community development, and to explore ways in which public health agencies may

8 The Community Reinvestment Act (1977) authorized federal regulatory agencies to take into consideration investments made by financial institutions in areas of concentrated poverty in their review of proposed mergers and acquisitions. Investments by banks in affordable housing and other forms of physical infrastructure, as well as services such as building financial literacy were intended to help reverse the negative impact of decades of "redlining" practices that concentrated African Americans and other ethnic minorities in low-income neighborhoods with limited access to services, job opportunities, and functioning schools.

9 Low-Income Housing Tax Credit and New Markets Tax Credit programs incentivize investments.

collaborate with the community development community to better align programs, services, interventions, and investments.

The same low-income communities that are the focus for CRA-related investments are also the focus for community benefit resource allocations by tax-exempt hospitals. There is immense opportunity to optimally leverage the resources of both sectors. With this in mind, the initial discussions convened by the Federal Reserve Bank have now been expanded to include the healthcare community to explore ways in which to align the resources of the health and community development sectors.

The field has responded quickly to this opportunity, thanks in part to targeted support from private philanthropic organizations such as The Kresge Foundation, the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, and the MacArthur Foundation. A number of national community development financial institutions (CDFIs) such as The Reinvestment Fund (TRF) and the Low Income Investment Fund (LIIF) have also provided leadership in facilitating dialogue and planning processes. There are approximately 1,000 CDFIs across the country, mostly local non-profit organizations that help organize and aggregate investments from financial institutions and other entities to support development in low-income communities. There are also a number of national initiatives that have been launched to foster intersectoral alignment, including The Way to Wellville, Alignment for Health Equity and Development (AHEAD), the BUILD Health Challenge, and the Build Healthy Places Network.

Finally, there are a small number of health systems[10] that have been working in this intersection for some years, carving out a small percentage of their larger investment portfolios to provide low-interest loans for community development; often at the pre-development phase, when smaller loans are needed to support the planning phase, securing permits, and infrastructure development. These loans serve as a critically important financial bridge that enables CDFIs to develop a risk reduction strategy that will increase the potential for securing larger-scale loans from financial institutions and other investors for development projects in low-income communities.

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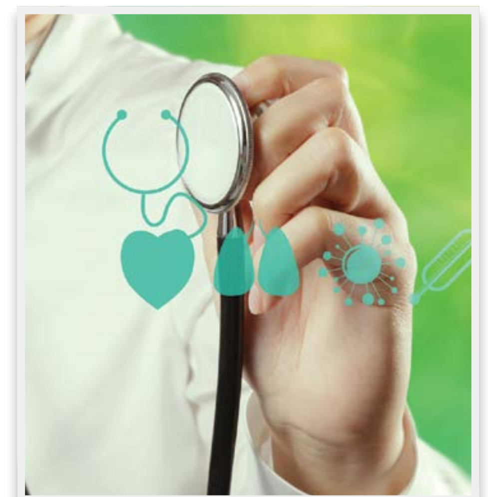
Voluntary Leadership in the Field

In recognition of the need for support to accelerate innovation across the country, two national initiatives have been launched to support collaborative learning processes.

In 2012, the Health Systems Learning Group was established through the leadership of Gary Gunderson and Teresa Cutts at Methodist Le Bonheur Healthcare in Memphis, Tennessee. A network of over 30 health systems (with a core of 10 sponsoring systems) have participated in a series of regional and national meetings in the last three years, most recently at the White House in mid-April.

A team of leaders from these systems developed a monograph released in April 2013 which staked out a three-part agenda: 1) to build more in-depth working relationships with diverse community stakeholders, 2) to more strategically invest charitable resources to reduce preventable utilization and readmissions, and 3) to focus more explicitly on addressing the social determinants of health. The Department of Health and Humans Services' Center for Faith-Based and Neighborhood Partnerships has played a critical role in helping to coordinate these meetings and holding a series of national Webinars to highlight specific innovative practices. Under the new title of Stakeholder Health, this learning collaborative has initiated work on a second monograph for release in 2016.

In the past year, IHI, in partnership with organizations such as Communities Joined in Action and Community Solutions, launched the 100 Million Healthier Lives campaign. The 100 Million Healthier Lives campaign is also a collaborative learning model that views communities as the core focus of a larger transformational process involving the full spectrum of stakeholders with a shared interest in improving community health. In a few short months, there are already over 500 organizations that have joined the campaign. With funding



10 There are three health systems that have provided leadership in this arena: Bon Secours Health System, Dignity Health, and Trinity Health.

from the Robert Wood Johnson Foundation, the SCALE (Spreading Community Accelerators through Learning and Evaluation) initiative was launched under the auspices of 100 Million Healthier Lives to provide funding for 24 communities that have demonstrated commitment to comprehensive approaches to health improvement.

The leadership team of 100 Million Healthier Lives will facilitate technical assistance, documentation and dissemination of innovations, and evaluation processes that help illuminate key elements and lessons to support the broader field. There are a series of both content and geographic "hubs" being formed to support dialogue among leaders in the field; identify, document, and disseminate exemplary practices from across the country; and provide targeted technical assistance to support acceleration and scaling of innovations.

Putting It All Together

Returning to Jessee's commentary in *Trustee*, it is appropriate to be thoughtful about making investments to build population health capacity. At the same time, there is an equal imperative to avoid confusing prudence with inaction. As is demonstrated on a daily basis by leading-edge hospitals and health systems across the country, there is much that can be done, even in environments where payment systems are firmly in fee-for-service mode.

As stated previously, community benefit offers an investment pool to build population health capacity—hospitals have an obligation to make net contributions (if you get a financial return on these investments, that return must be subtracted from the net total reported in fulfillment of your tax-exempt obligations). As such, the more important consideration is how to strategically invest these resources in a way that represents optimal stewardship. Does it produce measurable improvements in health status? Does your approach enable you to provide tangible benefits for a larger number of people? Does it create conditions that help your primary care providers do a better job? Does it help build expertise that will help your hospital thrive economically in a new financial environment?

For hospitals and health systems in predominantly fee-for-service environments, the initial focus for investments of community benefit dollars and building population health capacity should be on

uninsured and underinsured populations, developing proactive strategies that make better use of limited charitable resources. Many of these payment environments happen to be in states that continue to reject the Medicaid expansion—as such, they have a much larger pool of patients for whom investments in population health represent a prudent business practice; you reduce high-cost preventable ED and inpatient utilization, achieve savings (in the form of reduced charity care) that can be reinvested for further capacity building, and build experience with innovations that can be more readily scaled as value-based payment systems emerge.

For hospitals and health systems in environments that are moving more rapidly towards value-based payment, it is time to more explicitly integrate community benefit functions and knowledge into the core business practices. Investments in building GIS capacity and developing team-based care models must be complemented by the development of working relationships with diverse community stakeholders, fostering an environment of shared ownership for health, and focusing strategically in communities where health disparities are concentrated.

Let's be clear: there will be winners and losers in the midst of such profound and rapid change in the field. There will also be mistakes made every day in hospitals across the country—in some cases expensive mistakes. It is important that we learn from these mistakes, make appropriate adjustments, and keep moving forward. Now is not the time to stand on the sidelines.

As for my fellow hospital and health system board members—yes, ask the hard questions—demand that attention be given to prudent business practices, but make sure that your leadership recognizes and is acting on the imperative for fundamental change in the way we deliver and finance healthcare. It is time to move well beyond the four walls of our acute care facilities.

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.