Outside the Walls:

Exa\n\nmining New Opportunities to Successfully Achieve Population Health Improvement

Communities Achieving Excellence and Accountability Conference
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“Successful redesign of health care is a community by community task. That’s technically correct and it’s also morally correct, because in the end each local community – and only each local community – actually has the knowledge and the skills to define what is locally right.”

--Don Berwick
Health Care Transformation – Drivers of Change

- **Delivery Restructuring**
  - Integrated Delivery
  - PCMH – Team Based Approach

- **Patient Engagement**
  - Individual Health Assessment
  - Prevention – Keeping People Well
  - Personal Participation

- **Data Driven**
  - Risk Stratification
  - Measure for Quality/Clinical/Access and Cost Goals

- **Payment For Value Not Volume**
  - Target (reduce) high frequency use
  - Improve Outcomes

- **Community Assets and Public Health Tools**
  - Community Needs Assessment
  - Environmental and Socioeconomic Factors
Things To Consider This Morning and Going Forward..

Health Care is Undergoing Rapid Transformation
Moving from Volume to Value
Think: Auto Industry 1970’s and ‘80’s
Redesign is at Multiple Levels
Hard wired data and value - ROI

Three-level Chess
National – Policy Change and Payment
States – Medicaid as a Laboratory
Local – Place-based Disruption

We Are All Now In the Business of Health Care
What is Your Next Step?

*In a time of rapid change, standing still is the most dangerous course of action*

*Say Quotable*
The goals of improved health, improved care quality, and lower per capita cost of care have become the organizing framework for the U.S. health care system, injecting patients’ social needs into the health care continuum.

New public and private payment models are holding providers accountable for health care quality and costs; almost two-thirds of providers report they are signing value-based contracts with commercial payers.¹

With Medicaid expansion for adults with incomes up to 133% FPL and the availability of subsidized coverage for individuals and families with incomes up to 400% FPL, the demand for care has increased.

## Payment Drivers...the Business Case for Change

**Enhanced Reimbursement**

Delivery models that incorporate interventions addressing patients’ social needs may be eligible for enhanced reimbursement, such as through:

- Payment incentives for Patient-Centered Medical Home (PCMH)-recognized providers, that are required to **deploy care coordination** and self-care supports with **linkages** to community social service agencies
- Health home provisions under the Affordable Care Act (ACA), which allow for reimbursement for social interventions targeted towards complex, chronically ill patients
- New Medicare payment codes for complex care management services that assess and address patients’ psychosocial needs

**Shared Savings**

Shared savings programs incent providers to reduce spending on a defined patient populations by sharing savings. Providers who are successful in shared savings programs **address their patients’ social needs.** Examples can be found in:

- Medicare Shared Savings Program and Pioneer ACO Program
- Medicaid ACO pilots

**Capitated, Global, and Bundled Payments**

New capitated payment models require providers and provider systems to take risk for managing covered services within a fixed budget, **implicating patients’ social needs.** Examples include:

- Medicare Bundled Payments for Care Improvement Initiative
- Oregon Coordinated Care Organizations
- Medicaid managed care organizations, including emerging programs for dual eligibles

**Readmission Penalties**

Social factors are linked to readmissions risk. Providers are now financially penalized for excess 30-day readmissions under the ACA’s Medicare Hospital Readmission and Reduction Program, incentivizing hospitals to address social needs as part of their efforts to reduce readmissions.
Integrated Delivery Networks – Community Health

How will large integrated systems connect with diffused community infrastructure?
The Patient Centered Medical Home – Direct Community Linkage

- Team Based Care – Not Physician Centered – Patient Centered
  - Physician
  - Nurse
  - Medical Assistant
  - Care Coordinator
  - CHW
  - Social Worker
- Access is Convenient
  - More online tools
  - Appointment and Personal Information
- Focus is on Wellness & Prevention
  - Health Coach
  - Targets behaviors
- How Patient Experiences Care is Critical
  - Patient Assessment for SDH
  - Satisfaction with Service – ties to reimbursement
- Process Improvement is Continuous
- Care is Coordinated
  - Embedded Care Management
  - Coordination Across Clinical and Community Settings
- Data
Getting Outside the Walls....

• You cannot go it alone.
• Success requires partnership with community.
• It takes time to find common ground and build trust.
• The challenge: bridge differences

Population Health cannot succeed without linking directly to the places where people live, work and play.
“A recent study in Health Affairs found the risk for hospital admission for hypoglycemia in low-income patients with diabetes increased by 27% during the last week of the month when food budgets are strapped and food stamps run out — compared with the first week of the month.”
Resource Alignment: Addressing Those With Greatest Need

Complex Patients & Multiple Social Determinants
Identify and use community assets to stabilize people

- Homeless
- High risk pregnancy
- Parolees
- Behavioral Health Including Substance Use
- Multiple Chronic Conditions
- Dual Eligible – poor and fragile
- Heavy use of ED
# Clarke’s Story

## Medical Situation
- History of Chronic Illness
- Entered through ED
- Hospitalized – Including Intensive Care
- Diagnosed with Ventricular Aneurism
- Stabilize for Surgery
- Discharged with Physician Orders including daily monitoring of medication – Coumadin
- Bill at Discharge: $25,000

## Personal Situation
- Homeless
- No Income/No Job
- No Primary Care Physician
- Substance Use Disorder – long term
- Uninsured
- No Family or Other Support System
- Failed Mental Health Exam
- No Personal Identification/Paper Trail
- No Transportation
- No Ability to Manage Diet
“If the not-for-profit hospitals that dominate the healthcare system really want to become health stewards of the populations in their catchment areas—and not just “sick care” institutions—their community benefit priorities need to change.”

Modern Healthcare - 2016
Before ACA: Hospital CB Programming/Investment – Chaotic

- **Activity** (Sponsored by Physicians)
- **Activity** (Sponsored by Board)
- **Activity** (Sponsored by Administration)
- **Activity** (Sponsored by Mission)
- **Activity** (Sponsored by Community Benefit)
- **Activity** (Sponsored by Nursing)

**Disorganized Chaos**
The Needs Assessment and Implementation Plan – 501(r)

CONDUCT ASSESSMENT – GATHER AND ANALYZE DATA

• Shared Process
• In collaboration with others
• Hospitals, state, local health departments, community*
• Demographic data – qualitative and quantitative

INCLUDE INPUT FROM PERSONS

• State, local, or regional governmental health department
• Members medically underserved, low-income, minority populations
• Written comments on previous assessment and implementation strategy

*Joint assessment and implementation strategy permitted if same definition of community used by all participants and each hospital clearly identified.
Poor Accountability Drives New Requirements

Hold non-profit hospitals to a higher standard;
Penalize those that don’t deliver;
Failure to complete CHNA or CHIP face a potential $50k fine;
Penalties can accumulate and might jeopardize tax exemption;
Define and Validate Needs Assessment Priorities

Establish criteria to identify priorities - could include

1. Burden
2. Scope
3. Severity or urgency of the need
4. Estimated feasibility and effectiveness of interventions
5. Health disparities associated with the need
6. Importance the community places on addressing the need

Identify priorities with community input using methods such as ranking, discussion and debate; Validate priorities - confirm with community and internal staff
Community Benefit Requirements

GOP senators press IRS on enforcement of community benefit standards

By Susannah Luthi | February 15, 2018

Leading GOP senators are pressuring the IRS on whether not-for-profit hospitals are meeting the standards of charity care and other community benefits required of their tax-exempt status, and how the agency enforces current policies if they’re not.

In a letter to David Kautter, acting commissioner of the IRS, Senate Finance Committee Chair Orrin Hatch (R-Utah) and Judiciary Committee Chair Charles Grassley (R-Iowa) demanded to know whether the agency collects information on not-for-profit’s contributions to their communities.

Not-for-profit hospitals are required to contribute to their communities based on assessment of their community’s health needs as part of their tax-exempt status.

- Every 3 years – Every nonprofit hospital is audited for compliance;

- There is a sense that hospitals are not doing enough; Transparency...

- http://www.communitybenefitinsight.org

- Mr. Grassley is returning to the Finance Committee – reportedly – is interested the progress by hospitals since the ACA passage;
Intersection: Population Health and Community Need

- Can we see our CHNA –
- What are we Investing In?
- Community/Clinical Linkage for Referrals
- Who can we refer our patient to?
- How Do I get a Community Health Worker?
Where We Grow Up Matters

Children from poor families who grow up in this tract are expected to earn about $33,000 a year in their adult households.
Hot Spotting Tools: Geo-Mapping Community – Zip Code 83704

Mapped Records: 6,527  Total Records: 6,598
Using the Resilience Zone Model as a Population Health Strategy To Address The Social Determinants Of Health

Muskegon’s Community Health Innovation Region (CHIR)

Health Resilience Zones

Goal of Health Resilience Zones
Putting better health, community development, and economic well-being in reach for all

Why Health Resilience Matters
Data show that nearby zip codes, or even adjacent neighborhoods, can often have striking differences in health outcomes. It’s not just access to medical care that causes health disparities.

First, we must shift our investments to the place where health happens the most: our communities.

Each Health Resilience Zone conducts a collaborative community-led needs assessment.

Diverse teams plan to address social, economic, and environmental needs preventing people from being as healthy as possible.

Investments are made to address differences in health outcomes.

Health Resilience Zones are geographic areas.

Community

Research tells us that healthy communities have adequate transportation, employment opportunities, clean, safe, and affordable housing, parks and open space, access to fresh, healthy foods, a high-quality education system, and safe streets. Those offer the best return on investment in health: places where people want to live, work, learn, and play.

Muskegon’s Community Health Innovation Region (CHIR)

CHIRs are mandated to achieve population health improvement by addressing those upstream social determinants of health.

Why CHIRs Need Health Resilience Zones

80% of our health is determined outside the doctor’s office and inside our homes, schools, jobs, and neighborhoods.

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Muskegon’s Community Health Innovation Region (CHIR)

CHIRs are mandated to achieve population health improvement by addressing those upstream social determinants of health.

Health equity recognizes the differing community needs, investing in the specific resources each community needs to give everyone a fair chance at good health.
Our Zone

Muskegon Heights Census Tract 14.02
Census tract 14.02 has a population of 4,442 residents. Of this number 2,057 or 46.2% are male and 2,385 or 53.7% are female. 31% of the population are children under the age of 18.

- **EMPLOYMENT**: Of individuals aged 16 and older 46.8% are in the labor force while 14.8% are unemployed and 38.4% identified as not in the labor force.
- **INCOME**: 22% of those in all households (N=1,628) have income of less than $10,000 a year. In total 57% of all households have an annual income of $24,999 or below. The median earnings for workers (full and part-time combined) who live in the Zone is $16,517.
- **HEALTH INSURANCE COVERAGE**: 3,025 or 68.1% of individuals living in the Zone have public health insurance coverage and 482 individuals (10.9%) are uninsured.
- **EDUCATION**: Of individuals aged 18 – 24 (N=489) 81 or 32% have less than a 9th grade education; 317 or 64.8% have graduated high school or have an equivalency degree. Of individuals 25 years and over (N=2564) 3.2% have less than a 9th grade education and 15.4% have some high school but no diploma.
- **POVERTY AND EDUCATION**: 45.5% of those without a high school diploma live in poverty as does 31% of those with only a high school diploma.
- **HOUSING**: There are 1,990 housing units in census tract 14.02 with most – 81.8% being occupied. Most of these housing units – 80.4% are single unit detached. The housing stock is old – 84% was before 1960 with 64% built before 1940.
- **TRANSPORTATION**: 26.2% of households have no vehicle available to use; with 44.3% have one.
CHIR Aims

- Health Equity
- Resilience Capacity

Primary Drivers

- Resident Stakeholders:
  - Zone Residents
  - Local Churches
  - Local Educators
  - Public Safety
  - Civic Associations

Institutional Stakeholders:

- Businesses
- Government
- Philanthropy
- Hospital CB
- CRA Funds

Empowerment Partnerships

- SDoH Screens
- ACEs Screens

- CHIR / ABLe Change Process

Operational Partnerships

- Local Engagement

- CHIR Oversight

Secondary Drivers

CHIR Strategies For System Change

- Improved Medicaid Outcomes: Community clinical linkage, PCHM engagement, CHW & health coaching strategies to reduce ED utilization and improve population health metrics

- Medicaid Employment Support: Education and workforce development strategies

- Housing Security: Affordable housing and neighborhood safety strategies

- Food Security: Strategies to ensure sustained access to nutritional food and dietary education

- Harm Reduction: Strategies to support a trauma informed community based on the ACEs screening

- Employment Opportunity: Strategies to partner with business through Opportunity Zone investments

- Health Coverage Alignment: Strategies to align affordable coverage to support transitioning from Medicaid to private coverage

CHIR capacity development to empower residents of a Resilience Zone to address the social determinants of health and improve the population health of the zone.

& System Change Targets
Improving Health Equity in Muskegon

Goal 1: Transform the Zone
Improve Social Determinants of Health Equity in 8 block zone of Muskegon Heights

Who is working on this goal?
Zone residents and local organizations

Goal 2: Transform the System
Improve cross-sector service system coordination and alignment, responsiveness to resident voice, and system policies and practices promoting equity

Who is working on this goal?
Organizations across the county with input from residents

System Policies and Practices Promote Equity

Healthy Thriving Residents

Zone Work

Other areas prioritized by Zone residents

Mental Health & Substance Use Support

Healthy Food Access

Equitable, High Quality Education

Social Cohesion in Trauma-Informed Community

Affordable Housing

System is Coordinated and Aligned

System is Responsive to Resident Voice
Community Care Management

Identify the Social Determinants of Health
  • Patient Assessment

Identify Community Resources – Align with Needs
  • CHNA – Where are Resources?
  • Gap Analysis – Where do you need to build Capacity?

Create a Process for Coordinating linkage to Community Resources
  • Eliminating Silos to Allow for Coordination and Data Sharing

Assist patients with accessing resources
  • ACO or PCMH Staff
  • Use of a HUB
  • 211 Linkage

Document – DATA – success and feedback loops to referral source
...screening for social determinants can detect adverse exposures and conditions that typically require resources well beyond the scope of clinical care. Screening for any condition in isolation without the capacity to ensure referral and linkage to appropriate treatment is ineffective and arguably, unethical...

Avoiding the Unintended Consequences of Screening for Social Determinants of Health
http://jama.jamanetwork.com/
July 21, 2016
## Patient Screening Tool - Example

### Social Determinants of Health: Patient Question Domains

<table>
<thead>
<tr>
<th>Domain</th>
<th>Question</th>
<th>Response</th>
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</table>
| Healthcare                    | In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby?  
In the past year, was there a time when you needed to see a doctor but could not because it cost too much? | Yes      |
| Food                          | Do you ever eat less than you feel you should because there is not enough food?                                                                                                                                | Yes      |
| Employment and Income         | Do you have a job or other steady source of income?                                                                                                                                                           | Yes      |
| Housing and Shelter           | Are you worried that in the next few months, you may not have safe housing that you won, rent, or share?                                                                                                      | Yes      |
| Utilities                     | In the past year, have you had a hard time paying your utility company bills?                                                                                                                                  | Yes      |
| Childcare                     | Does getting child care make it hard for you to work, go to school or study?                                                                                                                                 | Yes      |
| Education                     | Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?                                                                     | Yes      |
| Transportation                | Do you have a dependable way to get to work or school ad your appointments?                                                                                                                                  | Yes      |
| Clothing and Household        | Do you have enough household supplies? For example, closing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.                                                                                     | Yes      |
| General                       | Would you like to receive assistance for any of these needs?                                                                                                                                                 | Yes      |
|                               | Are any of your needs urgent?                                                                                                                                                                               | Yes      |
Community Benefit Population Health Hub & Spoke Model

Sample community and CB programs/services

CB programs listed are examples only
Sample Housing HUB
Comprehensive Health Improvement Plan
The Development of an Individual CHIP

**Patient Assessment**
- Patient HRAs
- SDoH Screenings
- Biometric Screenings
- Patient Risk Analysis
  - Tiered Risk Analysis

**Patient Engagement**
- Personal CHIP Development
  - Based on Risk Tier
  - Disease & Lifestyle Focus
  - Health Coaching Support
  - Patient Compliance Support
  - Health Education
    - Lifestyle Improvement Classes
    - Chronic Disease Management
  - SDOH Advocacy
    - SDOH Pathways
    - Health Advocacy

**Practice Engagement**
- Care Coordination Support
  - Community Clinical Linkage
  - SDoH Support

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Patient Engagement Practice Engagement
Medicaid Is Changing – What Will Be the Local Impact?

- **WORK REQUIREMENTS**
  (Arkansas & Michigan)

- **GED SUPPORT**
  (PA – Medicaid Health Plan)

- **RISK BEHAVIORS**
  (Wisconsin)

- **HOUSING**
  (Under Discussion)

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**CMS may allow hospitals to pay for housing through Medicaid**

By Paul Barr and Virgil Dickson | November 14, 2018

(*Updated at 5 p.m. ET*)

HHS Secretary Alex Azar on Wednesday said Medicaid may soon allow hospitals and health systems to directly pay for housing, healthy food or other solutions for the "whole person.*

In a speech supported by the Hatch Foundation for Civility and Solutions and Intermountain Healthcare in Washington, Azar said Center for Medicare and Medicaid Innovation officials are looking to move beyond existing efforts to partner with social services groups and try to manage social determinants of health as they see appropriate.
SDoH Coverage Model Characteristics

Multi-share SDoH Coverage Model
• Market: Uninsured, low-income, workers in small business
• Non-insurance (unregulated), first dollar coverage
  ▪ Member & business partner shares at $65 PMPM
  ▪ Subsidy share at $130 PMPM
• Comprehensive benefits & Access Health CHI services

Financial Assistance SDoH Coverage Plan
• Market: Uninsured participants in hospital’s financial assistance program
• In-network medical care & eligible community health resources
• Access Health CHI services
Population Health Is Disruptive
Managing Disruption Requires a Shared Vision

• It’s like a Mission or an “Audacious” goal...

• Demands a common/shared understanding by partners;

• Partners willing to give up personal or organizational agenda for the common good;

• Based on Cross Sector Collaboration:
  • Stakeholder disagreement is common
  • Consider the use of an external facilitator to help guide the process

• Alignment around a common goal is intended to also align resources;

• Funding requests evolve to show continuity – reducing fragmentation in the community;

• A common agenda requires an understanding of root cause;
Shared Vision – A Balanced Portfolio of Interventions – Linking Silos
Example: ED Data Indicates Recurring Asthma Episodes

- TREATMENT
  - Acute Care
  - Primary Care
  - Emergency Room
  - PCMH/FQHC

- INTERVENTION
  - Clinical-Community
  - CHW Navigators

- INTERVENTION
  - Human Services
  - SOCIAL DETERMINANTS

- PREVENTION
  - Community and Consumer Education

- ENVIRONMENTAL
  - Smoke-free Zones
  - Air Quality

- POLICY & SYSTEM CHANGE
  - Housing Codes
  - Tobacco Tax
Shared Measurement

Success is measured through the use of common metrics;
- Mining data – Your CHNA;
- Use of a dashboard

Use of data by each of the partners is one way that the Collective Impact model holds the partners accountable for their part in the continuum of activity;
- Partners understand the importance and power of shared data
- Decisions are made based on this data
- Partner responsibility is tracked

Transparency of data also allows for the ability to spot patterns, identify solutions and respond rapidly to environmental change;
- Camden Coalition – targeting utilization & cost
- Jesse Tree Program – Galveston Texas – targeting food insecurity & access
Be Strategic: This is the Key to Managing Population Health!

one bite at a time...
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