Implementing and Integrating Population Health in Hospital Work

Tatiana Lin, KHI and Cindy Samuelson, KHA
2019 Population Health Workshop
June 28, 2019

Presentation Overview

• KHA and KHI Collaboration on Population Health
• Resources and examples
• Integrating population health in:
  • Community Health Needs Assessments (CHNAs)
  • Community Benefit
  • Strategic Planning
  • Daily Work
• Implementing strategies across areas (e.g., transportation, housing)
Population Health: Awareness and Education on the Hospital’s Role

- KHA/KHI population health collaboration
- Population health survey of hospital leaders
- Case studies of Kansas hospitals
- County health rankings event
- Implementing and integrating population health

Summary Definition of Population Health

Strategies that link clinical and non-clinical approaches (such as housing or access to food) for improving the health of a group of individuals, including the distribution of such outcomes within the group. These groups can be geographically defined (e.g., zip code or city) or they may share some characteristics (such as age or income level).

Survey of Kansas Hospital Leaders

- Definition of population health
- Drivers of population health activities
- Types of activities
- Challenges / barriers
- Resource and education needs

Population Health Survey: Key Findings

Three-quarters (75.5%) of survey respondents agreed or strongly agreed that their hospital should focus on addressing the health of population beyond patients.

"Improve health of the community" and "reduce readmissions" were identified by respondents as the strongest incentives for addressing population health.

"Available funding" was identified by respondents as the main challenge associated with addressing social and economic factors in the community such as housing and transportation.
A higher proportion of respondents implemented population health efforts in the areas of “access to health care” and “access to physical activity,” while a lower proportion of respondents implemented efforts in the areas of “housing” and “environmental quality in the community.”

More hospitals tended to engage in activities focused on providing referrals to community services, and fewer respondents implemented activities that involved advocating for policies.

To advance population health, respondents indicated that hospitals will need assistance identifying funding sources for covering this work and training on evidence-based strategies.

Figure 3. Awareness, Interest and Implemented Activities by Population Health Area

Population Health Video

The Value of Population Health and Strategies for Engagement

17-minute video
Discussion Guide Available
Neosho Memorial Regional Medical Center in Chanute and Republic County Hospital in Belleville were the satellite locations of "County Health Rankings in a Changing Kansas."

Highlights

• Partnership: KHI and KHA
• More than 170 participants (in-person, online and satellite sites)
• Local and national speakers
• Discussion: County Health Rankings, demographics, behavioral health

Population Health vs. Population Health Management

Source: American Hospital Association, 2018 Population Health Survey
Community Health Needs Assessments: Strengthening Population Heath Focus

CHARITABLE HOSPITALS MUST:
• Complete Community Health Needs Assessment
• Meet Financial Assistance Policy Requirements
• Adhere to Limitations on Charges
• Follow Billing and Collection Practices

The Affordable Care Act, enacted March 23, 2010, created a new IRS Code Section 501(r)(3) which imposes four additional requirements for hospitals exempt from taxation under Section 501(c)(3).

CHARITABLE HOSPITALS MUST:
• Complete Community Health Needs Assessment
• Meet Financial Assistance Policy Requirements
• Adhere to Limitations on Charges
• Follow Billing and Collection Practices
Community Health Needs Assessments

- Conduct at least once every three years.
- Define the community served.
- Assess health needs of the community served by the hospital.
- Include input from persons who represent the broad interest of the community, including those having public health knowledge or expertise.
- Make two subsequent CHNA reports widely available to the public.
- Include on hospital Web site; give to anyone who asks.
- Adopt a written implementation strategy to address identified community needs that is adopted by an authorized body of the facility.
- Failure to comply results in excise tax penalty of $50,000 per year.

Patient Protection and Affordable Care Act (Health Care Reform Law March 23, 2010)
* Notice 2011-52 – must be approved by authorized governing body (board of directors)

Population Health: Community Engagement

Use culturally, linguistically and physically appropriate methods to increase participation of community residents and community-based organizations.

- Build personal relationships
  - attend community driven gatherings
- Create welcoming atmosphere
  - utilize facilitators from the community
- Increase accessibility
  - address barriers (language, location, time, transportation, childcare, power dynamics)
- Develop an alternative methods of engagement
  - conduct interviews, photovoice
- Maintain presence within the community
  - establish places for ongoing interactions
- Partner with diverse organizations
  - connect with organizations who have already ties with target communities
Engagement Beyond Surveys

Focus Group 1 Participants in Hays, Kansas
November 6, 2012
Lisa Kenney, Health Department Director
Shane App, Community Relations
Audrey Scriver, Director
Lynne Noller, Superintendent of Schools
Jennifer Jones, Director of Case Management
Bridget Fling, Director of Community Relations
Darin Miller, Executive Director
Mike McGill, Director
Amy Henninger, DOD
Terri Beck, CIC
Shelley Boleyn, Coordinator

Focus Group 2 Participants in Manhattan, Kansas
November 6, 2012
Susan Hinkle, Executive Director
Lee Wolf, CEO
Casey Strickland, Park Superintendent
Lisa Doty, Director of Communications
Ruth Mull, RN, Manhattan High School
Madonna Gable, Emergency Room Charge Nurse
Joel Werner, Emergency Room Charge Nurse

Focus Group 3 Participants in Manhattan, Kansas
November 16, 2012
Ellyn McCoy, Director of Public Health
Kasey Anderson, Administrative Director
Robert Cole, Executive Director
Jennifer Ouellet, Director
Lucy Hillinger, Health Education
Beverly Ugle, Executive Director
Andy Hutchinsen, Program Director

Population Health: Data Collection

Include data collection on health disparities, social and economic determinates of health impacting vulnerable populations within its community.

- Collection methods: community surveys, focus groups, data hospitals collected through routine screenings.

How Does This Indicator Differ By...?

Race/Ethnicity

Geography

Income

Education

Which group is the best performer?
Who is not doing well?
What is the difference between them?
Is it meaningful?
What factors could be contributing to that difference?
Example: Population Health: Data Collection on Disparities

Table 1. Adults not participating in recommended aerobic and strengthening physical activity

<table>
<thead>
<tr>
<th>State of Kansas 2015</th>
<th>Significantly less likely to participate in recommended strength training and aerobic exercise among:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females Compared to Males</td>
</tr>
<tr>
<td>Adults aged 25 years and older</td>
<td>Compared to Adults 18 – 24 years</td>
</tr>
<tr>
<td>Hispanics and non-Hispanic African-Americans*</td>
<td>Compared to Non-Hispanic Whites</td>
</tr>
<tr>
<td>Lower education**</td>
<td>Compared to Higher education</td>
</tr>
<tr>
<td>Lower annual household income</td>
<td>Compared to Higher annual income ($50,000 or more)</td>
</tr>
<tr>
<td>Disability</td>
<td>Compared to Living without a disability</td>
</tr>
<tr>
<td>No insurance</td>
<td>Compared to Insured</td>
</tr>
</tbody>
</table>

* Age-adjusted to U.S. 2000 standard population
** Douglas County Disparity

Population Health: CHNA’s Priorities

The hospital’s CHNA report identifies at least one health disparity, social and economic determinant of health as a significant community health priority.

- **Healthy Eating & Active Living**: 68 percent of Shawnee County residents are overweight or obese.
- **Access to Care & Chronic Conditions**: 17 percent of Shawnee County adults under the age of 65 do not have health insurance.

- **Social Determinants**: 60 percent of health outcomes are tied to social and environmental factors and the personal behaviors influenced by those factors (20 percent attributed to medical care and 20 percent to genetic predispositions).

- **Babies & Youth**: 54 percent of Shawnee County infants are not fully immunized by age two.
  - 9 percent of births are to teen moms (ages 15-17).

- **Mental Health & Substance Abuse**: 2.2 percent of adults will be diagnosed with depression sometime in their lifetime.
  - There is a shortage of mental health services locally and statewide.
  - 20 percent of Shawnee County adults smoke cigarettes.
Clearly describe how your hospital will commit resources, independently or in partnership with others. For example:

- Provide transportation to individuals that have transportation needs to social and health care services (e.g., grocery stores, jobs, clinic visits, pharmacy, outpatient visits).

- Offer home safety assessments for environmental hazards and health risks (e.g., lead, pests, etc.).

- Work with local grocery providers and restaurants to offer fresh, affordable, healthy choices.

Implementation Strategy Examples

<table>
<thead>
<tr>
<th>Needs to be Addressed and Measured</th>
<th>Description</th>
<th>Measures</th>
<th>Start Date</th>
<th>Expected End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to healthy food options - goal is to increase access to healthy food options through proactive community partnerships and education</td>
<td>Number of participants that complete the program</td>
<td>5/1/2021</td>
<td>12/31/2021</td>
<td></td>
</tr>
<tr>
<td>Reduce Obesity in Anderson County</td>
<td>Number of participants that complete the program</td>
<td>5/1/2021</td>
<td>12/31/2021</td>
<td></td>
</tr>
<tr>
<td>Reduce Food Insecurity in Anderson County</td>
<td>Number of screenings</td>
<td>3/1/2021</td>
<td>12/31/2021</td>
<td></td>
</tr>
</tbody>
</table>

PO经略HEALTH PRINCIPLES

- Aim to reduce disparities
- Tackle social, economic and environmental determinants of health
- Focus on broader populations beyond patients
- Engage cross-sector partners and community
- Use non-clinical data (e.g., access to food)
Community Benefit: Strengthening Population Health Focus

Definition of Community Benefit

Community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. They are not provided for marketing purposes.
What is Community Benefit

Hospitals can report costs as community benefit if the program:

**Addresses an Identified Community Need** …

and meets at least of the following criteria

- Improves Access to Health Services
- Enhances Population Health (health of the community)
- Advances Medical or Health Knowledge
- Relieves or Reduces the Burden of Government or Other Community Efforts


Community Benefit Includes

- Financial Assistance

- Government-sponsored means-tested programs — unpaid costs of public programs

- Other Community Benefit Services
  - Community Health Improvement Services
  - Health Professions Education
  - Subsidized Health Services
  - Research
  - Cash and In-Kind Contributions
  - Community-Building Activities
  - Community Benefit Operations
Integrating Population Health in Community Benefit Program

• Be clear and transparent about the process the hospital will use to make community benefit decisions.

• Ensure that staff responsible for the community benefit program reflects the population the program serves.

• Provide clear, comprehensive public reports about hospital’s community benefit programs and budgets that trace the connection between priority community needs identified in CHNA report and implementation strategy.

Integrating Population Health in Community Benefit Program

• Provide community partners with access to evaluation data and opportunities to inform the design and implementation of community evaluation.

  ▪ Ensure that community benefit evaluation plan includes specific goals, outcomes and metrics to measure improvements in health disparities.

  ▪ Use the evaluation findings to inform future interventions and to increase engagement and depth of partnership.
Addressing Housing as Community Benefit

• “Physical Improvement and housing” – listed as Part II (Community Building)

• In 2011, IRS amended instructions to Schedule H to say:
  - Some community building activities may also meet the definition of community benefit…”

• The IRS further clarified in a December 2015 IRS Executive Order Update:
  - …some housing improvements and other spending on social determinants of health that meet a documented community health need may qualify as a community benefit….”

Condition #1
Housing-related activity must be provided primarily to address an identified community health need.

Condition #2
Should be reasonable evidence that the activity is known to improve health.
### Supportive Housing Services
To formally homeless or incarcerated, disabled or low-income persons to ensure they become and remain stably housed. Services: case management, peer-support services, substance abuse services, independent living classes, mental health services.

### Screening
For housing-related needs (e.g., housing instability) during patient visits.

### Health Assessments
Partnering with affordable housing developers to analyze resident health needs and the impact of the housing development on these needs.

### Legal Aid
Facilitating access to legal aid for low-income persons to help them address poor-quality housing conditions.

### Housing Quality Improvement
Mitigating housing conditions that can cause elevated blood lead levels; remediating housing-based asthma triggers, weathering homes.

### Housing Subsidies
Temporally subsiding housing for individual who are low income, chronically homeless, formerly incarcerated, disabled to help them remain stably housed.

Strategic Plan: Strengthening Population Heath Focus

Strategic Planning

A roadmap for how you will build on your history, your existing strengths and your values as you move forward to transform delivery of care in your community.

What will your organization look like and how will it serve the community in the future?
**Strategic Planning**

**POPULATION HEALTH PRINCIPLES**

- Aim to reduce disparities
- Tackle social, economic and environmental determinants of health
- Focus on broader populations beyond patients
- Engage cross-sector partners and community
- Use non-clinical data (e.g., access to food)

**Integrating Population Health in Strategic Plan**

**Funding: Focus on Determinants of Health**

- Align grant writing efforts with community needs and priorities (specifically related to social, economic and environmental issues).
- Pursue grant funding focused on addressing disparities and determinants of health.

**Staff: Focus on Building Capacity in Population Health**

- Increase staff understanding of population health and how to integrate specific strategies in their work.
- Designate staff (staff time) to work on addressing population health.
- Build staff expertise and internal capacity to support population health initiatives.
Integrating Population Health in Strategic Plan

Hospital Facility: Focus on Becoming a Convener of Population Health Conversations

- Hospital’s facility hosts community and regional conversations about population health needs. Participants include representatives from various sectors and various parts of the community.

Partnerships: Focus on Cross Sector Collaboration

- Expand and strengthen relationships with organizations from various sectors.
- Serve on committees, workgroups, coalitions aimed at improving population health.
- Engage with partners in initiatives aimed at addressing determinants of health and reducing disparities.

STRATEGIC PLAN 2018-2020

4.1.1 Study the gap between needs and resources for areas identified in the 2018 needs assessment and market analysis, including but not limited to:
- Behavioral Health
- Oncology
- Substance Abuse
- Aging population needs

4.1.2 Develop cross-sector work groups to address findings of gap analysis, best practices, integrated programs to address identified needs, etc.

4.1.3 Seek funding strategies to develop programs.

POPULATION HEALTH PRINCIPLES

- Aim to reduce disparities
- Tackle social, economic and environmental determinants of health
- Focus on broader populations beyond patients
- Engage cross-sector partners and community
- Use non-clinical data (e.g., access to food)
Integrating Population Health in Strategic Plan

Understand Community Needs: Focus on Collecting Quantitative and Qualitative Data

• Regularly (1-3 years) collect data and when possible analyze it by race, ethnicity, gender and etc.

Initiatives/Activities: Focus on Determinants of Health (name specific areas)

• Identify and engage in improving population health by focusing on transportation, housing, access to healthy foods.

Examples:
Population Heath Efforts Across Kansas
Addressing Food Insecurity and Access to Healthy Foods

- Build Greenhouses
- Create Gardens
- Host farmers markets
- Partner with food pantries
- Host / support summer lunch programs
- Collaborate with local food service providers and farmers
- Provide healthy food “prescriptions”

Farmer’s Market at Geary Community Hospital, Junction City, Kansas

Addressing Transportation

- Hospital-provided transportation to:
  - Pharmacy
  - Medical appointments
  - Grocery store
  - Fitness programs
- Develop walking paths
- Support safe sidewalk programs
- Create indoor walking paths at the hospital
- Provide walking “prescriptions”

Prescriptions for Walking, Finney County, Kansas

Bike share at Kearny County Hospital, Lakin, KS
How to Integrate Population Health Into Your Daily Routine

Overview
- Capacity to address specific needs
- Referral network
- Ease of use

Activities
- Integrate with existing services/tools
- Conduct an inventory of community’s resources (e.g., 211 system, Healthify)
- Establish relationships with non-traditional partners (e.g., food banks)
- Conduct referrals and/or “warm hand-off”

Impacts
- Growing evidence indicates – potential to narrow gap between clinical services and community services

Social Needs Screener

<table>
<thead>
<tr>
<th>Overview</th>
<th>Activities</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Assess social needs &lt;br&gt; - Standard tool that can be adopted &lt;br&gt; - Connect to services</td>
<td>- Integrate with existing services/tools &lt;br&gt; - Conduct an inventory of community’s resources (e.g., 211 system, Healthify) &lt;br&gt; - Establish relationships with non-traditional partners (e.g., food banks) &lt;br&gt; - Conduct referrals and/or “warm hand-off”</td>
<td>- Growing evidence indicates – potential to narrow gap between clinical services and community services</td>
</tr>
</tbody>
</table>

Social Needs Screener Example:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How has your child done at school this year?</td>
<td>Good</td>
</tr>
<tr>
<td>Has your child been in trouble at school?</td>
<td>No</td>
</tr>
<tr>
<td>Does your child have any problems going to school or staying in school?</td>
<td>None</td>
</tr>
<tr>
<td>How has your child done at work or school?</td>
<td>Good</td>
</tr>
<tr>
<td>How has your child been feeling lately?</td>
<td>Happy</td>
</tr>
<tr>
<td>How has your child been sleeping lately?</td>
<td>Good</td>
</tr>
<tr>
<td>How has your child been eating lately?</td>
<td>Good</td>
</tr>
<tr>
<td>How has your child been exercising lately?</td>
<td>Good</td>
</tr>
<tr>
<td>How has your child been spending their time lately?</td>
<td>Good</td>
</tr>
</tbody>
</table>

Care Team Notes:
Next Steps

- Secure leadership commitment to working on population health
- Review data from CHNA, County Health Rankings or Kansas Health Matters
- Identify any ongoing efforts (e.g., community coalitions)
- Engage with stakeholders and community
- Review a list of potential activities (KHA and KHI resources) and identify an area of potential work

Don’t afraid to start small!
Implement activity!
Evaluate results, make changes and sustain!

Thank you!
Any Questions?

You can connect with us:

Tatiana Lin, M.A., tlin@khi.org, (785) 233-5443
Kansas Health Institute

Cindy Samuelson, csamuelson@kha-net.org, (785) 233-7436
Kansas Hospital Association
Information about KHA and KHI

KHA
Kansas Hospital Association
KANSAS HOSPITAL ASSOCIATION
The Kansas Hospital Association (KHA) is a voluntary, non-profit organization acting to be the leading advocate and resource for members. KHA membership includes 223 member facilities, of which 124 are full-service, community hospitals. KHA and its affiliates provide a wide array of services to the hospitals of Kansas and the Midwest region. Founded in 1910, KHA's vision is "Optimal Health for Kansas.”
215 SE 8th Avenue | Topeka, Kansas | 66603
785.233.2436 | kha-net.org
facebook.com/KansasHospitals | twitter: @KansasHospitals

KANSAS HEALTH INSTITUTE
The Kansas Health Institute (KHI) delivers objective information, conducts credible research, and supports civil dialogue enabling policy leaders to make informed health policy decisions that enhance their effectiveness as champions for a healthier Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI is a nonprofit, nonpartisan educational organization based in Topeka.
212 SW 8th Avenue | Suite 300 | Topeka, Kansas | 66603
785.233.5443 | khi.org
facebook.com/KHIorg | twitter: KHIorg