Hospital and health system role and accountability toward population health in the context of the Affordable Care Act

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Designing and planning strategies to address community health needs: Lessons learned from Kaiser Permanente

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Presenter Disclosures

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(1) The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months: No commercial interests relevant to this presentation (employed by Kaiser Permanente)

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Implementation Strategy Requirements

- ACA requires Implementation Strategies that respond to prioritized community health needs for all non-profit hospitals, every three years
- Implementation strategies must link explicitly to needs
- Specific requirements:
  - Specify criteria and process used to select health needs
  - List selected health needs
  - Develop Implementation Strategies for each need selected, including anticipated impact
  - Provide rationale for needs not selected
- Both hospitals and non-hospital areas followed requirements
- Filed with Internal Revenue Service
- Adoption by hospital governing body

‘Spirit’ of the ACA Regulations: Accountability for Population Health

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The Institute of Medicine Roundtable for Population Health Improvement uses the following definition:

Population Health is “the **health outcomes of a group of individuals**, including the distribution of such outcomes within the group” [1] While not a part of the definition itself, it is understood that such population health outcomes are the product of **multiple determinants of health**, including medical care, public health, genetics, behaviors, social factors, and environmental factors.

Measures of total population health should be viewed as the **health outcomes and behaviors** that could be achieved through the **shared and collective efforts of an interconnected system of partners** whose mission and vision in some capacity is linked to improving health: **clinical care, government public health, non-government agencies**[2]

(1): Kindig, D., and G. Stoddart. 2003. What is population health? American Journal of Public Health 93(3):380-383. (2) Jacobson, D. M., and S. Teutsch. 2012. An environmental scan of integrated approaches for defining and measuring total population health by the clinical care system, the government public health system, and stakeholder organizations. Washington, DC: The National Academies Press.

Staging for planning: defining our population

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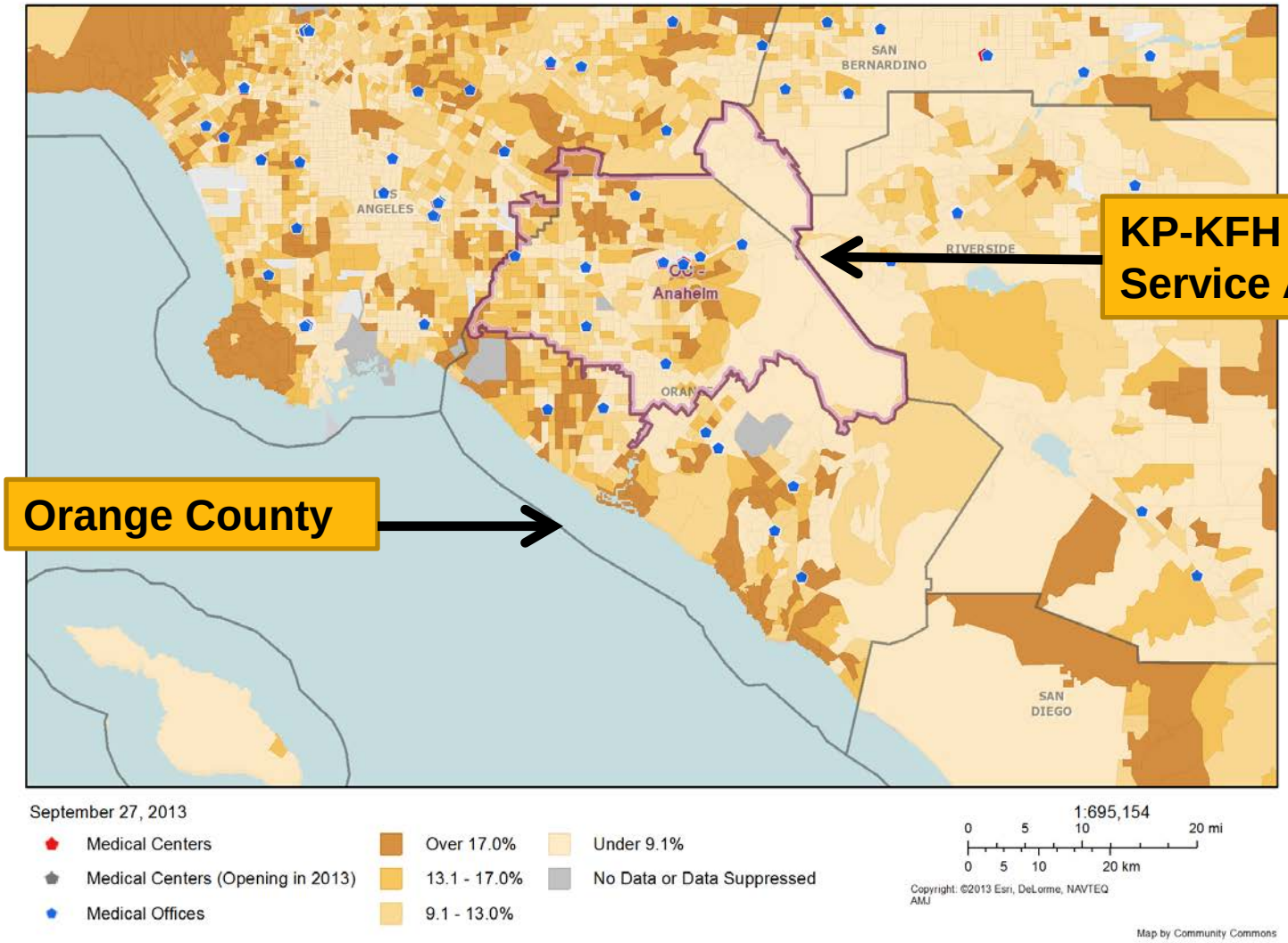
Population Age 65+; US Census Bureau, American Community Survey: 2007-11.



Staging for planning: organize the data

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Sample indicators for each category*

Demographics

- Total population
- Race/ethnicity
- Age

Social & Economic Factors

- Poverty level
- Education level
- Uninsured level

Health Outcomes (Morbidity & Mortality)

- Children with asthma
- Overweight Adult and children
- Heart disease mortality

Physical Environment

- Fast food restaurants
- Park access
- Particular matter 2.5 above standard

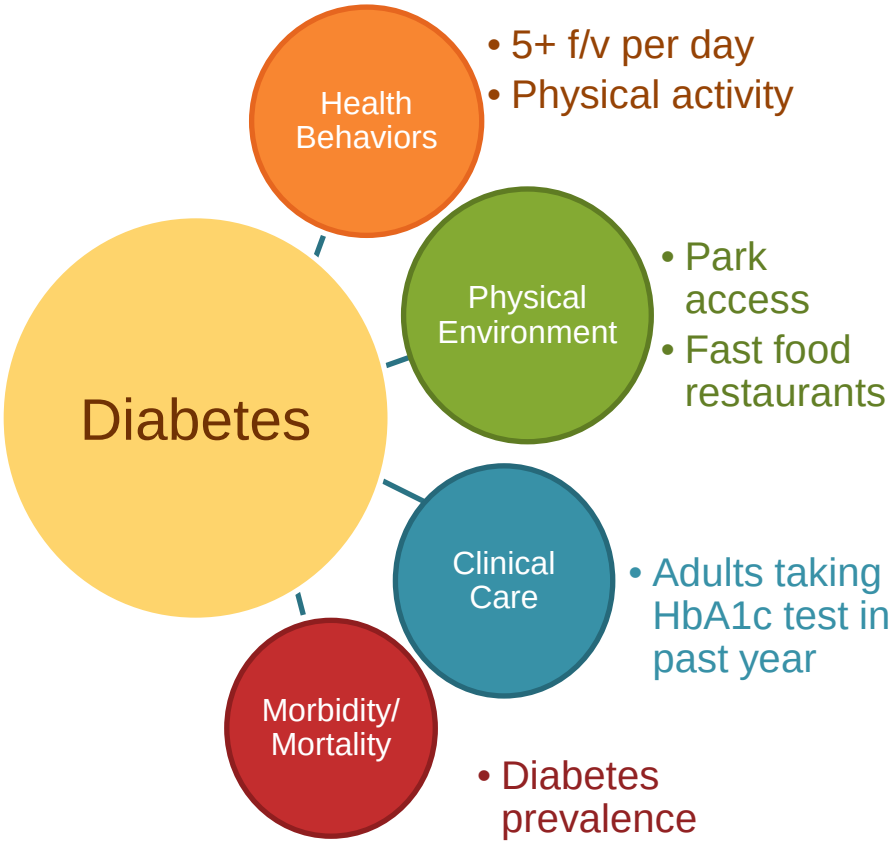
Clinical Care (Access to Care)

- Consistent source of primary care
- Adults 18-64 ever tested for HIV
- Adults with dental visits in past year

Health Behavior

- Adult Tobacco use
- Children consuming 5+ serving F/V consumption
- Initiate breastfeeding

Example of a health need and its health indicators:



* List not exhaustive

Staging for planning: presenting our findings

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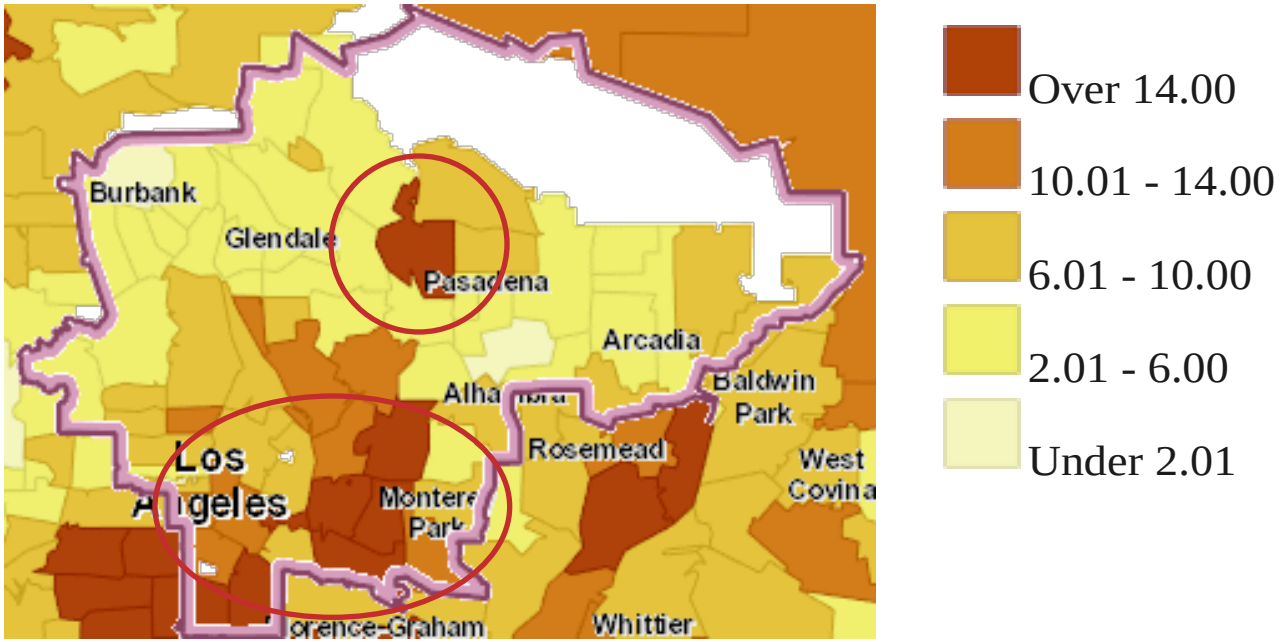
Develop high level summary of a specific health need identified in the community that provides an integrated analysis of gathered data

- **Narrative summary of the issue** – why is it important?
- **Statistical data** - What is the prevalence/incidence of the health issue in the community? (with sources and benchmarks)
- **Associated drivers** – what is driving the health need in the community?
- **Disparities** – subpopulations and geographic areas of greatest impact (with illustrative maps)
- **Community input** – what do community stakeholders think about the issue? (with key supporting quotes)
- **Assets** – what are the assets that can address the health need?

Example: how we describe what we're finding

Diabetes Discharge Rate (Per 10,000 Pop.), OSHPD, 2010–11



- Diabetes prevalence is higher in KFH-LA (18.5%) versus Los Angeles County (10.5%)
- More African-Americans and Hispanic/Latinos experienced hospital discharges resulting from diabetes than other groups
- Diabetes is linked to:
  - Obesity, hypertension
  - Lack of access to healthy food
  - Lack of access to health services
  - Language barriers, transportation

Broader engagement of stakeholders

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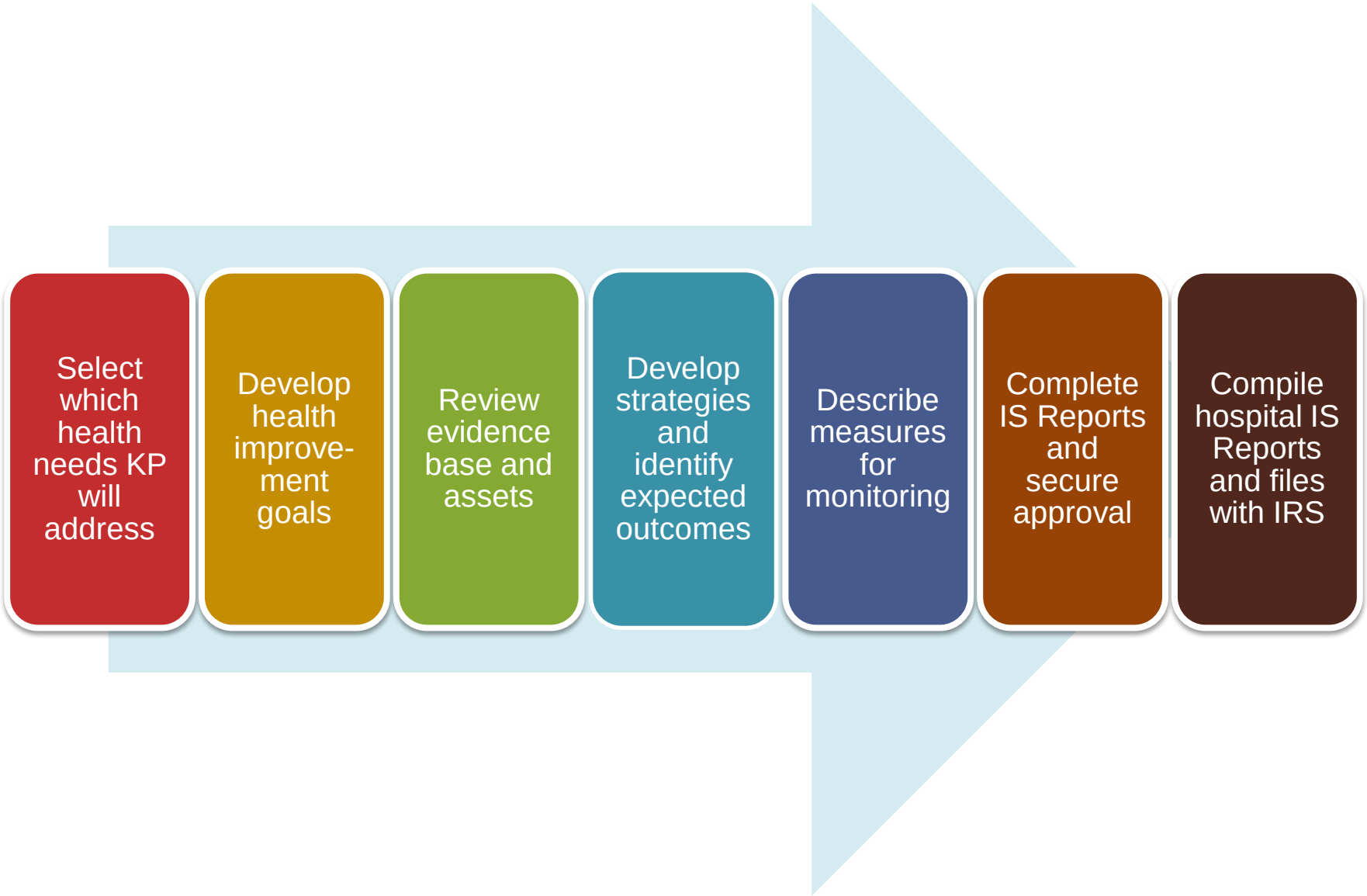
Sample stakeholders involved in planning:

- Senior Operational Leaders
- Community Benefit/Relations Manager/Staff
- Public Affairs Director/Managers
- Medical Directors/Physicians-in-Chief
- Communications Managers
- Compliance Officers
- Human Resources managers
- Research and Evaluation experts

Implementation Strategy Process



Criteria used for selecting health needs

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Criteria	Definition
Magnitude/scale of the problem	The health need affects a large number of people within the community.
Severity of the problem	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
Health disparities	The health need disproportionately impacts the health status of one or more vulnerable population groups.
KP assets	KP can make a meaningful contribution to addressing the health need because of its relevant expertise and/or unique assets as an integrated health system and because of an organizational commitment to addressing the health need.
Ability to leverage	Opportunity to collaborate with existing community partnerships working to address the health need, or to build on current programs, emerging opportunities, or other community assets.

Evidence-Base Snapshot: Obesity/Overweight

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Long-Term Goal: Reduce obesity/overweight among at risk populations	
Evidence-informed intermediate goals	**Evidence to inform strategies (sample list)**
Increase physical activity	**Access and availability** Develop joint use agreements to allow public access to existing facilities[4] **Knowledge, attitude, skills** Behavioral interventions to reduce screen time[4]
Increase healthy eating	**Access and availability** Increase the availability of lower-calorie and healthier food and beverage options for children in restaurants[1]
Improve Weight management skills	**Clinical care** Clinicians screen for obesity in children ages 6 years and older and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status[5]

Evidence-Base Snapshots

Evidence Base Snapshot – OBESITY and OVERWEIGHT

The goals and strategies were informed by the following sources:

[1] Accelerating Progress in Obesity Prevention: http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx
[2] The Community Guide – Community Preventive Services: http://www.thecommunityguide.org
[3] County Health Rankings: http://www.countyhealthrankings.org
[4] The Community Guide: Guide to Clinical Preventive Services: http://www.thecommunityguide.org/about/guide.html

Health Need	Obesity/Overweight	
Long-term Goal	Evidence-Informed Intermediate Goals	Evidence to Inform Strat
Reduce obesity / overweight among at risk population	Increase physical activity	Access and Availability • Community design and • Require quality physica • Creating or enhancing • Improve streetscape de • Increase green space/p • Joint Use Agreements[5] Knowledge/Attitudes/Skills • Provide and support co • Individually-adapted he physical activity into th • Behavioral intervention • Community-based soci strengthening, and mai • Point-of-decision prom

Sample source list for obesity/overweight:

[1] Accelerating Progress in Obesity Prevention:
http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx

[2] The Community Guide – Community Preventive Services:
http://www.thecommunityguide.org

[3] Educating the Student Body:
http://www.iom.edu/Reports/2013/Educating-the-Student-Body-Taking-Physical-Activity-and-Physical-Education-to-School.aspx

[4] County Health Rankings:
http://www.countyhealthrankings.org/policies

[5] The Community Guide - Guide to Clinical Preventive Services:
http://www.thecommunityguide.org/about/guide.html

[6] Strategic Directions and Examples of CDC-Recommended Evidence and Practice-Based Strategic Table:
http://www.ehhd.org/filestorage/103/272/996/RecommendedEvidenceandPracticeBasedStrategies.pdf

Goals/Strategy Example: Colorado

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Long-term Outcome

- Increase access to affordable, healthy foods, expand opportunities to lead physically active lifestyles and build economically vibrant communities in the KP Colorado service area

Intermediate Outcome

- Increase the number of policies, community programs and social and economic resources to support and promote healthy eating

Strategy

- **Grant-making** to increase access to daily recommended levels of physical activity before, during, and after school

Expected Outcomes

- Increased number of children who get recommended daily minutes of physical activity

Strategy Types

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<u>Long Term Goal</u>: KFH-San Diego aims to reduce obesity/overweight and prevent Type 2 Diabetes and improve management of this disease among vulnerable populations through:

Programs

Educational Theatre Program's Amazing Food Detective to educate students on healthy eating and active living.

KP Physician Champion conducts diabetes self-management education in community gathering places for adults with Type 2 diabetes.

KP Assets

Grants

Grants to organizations that work on environmental and policy change efforts related to healthy eating and physical activity.

San Diego Childhood Obesity Initiative's Leadership Council to promote environmental and policy change related to healthy eating.

Partnerships/ Collaboration

Work ahead

Strategic Planning

*How do we design and coordinate our **health system / operational efforts / partnerships** to address health needs and improve community health……?*

….What are the realistic population level outcomes/impacts of those efforts and how do we monitor and evaluate them?

Evaluation

Successes, learnings and takeaways

- **Aligned and standard approach** across hospitals – new language and framework
- Surfaced **new & emerging health needs**
- More **intentional community engagement**
- Greater use of **evidence-base** to develop strategies
- More intentional about **leveraging KP assets and partnerships**
- **Developing outcomes and metrics** for strategies – shared outcomes among accountable partners
- Stimulate deep thinking about **Kaiser Permanente's role and potential to impact Community Health** - both within and outside our walls
- Better identify **community partners** co-accountable toward population health