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)
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.
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.

Staging for planning: organize the data

Sample indicators for each category*

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Social &amp; Economic Factors</th>
</tr>
</thead>
</table>
| • Total population  
• Race/ethnicity  
• Age       | • Poverty level  
• Education level  
• Uninsured level |

<table>
<thead>
<tr>
<th>Health Outcomes (Morbidity &amp; Mortality)</th>
<th>Physical Environment</th>
</tr>
</thead>
</table>
| • Children with asthma  
• Overweight Adult and children  
• Heart disease mortality | • Fast food restaurants  
• Park access  
• Particular matter 2.5 above standard |

<table>
<thead>
<tr>
<th>Clinical Care (Access to Care)</th>
<th>Health Behavior</th>
</tr>
</thead>
</table>
| • Consistent source of primary care  
• Adults 18-64 ever tested for HIV  
• Adults with dental visits in past year | • Adult Tobacco use  
• Children consuming 5+ serving F/V consumption  
• Initiate breastfeeding |

Example of a health need and its health indicators:

- **Diabetes**
  - Health Behaviors
    - • 5+ f/v per day
    - • Physical activity
  - Physical Environment
    - • Park access
    - • Fast food restaurants
  - Clinical Care
    - • Adults taking HbA1c test in past year
  - Morbidity/Mortality
    - • Diabetes prevalence

* List not exhaustive
Staging for planning: presenting our findings

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 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

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

1. Select which health needs KP will address
2. Develop health improvement goals
3. Review evidence base and assets
4. Develop strategies and identify expected outcomes
5. Describe measures for monitoring
6. Complete IS Reports and secure approval
7. Compile hospital IS Reports and files with IRS
Criteria used for selecting health needs

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Magnitude/scale of the problem</strong></td>
<td>The health need affects a large number of people within the community.</td>
</tr>
<tr>
<td><strong>Severity of the problem</strong></td>
<td>The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.</td>
</tr>
<tr>
<td><strong>Health disparities</strong></td>
<td>The health need disproportionately impacts the health status of one or more vulnerable population groups.</td>
</tr>
<tr>
<td><strong>KP assets</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Ability to leverage</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
### Evidence-Base Snapshot: Obesity/Overweight

<table>
<thead>
<tr>
<th>Evidence-informed intermediate goals</th>
<th>Evidence to inform strategies (sample list)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase physical activity</td>
<td><strong>Access and availability</strong>&lt;br&gt;Develop joint use agreements to allow public access to existing facilities&lt;sup&gt;4&lt;/sup&gt; <strong>Knowledge, attitude, skills</strong>&lt;br&gt;Behavioral interventions to reduce screen time&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Increase healthy eating</td>
<td><strong>Access and availability</strong>&lt;br&gt;Increase the availability of lower-calorie and healthier food and beverage options for children in restaurants&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Improve Weight management skills</td>
<td><strong>Clinical care</strong>&lt;br&gt;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&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Long-Term Goal: Reduce obesity/overweight among at risk populations
Evidence-Based Snapshots

Sample source list for obesity/overweight:

1. Accelerating Progress in Obesity Prevention:

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

3. Educating the Student Body:

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

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

6. Strategic Directions and Examples of CDC-Recommended Evidence and Practice-Based Strategic Table:
Goals/Strategy Example: Colorado

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

<table>
<thead>
<tr>
<th>Programs</th>
<th>Grants</th>
</tr>
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<tr>
<td><strong>Educational Theatre Program’s Amazing Food Detective</strong> to educate students on healthy eating and active living.</td>
<td><strong>Grants to organizations that work on environmental and policy change efforts related to healthy eating and physical activity.</strong></td>
</tr>
<tr>
<td><strong>KP Physician Champion</strong> conducts diabetes self-management education in community gathering places for adults with Type 2 diabetes.</td>
<td><strong>San Diego Childhood Obesity Initiative’s Leadership Council to promote environmental and policy change related to healthy eating.</strong></td>
</tr>
</tbody>
</table>

**KP Assets**

**Partnerships/Collaboration**
Strategic Planning

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

Grants, Programs, Assets, Partnerships

Address Health Needs & Improve Health

Expected Outcomes and Impacts?

….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
- Surfed **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