M21: Health Systems Transformation

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Who We Are

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Session Objectives

- Assess their readiness to improve health at scale
- Create a strategic plan for health system transformation, including governance, leadership engagement, and workforce engagement

OUR TIME TOGETHER

- Get to know one another
- Develop common language and frameworks.
- The journey to population health
- Understand where you are on the journey to improving the health, wellbeing and equity of people, communities and populations.
- Create a plan for moving forward and present it to Don Berwick for feedback.
Working Agreements

- Share your experience
- Practice "Yes...and" vs "Yes...but"
- Stay curious
- Steal shamelessly, share generously
- Respect time
- Be responsible for your learning
- Show up, CHOOSE to be present

#100MLives

Introductions

- Who you are, where you’re from
- The story of your name or your theme song
- What questions you are bringing with you today
Identity: An unprecedented collaboration of change agents pursuing an unprecedented result:

100 million people living healthier lives by 2020

Vision: to fundamentally transform the way we think and act to improve health, wellbeing and equity.
Shared priorities: “TheWhats”

1. Close equity gaps (price of admission)
2. Help veterans to thrive
3. Address and improve social determinants across the continuum
4. Improve wellbeing of indigenous communities
5. Help all kids have a great start to life
6. Make mental health everybody’s job and take a prevention approach
7. Engage people in their own health (nutrition, exercise, sleep, stress, food security)
8. Improve employee health and wellbeing
9. Create wellbeing in the elder years and end of life

Shared priorities: “The Hows”

1. Shift culture and mindset
2. Develop the health workforce
3. Elevate peer to peer approaches
4. Build improvement capability at the community level
5. Use chronic diseases and risk factors to build the health continuum
6. Improve high quality primary health care access for all
7. Integrate data across siloes
8. Create new financing strategies
9. Transform from a sick care system to a health system
Come to our special interest breakfast to learn more! Wed at 7, Crystal Ballroom A-C

The Triple Aim

- A System design that is one aim with three dimensions:
  - Improving the health of the populations;
  - Improving the patient experience of care
  - Reducing the per capita cost of health care.
Our care system was built for a different set of population health issues


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Cambridge Health Alliance (CHA)

Customers (50% speak language other than English, 70% publicly insured)

Trainees (actively engaged in creating transformation)

Community (7 cities)

3393 Employees (in 18 labor unions)

Integrated care delivery system serving 100,000 patients (12 community clinics, 2 hospitals, 3 EDs, specialty sites)

Public health

“Whose life got better because we were here?”
Cambridge Health Alliance Experience

- Changed our payment model and our delivery model from fee for service to global payments (230 people to 60% population)
- Improved experience
- 10% reduction in total cost (15% reduction compared to rest of network for Medicaid managed care)
- Improved quality health outcomes for a safety net population to above the national 90%ile
- Improved joy and meaning of work for the workforce
36% Reduction in Hospitalization Rate for Patients with Diabetes

Cost of chronic disease unsustainable

THE STAGGERING COST OF DIABETES

Today, 4,660 AMERICANS WILL BE DIAGNOSED WITH DIABETES

NEARLY 30 MILLION AMERICANS HAVE DIABETES

86 million Americans have prediabetes more than the population of the net cost from Connecticut to Georgia

$1 in 5 health care dollars is spent caring for people with diabetes

$1 in 3 Medicare dollars is spent caring for people with diabetes

People with diagnosed diabetes have health care costs 2.5 times higher than if they didn’t have the disease

Learn how to combat this costly disease at diabetes.org/congress

American Diabetes Association

STOP DIABETES
The context of our communities

Exposure to toxic stress in early childhood may lead to as much as a 40x increase in rate of chronic disease by the time you’re 50.
Cycle of violence, substance abuse, incarceration and reincarceration

1 in 5 people are addicted to a substance in Revere
76% prisoners released are rearrested “School to prison pipeline”

Interrelationship between the health, wellbeing and equity of people, communities and populations
Equity as a System Property

- The life expectancy of Denmark and Zambia in the space of a few miles
- 10 - 25 year difference in life expectancy depending on where you are born.
- Poverty is a huge factor in disparities.
- Race widens the disparity gap inherent in poverty

Our care system was built for a different set of population health issues

Borrowed with permission from Rob Janett
Adapted from McGuinnis et al.

Coming to Terms with Health Inequities

- Unhealthy housing
- Exposure to array of environmental hazards
- Limited access to healthy food sources & basic services
- Unsafe neighborhoods
- Lack of public space, sites for exercise
- Limited public transportation options
- Inflexible and/or poor working conditions
- Health impacts (e.g., allostatic load) of chronic stress
Stressed vs. Stressed Out

- **Stressed**
  - Increased cardiac output
  - Increased available glucose
  - Enhanced immune functions
  - Growth of neurons in hippocampus & prefrontal cortex

- **Stressed Out**
  - Hypertension & cardiovascular diseases
  - Glucose intolerance & insulin resistance
  - Infection & inflammation
  - Atrophy & death of neurons in hippocampus & prefrontal cortex

Source: Anthony Iton, MD, JD, SVP, The California Endowment

When the external becomes internal: How we internalize our environment

- Allostatic Load
  - Inadequate Transportation
  - Long Commutes
  - Housing
  - Lack of social capital

- Stress
  - High Demand-Low Control Jobs
  - Lack of access to stores, jobs, services
  - Crime

Source: Anthony Iton, MD, JD, SVP, The California Endowment
Service Area Exclusion of Geo Areas with Concentrated Poverty

100 Million Vision and Measurement
Historical Context: A Tale of Two Communities

Post WWII Migration and Investment Patterns

- Despite economic growth associated with war-related manufacturing during the early 1940s, poverty became more concentrated in urban communities across the country. Key factors included:
  - Substantial federal support for housing development in suburbs for returning veterans contributed to a flow of middle class out of urban areas.
  - Highway development projects bisected and/or otherwise obliterated urban neighborhood environments. See Harrington’s “The Other America.”
  - Public housing projects in 1930s – 60s focused in minority neighborhoods (established through redlining) and contributed to further geographic concentration of poverty.
  - Movement of employers from urban centers to suburban communities, eliminating employment network environments.
  - Erosion of tax base through loss of employers and affluent residents negatively impacted available services in urban inner city.
Key Facts in History of Redlining

- The Home Owner's Loan Corporation established in 1933 as part of the New Deal, and drafted maps of communities to determine which were worthy of mortgage lending. Neighborhoods ranked and color-coded, and the D-rated ones — with "inharmonious" racial groups — outlined in red.

- This strategy was quickly adopted by private banks, and carried out during a period of massive expansion of home ownership. “Redlined” communities were effectively cut off from essential capital, and business investment followed suit.

- Redlining technically outlawed by the passage of the Fair Housing Act of 1968, but more subtle forms of discrimination continued – see Beryl Satter’s “Family Properties” to read about contract mortgages in Chicago.

- Important to recognize that denial of opportunity for capital accumulation for these populations has a multi-generational impact – see Picketty’s “Capital,” and impacts of the great recession.

To This Day...

In late June, HUD settled with Associated Bank, the largest bank headquartered in Wisconsin over claims that it discriminated from 2008-2010 against black and Hispanic borrowers in Wisconsin, Illinois and Minnesota.

HUD concluded that the bank denied qualified loan applicants in predominantly minority neighborhoods in Chicago, Milwaukee, and Minneapolis, compared to other lenders operating in these same communities.

Associated Bank has agreed to finance nearly $200 million in home loans in majority-minority census tracts within these cities, and pay nearly $10 million in down payment assistance to borrowers or in lower interest rates. It must also open four new offices in minority neighborhoods in Chicago and Milwaukee, and invest $1.4 million in marketing loans in many of these same underserved communities.
Ford Foundation Grey Areas Program

- Began in the late 1950s as a strategy to support *systematic approaches to the social and physical problems* of urban “grey areas” of decline. The grants created “community action agencies” to coordinate programs in areas such as youth employment and education. Grants were awarded to Oakland, New Haven, Boston, and Philadelphia, and North Carolina. The program was intended to address the following identified problems:
  - Many welfare programs were not reaching the poor
  - Services were often *inappropriate to needs*
  - Delivery mechanisms were *fragmented*
  - *Limited understanding of problems* by professionals & leaders
  - Research *not designed to increase understanding of aggregate impact*
  - Lack of political leadership
  - *Lack of participation of beneficiaries* in design and delivery

Community Action Program

- Initiated in 1964 as part of the Johnson Administration’s War on Poverty.
- Coordination of neighborhood services and bureaucratic reform were central elements. Modeled after Gray Areas Initiative.
- 40% of CAP funding supported local priorities, and 60% supported federal programs such as Head Start and Job Corps.
- Central focus on “*maximum feasible participation*” of residents, but lack of understanding of the goals of participation. In the context of struggle for civil rights, mobilization led to conflicts with local political leaders.
- CAP *established programs such as Head Start and created a generation of minority CBO leaders.*
- There are approximately 1100 CAAs in the U.S., covering 94% of geographic areas.
Model Cities

- Shifted the leadership for implementation to local governments, in part in reaction assertion of power by residents in CAP program.
- Expanded beyond coordination of social services to include physical infrastructure and economic development.
- Reduced funding for low income housing by year two, driven by pressures associated with spending on the Vietnam War.
- Local governments required to select specific neighborhoods and develop a comprehensive revitalization strategy.
- Set a precedent for comprehensive approaches by linking health and social services coordination to physical and economic development.
- Highlighted the limits of community revitalization that could not overcome racial discrimination, economic restructuring, and the flight of white residents and jobs.

Devolution and Privatization

- Federal programs targeting low income neighborhoods were shifted to the Community Development Block Grant (CDBG) program in 1974.
- CDBG gave local governments more autonomy to select communities, and funds shifted away from low income neighborhoods towards broader economic development.
- Reagan administration argued against place-based funding with claim that aid for high poverty areas interfered with market forces.
- Implemented a parallel reduction in federal funding for safety net services at the local level.
- Reduced safety net support and the loss of tax revenues associated with outmigration to suburbs led to increased scrutiny of tax exempt hospitals in cities, at least some of which were focusing their marketing and services to commercially insured patients in the suburbs.
Evolution of Community Policies and Practices

Community Benefit Defined

**IRS definition** - The promotion of health for class of beneficiaries sufficiently large enough to constitute benefit for the community as a whole.

- Reference to a defined community suggests a population health orientation
- Determining the minimum size for the “class of beneficiaries” needed suggests accountability for a measurable impact.

*IRS Rulings 69-545 (1969) and 83-157 (1983)*
Evolution of National/State Policies

- IRS redefinition of charity 1969/83
- Local class actions in 70s
- Intermountain Health Care – 1985
- Two models of state statutes: UT & NY – 1990
- National congressional initiative (Roybal/Donnelly)
- Other state approaches TX, MA, CA, PN, NH
- IRS Field Advisory 2001
- Yale-New Haven case (2005) – the game changer
- Congressional hearings (2006-2009)
- Illinois Supreme Court ruling on Provena
- IRS 990 Schedule H
- National Health Reform and the coming change

Historical Tendencies in Practice
**Evolution in Practices: Areas for Improvement**

- **Programmatic**
  - Program scale inadequate to produce measurable impact
  - Lack of specificity in targeting
  - Lack of coordination across programs to take advantage of potential synergies
  - Proprietary orientation

- **Institutional**
  - Lack of infrastructure for critical review and oversight
  - Lack of knowledge and understanding among leadership
  - Lack of integration of community benefit function
  - Inadequate FTE allocation and staff competencies

**Transparency**

- **Pricing**
  - Billing for procedures, equipment, pharmaceuticals
  - Comparative analysis of reimbursements, reported shortfalls, other CBs

- **Outcomes**
  - Public “ROI” for care

- **Location**
  - Payer mix
  - Jurisdiction
  - SDH

- **Public expectations**
  - IRS reporting requirements opens the door to a broad set of questions
Compliance – IRS Final Regulations

- Setting priorities – “community input in identifying and prioritizing significant health needs, as well as identifying resources.”
- Documentation of input – “take into account comments received on the previously adopted implementation strategy”
- Focus on disparities – “joint CHNA conducted for a larger area could identify a significant health need a need that is highly localized in nature or occurs within only a small portion of that larger area.”
- Social determinants of health – “expand health needs to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”
- Evaluation – “the CHNA to include an evaluation of the impact of actions taken since the hospital facility finished conducting its immediately preceding CHNA.”

Focus of CHIDSS Development

- How
  - Community is defined
  - Community stakeholders are engaged
  - Priorities are set
  - Implementation strategies are designed
- Select specific geographic regions to allow for comparative analysis
- Sources of data are public reports from
  - Hospitals
  - Public health agencies
  - United Ways
  - Community Action Agencies
What does population health mean to you? 

It’s a Fan! 

It’s a Wall! 

It’s a Spear! 

It’s a Snake! 

It’s a Rope! 

It’s a Tree!

#100MLives
What does health mean to you?

- People define health for themselves
- Adaptation of World Health Organization domains:
  “mental, physical, social, [and spiritual] wellbeing...”
- “Health is not the absence of disease but the addition of confidence, skills, knowledge and connection. But most importantly, it is simply a means to an end—which is a joyful, meaningful life.”

Cristin Lind

What does this mean at the level of the individual, the community, and society?

[Diagram showing connections between Individual, family, Community, and Society with Health, wellbeing and equity at the center]
Two kinds of populations

Geographic or Place-Based Population

Defined by a place
- Children living in three neighborhoods of Chicago

A Network Population

Defined by a common characteristic
- Patients at a community health center
- Children with sickle cell disease who live in the midwest
- People attending a megachurch

Population Health

<table>
<thead>
<tr>
<th>Medical Model Population Health</th>
<th>Place-Based Population Health</th>
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<tbody>
<tr>
<td>Assess patient health status</td>
<td>Assess patient health status, <em>social and environmental risk factors</em></td>
</tr>
<tr>
<td>Ensure timely access to clinical services and medications</td>
<td>Ensure access to clinical services &amp; <em>link to social support systems</em></td>
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<tr>
<td>Clinical case management through team-based care</td>
<td>Case management through clinical and <em>community-based teams</em></td>
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<tr>
<td>Patient education</td>
<td><em>Community-based education, problem solving, and advocacy</em></td>
</tr>
<tr>
<td>Use EMR to ID and group risk populations, monitor service utilization and patient outcomes</td>
<td>Use <em>EHR and GIS</em> to identify geo conc. of <em>health disparities, target interventions, &amp; monitor population health outcomes</em></td>
</tr>
<tr>
<td><strong>Lament</strong> persistent patient noncompliance</td>
<td><strong>Leverage HC resources through strategic engagement of diverse stakeholders</strong></td>
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</tbody>
</table>
The journey to population health

- **Level 1:** Panel health and equity
  - Optimizing the physical and behavioral health of your patient panel

- **Level 2:** Panel health, equity and wellbeing
  - Addressing the mental, physical social and spiritual drivers of health and wellbeing

- **Level 3:** Community health, wellbeing and equity
  - Being active partners in improving health, wellbeing and equity of the overall community

- **Level 4:** Communities of solution
  - The capacity of people is unlocked to improve their health and the health of their communities

What does this mean at the level of the individual, the community, and society?

- **Levels 1&2**
  - Individual, family
  - Health, wellbeing and equity
- **Levels 3&4**
  - Community
  - Society
Activities of panel health

- Effective patient-centered medical home transformation
  - Team-based care
  - Proactive planned care
- Health coaching in the clinic or in the community
- Integration of behavioral health into primary care

Level 1 Panel health
Optimizing the physical and behavioral health of your patient panel

Activities of panel health, wellbeing and equity

- Screening for and addressing the social drivers of health
- Complex care management if it addresses food, housing, violence, etc
- Community health workers with lived experience
- Addressing health equity
- Social and health sector connected – partnership and data

Panel health, wellbeing and equity

Level 2
Addressing the social and spiritual drivers of health, wellbeing and equity for your patient panel in community
Activities of community health

- Being part of the community team to improve place-based health, wellbeing and equity
- Life course view
- Analytics based on place
- Ability to share data across partners
- Financing and policy mechanisms to move funds across sectors
- Anchor institution role

Community health

Level 3
Being active partners in improving health, wellbeing and equity of the overall community

Communities of solution

- Grow the capacity of residents to take over the process of creating health and wellbeing for themselves and for their community
- Peer to peer approaches are abundant
- Systems support growing capacity over time and make the path easier
- Long-term planning for the health of a community

Communities of solution

The capacity of people is unlocked to improve their health and the health of their communities
## A moment of reflection

- Which bucket best reflects where you are now?
  - Where would you like to be in 1 year?
  - Where would you like to be by 2020?
- What activities do you have in all 3 buckets?
The Four Ps:
Patients, Populations, People and Places

- Hospital A Patients
- Hospital B Patients
- U/Uninsured People
- FQHC
- Low Income Census Tract
- County Jurisdiction
- Hospital B

Imperative for Transformation

- Expanded coverage in low income communities
- Shift in financial incentives
- Health care providers/payers increasingly at financial risk for poor health driven by factors outside health care
- Emerging societal imperative to address fundamental inequities
- Growing awareness of need to align health and community development sectors and build shared ownership where inequities are concentrated
- Need to better align and optimally leverage EXISTING resources
- Increase focus and support local infrastructure to manage, facilitate, evaluate, and sustain
Building a Seamless Continuum of Care: Ambulatory Care Sensitive Conditions

- CMS move on re-admissions only the 1st “shot across the bow”
  - Near term challenge for hospitals to ID, engage, and strengthen community support systems after discharge of patients.
- Opportunity to “bend the cost curve” by reducing preventable ED and inpatient utilization.
  - Research by John Billings established framework of ambulatory care sensitive conditions (ACS) in the 1990s
- GIS coding of utilization data, with overlay of demographic and health status metrics provides a clear path

Challenges to be Addressed

- **Crisis Management**
  - IS development, consolidation, acquisitions
  - Preparing for constraints on reimbursement
  - CB viewed as compliance issue, rather than an engine for transformation
- **Knowledge Gaps**
  - Local leaders don’t know what they don’t know
  - Power used to date by system leaders limited in population health capacity development
- **Competitive Dynamics**
  - Limited focus on clinical care coordination is impeding potential for collaboration on broader issues
Integrating CB and Pop Health Mgmt

- Optimize data collection/analysis
  - Focus on chronic diseases, PQIs
  - Geocoding utilization data
  - Addition of SDH indicators
  - Overlay of demographics (e.g., race/ethnicity, HH income, etc)
  - Data pooling with FQHCs, other hospitals

- ID synergistic opportunities
  - Overlap between patient populations and place-based drivers
  - Start with readmissions, move to PQIs across payer groups
  - Facilitate links between care teams and CB activities
  - Set Triple Aim targets for patients, populations, people
  - Establish incentives across departments

Defining Community

<table>
<thead>
<tr>
<th>Issue-Specific Assessments (Health Impact Assessment)</th>
<th>Local Health Departments (CHAs/CHPs)</th>
<th>Tax-exempt Hospitals (CHNAs/1115s)</th>
<th>Community Health Centers (Section 330 Application)</th>
<th>United Ways (CHAs)</th>
<th>Community Action Agencies (Community Services Block Grant Application)</th>
<th>Financial Institutions (CRA Performance Context Review)</th>
</tr>
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<tbody>
<tr>
<td>Generally varies, one element of an HIA includes Scoping, which establishes the population affected by the proposed policy plan or program.</td>
<td>Jurisdictions that determine the service populations of LHDs vary, including: county, districts, city, and combined city-county areas.</td>
<td>Regulations allow flexible framing in geographic service area, with consideration of principal functions and target populations. Cannot define community in a way that excludes medically underserved, low income, minority groups, &amp; groups with chronic disease needs.</td>
<td>Located in or serve a high need community such as MUs (designated Medically Underserved Area or Population).</td>
<td>UW jurisdictions typically include county/ and multi county/ regional areas.</td>
<td>Established in 1964 as part of the War on Poverty, the 1100 CAAs define their communities as broad geographic areas, ranging from multi-county regions and MSAs to more targeted municipalities or inner city areas. The central focus in low-income communities.</td>
<td>CRA “assessment areas” include one or more MSAs or one or more contiguous political subdivisions, such as counties, cities or towns. Attention is given to the location of main offices, branches, ATMs, and loan origin geo locations. Areas may not arbitrarily exclude low- or moderate-income areas.</td>
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## Opportunities for Alignment

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<th>Issue-Specific Assessments (Health Impact Assessment)</th>
<th>Local Health Departments (CHAs/CHIPs)</th>
<th>Tax-exempt Hospitals (CHAs/ISS)</th>
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<td>When available, HIAs provide an additional layer of information, most often relating to broader environmental impacts, in the design of strategies to improve health.</td>
<td>Given reduced public funding, ongoing collaboration with diverse stakeholders provides an opportunity to leverage expertise and secure political support for LHD leadership in monitoring and advancement of policies that reinforce and sustain improvements in health status and quality of life.</td>
<td>IRS allows hospitals to develop ISSs in collaboration with other hospitals and State and local agencies, such as public health departments. Expanded enrollment and movement towards global budgeting will require work with others who can help address the determinants of health and reduce health disparities.</td>
<td>CHCS are encouraged to link with other providers such as LHDs and hospitals to provide better-coordinated, higher quality, and more cost-effective services.</td>
<td>UWs have an established history of collaborating with other stakeholders in conducting assessments and addressing unmet health needs.</td>
<td>Standard 2.1 emphasizes partnerships across the community, CAAAs can often &quot;serve as a backbone organization of community efforts to address poverty and community revitalization: leveraging funds, convening key partners...&quot;</td>
<td>Targeted CRA investments in housing, retail, education, and job creation in targeted low-income census tracts that are aligned with parallel interventions and investments of health care and public health stakeholders provide an opportunity to address social determinants of health and help reduce health care costs.</td>
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## Potential Partners - Roles

- **Public health agencies**
  - Assessment, community outreach, evaluation, policy development

- **Social service agencies**
  - Service coordination/integration, enhancement, leveraging

- **Service-based CBOs**
  - Community engagement, mobilization, facilitation, policy advocacy

- **Community Action Agencies**
  - Core operating infrastructure development, sustainability

- **Faith Community**
  - Alignment with planning priorities, secure political support

- **Advocacy CBOs**
  - Local Philanthropy

- **United Way**
  - City agencies
## What do we mean by “Alignment?”

<table>
<thead>
<tr>
<th>Forms of Alignment</th>
<th>Practical Application</th>
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<tbody>
<tr>
<td><strong>Spatial</strong></td>
<td>Co-locate services/programs to increase accessibility and convenience for residents with similar needs.</td>
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<td><strong>Temporal</strong></td>
<td>Establish common hours of operations.</td>
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<tr>
<td><strong>Financial</strong></td>
<td>Pool resources to accomplish objectives not possible alone.</td>
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## What do we mean by alignment?

- **Complementary**
  - Share expertise, re-design, and build explicit links across services/programs to create mutually reinforcing effects
  
- **Advocacy**
  - Build common platforms for advocacy on core issues that impact all residents and businesses serving the community.

- **Strategic**
  - Re-organize and merge as appropriate to share expertise, build administrative economies of scale, and increase reach.
Visualizing Different Perspectives

Invention Selection Framework: Return(size), Evidence Support (Y-axis), Time to Maturity (X-axis)

Domains of Activity, Geography, and Primary Focus of Interventions

<table>
<thead>
<tr>
<th>Domains of Activity</th>
<th>Physical Environment</th>
<th>Social Determinants</th>
<th>Behaviors</th>
<th>Clinical</th>
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<td>Geography of Interventions</td>
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<td></td>
<td>Regional – county</td>
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<td>Municipal – neighborhood</td>
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<td>Primary Stakeholders</td>
<td>Chambers of commerce</td>
<td>Physicians groups</td>
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<td>Metropolitan planning</td>
<td>Retail providers</td>
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<td>CDFIs / CDCs</td>
<td>Corrections</td>
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<td>Regional employers</td>
<td>Health Plans</td>
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<td>State agencies</td>
<td>Hospitals</td>
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<td>Community Clinics</td>
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<td>Public health agencies</td>
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<td>Community Action Agencies</td>
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<td>Homeless Shelters</td>
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Opportunities for Hospitals/HS

- Establish zones of collaboration with diverse stakeholders, including competitors to build the critical mass needed to measurably impact the social determinants of health.

- Align community benefit and community investments with the core business strategy for the hospital/health system.

- Investments in data analysis and interoperability that build shared ownership for health at the local and regional level.

Potential Areas of Investment with Health Impacts

- Areas of Focus
  - Housing development – renovation
  - Services – retail (e.g., food)
  - CHC development / expansion in scope of services
  - Child care / development
  - Small business / job development

- Alignment Strategies
  - Geo focus in targeted neighborhoods (rather than regional) aligned with hospital/PH interventions
  - Social capital investments, foundation grants to address pre-development obstacles to focused investment
Focus on Obesity: Stakeholders and Areas of Focus

Community
- Public Sector
  - Public Health
  - Parks and Recreation
  - Community Development
- Health Education
- Policy Development
- Community Mobilization
- Neighborhood Walking
- Shared Metrics
  - Diabetes PQI
  - Food Access
  - Options in schools
  - Awareness/knowledge
  - Physical activity

Backbone Entity

Public Sector
- CBOs/Coalitions
- Local Philanthropy

Components of Obesity-Focused Convergence Strategy

Hospital A: Support development of a community garden
Hospital B: Design culturally relevant cooking classes
Hospital C: S pestic school-based HEAL program
Healthcare provider: Provide site for cooking classes
Local restaurant: Link food bank to grocery store, support CDC
CBO: Ka-Ma, relationship skills development
Local agency: Advocate for HEAL, public policy
Community Health Workers: Home and community-based patient assessments, management
CDC/DEP: Leverage investments for additional grocery store and food bank

Data geo-coding and pooling across providers and payers for diabetes and pre-diabetes patients
3rd party contractor with CHW teams for home and community-based patient assessments, management
Consolidation, re-design, co-location, and scaling of nutrition education classes in community-based settings.
Supplement cohort-based metrics with aggregate, geographic-based population health metrics
Components of Obesity-Focused Convergence Strategy

- Engagement of school students as volunteers in scaling of community garden and integration of experiential learning into academic curriculum.
- Recruitment of community residents engaged in community garden to family walk program.
- Secure donation of materials and support hardware store marketing promotion of scaled community garden.
- Sales of expanded produce production in local farmers market to generate income for garden.

Components of Obesity-Focused Convergence Strategy

- Completed analysis justifying investment in grocery store by CDFI
  Case for investment supported by coordinated engagement and solicitation of input from residents on types of food, related goods desired in grocery store as part of nutrition education programs and community gardens.
  Resident youth employment by grocery store based on skill development supported by UW
  Increased public awareness and support for HEAL public policies based upon broad support from providers, employers, schools, and the general public.
Convergence at the Center

Hospital Community Benefit
- Compliance Orientation
- Annual Reporting
- Programs and Services
- Process Measures
- Proprietary Bias
- Limit exposure

Intersectoral Place-Based CHI
- Transformational Orientation
- Intersectoral Shared Ownership
- Data Sharing
- Quality Improvement
- Measurable Outcomes
- Sustainability

Community Development
- Transactional Orientation
- Reduce Risks
- Close the Deal
- Build Track Record
- Stimulate Replication

Total Health Impact:
Applying all Kaiser Permanente Assets for Health

Tyler Norris, Vice President, Total Health Partnerships
December 7, 2015
Building on our DNA and our roots, who we are...

Creating a Shared Agenda rooted in set of core beliefs:

- We believe that life, liberty, and the pursuit of happiness require total health – and that includes equal access to health care for all Americans.
- We believe that total health is more than freedom from physical affliction – it’s about mind, body and spirit.
- We believe that health care must be affordable for all – because thriving individuals, families, and communities require that.
- We believe in a healthy and engaged life – with good beginnings and dignified endings.

Creating a Shared Agenda rooted in set of core beliefs:

We’re #1 in Health Care...

Leads the nation in the most No. 1’s in Effectiveness of Care Measures

All Kaiser Permanente regions received 5-Star ratings, the highest possible rating.

Kaiser Permanente is the only health plan in California to earn the highest rating for overall quality of care in the Healthcare Quality Report Card.

Kaiser Permanente has received 36 Stage 7 Hospital Awards for successful electronic health record implementation.

27 Kaiser Permanente facilities honored as “Top Performers” for Quality and Safety by The Joint Commission.

Kaiser Permanente Hospitals are the safest in the nation.

KP won five 2013 eHealthcare Leadership awards, including the highest honor for Organizational Commitment, and the 2013 Hospital Website Transparency Award with Distinction.

Kaiser Permanente has received 36 Stage 7 Hospital Awards for successful electronic health record implementation.

The KP flagship and Every Body Walk! apps have received Silver Web Health Web Awards recognizing high-quality digital resources for consumers.

KP’s California health plans receive top rating – 4 Stars – for quality and service.

16 Kaiser Permanente hospitals listed among the nation’s elite in annual “Best Hospitals” rankings.
...but health is not equitably distributed in our communities

PLACE MATTERS: Male life expectancy in Hough & Lyndhurst OH
Moving From Contribution to Accountability

Do Good Things
- Assure access
- Support community organizations
- Educate

Make an Impact
- Address determinants of health in physical, social, natural environments
- Measure impacts

Be Accountable for All Our Impacts
- Understand our social, ecological and economic footprint, and its impact on community health
- Leverage all our assets

“What Counts” “Making it Count” “Being Accountable”

Hand Printing: the good an organization does minus its footprint, accounting for positive actions to help drive an organization or individual to be net-positive

Strategic Commitment: Connect and Deploy All Assets

Deploying All Kaiser Permanente Assets for Total Health

Bringing together our mission, brand, knowledge and capabilities.

Physical and Mental Health Care
- “Body, Mind and Spirit”

Clinical Prevention

Research and Technology

Purchasing and Employment Practices

Community Health Initiatives

Environmental Stewardship

Public Information

Living Wage Payroll

Individual / Family

Home / School / Worksite

Neighborhood / Community

Society

Health Education

Healthy Eating Active Living

Access to Social and Economical Supports

Schools / Worksite & Workforce Wellness

Public Policy

Facilities
An Analytical View for Total Health (TH Framework)

Social & Economic Factors
- Education
- Employment
- Income
- Family & social support
- Community safety
- Culture

Physical Environments
- Built environment
- Food environment
- Media/information environment
- Environmental quality

Health Behaviors & Other Individual Factors
- Diet & activity
- Tobacco use
- Alcohol use
- Unsafe sex
- Genetics
- Spirituality
- Resilience
- Activation

Clinical Care & Prevention
- Access to care
- Quality of care
- Clinic-community integration

Health Outcomes & Wellbeing
- Physiology
- Disease and injury
- Health and function
- Wellbeing

Settings: Home Workplace School Neighborhood Clinic Virtual

What Do We Mean By Total Health?

What Do We Mean By Total Health?

Whole Person

Whole System: Clinic + Community

Whole Enterprise
Total Health begins with the whole person:

Mind • Body • Spirit

FEED YOUR MIND.
FEED YOUR BODY.
FEED YOUR SOUL.

Health Activism: Stakeholder Engagement at Every Level

Deliberate, informed, irresistible engagement of human beings as a co-producers of health, for the vitality and well being of...

My Community
My Family and Friends
Me

Stakeholders: Employees, Physicians, Members, Customers, Families, Org. Partners, Communities

Settings: Home Workplace School Neighborhood Clinic Virtual
Total Health Across the Lifespan T-9 Months > End of Life

CHNA Informs Areas of Priority

Violence Prevention
Economic Viability
Community Safety
Healthy Eating
Active Living
Mental Health
Social & Emotional Wellness
Maternal & Child Health
By applying social movement praxis and a "total health lens" to all we do, Kaiser Permanente creates economic, environmental and social value, while delivering on our mission and margin. Total Health becomes an operating system for engaging the gifts, assets, and aspirations of our people, organization, partners and communities to deliver positive impact at scale.

Total health is a "how" not series of "what's" (programs/initiatives) that simply use the name.

**Executing Our Total Health Agenda**

We launched an approach to implementing Total Health around a coordinated set of activities, focusing on some key initial areas while developing core capabilities and enhancing efforts on work underway.

- **Total Health Signature Initiatives**
  - Focus as first and relatively complete demonstrations of Total Health, done everywhere in KP
  - Thriving Schools
  - Workforce Wellness

- **Core Capabilities “Fundamentals”**
  - Essential components needed to realize Total Health
  - Behavior Change
  - Social/Non-Medical Needs
  - Community Health Initiatives
  - Total Health Impact

- **Applications of Total Health**
  - Work underway but Total Health lens can help deepen the work and re-double our efforts
  - Integrated Physical Activity
  - Healthy Food Systems
  - Social/Emotional Wellness

*Effective Impact Measurement* (to shape investments and actions) + Internal and External Communications (to align organizational messages that engage all our stakeholders) + light Project Management to assure shared accountability for outcomes.
Total Health Streams of Work 2016-2017

**Sponsorship**
- NET + Regional Presidents + EMD’s
- 2016 CB Goals with Total Health opportunity

**Regions**
- Cultivate “Total Health Mindset” in all we do
- Signature and Capacity initiatives + Impact Demonstrations
- Establish/apply measures, set goals and targets, build capacity

**National Functions**
- Develop charters, establish and apply impact measures
- Set goals and targets, engage across teams
- Develop action “Playbook”

**Impact Measurement**
- Impact model with pathways to health impact
- Define metrics and establish baseline
- Inform investments and actions, track outcomes

**Communications**
- Develop message framework and toolkit
- Find and tell great stories
- Ongoing coaching and training

**Core Operations / Hub**
- Total Health Workgroup
- Programwide summit gathering May 2015
- Grow distributed leadership with accountabilities

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### Applying All KP Assets for Health

*We can leverage many of our activities in key functional areas to understand the economic, environmental and social impacts.*

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[Diagram showing various functional areas such as Health Care Services, Treasury, Technology, and others, with a central focus on Total Health Impact.]
Total Health in the Regions

2016 Community Demonstrations in regions:
- Clear success criteria (design and implement with rigor)
- Tied to CHNA and Social Non-Medical (SEB) Needs
- Apply ecosystem model (high dose economic, social, environmental investments) coordinating functional assets with regional strategy

Washington + Group Health

Northwest
- TS + WFW
- BUILD
- OR Healthiest State

NCAL
- TS + WFW
- Anchors for Resilient Communities
- Oakland Healthiest City

SCAL
- TS + WFW
- Cultivate

Hawaii
- TS + WFW
- SWITCH
- THI Forthcoming

Colorado
- TS + WFW
- Hunger Screening
- THI Forthcoming

Georgia
- TS + WFW
- THI Forthcoming

Mid-Atlantic States
- TS + WFW
- Baltimore Expansion
- PG County
- DC Central Kitchens

Kaiser Permanente Illustrative Value Chain Impact Diagram
Strong evidence that antibiotic use in food-producing animals transmits resistant bacteria resulting in negative impacts on public health

Sustainable food purchasing: Reducing antibiotic-resistant bacteria in environment through KP’s purchases of sustainable foods (antibiotic-free meat and vegetables)

$14.9 billion in wages and economic prosperity from KP job creation that contribute to total health in our communities.
Understanding the Drivers: Climate Change Action

- 20 year agreements with NRG and NextEra Energy on wind and solar
- KP to meet 30% GHG reduction goal in 2017, three years ahead of schedule
- Reduced water usage KP-wide by 7.6% in 2014 from 2013
- Employee discounts on home solar

Becoming a Total Health Organization

Our Buildings in the Past...

Imagine if...

- We located, designed and built new facilities in ways that attracted economic and social activity and energized local neighborhoods and business districts.
- We formed partnerships with like-minded organizations to accelerate use of sustainable energy, reduce pollution, conserve water and promote livable communities.
Pull some Kouletsis language from his emails to Tyler about what their team is doing.
W117299, 9/24/2015
IMAGINE IF...

We partnered with other hospital systems, schools, universities and businesses in the community to create local food systems that fostered market demand for locally sourced, sustainable food for our patients, children, students and workforces.

IMAGINE IF...

We leveraged local partnerships with schools, community colleges and universities to create a skilled workforce pipeline and promote leadership and civic engagement.

Our sourcing and purchasing initiatives actually helped foster vibrant economic development in local neighborhoods.
Total Health Value Proposition

- **Increase member engagement** (via health activism) = members act as co-producers of health, not just as consumers of care and services
- **Improved member health** (via clinical community integration) = moves us from excellent clinical quality to total quality
- **Improved population health** (via focusing and leveraging all KP + partner assets) = healthier, equitable communities
- **Reduce preventable demand/utilization** (via ‘all in’ approach) = affordability by decreasing demand-driven costs
- **Differentiate KP brand via social value creation** = attract secure and retain value purchasers, millennials
- **Complement growth strategies** (core and contiguous) = effective market entry and build-out
- **Increase employee engagement** (discretionary energy/creativity) = recruitment, retention, peak performance
- **Lead (set the pace) for the health sector** in delivering the highest quality care experience, with affordability, while contributing to healthiest communities in the nation

An Invitation: To Lead From Wherever

**Total Health starts with you:**

It will take each of us, all of us to deliver on our commitment to total health:

- How can you embed total health thinking and practice in your life and the places where you live, work, learn, play and worship?

- How can you, as a leader at any level in this organization, identify opportunities to help KP apply all our assets, investments, policies and practices in ways that build the health of our members and the communities we serve, while contributing to long term affordability?
Together we help our communities

THRAVE

Kaiser Permanente

How do we move forward?

100 Million Healthier Lives
Switch framework

Key levers - the “roles” you can play

- Care delivery
- Employee health and wellbeing
- Food service provision
- Purchasing
- Investing
- Community partnership
- Systems change agent
- Advocacy
- Policymaking

From Chip and Dan Heath, *Switch*
Leading in an integrated way

Leading for equity
Leading for outcomes
Leading together
Leading from within

Leading from within
- The narrative of your mission – personal and organizational
- Equity as a unifier
- Leadership and governance alignment
- Whole person, whole community orientation

Leading together
- Partnership across sectors
- Shared ownership and accountability for vision and outcomes
- Collaborator in community-wide health needs assessment process
- Community benefit redesign and integration
- Workforce transformation
Leading in an integrated way

Leading for outcomes
- Improvement based on whole people and populations
- Data exchange across sectors
- New business models and payment mechanisms, including those through the ACA
- Policy change

Leading for equity
- Use data to close gaps in outcomes
- Address personal and structural racism

Key opportunities
1. Close equity gaps (price of admission)
2. Help veterans to thrive
3. Address and improve social determinants across the continuum (high priority: housing, education, food security)
4. Improve wellbeing of indigenous communities
5. Help all kids have a great start to life
6. Make mental health everybody’s job and take a prevention approach to family and community violence, trauma and addiction
7. Engage people in their own health (nutrition, exercise, sleep, stress, food security) especially if they have a chronic disease
8. Improve employee health and wellbeing
9. Create wellbeing in the elder years and end of life
A moment of reflection

- What are the priority needs in your community?
- Which levers fit best for your health system?
  - Which levers?
  - Which population(s)?
  - Which opportunities for leadership?

Childhood Asthma Outcomes: Seeing Admissions And ED Visits As A Safety Issue

[Graph showing Childhood Asthma: % Patients with Asthma Admissions and ED Visits]
A spiral of collaboration and outcomes

- Tobacco
- Obesity
- Health and wellbeing of the elderly
- Mental health
- Substance use
- Breaking the cycle of violence and incarceration
Kotter’s framework for change management

1. Establish a Sense of Urgency
2. Create a Guiding Coalition
3. Develop a Vision & Strategy
4. Communicate the Vision
5. Empower an Action Coalition
6. Accomplish Quick Wins
7. Leverage Gains to Accelerate Momentum
8. Anchor New Approaches to Change Culture

Kotter J www.kotterinternational.com/the-8-step-process-for-leading-change

Cambridge Health Alliance (CHA)

Public health

Integrated care delivery system serving 100,000 patients
(12 community clinics, 2 hospitals, 3 EDs, specialty sites)

Community
(7 cities)

Customers
(50% speak language other than English, 70% publicly insured)

Trainees
(actively engaged in creating transformation)

3393 Employees
(in 18 labor unions)

“Whose life got better because we were here?”
CHA’s ACO Components

Primary Care Redesign: Patient-Centered Medical Home
Integrating Patients

Upstream
• define the problem with the patient
• design potential solution together
• pilot
• study results
• If it didn’t work, ask team (incl. patient)

Downstream
• Clinic defines problem
• Clinic designs potential solution
• pilot
• study results
• If it didn’t work, ask staff
  • ask patient
  • redefine
  • redesign
  • repeat

Improvement Support

Tools

People
PIT Support / Coaching

Lead Patient Partner

Toolkits
Improvement Tools
How can we improve the health of our population of 120,000 patients?

One panel at a time, through relationships.

Population view

- Complex Care Management (top 5%)
  Team: social worker, nurse, CHW/resource specialist

- Chronic disease management (50%)
  Nurse, pharmacist, specialist

- Maintain health, prevent disease (medical assistant, receptionist, PA with doctor/NP)
Relationships based on the whole person + reliable, proactive approach + quality improvement = outcomes

Systems: Making Follow-up Easier
CHA Initiatives To Create Medical Neighborhood

1. Referral Standards – agreement about access and collaboration
2. Care Transitions
   - Hospital to Home
   - Emergency Room to Home
3. Primary care-specialty linkages for patients with chronic disease or high risk conditions (abnormal cancer screen)
4. Mental Health Integration
5. Electronic health record connections – shared notes, care plans
6. Strategic partnerships for services not provided in local community hospital

Some Outcomes

1. 25% reduction in readmissions to the hospital
2. 20% reduction in emergency room revisits within 72 hours
3. 36% reduction in hospitalizations for patients with diabetes
4. 50% reduction in emergency room visits and 40% reduction in hospitalizations for complex patients, leading to improved flow
5. Improvement in a wide range of quality indicators
6. 10% reduction in absolute cost
7. Improved joy of work and job satisfaction
Perception of Teamness by Overall Job Satisfaction

- Higher Team Perception
- Lower Team Perception

"Overall I am satisfied with my current job"

Between Groups P<0.01

A generation of new leaders

[Images of people]
What supports are available for the journey?

www.ihi.org/100MLives
sstout@ihi.org

Purpose of Health Systems Transformation Hub

- Create an unprecedented collaboration of support organizations that can help health systems and providers make this transition.
- Create common messaging for health care systems on the journey to population health.
- Create an oasis of support that meets health systems where they’re at and supports them to move forward in effective ways.
- Engage a critical mass (40-60%) of health systems on the journey to population health.
Aims, drivers, measures you are using
How will your hub create sustainable, equitable wellbeing?

- Partnership between core health system support organizations
- Common vision and language
- Use existing assets and opportunities to amplify core common messages
- Common “flood the zone” messaging
- Development of a connected support pathway – the “oasis”
- Shared design of the oasis; leverage common assets
- Engage health systems on the journey
- Leverage our combined reach to our membership

A critical mass of health systems effectively moving to population health

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Partners and members creating our hub

- Public Health Institute
- Institute for Healthcare Improvement
- Stakeholder Health
- Prevention Institute
- America’s Essential Hospitals
- Institute of Medicine Roundtable, Pop. Health
- American Hospital Association (ACHI)
- Trust for America’s Health
- American Medical Association*

- Moving Healthcare Upstream
- Healthcare systems on the journey
- Thought leaders (Jim Hester, Prabhjot Singh, Jim Diegel)
- In collaboration with Centers for Medicare and Medicaid Innovation Population Health Group
- Health Begins
- HealthLeads, Pathways Community Hub
- Democracy Collaborative
Domains the oasis will likely address

- Senior Leadership / Governance
- Cross-sectoral collaboration
- Data Systems and Measurement
- Community Needs Assessment/Community benefit redesign
- Financial Innovations
- Policy Development
- Delivery system innovations
  - Primary care transformation
- Equity and social determinants of health
- Build capacity to capture and share bright spots
- Readiness, needs and asset assessment
- Tangible opportunities for health care system impact (eg education)
- Role transformation for health care systems
- Workforce Development

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