Professional Research Consultants, Inc.



March 2013

community health connection

Hard Numbers | Hard Dollars

Solid research helps Columbus Regional Hospital gain funding.

"While anecdotal stories about the need in our community provide interest and color, it's really the quantitative data that the funders want to see."

Hard Numbers Result in Hard Dollars

Perceptions are in the eye of the beholder, especially when it comes to community health needs. Some people believe that health fairs should be a priority while others strive to focus on school-based nutrition education. Still others believe that their "pet cause" is most important. Columbus, Indiana, is no different; they, too, want to know the specific health needs of their community.

Since 1996, Columbus Regional Hospital (CRH) has been working diligently to determine exactly what these needs are through research that has reported on general health status, modifiable health risks, access to health services, quality of life and much more.

Beth Morris, CRH's Director of Community Health Partnerships, says the reasons for assessing Columbus' health needs via statistically sound methods are two-fold. "We must understand the unmet needs of the community and what role the hospital should take to help meet those needs," she explains. "We need to know the true needs, not the perceived needs. Additionally, we have to measure the impact of the initiatives that we've already taken on."

Although the data the hospital has gleaned from its multiple Community Health Needs Assessments are valuable in so many ways, there's more to making a difference than just knowing the community's needs – you also need the money to support initiatives that will impact these needs.

Data Trending Proves Credibility

Data provided from PRC's CHNA studies have proven to be effective for Columbus Regional Hospital in its grant applications. CRH has successfully used its Community Health Needs Assessment data to gain funding from local organizations including the United Way and community foundations, as well as from state and federal organizations.

"While anecdotal stories about the need in our community provide interest and color, it's really the quantitative data that the funders want to see," says Morris. Fortunately for Columbus Regional Hospital, it has a lot of quantitative data to refer to. Having conducted assessments for the past 17 years, CRH has six data points to refer to when showing trends. Morris explains, "We can really show trends over time, and that helps lend credibility to any request that we might make."

PRC's assessments emphasize the importance of primary data, and Columbus Regional Hospital backs up that claim with its history of receiving funding. Morris says, "Given the methodology that PRC uses in collecting data, we feel good about putting it out there as a true depiction of what life in reality is like. Unlike relying solely on secondary research, we are certain primary data solidly tells the picture of our community and its needs."

While secondary data is inexpensive and relatively easy to locate, the value of the data is often disputed because it may be several years old and irrelevant to the cause. Secondary data oftentimes doesn't represent a specific city, service area or county. On the other hand, primary data is customizable and targeted to reflect the exact population and geographic area of interest. "Having data specific to the county we serve was considered of primary importance to our leadership," Morris explains.

Foundation Support is Key

The hospital is thankful that its foundation is able to fund many of its initiatives. Morris says, "I'm sure the president of the foundation will tell you

Where Does Foundation Money Go?

Funds raised by the Columbus Regional Hospital Foundation support both the hospital and the community as a whole. The Foundation's overall goal is to promote healthy choices and lifestyles. The Foundation funds eight initiatives in the Columbus, Indiana, area:

1. **Volunteers in Medicine** – a clinic to serve the uninsured
2. **Proyecto Salud** – to remove language and cultural barriers to healthcare access
3. **Community Medication Assistance Program** – to provide access to affordable prescriptions
4. **Tobacco Awareness** – to reduce tobacco use
5. **Healthy Lifestyles** – to improve nutrition and increase physical activity
6. **Breastfeeding Coalition** – to increase breastfeeding initiation and duration
7. **Domestic Violence** – to develop a coordinated community response to domestic violence and sexual assault
8. **Caring Parents** – a home visitation parent support program for parents of infants up to one year old

that it makes her job much easier to raise money on our behalf because she has solid data to show funders where the need lies." The foundation is the primary funder of CRH's eight initiatives – including access to healthcare, healthy lifestyles and healthy relationships.

"We love using PRC's data as a testament to our commitment to measure results," explains Morris. "It proves that we're sincere about making a measurable difference in the initiatives we take on, and that we'll continue focusing on that commitment if we're funded."

The impact of funding received over the years has been impressive for Columbus Regional Hospital. Based largely on CRH's documentation of need, Bartholomew County (CRH's primary county) received a two-year, $2.1 million grant for obesity prevention from March 2010 to March 2012. "There is no question that this money allowed us to have far greater visibility," says Morris. "We were able to have a greater presence in the media, which in turn helped us recruit and generate more interest in our 700 volunteers." This grant money also paid for the hiring of temporary staff to help support healthy lifestyles initiatives, and allowed the school to strengthen wellness policies.

While PRC gathers the data for Columbus Regional Hospital that shows unmet needs and measures the impact of the initiatives previously implemented, it's the additional funding that ties everything together.

Morris says, "With the amount of financial support we've received over the years, we've been able to make progress in areas that would have been impossible otherwise. We're really grateful not only for the PRC data, but for the ability to use that data to gain funding that helps us make a difference."

Since its inception in 1994, CRH's Healthy Communities Initiative has received more than **$7 million** in grant funds. Morris says, "Nearly **85%** of all our funding comes from grants from various sources."

Post CHNA:

Developing an Intervention

Jana Distefano, MPH – *Community Health Consultant & Analyst*

You've just received the final version of your PRC Community Health Needs Assessment (CHNA) – more than 200 pages of information about health status, behaviors and areas of opportunity to improve your community's health. But where do you go from here?

The IRS requirements state that in addition to conducting a needs assessment, hospitals must identify and prioritize health needs, and subsequently provide a written implementation strategy. An important part of the PRC CHNA is that it provides you with a list of identified community health needs — "areas of opportunity" — to help narrow the focus. These areas are identified based on data revealed through the assessment. This short list helps organizations begin to prioritize the health issues that should be addressed.

Once health priorities are established, the next step is to begin thinking about creating the most efficient and effective interventions. Hospitals should consider successful programs implemented in other communities, talk to local organizations already combating the issue, and collaborate or review evidence-based practices. Another method to consider when beginning program development is to conduct a "root cause analysis" or RCA. An RCA helps users identify the antecedent conditions of a problem and create upstream approaches to health interventions. In other words, preventing the problem at the source.[1]

For example, when using RCA to look at the topic of obesity, researchers consider the many factors responsible for population health: individual factors; individual behaviors; public services and infrastructure; living and working conditions; and social, economic and political factors.[2]

Sample A

Ask "Why" an Issue Exists

Sample B

Expand All Possibilities

Sample C

The Complete Picture

The first step is to ask "why" an issue exists. In ***Sample A***, researchers first came up with three reasons for obesity – sedentary lifestyles, genetics and the availability and consumption of high calorie foods.

The next step is to explore each of those reasons further. You continue to ask "why," expanding the diagram in ***Sample B*** until you've exhausted all possible rationales. Asking topic experts and community organizations, and considering existing research are ways to strengthen your diagram(s).

In the end, you should be able to start at the left-side of your page and form one logical sentence following the arrows across the page. Based on this, your example would read: Lower income individuals may live in neighborhoods that lack safe infrastructure for outdoor activity, which leads people to spend hours in front of televisions, which causes families to live sedentary lifestyles. A sedentary lifestyle can lead to obesity.

Continue to build your diagram until you believe you have the complete picture. The complete RCA may look similar to ***Sample C***, which allows users to examine all the social determinants affecting a health topic. It provides a simple, straightforward approach to examining complex health issues. Users can then decide where an intervention should occur along the causal pathway in order to have the most impact.[3]

For example, an educational program aimed at increasing physical activity may not be "upstream" enough to have an impact. Users can decide where they want to create interventions and shade these boxes, but keep within the overall diagram to ensure the program takes into account other variables. The final diagram illustrates that there may be many reasons why an individual leads a sedentary lifestyle, which contributes to their higher weight status. Possible upstream approaches to improve physical activity could include interventions that improve the built environment by adding streetlights or working with city planners to build sidewalks.

Once your organization has decided on a path(s) for intervention, the next step is to develop a logic model. Most logic models examine inputs, outputs (what and who) and outcomes. Some take into consideration assumptions and external factors. Logic models provide a global perspective of the program and can help create evaluation tools.[4] In addition, it's critical to have SMART goals and objectives (Specific, Measurable, Attainable, Relevant and Time-Bound), so you already have measurements for evaluation purposes.

Upstream approaches to health interventions may focus on policy development, social marketing campaigns or environmental planning, but regardless of the mechanism, they are all uniquely designed to focus on the root causes – the "real problems" at hand.

References

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Examples of Prioritization Criteria

Before developing interventions, you need to establish what health issues are a priority in your community. For this prioritization process, consider the following criteria for each health topic assessed.

- **Magnitude**
  - How many people are affected by a given health issue?
  - How do we vary from state or national benchmarks? Healthy People 2020 targets?
- **Seriousness & Impact**
  - To what degree does this health issue lead to death or disability, or impair quality of life?
  - To what degree does this health issue impact other quality of life and health-related issues?
- **Feasibility**
  - What is the likelihood of impacting this health issue, given available resources?
- **Consequences of Inaction**
  - What is the risk of exacerbating the problem by not addressing it at the earliest opportunity?
- **Other Potential Criteria**
  - Does the issue align with our mission, vision and goals?
  - Does the issue fit within our definition of "health" or a "healthy community"?
  - Will the issue have community support?

Several Organizations Team Up to Conduct One Assessment

The Missouri River separates Nebraska and Iowa, but the health and culture of the Omaha/Council Bluffs Metro have always been intertwined.

That's why Dr. Adi Pour, Director of the Douglas County Health Department in Omaha, Nebraska, proposed that the health systems and health departments in the area work together to meet the requirements under the Patient Protection and Affordable Care Act.

"We didn't want five or six Community Health Needs Assessments going on at once," says Pour. "It made sense to have all of us work together and share the cost."

The Douglas County Health Department has completed Community Health Needs Assessments (CHNAs) with PRC since 2002, but the health systems in the area didn't have experience with them. To maintain credibility and a professional outcome, the group decided to have PRC complete their CHNA.

Since patients certainly don't stay within county lines, three counties, three health systems and one health organization joined the Douglas County Health Department to collaborate on one shared CHNA.

Pour says, "The Douglas County Health Department already had experience with PRC, and has been very pleased with their professionalism and expertise, so we wanted to stay with them. A big benefit for us was that we could look at local trend analyses, share that knowledge and implement programs accordingly. Our partners also saw the professionalism of PRC and no further bids were collected."

The CHNA covered three counties in Nebraska and one in Iowa. However, the data could still be broken down to smaller areas, as each organization desired.

"Each county and health system could establish specific geographic areas to glean the information they needed," says Pour. "For example, we divided Douglas County into five specific geographic areas, based on ethnic and racial groups. The interpreted data is more impactful when we can use small parameters as well as the comprehensive data."

Competitors Become Collaborators

The health systems involved in this particular CHNA usually consider themselves to be competitors, but while developing the questions for the survey, they worked together closely. Every voice was heard, and all concerns were addressed.

The group knew what data they needed, but as Pour says, "We aren't experts at wording questions to get the proper information. That's where the PRC professionals really helped us." PRC's CHNA team helped with wording to assure that meaningful data were collected.

"The CHNA team has vast knowledge, and we put it to good use. They helped us with the questions and even with technical assistance," Pour says.

Informing the Community

For years, the results of the Douglas County CHNA have been presented as a community report card during the Omaha Health Summit organized by Live Well Omaha, a community health collaborative, where trends, assets and priorities are discussed every year. Now, the goal has expanded to specifically identify what each hospital will address.

"A community health improvement plan requires some action by each organization," says Pour, "and together we can focus and identify those actions better, so each organization can create an improvement plan that won't be redundant with other area organizations."

Public Policies Matter

The target audiences of the organizations involved in the CHNA varied from urban to rural, so the people and policies they deal with on a daily basis were also somewhat varied.

"We talked a lot about policy, so naturally, we included policy questions," explains Pour. "Douglas County includes Omaha, which is urban, Cass County is more rural, and Pottawattamie and Sarpy counties are a bit of both. We got a nice

picture with urban and rural aspects."

The CHNA also crossed state lines, and there was an unexpected disparity between Nebraska and Iowa – the number of children tested for lead poisoning. Iowa has specific requirements to ensure universal testing of children for elevated blood lead levels, which leads to better and earlier prevention. Pottawattamie County (IA) residents reported that 80.8% of children ages 0-6 have had a blood test to check for lead, while only 49.5% of children ages 0-6 have been tested in Douglas County (NE).

This could prove to be a very significant find, because in Douglas County, lead exposure tends to be high, but with no testing requirements in Nebraska, screening and early detection is much more difficult. It's an area that wouldn't have been on the radar if this collaboration across state lines hadn't taken place.

Another interesting find was that transportation – long thought to be one of the key barriers in getting people access to healthcare – is not a significant factor. Rather, the cost of doctor visits and pharmaceuticals are the main obstacles in people gaining access to healthcare. In the Metro Area, only 4.7% of participants identified lack of transportation as a barrier in accessing medical care, while 14.5% of respondents went without a needed doctor visit because of cost. This could lead to a change in focus when it comes to public policy.

The Data Tells the Story

"PRC is very knowledgeable about the data, and they presented a tailored message for each group to whom they presented," says Pour. "They could handle very pointed questions from the healthcare community and community leaders even as it relates to national trends. PRC provided an exceptional service to us.

"The hospitals are being very open-minded and creative in how to handle all of this information," says Pour. "They're letting the data tell the story, so they can determine what to do with it. Working together from beginning to end has been a very rich experience for all of us."

Spheres of Influence Minimize Redundancies

The health organizations involved in the PRC CHNA are using the data to determine where each can make the biggest difference in the community. By working together to address the needs of the community, each organization can decide where its passions and resources lie.

Pour explains, "Now, they can work together in the same direction, complementing each other, not duplicating their efforts."

For example, Methodist has a women's hospital, so women's health is a key priority for them. On the other hand, Alegent Creighton Health is a Catholic health system, which influences their priorities, one of which is mental health.

"By sharing information and determining priorities, we can do the most good in our communities," says Pour.

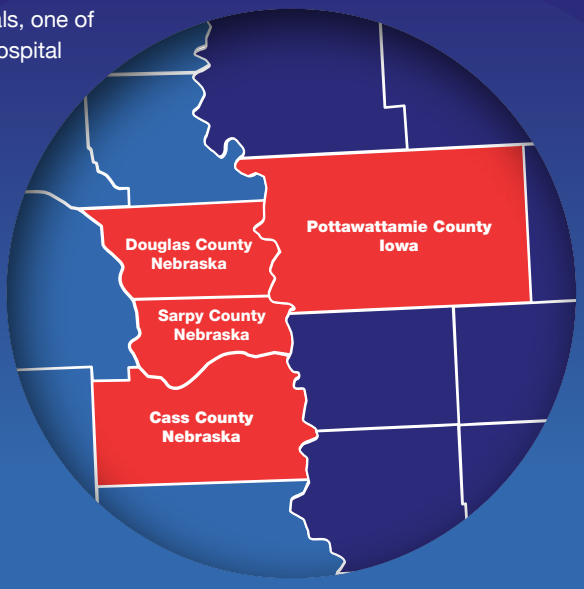
Sponsors and Collaborators for the 2011 CHNA

Nebraska:

- **Alegent Creighton Health** – includes six hospitals and one recovery center within the assessment area
- **Douglas County Health Department**
- **Live Well Omaha** – a collaborative effort including schools, healthcare professionals, faith-based organizations, private sector companies and more, created to improve the overall health of area residents
- **Methodist Health System** – includes three hospitals, one of which is a women's hospital
- **Sarpy/Cass County Health Department**
- **The Nebraska Medical Center** – includes a medical campus and cancer center

Iowa:

- **Pottawattamie County Public Health Department/ VNA**



The Health of America's Children

- **81.5%** of parents rate their child's overall health as "excellent" or "very good."
  - Midwest and West region perceptions of Overall Health are the least favorable.
- **64.5%** of parents report that their child has one or more special health needs.
- **30.7%** of all children are classified as overweight or obese.
  - Only 13.3% have been told by a school official or healthcare professional in the past year that their child is overweight.
  - For overweight (but not obese) children, 71.9% of parents perceive their child to be about the right weight.
- **54.7%** of children aged 5-17 spend 3+ hours of "Screen Time" each day.
  - This percentage is highest among teenagers and African American children.
- **12.0%** of children currently have asthma.
- **69.7%** of parents report their primary source of healthcare information for their child is the family doctor/pediatrician.
- **30.3%** of parents report at least one difficulty accessing healthcare for their child in the past year.

Assessing the health needs of children and adolescents in local communities is more important than ever before. In 2012, PRC administered the PRC National Child & Adolescent Health Survey to measure the top health issues for children in America.

More than 700 parents were surveyed for this study, which focused on topics such as children's overall health, difficulties accessing pediatric healthcare services and childhood obesity. A robust set of measures were addressed, including:

- Access to healthcare services, including insurance coverage and primary care utilization
- Modifiable health risks, including nutrition, physical activity and injury
- Physical and mental health status
- Special health needs and prevalence of select chronic conditions
- Behavioral concerns
- Personal safety, including neighborhood crime
- Health education and outreach
- Demographic breakdowns across all categories

PRC's experts **Jana Distefano**, MPH, and **Dustin Strickler**, MBA, reported on the findings from the survey. To view their entire presentation, please visit **http://bit.ly/healthofamerica** or scan the QR code.

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10 Facts About Population Health

With more than 20 years in health care as a physician and administrator, it's become evident to Benjamin Chu, M.D., that providers treat people "at the end point" of a long slide, after all the factors that contributed to a medical condition have had their effect. "We're downstream, we're right at the end of all these tributaries, so we're sort of in a delta, catching all of this stuff as it's coming down," Chu says. Most determinants of serious conditions, he observes, "are amenable to early intervention."

Now chair-elect of the American Hospital Association board of trustees and group president of Kaiser Permanente's Southern California Region and Hawaii, Chu's "biggest awakening" came when he ran an emergency department in New York that not only had a high number of asthma-crisis cases but "time and time again were the same people," he recalls. "It begs the question: Could we actually do a better job of realigning some of the resources by focusing a little bit more upstream on some of those determinants?" In short, do more earlier instead of at the end?

The answer to that question should be a resounding "yes" in this emerging era of accountability for the overall health of people. Led by a range of Medicare pilot programs emanating from the Patient Protection and Affordable Care Act, providers are being held responsible for the health status of a defined population instead of just those who see a clinician or go to a hospital. This step up to population-level health involves identifying the people in a community who need attention and giving it to them.

What trustees need to know about this facet of delivery system transformation

Population health is in large part a quest to systematically find and proactively fix health care problems that afflict whole classes of people similarly. "The reason we fail as health care organizations is we only realize who we are impacting by who we see," says Donald Caruso, M.D., a family physician and medical director at Cheshire Medical Center/Dartmouth-Hitchcock Keene (N.H.). "There's a population out there that doesn't come and see us — but they don't see anyone. Yet they're the people we take care of in their 50s and 60s, 70s and 80s with all their chronic-disease problems."

His message to governing board members: "As a trustee, as a member of the community, you have an obligation to look at your community and say [for example] just treating someone's cardiovascular disease and sending them for a stent at the tertiary-care hospital can't be all we should be doing. It really has to be: How do we keep people from getting there?"

To bring the urgency and opportunity of population health closer to home for trustees of health care organizations, *Trustee* interviewed experts on it as well as executives of health systems that took a population-based and community-focused approach a number of years ago. Their advice and observations are distilled into a list of 10 things trustees should know about population health.

1. This is not voluntary. Accountability for the health status of a population is where we're headed.

So says David Nash, M.D., dean of the Jefferson School of Population Health in Philadelphia. Hospitals already are on the hook to prevent discharged patients with certain diagnoses from having to be readmitted within 30 days. "That's all about practicing effective population health to prevent a readmission," says Nash. The ACA's experiments in accountable care organizations and other value-based, outcome-oriented models of approaching health improvement are pilots now but suggest the paths the government will take.

The clear message from Medicare is that it's heading toward forms of fixed payment, recognizing the impact of health care professionals on the overall health of its beneficiaries; that reality will be upon us in three to four years based on the trajectory of the ACA, Nash asserts. No matter what happens in Washington regarding challenges to the law itself, it won't change the fact that "there's no new money; everything starts with that premise," says Nash. "That's population health: no outcome, no income."

2. Trustees have to think outside the figurative four walls of the institution.

In the new era, hospitals and physician offices become way stations in the larger health management of "covered lives," which will take the place of "patients" as the main focus of a health system's activities. "The customer under accountable care isn't just the person who enters the hospital, it's somebody who hasn't even entered the health care system yet but is part of the defined population that you are, in fact, responsible for," says Barbara Gray, vice president for accountable care collaboratives at Premier Inc. "How do you reach out and find those people — how do you engage them, and how do you work with them and empower them and educate them in a system to help them take care of themselves?"

"Board members are going to have to start asking questions like, 'What's our allocation of resources with regard to paying attention to indices of community health and well-being? How are

we connected to our local community?'" Nash says. "That calls for all kinds of services not currently offered: for example, maybe it's of value for a hospital to support a local senior center — put some physicians and nurses, case managers into that center to decrease unnecessary admissions, reduce readmissions."

3. Promoting the good health of the community has to become more than a nice mission statement; trustees need a keen understanding of how to do it.

"This is going to really stretch the skill set for most boards as currently constructed," Nash says. Running a hospital and other associated facilities and offices does not get at community health. "They put it in the mission statement: 'We want to deliver the best quality of care for our community and keep our community healthy.' Oh really. Well, how exactly are you going to do that?"

A first step, he says, may be the outward moves required to extend the hospital's reach past its usual terminus of responsibility at discharge: a nurse call center to contact people recently discharged, a case manager to visit patients at home and make sure they return for follow-up appointments.

Good health also involves helping clinicians do more for patients than current care settings can accomplish. "The biggest battle that I've had is on the ground, in the exam room, getting people to change lifestyle and do the things that actually impact their health outcomes," Caruso says. "Physicians have some influence, but don't have the influence that really occurs within society."

4. Boards have to reengineer their strategic priorities from the ground up to make population health a central theme, reallocate resources and commit to the changes.

"It's not just concentrating on doing the best job in the hospital," says Chu. "Those things are important, but boards are going to have to think about how we go upstream." It goes to the heart of what a nonprofit hospital should do to demonstrate community benefit. Typically, profits are plowed into medical education and expanding services, he says, "but a portion maybe should be devoted to thinking about what would make a bigger impact on communities overall."

Nash says trustees are "going to have to recognize this as a new agenda item that they haven't perhaps otherwise thought of, and they're going to have to approach it first by building it into the strategic planning process; second, by asking management, 'Do you have enough resources to tackle these issues?'; third, what's the board's dashboard of indicators that we're making progress in this area?; and fourth, what's the big dot we want to move? It would be analogous to reducing mortality, reducing medical error by one-third. In other words, what's the measurable population-health goal the board is working toward?"

5. The ability to identify and track target populations, then analyze preventive and interventional needs, is the foundation of population health.

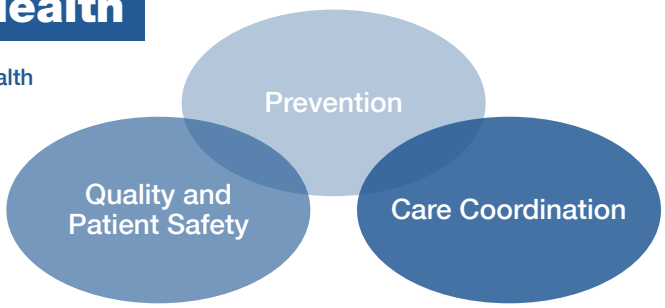
One problem with undertaking population health until now was the difficulty of establishing a target. "You can only (have an) impact on the health of a larger community over time if you have good information about their characteristics — what are their health habits, what are their chronic conditions, how often do they participate in preventive health measures and screening programs that can identify conditions early enough so that you can intervene and prevent the more extreme things from happening?" Chu says. "The big gift to us is that we can actually do that with a digital or electronic record and population-management tool. We can in this day and age track the relative health of our population over time."

The two most important things to know here are an electronic health record is critical, but an EHR by itself is not enough. EHRs are "the beginning of getting data in place, but you still have to learn how to use it," says Steven Hester, M.D., senior vice

How to Improve Population Health

Population health resides at the intersection of three distinct health care mechanisms. Improving it requires effective initiatives to:

1. Increase the prevalence of evidence-based preventive health services and preventive health behaviors.
2. Improve care quality and patient safety.
3. Advance care coordination across the health care continuum.



Source: "Managing Population Health: The Role of the Hospital," Health Research & Educational Trust, April 2012, www.hpoe.org

president and chief medical officer of Norton Healthcare, Louisville, Ky. Once an EHR capability is in place, says Hester, "do you have an appropriate infrastructure to help you analyze and decide who needs services?" At minimum, says Caruso, a health care organization should be able to split its population into registries that identify people with certain similar conditions and needs — diabetes or heart failure, prenatal care, obesity and the like — "and then be able to risk-stratify that population." Once that's done, the next move is to "prevent people from moving from the middle-risk category to the higher-risk categories" as well as keep low-risk individuals right where they are through preventive activities.

At Kaiser, which has all these tools, Chu can tell the characteristics of 625,000 covered lives in Southern California, which are available not just to doctors, but also any authorized caregiver who comes into contact with someone in person, on the phone or by email. That's how it has been able to control the hypertension symptoms in 87 percent of the people so diagnosed, as well as make big strides in other paths of health improvement. "You want to see ultimate declines in those end-stage outcomes that you're trying to avoid — heart attacks and strokes, colon cancer, breast cancer," Chu says. "You want all those things to either be diagnosed early so you maybe cure it, or really make some big difference in someone's quality of life."

6. Physician leadership development is a smart investment.

For those in the community who are successfully targeted and start receiving health services, the clinical vehicle for executing accountable care is a closely cooperating contingent of health professionals formulated to personalize care for people before, during and after their visits to the physical office setting, says Gray. Called a patient-centered medical home by some, and a health home by Premier, this health team is led by a primary care physician and can include physician assistants, nurse practitioners, a behavioral therapist, and health coaches for diet, exercise and lifestyle changes.

"In the new model ... the physician really is the captain of the team. That physician is going to have to learn a number of new skill sets, frankly, around communication, influence, being able to pull a team together and manage a team," Gray says. Given that, "the role of physician development is absolutely critical," she says. "Physician leadership will make or break an accountable care organization."

This new role "is a real challenge because the current training model is the autonomous decision-maker," Nash says. "What boards need to do is ask management, 'What are we doing to train clinical leaders in population-based care?' Do you have the right resources, current leadership and emphasis?"

7. Hospitals not only have to find the people in greatest need, but also leverage a community's existing resources in attempts to reach and support people where they live.

Local health departments, schools and other community resources likely are helping to keep their constituents healthy as part of their roles, says Michael Bilton, executive director of the Association for Community Health Improvement, a personal membership group of the AHA. The idea is not to reinvent services and duplicate them, but to find out what's being done already and strike mutually beneficial agreements. Many hospitals have relationships with YMCAs to help run wellness, fitness or diet-nutrition programs. But these programs don't occur enough, and as providers become accountable for outcomes beyond a procedure or episode, "these other components become more strategically important," he says.

Community partners can be social, governmental or clinical. Premier advocates establishing a "high-value network," comprising other professionals at the direction of the health home — specialists, skilled nursing facilities, public health agencies, other hospitals. Entities in the larger community "may have a great deal of information and know a whole lot more about people you're managing than perhaps the physician himself," Gray says. Besides other health sites, efforts should be on "treating people where they are," such as workplaces, community centers and churches.

8. Limited resources have to be put to the most pressing need with the biggest possible impact.

Having the characteristics of a community in hand is a mixed blessing: How do you fully serve the needs of all with a limited

budget? The answer may be that you don't. Instead, focus on the medical minority that stands out, at least initially. "There's a lot of evidence that a relatively small proportion of the population accounts for a disproportionately large share of health care use and health care cost — and suffering through ill health," Bilton says. It makes sense to "identify those higher-risk or higher-using, less-healthy groups and then deploy a range of population health strategies in service to improving their health, which should help ease the burden on the health care delivery system."

Normally, the clinical objective is to apply the same standardized set of screenings and treatment for anyone with a particular medical condition, Hester says. "There's some benefit to that, but maybe not everyone needs all those intensive resources, or maybe someone needs more resources." Health data can show what's happening and where, but now it needs to predict who will benefit most from various interventions, "a totally different utilization of data than we've done in the past." With a group of, say, 500 people, the aim is to know the 100 using health services the most and what the health system can get to them for the greatest impact.

9. Good programs and value-oriented goals are meaningless without payment that rewards population-level health management and its measurable health and cost-containment gains.

Payers should be just as interested as providers in aligning

around improving quality outcomes while controlling costs and improving member experience, Gray says. Boards should ask what the role of local payers likely will be — for example, who will be responsible for care management and what the criteria are to evaluate potential payer partners.

Partnership means sharing data comprehensively, and sharing savings from population management. Reducing admissions and ED visits will save money for the payer, and that savings must be shared with providers to offset the loss of revenue under the traditional business model, Gray emphasizes.

As private payers and Medicare take to population management and reward accordingly, she adds, health systems will be faced with changing their contractual arrangements as quickly as possible to erase conflicting incentives and get their workforces to produce under new emphases on outcomes and cost control. "If you're [still] being rewarded on volume vs. value, your behavior is going to be different," she notes. But it's a daunting balancing act, because the strategic and operational changes have to be accomplished ahead of the contractual changeover.

10. The health care field as currently constituted has insufficient skills for the challenge.

The need for new expertise, Nash says, may have to start at the board level: for example, representation in the fields of wellness, chronic-illness care, public health, preventive approaches, and notably epidemiology, or the study of the distribution and determinants of all things health-related, including diseases.

Hester says boards have to oversee analysis of the talent pool in the organization to ensure that the higher degree of sophistication in data management and priority-setting within identified problem populations can be well-executed. Those skills may have to come from somewhere else. "There are folks outside the health care industry who can be very valuable to us to make decisions and from an analytical standpoint," he says. They include people with actuarial experience; people who understand data and create predictive models; and experts in data interpretation.

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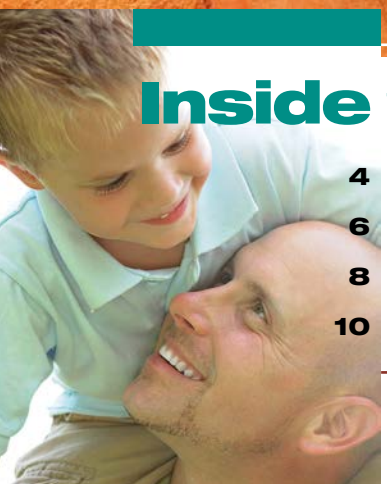
Have You Finished Conducting a Community Health Needs Assessment?

Which Direction Next?

Look inside to find out more about developing an intervention.



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