

2016 Committee on Research Next Generation of Community Health



Report produced by the AHA Committee on Research – 2016

American Hospital Association Committee on Research 2016

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Introduction

America's health care system is undergoing significant transformation, and the myriad of changes occurring will continue to evolve quickly. Many current reforms are driven by the Triple Aim, which will necessitate that hospitals and health systems move away from a volume-driven, fee-for-service model. Instead, new payment and delivery systems will focus on providing high-quality care, improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care.

Hospitals are looking at ways to further enhance the community outreach and community benefit activities they provide through integrating activities with public health, collaborating with community partners along a full continuum of care and building a community health infrastructure that is stronger, more targeted and more effective. In short, through focusing on community health, the hospital field is devising new ways to improve the physical, emotional, mental and spiritual well-being of people and communities. The next generation of community health will be integrally aligned with this care evolution and will serve as the foundation for total population health. It will connect population health management or managing the health of a specific patient or clinical population to the broader intersection of population health. Doing so brings together multiple sectors including public health departments and other community organizations. This new version of community health recognizes that investing in ameliorating the social and economic determinants of health will be as important as delivering high-quality medical services.





COMMUNITY HEALTH, POPULATION HEALTH AND POPULATION HEALTH MANAGEMENT: THE DIFFERENCES

The concepts of population health and community health are often used interchangeably, and though related, they do have different definitions with significantly different implications.

- **Community health** – Communities can be defined as towns, cities, counties or service areas. The health of a particular community can be measured in many different ways. Generally, community health initiatives tend to be directed at the cumulative impact of social determinants of health, especially behavioral or environmental determinants. Outreach efforts are applied broadly and to people who may or may not be receiving health care services at a specific hospital.
- **Population health** – Population health involves the accountability for health care outcomes and costs of caring for a defined population of people. The accountability results from the incentives and penalties are both associated with caring for the population as determined by a value-based arrangement.
- **Population health management** – Population health management speaks to the use of data and the analysis of data, resources and other relevant information to manage clinical health decisions.

Success in population health provides credibility to hospitals for further community health efforts through investment, partnerships and advocacy. Population health contributes to community health. As a general rule, about 10 percent of a community's health status is determined through the access to care and services provided by local health care providers. Efforts around community health should be directed at mitigating the health risks identified in population health efforts.

*** Definitions adapted from St. Luke's Health System, Boise, Idaho

A moment of opportunity exists for health care leaders as they consider how to be the strongest partners possible in looking to solve for discreet challenges, address broader determinants of health and ultimately leverage best practices and evidence-based interventions to accelerate improving community health. The underpinning of effective community health is the development of strategic and meaningful collaborations that will allow for sustainability and success.

Hospitals have long been committed to providing high-quality care. That mission will not change, but it will evolve. As hospitals look to adopt “second generation” strategies and move toward integrating community health and wellness into all they do, hospital leaders should consider three key elements:

1. Spectrum of services offered by the hospital or health care system
2. Locations where care will be provided
3. Partnerships through which that care is facilitated

Care will become better coordinated and more comprehensive and will increasingly take place outside hospital walls. Traditional inpatient hospital care has already begun this transformation by intersecting with public and community health to reduce readmission rates. The U.S. health care system continues to grapple with increased chronic disease management, changing national demographics, increased responsibility around care coordination and medical homes, and the elimination of disparities in care. It is essential that health policy addresses and patients, caregivers and community leaders recognize how social determinants of health can greatly impact a patient’s ability to achieve good health. Hospitals will play a significant role in creating and implementing new strategies that catalyze meaningful change on all of these issues. As a health care system originally built for illness shifts to one driven by wellness, hospitals will have a unique role to play in making good decisions easier for patients and helping to build community infrastructures that support health and healthy choices. Engaging in community health must be done in a thoughtful and strategic manner. Such engagement also requires:

- Executives and trustees setting clear expectations and direction based on a mission to improve health
- A designated community health director who can be visible, working with internal staff as well as with community partners
- A strong connection with front-line staff who may know what gaps exist and already volunteer within the community

The AHA’s Committee on Research (COR) is exploring what the next generation of community health may look like as hospitals redefine themselves to keep pace with the changing health care landscape. There will be different paths of transformation and different approaches taken to improve community health status. This report is intended to encourage activity within the field to improve community health, offer an overview of current strategies as well as provide new ones, and spotlight tools and best practices. It is organized into three sections: Trends Driving Community Health, Results from a Community Health Focus and Benefiting the Community Beyond the Four Walls of the Hospital (First and Second Generation Strategies).



This work aligns very closely with the AHA's Advancing Health in America initiative (AHIA), developed to better communicate about the changes underway in the U.S. health care system, enhance awareness and understanding of transformation paths, and underscore the importance of collaboration as well as proactive patient care. The vision that guides both the AHIA strategy and the work of this year's Committee on Research are the same: a society of healthy communities where all individuals reach their highest potential for health. Given that vision, the key components of AHIA are:

- **Access** (access to affordable, equitable health, behavioral and social services)
- **Value** (the best care that adds value to lives)
- **Partners** (embrace diversity of individuals and serve as partners in their health)
- **Well-being** (focus on well-being and partnership with community resources)
- **Coordination** (seamless care propelled by teams, technology, innovation and data)

Again, this strategy is forward thinking in terms of the role that hospitals, health systems and health care organizations will play in the future, and doing so identifies multiple audiences including patients, clinicians, family caregivers, policymakers and community thought-leaders who must be engaged. Together, this work will further identify and spotlight tools and resources that hospitals can use to advance health and move toward the second generation of community health.

All hospitals and all communities are at different points on their transformation journeys. Similarly, the path toward all individuals recognizing their full potential for health and well-being will have many approaches. While working to improve community health, hospitals should collaborate with other community organizations to identify specific community health needs but also employ a metric or gauge to determine the possible "appearance" of good health. Although strategies and interventions will differ from community to community, there are some common, generally agreed upon indexes for good health.

Sample Community Health

Dashboard – Live Healthy Fairfax is a web-based resource that allows people and organizations in the community to access data on topics like health, economy, education, environment, government and politics, public safety, social environment and transportation. www.livehealthyfairfax.org. The website also offers a number of other dashboards, including a disparities dashboard. Equitable growth profile and community health improvement indicators include items like:

- **Healthy and safe physical environment:** (physical environment ranking, recreation and fitness facilities, access to exercise opportunities)
- **Active living** (adults engaging in physical activities, adults who are overweight or obese, low-income preschool obesity, workers who walk to work, adults 20+ who are sedentary)
- **Healthy eating** (farmers market density, SNAP certified stores, food insecurity rate, children with low access to a grocery store, food environment index)
- **Tobacco-free living** (adults who smoke, age-adjusted hospitalization rate due to asthma, death rate due to chronic lower respiratory disease, hospitalization rate due to COPD, lung and bronchus cancer incidence rate)
- **Health workforce** (clinical care ranking, primary care provider rate, non-primary care provider rate)
- **Access to health services** (adults with health insurance, age-adjusted death rate due to suicide, frequent mental distress, preventable hospital stays, children with health insurance)

Whether developing a new dashboard or tapping into existing electronic platforms, hospitals and other community partners should be cognizant of what factors correspond to a healthy community. These factors will guide and inform the need for action and activities to improve health status.

Trends Driving Community Health

Health care systems and hospitals have spent much time advancing the diagnosis and treatment of illness and also have engaged in education and prevention of disease so that working collaboratively with other partners to advance community health is a natural extension of their mission to improve health. The forces described here are driving change within the community health realm. They offer an explanation of why hospitals and health systems are looking to evolve in a manner that further expands the care they provide outside of the traditional hospital setting to incorporate community health as a comprehensive part of their mission.

Coverage gaps

Through recent reforms, health insurance coverage has been extended to millions of previously uninsured Americans. Coverage expansion will allow the field to move toward better, more appropriate care. Newly covered individuals can now engage in routine, preventive care as well as receive treatment and services to enhance both physical and mental health status. While increased access to care has certainly improved health outcomes for many, gaps in coverage still exist as do social determinants of health that inhibit health and wellness. The health care field must now focus on addressing the factors that can contribute to poor health outcomes and work toward improving the total health status and infrastructure for good health within communities. Further, we are learning that people won't enroll if they don't know or understand their coverage options. Every day, the caregivers in America's hospitals see first-hand how these gaps affect people's ability to access the right care, at the right time and in the right place. This is why individual hospitals across the country are working in a variety of ways to enhance access to needed services through community outreach programs, as well as dedicating time and resources to help people understand their options and enroll in affordable health coverage. Access and coverage are essential components of achieving true community health. The AHA has been active at a national level with efforts like Enroll America, and local hospitals are working to do the same.

Baptist Memorial Health Care – (Memphis, Tennessee)

Baptist Operation Outreach is a mobile health care clinic for the homeless and the result of a partnership between Baptist Memorial Health Care and Christ Community Health Services. The van provides free acute and primary health care, information on disease prevention and guidance, and a medical home to thousands of area residents without permanent housing. Patients have direct and immediate access to medical examinations, health information, illness prevention and medications as well as vision, dental and referral services. A certified nurse practitioner delivers screenings, health and developmental assessments for children, immunizations and other preventive care,

diagnosis of medical problems, and treatment and management of specific disease problems and minor injuries.

This outreach program is for homeless residents in the city of Memphis, Shelby County and surrounding areas. For many of the thousands of people without homes in Memphis, Baptist Operation Outreach is the only option for health care. About 3,000 patients visit the mobile clinic each year, making Baptist Operation Outreach one of Memphis' largest health care providers for the homeless.

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Holistic focus on health

Extensive research on social determinants of health clearly illustrates that where people live, their age, race and ethnicity, and language preference along with income and education influences have a strong correlation to individual health outcomes. Hospitals are now looking more holistically – beyond single ailments or injuries – at how to improve an individual's health status, offering a more coordinated and integrated approach to caring for the whole person. A holistic approach to health care accounts for how a patient may perceive their health and all factors that influence that: physical, mental, environmental, social and spiritual. Increasingly, care teams are integrating behavioral and emotional health as well as addressing social determinants that can greatly improve an individual's ability to achieve success in becoming healthy and maintaining a healthy lifestyle. This work can include engaging in activities to build a community infrastructure that allows access to healthy food, transportation to medical appointments, guidance on exercise and fitness regimes, and support for adequate and safe housing options, as a greater recognition that all aspects of a person's wellness need to be considered. With the move toward a value-based system, such patient-centered, holistic care is likely to happen with greater frequency.

Additionally, if hospitals and caregivers are truly to provide holistic care for a patient, cultural competency must play a key role. Caregivers must understand the beliefs and cultural traditions that may impede a patient's ability to achieve good health. Enhanced cultural awareness and education can help clinicians move upstream in caring for their patients and in further improving the health infrastructure within a community.

Cincinnati Children's Hospital – (Cincinnati, Ohio)

The Therapeutic Interagency Preschool (TIP) Program provides educational, developmental, mental health and safety monitoring services to very young children in need. Currently, TIP cares for 60 children at a time with a constant waiting list, making use of psychiatrists, mental health, speech, occupational and physical therapists from Cincinnati Children's; teachers from Hamilton County Head Start; and caseworkers from Hamilton County Children's Services.

The program was designed for children under six years of age

who have been victims of severe abuse or neglect. Overburdened caseloads and court system can mean that decisions on permanent placement could take four years or more. Integrated continuity of care is needed for children who remain in unstable placements or experience frequent changes in placement. Data show that children who participate in TIP for one year, even those who begin the program as the most at-risk, make the most developmental and behavioral progress of any preschoolers in the county's Head Start program.

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Payment for value

While the health care payment system is undergoing a move toward a value-based reimbursement system, providers have opportunities to deliver higher-quality care for patients at a lower cost and better value. Payment programs are being designed to reward or penalize hospitals for the quality of care they provide and the ability to keep patients healthy and living at home. By learning more about the social determinants of health affecting patients and how those factors influence their ability to achieve good health, hospitals and health systems can be more intentional around decisions affecting how, when and where care is delivered within a community.

As hospitals determine their best path forward for transformation, they may consider realignment of staff and resources to better circle around the needs of patients and of the community. Additionally, strategic collaborations will help hospitals navigate the new requirements being asked of them. The strategic planning process might also include sessions open to the public to garner direction, feedback and buy-in of community health priorities and education around initiatives and partnerships.

Western Maryland Health System – (Cumberland, Maryland)

In 2009, Western Maryland Health System (WMHS) chose to participate in a total patient revenue demonstration project. Participation in this program changed the hospital overnight: one day they were looking for opportunities to increase volume and the next, looking to contain volume. Participation in this project put WMHS on a path of early transition from the first, volume-driven business model to the second, value-driven business model. WMHS set goals to become better coordinated and more efficient in providing care and to improve the quality of patient care.

As the health system made this dramatic shift in both philosophy and in business model, the focus on achieving the IOM's Triple Aim became a guiding principle. All change and all education was done with the patient as the central focus. Hospital leaders recognized that education and engagement of staff would be critical for both adoption and acceptance among the hospital employees and physician community and within the general community.

Education and outreach began first with physicians and staff. Community outreach followed closely, and in all communications, the focus was to explain how the patient was central to all that was being done. Community education began with the health system's community advisory board and spread to the local chamber of commerce, rotary clubs, churches and economic development councils, among others. The hospital developed a presentation and proactively identified opportunities to present to different community groups, helping the community feel more comfortable about seeking care in different settings. Shifting locations of care, even if to a more appropriate care setting, was a change that needed to be clearly explained to the community. The health system also created new primary care centers within neighborhoods most in need. For example, WMHC created the Center for Clinical Resources to help treat community members with chronic disease, and it enhanced existing relationships with home health and nursing home settings to ensure better transitions of care.

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Benefit to the community

The people of America's hospitals are on the front lines providing high-quality care day in and day out, but they also do much more than that. Hospitals mend bodies and also make patients and communities healthier. Hospitals promote and support numerous activities with the sole purpose of improving community health. Hospitals are a vital part of their communities, and the services they provide to promote health extend well beyond the four walls of the hospital.

Benefits to the community vary from hospital to hospital, reflecting the individual needs of specific communities. Activities span from establishing free or mobile health clinics to increasing access to care to offering job training programs for unemployed residents or conducting health education and smoking cessation classes. Some hospitals provide back-to-school immunizations and sponsor literacy programs and housing projects. Through these and many other programs, hospitals demonstrate a strong commitment to improving health and addressing the unmet needs of patients and communities. As the health care systems transform and the needs of communities change, hospitals are creating new, innovative and collaborative partnerships that will allow them to remain a facilitator in building stronger, healthier communities. Community benefit has become woven into what hospitals do and will only grow with a renewed focus on community health.

Sentara Healthcare – (Newport News, Virginia)

The need for dental care for the underserved in Hampton Roads is continuing to increase exponentially. Sentara funded a Virginia Dental Association Foundation "Mission of Mercy" program for adults who have unmet oral health needs. Part of the program was a Mission of Mercy event that provided preventive, restorative and extraction services to between 400 and 500 adult patients. Care was administered by volunteer dentists, hygienists and supervised dental students across the state and was held in underserved neighborhoods. Additionally, Sentara is providing funding to help expand two safety net dental clinics – Beach Health Clinic and Lackey Free Clinic - as all clinics in the area are operating at full capacity with long waiting lists.

The oral health expansion program to add needed dental clinic service capacity is being coordinated by the Virginia Health Care Foundation (VHCF) in partnership with Delta Dental, who will provide matching grants, and other community partners. VHCF is working with clinics and helping to develop business plans for initial investments and ongoing operations. For this reason, Sentara's commitment to improving access to dental services and specifically the donation made to VHCF will not only double the available financial resources but also promote the development of strategic planning by providers as a prerequisite to obtain grant funding and increase sustainability.

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Children's Health System of Texas – (Dallas, Texas)

Children's Health and The Health and Wellness Alliance for Children (the Alliance) helped achieve remarkable success against the "wicked" problem of childhood asthma in Dallas. Systematic and comprehensive linking of community, public health, philanthropy, education, environmental, social, government and clinical programs was accompanied by a reduction in the number of unique patients visiting the Children's Health emergency department with a primary diagnosis of asthma by 49 percent in three years. Children's Health is the region's largest pediatric safety net system and has successfully forged uncommon partnerships to improve family health and well-being, in one of the fastest growing and most underserved major metropolitan areas in America.

Health care delivery systems have long recognized the impact of non-medical determinants of health, especially in underserved communities. Yet, they have been challenged to build integrated systems that extend beyond medical care. In 2012, Children's Health established the Alliance to address a universal problem: health in the context of the overall well-being of families who are challenged by poverty, transportation, employment, environmental and nutrition issues. The process included two parallel "deep listening" activities in the community: first, they engaged with over 200 families to share attitudes, beliefs and values concerning health and family well-being; simultaneously, they began a listening tour with community organizations serving

children and families. Following this qualitative research, which was reinforced by Children's Health emergency department data, the Alliance developed a community systems map for childhood asthma that led to an "asthma wellness equation" viewed from the lens of children and families. This equation depicted the interplay among three factors:

- 1) The family's knowledge, attitudes, behaviors and support systems
- 2) Environmental asthma triggers
- 3) Asthma medical management

A collective impact approach brought the organizations together in new ways with one agenda: All children in Dallas County with asthma achieve their fullest health, well-being and potential. The Alliance adopted mutually reinforcing activities that linked traditional medical care with actions in the community, like a school nurse-driven telehealth program, changes to city housing codes and home visits by AVANCE partner promotoras. Children's Health found that integrating community services with clinical delivery services through a family's trusted agents was critical for family engagement. Next steps include continuing to decrease the burden of childhood asthma and leveraging this experience and strong community partnerships to improve childhood weight management – another "wicked" problem.

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Results from a Community Health Focus

There is uncertainty within the health care system as to how transformation will play out for a specific hospital or community. But there is consensus around the belief that the next generation of health care and, by extension, community health, will have the patient at the center of a better, coordinated system of care that will be value driven. With these shifts, hospital leaders and their governing boards will see further alignment between mission and philanthropy and the business imperative to keep patients and communities healthy. As traditional health care evolves and aligns more closely with public health needs, addresses drivers of poor health such as socio-economic status and social determinants of health and expands to involve a broad base of community partners, the next generation of community health will be more pervasive, more efficient and more effective in keeping people healthy.

Engage your trustees... As board structure and make-up evolve to better reflect the true community, opportunities will increase for improved community health. Opportunities to:

- Make community health core to your hospital's mission
- Educate trustees about the community health needs assessment process and results
- Engage a diverse board that reflects the community in establishing partnerships
- Illustrate to your board how community health is a moral imperative but also a business imperative
- Commit to community health through dedicated staff and resources
- Measure and report success on meeting community health goals to your board
- Build a culture that supports sustained community health improvement

Better health outcomes

Hospitals are centers of innovation, bringing advances in medical science and health care technology to patients. Caregivers are continually improving practices to provide safer care that keeps people healthier. These breakthroughs allow people to live longer, more productive lives. Much of this is done through educating the future health care workforce and also patients and communities about how to achieve and sustain healthier lives and community wellness.

Moreover, hospitals are constantly striving to enhance safety and mitigate the risks inherent in health care. Evidence-based practices are being adopted, interventions to improve and streamline processes are being hardwired and peer-to-peer learning is taking place

– all in an effort to improve outcomes for patients and build a community infrastructure that maximizes outreach and interventions. Additionally, changes in the delivery system are moving the field toward a more coordinated approach to care throughout the continuum. This enables caregivers and patients to better combat chronic conditions and social determinants of health that impede community health from being fully recognized.

Reducing disparities in care

While improved access and affordability of health care are both extremely important, they alone will not negate the negative and harmful health implications of disparities in care and socio-economic status (SES). Low SES has been linked to a wide range of health problems including low birthweight, cardiovascular disease, hypertension, arthritis, diabetes and obesity as well as to contributing factors of increased tobacco use, sedentary lifestyles and poor diet. Responding to health challenges and making inroads in combatting chronic disease will require that hospitals understand the health disparities within communities and the patient populations they serve.

The collection of race, ethnicity and language preference data combined with information gathered through the community needs assessment process can equip providers to better ensure equity of care when treating patients. Hospitals and health systems are working

more closely with patients upon admission to address disparities in care and better understand how external challenges that a patient may face will impact care, recovery and possible readmission. Further, combining information and data collected on disparities with strategies that align outreach efforts to the specific subset of patients most in need will allow for the greatest impact on improving community health.

The elimination of health care disparities can no longer be just about morality or social justice; it has become an essential pillar for any organization that is striving for performance excellence and for making inroads into improving community health. Ensuring there is equity in the care provided should be the lens through which all clinical advancements are made, as well as community outreach strategies. The AHA and other partner organizations have prioritized the elimination of disparities and are continuing to advance the work within the field through Equity of Care and #123forEquity efforts.



The MetroHealth –
(Cleveland, Ohio)

In 2015, MetroHealth continued to address equity of care from a system level, engaging many stakeholders in the effort. Training and development, fostering cultural competence, leadership engagement, language access services, and the data collection and integrity initiative (race, ethnicity and language) were all a part of MetroHealth's focus for delivering equitable care. For instance, all of MetroHealth's 6,960 staff completed an inclusion and diversity online module that highlighted how the health system defines inclusion, diversity, and cultural competence and what it looks like in practice. The online module was followed by in-person

training and orientation for new employees and caregivers. MetroHealth has undertaken many efforts, including training and mentoring programs that have led to increased diversity in its leadership and governance. The health system also implemented leadership diversity dashboards that are presented to leaders to create awareness, discuss challenges and share resources on building a diverse team and inclusive culture. In 2015, the dashboards focused on race and gender, and in 2016 they will highlight additional dimensions of diversity.

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Addressing social determinants of care and health

Social determinants of health are the personal, social, economic and environmental factors or conditions that a person is born with and lives or works with and that influence a wide range of health issues and, ultimately, quality of life. More so, socio-economic factors can astutely shape an individual's health, access to health care services and ability to achieve positive health outcomes. For instance, poverty may negatively affect an individual's ability to access healthy foods; higher levels of crime, violence and traumas are linked to increased use of drugs, alcohol and tobacco; and a poor education system directly influences health literacy and employment opportunities. The connection between these factors is what impacts both an individual's health as well as the health of a certain population. As health care providers, public health professionals and policymakers become allies in working to make the United States healthier, interventions must take place among the continuum of care and must target multiple determinants of health beyond providing traditional medical care.

Where patients go when they are discharged from the hospital plays a vital role in whether they end up being re-hospitalized. For this reason, it is becoming more commonplace for health care facilities to dedicate staff resources to social workers, patient navigators and discharge planners. These individuals are part of the care team, working one-on-one with patients while they are in the hospital to identify potential barriers for improvement and overall health and resources needed at home upon the patient's discharge. The care team can follow up and provide assistance to patients by coordinating further treatment, transportation assistance, rehabilitation, social services support and health behavioral coaching.

Winona Health –
(Winona, Minnesota)

Winona Health's Community Care Network (CCN) was developed to improve individual health and quality of life, prevent hospitalization and emergency department (ED) visits and avoid unnecessary health care costs. In partnership with Winona State University, CCN trains students to become health coaches. CCN helps people struggling with chronic health conditions that may have a negative impact on all areas of their lives. Health coaches meet with clients in their homes and become nonclinical members of the individual's care team.

Health coaches are familiar faces who can help residents grasp the big picture of their overall health. CCN supports and empowers clients to take ownership of their health and to make positive changes. Through the program, 42 trained health coaches have made more than 6,000 visits to 103 clients. ED visits and hospitalizations for CCN clients have declined by more than 85 percent.

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HOSPITAL LEADER MUST-DO'S

- Have a clear awareness of what local or community resources exist
- Get to know your patients; understand their health needs and what factors impact their health status
- Collaborate with a wide spectrum of community partners, including other hospitals
- Assign a dedicated leader to implement a community health strategy; internal leadership is critical
- Conduct community health needs assessment and other healthy community dashboards to identify needs
- Convene community partners to coordinate and plan for keeping the community healthy
- Implement strategies that have clear metrics and accountability
- Ensure sustainability with transformational and incremental goals



Part 1: First Generation Strategies

Promoting community health is not a new premise, nor is it uncommon for a hospital to engage in a variety of community building activities that strengthen the infrastructure for continuous refinement and improvement of a community's health status. In many communities, particularly rural communities, hospitals are still the primary point of access to health care services. But even in urban communities where a larger health infrastructure exists, there is a moral imperative first and a business case second for keeping patients healthy. The health care system of the future will look different. As hospitals shift to meet these changing dynamics, an even greater emphasis must be placed on promoting health and wellness through addressing health indicators like violence, drugs, education and lack of behavioral health services and also working collaboratively with partners to build healthy communities.

One such partner for hospitals to engage with are patients and families; the insights and perspective that can be gained is immense in terms of improving quality and also in better understanding social determinants and community barriers to good health. As hospitals and caregivers continue to engage with patients and families, there is certainly more that can be done. Improving community health reflects invaluable aspects such as creating high functioning patient and community advisory boards, inviting patients and families to participate in community conversations to identify and prioritize community needs and ensuring that the patient and family perspective is reflected and communicated at the board level. The boards should truly reflect the community served both in terms of gender and ethnicity but also in terms of profession or "community standing."

Numerous strategies are currently being used to promote health and well-being. These "first generation" strategies will serve as the building blocks for further work in providing high-quality, high-value care not only when patients are admitted to a hospital but also as they travel through the continuum of other care settings, including home.

Community health needs assessment

Tax-exempt hospitals are required to conduct community health needs assessments (CHNA), and the value can be immense when prioritizing the outreach work being done. The learnings and partnerships that come from this process help identify strengths and health weaknesses within a community and help direct community benefit activities. Great success results when hospitals collaborate — hospitals with other hospitals, hospitals with public health departments, and hospitals with social service organizations. A collaborative needs assessment will be instrumental in developing a health improvement plan that is sustainable and that identifies specific areas of expertise among community partners that complement one another and allow for shared deployment of resources. By creating and using innovative ways to address social determinants of health, community health and health disparities — in addition to aligning community partners' strategic priorities — the next generation of community health will be fully realized.

Incorporating a research approach — robust data collection, monitoring and analysis — into the CHNA process can strengthen the process and hone the direction and action steps that

come out of the needs assessment. Research can also be key to identifying and developing strategic partnerships that broaden the scope of outreach possible. Linking with other organizations may enable a sole hospital to dive deeper into existing research, accessing resources and information to which a partner organization may have access. To reiterate, reviewing data collected from a CHNA will inform a hospital of the most pressing health needs within a community and allow plans for improvement to be focused and strategic. Engaging partners, such as other community organizations, patients and community members, throughout the process will make the CHNA more powerful and directive for hospitals and the communities they serve.

AtlantiCare –
(Egg Harbor, New Jersey)

Beyond the traditional role hospitals play in providing inpatient and outpatient medical care and helping people remain healthy, AtlantiCare also has the responsibility to identify, understand and meet the diverse healthcare needs of the individuals and families residing in its service areas. AtlantiCare strives to understand the root causes of disease and works to break through the barriers that impede health. AtlantiCare does this by conducting a Community Health Needs Assessment (CHNA) to identify local health care needs and barriers. Like most not-for-profit health care organizations, this assessment is updated every three years. The most recent assessment was completed in 2016.

This year, in addition to developing an Implementation Strategy

based on needs identified within the CHNA, AtlantiCare is engaging employees, physicians, board leaders, and key community members to assist them in prioritizing one key community issue. The establishment of a key community health initiative goal will allow AtlantiCare and its community partners to influence many overlapping health concerns simultaneously and advance its vision of building healthy communities. AtlantiCare's community health initiative goal will be determined in the spring of 2017, with a cascading work plan made up of key internal and external activities outlined to follow.

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The South Jersey Behavioral Health Innovation Collaborative

– (New Jersey)

Improvements to treatment access for mental illness and substance use disorders were identified as health priorities for southern New Jersey in 2013 through the Tri-County Health Needs Assessment of health systems in Burlington, Camden and Gloucester counties. In response, five health systems – Cooper Health System, Kennedy Health, Lourdes Health System, Inspira Health Network and Virtua – joined together to form the South Jersey Behavioral Health Innovation Collaborative (SJBHIC). The health systems, through a self-funded, collaborative effort, used a mixed-methods approach to understanding the quality, accessibility, capacity and coordination of behavioral health services for residents in the region. The SJBHIC completed an assessment drawing on a variety of data sources, including hot-spotting of wraparound, law enforcement and housing data, analysis of five years of hospital claims data and more than 50 interviews with key stakeholders. The result of the first year's work told a significant story, like that of "Jane." Every day, people like "Jane," a 40-year-old woman with multiple chronic conditions including mental

illness and substance use disorder diagnoses, seek treatment at New Jersey's hospitals. In a five-year span (2010–2014), Jane lived at four different addresses in South Jersey and visited hospitals in five different health care systems a total of 77 times. Her hospital stays totaled 294 days at a cost of \$4.4 million, with the hospitals receiving \$386,000 in payment. Jane is a real-life example of one patient struggling to navigate an outdated system where services and needs are mismatched. The story of Jane – and hundreds of other patients with similar stories – highlights the results of complex, high-need patients navigating a system of services ill-equipped to meet their physical, behavioral and social service needs. The SJBHIC continues its work and is focusing on creative solutions to care delivery that include comprehensive case management for individuals seeking care at more than one facility and standardized withdrawal protocols. The group also is exploring alternative models to screening and stabilization to meet the needs of individuals who do not meet the criteria for inpatient admission.

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Sonoma County (SC) Community Health Needs Assessment (CHNA) Collaborative – (California)

The SC CHNA Collaborative is the name given to the combined efforts of three major health systems (Sutter Health, St. Joseph's Health, Kaiser Permanente), three local government Health Care Districts (Sonoma Valley, North Sonoma County and Palm Drive) who also own and operate general acute care hospitals and the Sonoma County Public Health Department. The collaborative was formed and dedicated to improving the health of the communities with a dual focus on improving health care in each health system and collaborating with partners to address key determinants of health in the community. Collaboration is not new in Sonoma County; the three systems have been collaborating together, in conjunction with the County Health Department, for 20 years. The inclusion of the district hospitals was new in 2016.

The collaborative brought in consultants to help facilitate a process that included (1) the collection of

countywide and population-specific secondary data, (2) 23 interviews with key stakeholders in the county and (3) five focus groups, including more than 60 county residents. In the end, the collaborative and its consultants identified nine top health needs in Sonoma County, including early childhood development, access to education, and economic and housing insecurity. The final step in the process was to convene 45 stakeholders, including representatives of all six hospitals and from the community, and to rank order all nine needs by severity, disparities, prevention and leakage. The deliverable was a comprehensive 32-page community health needs assessment that all six hospitals can use to satisfy CHNA requirements under the Affordable Care Act. More importantly, the opportunity to work together and with other county stakeholder groups is helping Sonoma County reach its goal of being the healthiest county in California by the year 2020.

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Essential community partnerships

The health care field cannot solve the challenges around poor health on its own. Hospitals can serve as leaders and conveners within communities to tackle disparities and work with other organizations to address social determinants. Moving away from the silos seen in the past, innovative organizations are recognizing that a community-wide approach is needed to improve population health. Creating a true community health infrastructure requires stakeholders beyond the care continuum, including but not limited to providers, public health departments, social service organizations, law enforcement, education, the business community, insurers and policymakers, to identify and commit to joint priorities.

Partnerships are key. Establishing relationships across multiple sectors is the foundation for using all available resources most effectively and efficiently to improve the health of the community. Unique entry points for care and community influencers can be uncovered. Hospitals are not always the best suited to take on a particular community health need, but they should serve as conveners and collaborate with other community services organizations, coordinating efforts rather than duplicating services. Additionally, through partnerships with public health departments, health centers and other social service organizations, data collection can become more robust, which ultimately can allow for more targeted outreach.

The role and relationship between hospitals and public health departments can be a critical factor for success when embarking on initiatives to improve community health. With an aging population and obesity and chronic disease on the rise, public health priority areas are increasingly intersecting with hospitals' community outreach work. Instead of working individually, hospitals and public health departments should coordinate and complement health improvement initiatives.

Working together, health care leaders and other community leaders can create environments that encourage healthy lifestyles through public policy, address social determinants of health, eliminate health disparities and make investments that will enhance and encourage appropriate exercise, diet and wellness behaviors.

St. Catherine Hospital –
(Garden City, Kansas)

St. Catherine Hospital is an active participant in the Finney County Community Health Coalition (FCCHC), a coalition that brings together more than 50 community partners on a regular basis to identify community needs and find funding to support them. The coalition began by framing three major community needs: reducing risky behaviors for young people, including teen pregnancy, smoking and drinking; improving transportation; and supporting families and children through two agendas – literacy training and preventing domestic violence.

A small group of community leaders came together in early 2000 to develop a teen pregnancy-prevention initiative. Its success led to the formation of the coalition. From its beginning in 2000, the FCCHC has undertaken numerous initiatives such as helping to pass a no-smoking ordinance within the city limits, creating a fixed-route bus service and developing its Center for Children and Families.

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UMass Memorial, HealthAlliance Hospital

The CHART program (Community Hospital Acceleration, Revitalization and Transformation) was made possible through a two-year, multi-million dollar grant from the Massachusetts Healthcare Policy Commission (HPC). Combined with additional funding from HealthAlliance Hospital, these dollars supported the creation of a multiagency Health Integrated Collaborative Care Coordination system (HIC3). The CHART team is composed of three major community partners and multiple community affiliations. CHART's primary target population is patients with a primary diagnosis of mental illness or substance abuse who present for treatment in the emergency department. The major aims of the program are to reduce the recidivism of patients returning to the emergency department for non-emergency needs, reduce the length of stay for this population and establish "wraparound" services to keep patients healthy in the community.

These services include, but are not limited to, emergency assessments of medical, psychiatric, housing, financial and social needs of the patients. The goal is to establish resources for the patients within the community, negating the need to return to the emergency department. This reduces the costs of care, provides care in the right setting and keeps the patient in a state of wellness in the community. The net result allows the patient to

develop the skills of self-sufficiency in avoiding crisis and a safety net of care providers for support. This is all accomplished through an integrated medical record with community partners. The integrated medical record allows all partners to develop and enhance collaborative treatments planning and monitor progress. CHART provides care coordination activities in a safe environment, including but not limited to:

- Determining full spectrum of client needs
- Addressing potential barriers
- Setting appointments
- Assistance completing MASS Health Insurance Applications (Navigators are certified)
- Assistance completing housing applications
- Assistance completing food stamps applications
- Assistance applying for benefits
- Performing full intake assessments/self-sufficiency matrix
- Involving clients in the development of individualized service plans
- Bringing together outside agencies and providers to develop comprehensive, community care plans for higher-intensity clients
- Monitoring progress toward care plan goals

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Organizational assessments and checklists

Continuous improvement is possible only if leaders are willing to take a close look at the reality of the care and services they provide and to assess where opportunities for improvement exist. Putting a mirror to current practices can be a valuable tool. Continuous improvement is pursuant to continuous evaluation, and organizational checklists can do just that.

AHA's Community Connections initiative, along with other efforts, have offered anchoring themes for community outreach work. As a result, building the next generation of community health strategies and weaving them strongly throughout the fabric of an organization will be vitally important to a hospital's success moving ahead.

Using assessments and checklists can be a helpful strategy to employ at multiple levels and with a variety of professionals within an organization to help formulate effective strategies for listening, communicating and collaborating with local communities. To truly improve community health, it is more important than ever for hospitals to stay connected to the community and patients they serve. This enables hospitals to be responsive to community needs and to deepen the public's understanding of what changes may be coming to their health care or hospital. Hospital leaders should work to "hardwire" this kind of thinking and innovation into day-to-day management as well as strategic planning.

EXAMPLES/LINKS:

- AHA's Community Connections self-assessment and strategy checklist (www.ahacommunityconnections.org)
- CDC Healthy Places health impact assessment tool (www.cdc.gov/healthyplaces/)
- Association of State and Territorial Health Offices population health assessment tool (www.astho.org)
- IHI's Patient and Family-Centered Care Organizational Self-Assessment (www.ihl.org/topics/pfcc/)

Hot-spotting

Hot-spotting is a data-driven process for identifying patterns, behaviors and interventions to better address patients' needs and improve outcomes, as well as reduce costs, within a defined region or population. It offers the possibility for hospitals to be more targeted and impactful in their interventions. Hot-spotting data can help identify high-utilizer patients not only to determine their medical needs but also to better understand the social and environmental factors that may keep them on a path of poor health.

Hot-spotting, first used by Jeffrey Brenner, M.D. in Camden, New Jersey, is the ability to strategically focus on a patient population by specific neighborhoods or zip codes and then identify associated relationships between geography and health outcomes. Some

researchers believe that looking at a patient's zip code can be a strong indicator of the person's health, even more so than their genetics. The practice of hot-spotting takes big data sets, segments them to draw out specific patterns that, when combined with information about social determinants, can guide interventions and improve the health status of a population outside the hospital.

Hot-spotting, as described by the Camden Coalition, a citywide coalition of hospitals, primary care providers and community representatives in Camden, New Jersey:

Health care hot-spotting is the strategic use of data to reallocate resources to a small subset of high-need, high-cost patients. Hot-spotting uses data to discover outliers, understand the problem, dedicate resources and design effective interventions. It is a movement for a new system of multidisciplinary, coordinated care that treats the whole patient and attends to the nonmedical needs that affect health: housing, mental health, substance abuse, emotional support.

The use of hot-spotting has proved to be extremely helpful when refining broad community health and wellness goals that develop more targeted strategies to address the patients who are often admitted repeatedly to the hospital. Using data to better know patients and better understand the social determinants that impact their health can help hospitals be more successful in achieving a healthy community. Hospitals can combine the patient data they collect as well as real-time data, when available, with other public sources of data to refine the work they are doing. Data for hot-spotting can be sourced from public health data, census data and data collected during a hospital's community health needs assessment and from community partners.

Further, depending on where a patient lives, community health resources such as primary care, mental health services, dental services, physical therapy and easy access to healthy food may not be available. The combination of hot-spotting with a community health approach that recognizes and addresses socioeconomic status can build an infrastructure that starts to combat negative determinants of health. This would allow patients to enjoy safer and healthier lives with less time spent in the hospital.

Using hot-spotting initiatives, health care organizations have been able to be more strategic and focus initiatives and interventions on neighborhoods with social, economic and environmental barriers that lead to poor health outcomes and health disparities. Identifying and focusing on these specific patients and communities can be an effective strategy to reduce readmissions and decrease inappropriate emergency room utilization, while improving the overall health and wellness of a community. By focusing on patients for whom an intervention is likely to have the greatest impact, care management teams can improve access to care and provide medical, behavioral, social and faith-based supports that will benefit patients' overall health.

Sutter Health –
(Berkley, California)

In January 2014, three distinct philanthropic organizations from Alta Bates Summit Medical Center, Eden Medical Center and Sutter Delta Medical Center joined together to form Better Health East Bay. Better Health East Bay is a unique foundation with a specific commitment to actively fundraise and invest in opportunities to expand access to care and improve clinical outcomes for underserved residents in the East Bay community.

Better Health East Bay has invested in Sutter Health's use of the latest tools and technology to better understand the unique population of the East Bay and residents' most critical needs. This includes supporting Alta Bates Summit Medical Center's work to pilot the use of hot-spotting to identify "super-utilizers" – those patients who use emergency departments frequently for primary care needs. Working with Jeffrey Brenner, M.D., and the Camden Coalition of Healthcare Providers who pioneered the concept, researchers are using state-of-the-art technology and geographic information system mapping tools to better understand high-risk locations in a community where health problems are clustered, services are fewest and people have the hardest time getting care.

Through the innovative use of big data, the team is able to capture information in new ways that drive insights about the patients served. This includes helping better understand sub-populations of patients and their unique needs, as well as the community-based factors that influence health and how patients seek care. Providers and researchers are able to use this data to tightly focus their attention on critical interventions with the greatest potential to impact the community. This includes providing patients with access to a sophisticated and well-trained network of case managers for personalized support and follow-up.

By investing in innovative ways to solve patient problems faster and more cost effectively, Better Health East Bay will help reduce overreliance on emergency rooms for non-urgent care and control escalating costs, while greatly improving health outcomes in the community. This work also helps improve communication and coordination to support better care management and patient outcomes within and between emergency departments across health systems serving a geographic region.

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Palmetto Health –
(Columbia, South Carolina)

During a 2013 community health needs assessment, Palmetto Health identified areas of health disparities within their community, with diabetes being one of the worst. The hospital was seeing higher than normal rates of individuals with amputation and blindness, as well as a significant increase in the rate of pre-diabetics and individuals being diagnosed with Type 2 Diabetes above the age of 40. After examining the data more closely and conducting a secondary assessment, the hospital was able to target efforts to the specific communities that fell within the 29203 zip code. The specific assessment allowed the hospital to dive deeper and identify the social and environmental determinants that were influencing the poor health outcomes. In general, patients in the 29203 zip code had minimal access to fresh and healthy foods and engaged in little exercise, and many were obese.

The secondary assessment allowed the hospital to learn directly from more than 1,500 patients who lived in these communities and hear exactly what barriers to good health existed. Armed with this knowledge, Palmetto was able to target interventions to address the lack

of sidewalks in the community, the fear of loose stray dogs and poor access to public transportation and healthy foods. The hospital engaged the community and partnered with the schools, the YMCA, the city government and others to efficiently and effectively remove barriers to good health.

This targeted work is not exclusive to the diabetes prevention program and does not replace any other community outreach effort the hospital is engaged in. Rather, it allows for a deeper dive in geographic areas where the greatest impact can be made. Palmetto Health's Department of Health Works also works with hospital employees to improve health. Whether or not these efforts have an immediate return-on-investment impact, Palmetto strongly believes that improving the long-term health of a population is not only the right thing to do but that addressing disease upstream will benefit patients and the community as well as the hospital.

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Part 2: Second Generation Strategies

The strategies outlined previously—first-generation strategies—have brought great success and insight to the community health work done by hospitals and have improved population health. Second generation strategies will build on what is already being done by many hospitals to take community health to the next level. Following are some innovative ways to enhance current efforts, evolve relationships and build upon the existing outreach base. All hospitals, large or small, urban or rural, share a common mission of improving health. These strategies will help hospitals further achieve that goal.

Collaboration with other hospitals

Great success has resulted when hospitals collaborate – hospitals collaborating with other hospitals, with public health departments and with social service organizations. A collaborative community health needs assessment can be instrumental in developing a health plan that is sustainable and that identifies specific areas of expertise among community partners to complement one another and allow for shared deployment of resources.

Partnering with hospitals and other health care organizations deepens the roots of access and understanding of community needs. It broadens the scope of activities in which a hospital can engage and strengthens the ability to sustain work in priority areas. An individual hospital may become overwhelmed when faced with redefining itself in a manner that continues providing care and keeps needed services within the community, while still meeting community benefit standards designed to address community needs. Partnering, not competing, with other health care organizations is how many hospitals are finding the best way to improve traditional medical care while simultaneously integrating care coordination techniques into sustainable models of improvement.

Billings Clinic and St. Vincent Healthcare – (Billings, Montana)

St. Vincent Healthcare, Yellowstone City-County Health Department (RiverStone Health) and Billings Clinic launched Healthy By Design to encourage, recognize, educate and create a standard of excellence for promoting and improving health by working across sectors of the community. Three concurrent cycles of community health needs assessments have been completed, a community coalition has been built, and priority work has been diversifying and growing. Current priorities include mental health and substance abuse, healthy weight and access to health services.

This collective-impact framework consisting of shared agenda, measurement and reinforced activities, continuous communication and backbone support allows the community to embrace and sustain change. Accomplishments to date include multi-sector coalition engagement, a Complete Streets policy, a gardener's market in a federally recognized food desert, implementation of trauma-informed care strategies, community education on lifestyle activity and a refined medication assistance program.

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Children's National Health System, Howard University Hospital, Providence Hospital, Sibley Memorial Hospital and United Medical Center –
(Washington, District of Columbia)

District of Columbia Healthy Communities Collaborative (DCHCC) is a collaborative of D.C. hospitals and federally qualified health centers sharing the goal of reducing health disparities and increasing health equity for vulnerable D.C. populations. In addition, the DCHCC conducted a community health needs assessment and developed a community health improvement plan to address identified needs. DCHCC also sponsors "DC Health Matters," an interactive web portal providing actionable local health information along with resources, best practices and information about community events.

The program is offered to the entire Washington, D.C., community but focuses on the most vulnerable residents. The community benefits from DCHCC members working together and sharing resources to advance health in an efficient and community-centered manner and is strengthened by the partnership. In 2014, dchealthmatters.org attracted more than 3,770 unique visitors, 5,700 visits and 18,700 page views. Actionable community health data ensure focus on areas with the largest health disparities.

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San Diego County Community Health Needs Assessment Committee –

(San Diego, California)

This committee is composed of representatives from seven San Diego health care systems (representing all of the nonprofit acute care hospitals in San Diego County) who came together to conduct a joint community health needs assessment. The group further partnered with the Institute for Public Health at San Diego State University in drafting a report to share with the community and guide their respective community health work. The committee's objective was to prioritize the most critical health-related needs within San Diego based on collection of data and data analysis, as well as feedback from community residents in high-need neighborhoods. Community

engagement activities and discussions were conducted with a broad range of people including health experts, community leaders, and San Diego residents, in an effort to gain a more complete understanding of the identified health needs. Additionally, through this collaborative effort, the report includes a listing of resources needed to meet the identified priority needs. The hospitals involved are using the report to inform and adapt hospital programs and strategies, strengthen partnerships, and work collaboratively toward better meeting the health needs within San Diego County. Link to report: <http://hasdic.org/2016-chna/>

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Community visioning

One new approach to community health incorporates innovative thinking about how hospital campuses as well as broader communities can be redesigned to promote better health. This approach, called community visioning, begins with community stakeholders sharing a vision of health and then building a true infrastructure for health where, neighborhood by neighborhood, access to care is available. In addition, access to healthy food options, adoption of healthy behaviors, exercise and disease prevention, combating and changing negative environmental factors are obtainable. Community visioning takes planning and coordination among town and city governments, urban planning and transportation departments, health departments, health care organizations, community partners and many others to produce growth and create redesign that is smart, purposeful and done with health in mind.

Carolinas HealthCare System – (Charlotte, North Carolina)

The Carolinas HealthCare System Anson facility is a 15-bed hospital with emergency services and primary care providers using a medical home model located in Wadesboro, North Carolina. The redesigned facility, opened in 2014, was built after the community's engagement in wanting better health care options. The Carolinas team was committed to becoming what the community needed even if that meant looking different and providing different services. The facility engaged an artist to do a community visioning exercise to see what the future model for health care might look like.

It was recognized that many residents of Anson County went to the emergency room because there were not enough primary care providers. Given this knowledge and strong community involvement, the Anson facility has already decreased ER visits and increased access to primary care by having a centralized triage that can navigate patients to the appropriate level of care. Services provided by this facility include:

- 24/7 emergency care
- 15-bed hospital

- Primary care through a “medical home” team coordinated by a primary care physician and which can include dietitians, pharmacists, community health nurses, patient navigators, diabetes educators, case managers, and social workers
- Hospital services including radiology, digital imaging, laboratory, pharmacy, surgery, and inpatient services
- Community services, such as diabetes management, faith-based health care and community health nurses
- Access to specialty services nearby through Carolinas HealthCare System, including cardiology, pulmonology, behavioral health, OB/GYN, general surgery, urology and orthopedics
- Rehabilitation
- This facility also provides a community room for various Anson County organizations to use as a free meeting space.

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Predictive analytics and use of big data

The ability to identify and focus on those most in need within a community, as well as patients who are the most frequent users of the emergency room, begins with data. Collecting data from different sources that combine clinical findings, socio-demographic information about a patient as well as associated costs and utilization of services can be extremely insightful for hospitals. The ability to look at such information in aggregate, for a

specific patient population or for a subset of individuals across the community, allows an organization to better manage and coordinate care across the entire continuum from prevention to end of life. Additionally, this information helps better explain costs and identifies utilization patterns among a specific population, as well as in direct resources, and evaluates the effectiveness of care initiatives within a community.

Incorporating data analysis into strategic planning and community health work does not need to mean high dollar expenditures; opportunities exist to hone and inform efforts tapping into existing data. The promise of data can also be further recognized and strengthened through partnerships. Hospitals should first look to see what community data assets already exist and whether there may be unique partnerships with insurers to use payer data to target community health strategies. Hospitals then collaborate with public health departments and other community organizations to collect relevant data or engage with universities or other educational partners who can augment work around research, data analysis and even technology infrastructure.

Union General Hospital –
(Blairsville, Georgia)

This small, 45-bed hospital offers an example of how an investment in data analytics can be impactful, even without a million dollar budget. In 2015, the hospital invested \$50,000 in a data analytics program that staff could use to focus on caring for patients, think strategically on how to reduce readmissions and identify the best way to address community

health needs. The ability to collect and analyze data in real time is more efficient and more effective in identifying strategies to improve care and reduce readmissions. The hospital attributes the incorporation of data analytics to their significant reduction in readmissions.

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Providence St. Joseph Health –
(Seattle, Washington)

Providence St. Joseph believes that success in population health management requires not only a foundation of technology, data and informatics but also relentless effort to better understand a defined population's outcomes and how they are influenced. Because of this, Providence St. Joseph Health established an Office of Population

Health Informatics within its population health division to specifically manage health data coordination, quality measurement, advanced analytics, predictive modeling and the system's information technology collaboration.

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National collaboratives

Achieving a population where every individual has access to needed health care services, access to environmental and social needs that affect health and access to care without inequity or disparities is the ultimate goal all hospitals are working toward, but it is a tall order. Hospitals are committed to working toward that goal. While the hospital field itself offers a strong network for collaboration, many other entities are also working to improve health status. Even beyond the value found in community collaborations, there are organizations, foundations and insurers that are national in scope and that can provide cohesiveness to existing efforts, offer resources for expansion and broaden the scope and infrastructure for success.

■ **CDC** (www.cdc.gov)

■ **Community Health Improvement Navigator** (www.cdc.gov/chinav/)

The CDC Community Health Improvement Navigator (CHI Navigator) is a website for people who lead or participate in community health improvement work within hospitals and health systems, public health agencies and other community organizations. It is a one-stop-shop that offers community expert-vetted tools and resources to stakeholders. Because working together has a greater impact on health and economic vitality than working alone, CHI brings together health care, public health and other stakeholders to consider high-priority actions to improve community health.

■ **The CDC Community Health Improvement Navigator Health Impact in 5 Years** (www.cdc.gov/policy/hst/hi5/)

The Health Impact in 5 Years (HI-5) initiative highlights nonclinical, community-wide approaches that have evidence-based reporting; positive health impacts; results within five years; and cost effectiveness or cost savings or both over the lifetime of the population or earlier.

■ **RWJF** (www.rwjf.org)

- **Culture of Health Leaders program** will develop a large cadre of leaders from diverse sectors (e.g., public policy, business, technology, community development and planning, education, transportation, public health, health care and other sectors) to work with organizations, communities, health systems and policymakers to build a Culture of Health in America.

■ **HRET Hospital Improvement Innovation Network (HIIN)** (www.hret-hiin.org)

- National collaborative funded by CMS to continue efforts to reduce hospital-acquired conditions and readmissions. Participating hospitals have access to technical assistance, educational opportunities, training, resources and learning collaboratives specific to the target improvement areas.

Leadership Assessment

A graphic checklist for leaders will be included to gauge whether the action has been done, more work is needed or not done yet.

Leadership Assessment On Community Health Readiness

- Is community health part of your hospital's mission statement?
- Have you engaged your board in conversations about the need for community health/ community outreach activities?
- Do you share, report and track success of community health activities with your board?
- Do you have a diverse board that is an accurate reflection of the community served?
- How does your community health needs assessment guide your community partnerships and community health work?
- Do your community health activities align with identified health needs?
- Have you partnered with other community organizations, hospitals or health systems to conduct your community health needs assessment?
- Have you participated in any outreach activities to combat social determinants of health?
- What actions have you taken to strengthen the coordination and continuum of care when a patient is discharged?
- Have you participated in a community health dashboard to identify health markers within your community and assess existing resources?
- Do you engage with diverse partners throughout the community?
 - Other hospitals or health care organizations?
 - Community health/public health departments?
 - Schools/academia?
 - Law enforcement?
 - Social service organizations?
 - Local business?
 - Foundations or national collaboratives?
- Have you served as a convener for community conversations?
- What role does the hospital play in collaborative community health efforts? (leader, convener, participant, funder, etc.)
- Have you made a budgetary commitment to community health activities?
- Do you have dedicated staff responsible for advancing community health?
- Have you engaged in any hot-spotting or data analytics to further hone your community health work?
- Do you have dedicated resources for data analytics?
- How do you measure and report your success in improving community health?
- Has your organization successfully adopted a culture of health and wellness from the hospital to the community?

Existing AHA Resources

- American Hospital Association's Hospitals in Pursuit of Excellence
 - Creating Effective Hospital-Community Partnerships to Build a Culture of Health, HRET, August 2016
 - Guide to Health Care Partnerships for Population Health Management and Value-based Care, HRET, July 2016
 - Applying Research Principles to the Community Health Needs Assessment Process, HRET and ACHI, July 2016
- Association for Community Health Improvement is a membership association for community health, community benefit and healthy communities professionals.
- Community Connections is an initiative of the AHA designed to support and highlight the work hospitals do everyday.
 - Ideas & Innovations for Hospital Leaders (collection of case studies)
 - CEO Insight Series: The Importance of Community Partnerships (care coordination, prevention and wellness)
 - CEO Insight Series: The Importance of Community Partnerships (public health collaborations)
 - Telling the Hospital Story: Going Beyond Schedule H
 - Self-Assessment checklists – accountability and transparency
- AHA Awards offer a wonderful array of innovation and success within the field. Honorees are recognized for best practices that can replicated by others.
 - Foster G. McGaw Prize for Excellence in Community Service winners collectively paint a picture of creative, insightful, caring health delivery organizations that are exceptionally committed to improving the health and well-being of everyone in their communities.
 - AHA NOVA Awards honor effective, collaborative programs focused on improving community health status.
 - Carolyn Boone Lewis Living the Vision Awards are presented to organizations and individuals living AHA's vision of "a society of healthy communities where all individuals reach their highest potential for health.
 - AHA's Equity of Care Award is presented annually to hospitals or care systems that are noteworthy leaders and examples to the field in the area of equitable care. Honorees demonstrate a high level of success in reducing health care disparities and promote diversity in leadership and staff within their organization.

