Health System Leadership to Address Population Health & Reducing Disparities

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Health Research & Educational Trust
American Hospital Association
Changes in the Health Care Field

Is Walmart poised to disrupt healthcare before Amazon?

The retail giant already has a strong track record in pharmacy sales and medical care, but can it really make an impact?

As Ascension restructures, it hints at smaller hospital footprint

By Alex Keck | March 22, 2018

Ascension is restructuring as it pursues a new strategic direction, hinting at transitioning from a hospital-oriented system to one that's focused on outpatient care and telemedicine. That's what the largest Catholic health system told its 165,000 employees early Friday morning via a video featuring Ascension CEO Anthony Tersigni that Modern Healthcare has exclusively obtained.
## Paradigm Shift

<table>
<thead>
<tr>
<th>Today</th>
<th>Future</th>
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<tbody>
<tr>
<td><strong>Focus</strong></td>
<td>Community health</td>
</tr>
<tr>
<td>Individual patient</td>
<td>Coordinated, longitudinal care</td>
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<tr>
<td><strong>Care</strong></td>
<td></td>
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<tr>
<td>Fragmented, episodic treatment</td>
<td>Coordinated, longitudinal care</td>
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<tr>
<td><strong>Goal</strong></td>
<td>Achieving wellness</td>
</tr>
<tr>
<td>Treating sick</td>
<td></td>
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<tr>
<td><strong>Rewards</strong></td>
<td>Value, outcome driven</td>
</tr>
<tr>
<td>Volume driven (FFS)</td>
<td></td>
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<tr>
<td><strong>Setting</strong></td>
<td>Community based; range of settings</td>
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<tr>
<td>Institutional base; hospital oriented</td>
<td></td>
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<tr>
<td><strong>Leadership</strong></td>
<td>Systems thinking/integrated processes</td>
</tr>
<tr>
<td>Managing departments/divisions</td>
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20% of health and well-being is related to access to care and quality of services.
ADVANCING HEALTH IN AMERICA
THE PATH FORWARD

Our vision: A society of healthy communities where all individuals reach their highest potential for health.

Our commitment:

1. Access: Access to affordable, equitable health, behavioral and social services
2. Value: The best care that adds value to lives
3. Partners: Embrace diversity of individuals and serve as partners in their health
4. Well being: Focus on well-being and partnership with community resources
5. Coordination: Seamless care propelled by teams, technology, innovation and data

Our role: The ‘H’ of the future = Hospitals, Health systems, and Health organizations that are:

→ Partnering and leading in our communities
→ Striving toward the vision to advance health in America
→ Helping our communities beyond the four walls of the hospital
→ Creating new models of care, services and collaborators
AHA’s Population Health Approach

Advancing Health and Well-Being by Bridging Care and Community
Pathways to Population Health

P1: Physical and/or Mental Health
P2: Social and/or Spiritual Well-being
P3: Community Health and Well-being
P4: Communities of Solutions

Achieving Health Equity

**AHA Vision:** A society of healthy communities where all individuals reach their highest potential for health.

There can be **no quality without equity** — *diversity and inclusion practices and community building approaches are essential strategies toward that goal.*
How does the Pathways to Population Health framework resonate with you? What is missing?

What else would help you accelerate your journey to health and well-being using population health as the vehicle?

What is your organization doing to promote population health and address social determinants of health?
“Need to link social determinants strategies with clinical outcomes to provide value proposition to leadership.”

“Addressing social determinants is all about relationships and networks with patients and community stakeholders”

“Given slim margins for most non-profit hospitals, limited dollars for investing in population health strategies”

“Health disparities and equity must be prominent in any discussion of population health or social determinants”

“Hospitals can’t be at the center or have primary responsibility – we should be a convener or connector in the process.”

“...frustrated that after years of effort we’re not making more progress toward health improvement goals.”
Population Health Alignment

- Population health aligned with mission
- Strong collaborations with community organizations
- Population health aligned with clinical integration strategy
- Focus on a broad range of population health issues
- Priorities aligned with public health department’s priorities
- Financial resources available for population health initiatives
- Programs address socioeconomic determinants of health

Bridging the Gap

Source: Health Research and Educational Trust, 2014
Leadership Prioritization & Alignment

VISION
A clear and compelling value proposition supported by an inspiring purpose.

LEADERSHIP

CULTURE
Shared taken-for-granted beliefs that shape behavior.

OPERATIONS
An integrated set of capabilities and processes.

Leadership Engagement

Trustees

Physicians

Administrators
TRUSTEES ARE KEY

For building a culture of diversity and inclusion.

Aligning health care quality and equity supports the Triple Aim.

Improving patient experience of care

Reducing the cost of care

Improving the health of populations
Transitioning Payment Models

Source: Health Catalyst, 2017

Source: Innosight, 2017
### Workforce Capacity

#### FTEs DEVOTED TO POPULATION HEALTH

<table>
<thead>
<tr>
<th>Hospital Size</th>
<th>0-1.99 FTEs</th>
<th>2-5.99 FTEs</th>
<th>6-9.99 FTEs</th>
<th>10+ FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (&lt;100 beds)</td>
<td>15.1%</td>
<td>3.7%</td>
<td>18.0%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Medium (100-299 beds)</td>
<td>28.7%</td>
<td>9.9%</td>
<td>29.0%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Large (300+ beds)</td>
<td>45.3%</td>
<td>14.2%</td>
<td>29.0%</td>
<td>18.2%</td>
</tr>
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Workforce Competencies

• Community Health Assessment
• Community Health Improvement Planning and Action
• Community Engagement and Cultural Awareness
• Systems Thinking
• Organizational Planning and Management
Workforce Capacity

HOSPITAL & HEALTH SYSTEM EMPLOYEES ARE KEY
For building a culture of diversity and inclusion.

Aligning health care quality and equity supports the Triple Aim.

Improving patient experience of care
Reducing the cost of care
Improving the health of populations
Policy Levers to Advance Population Health

• Payment
  – APMs, MACRA, State-based initiatives (e.g. Medicaid 1115 Waivers), Accountable Communities for Health

• Data/Measurement
  – Outcomes, health services, community health (housing, healthy food access, opportunities for physical activity)
  – Data-sharing infrastructure

• Community Benefit/Community Health Needs Assessments
Accountable Health Communities
## Payment Models

### Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Category 1: Fee for Service – No Link to Quality</th>
<th>Category 2: Fee for Service – Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on FFS Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Payment based on volume of services and not linked to quality of efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or episode of care. Payment still triggered by delivery of service, but opportunities for savings or 2-sided risk</td>
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Beyond Community Benefit Requirements
The Need to Address Social Determinants of Health

1.48 million individuals are homeless in the U.S. every year.

3.6 million people in the U.S. can’t access medical care due to transportation issues.

42 million Americans face hunger.

12.7% of U.S. households are food insecure.
Addressing the Social Determinants

1. Traditional Clinical Prevention
   - Increase the use of clinical preventive services

2. Innovative Clinical Prevention
   - Provide services that extend care outside the clinical setting

3. Community-Wide Prevention
   - Implement interventions that reach whole populations
Setting the Goalposts
QUALITY IMPLICATIONS

Increasing diversity will have a significant impact on quality.

Disparities:

- More medical errors
- Longer hospital stays
- Avoidable hospital admissions and readmissions
- Over- or under-utilization of procedures
# Quality Improvement Approach

<table>
<thead>
<tr>
<th></th>
<th>Patient-Level</th>
<th>Health Care Organization Population-Level</th>
<th>General Population-Level</th>
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<tbody>
<tr>
<td><strong>Primary Prevention</strong></td>
<td>Financial literacy, support, &amp; nutrition programs for low-income families with strong family history of DM</td>
<td>Provide on-site Farmers’ Market, gym, walking trails or financial counseling for families at risk for DM</td>
<td>Advocate for local increase in minimum wage and supports for low-income families, particularly those at risk of DM</td>
</tr>
<tr>
<td><strong>Secondary Prevention</strong></td>
<td>Poverty screening &amp; financial assistance for DM patients at-risk of end-of-month hypoglycemia</td>
<td>Subsidize vouchers to local Farmer’s Market or hire a financial counselor for low-income DM patients</td>
<td>Change timing and content WIC &amp; school food programs to avoid food insecurity among DM</td>
</tr>
<tr>
<td><strong>Tertiary Prevention</strong></td>
<td>Reduce ED use among high-utilizer severe diabetics using food and income support referrals</td>
<td>Coordinate with local banks, collectors, lenders, to reduce debt burden for utilizer diabetics</td>
<td>Support legislation/ regulations to provide financial and “hotspotter” services to severe diabetics</td>
</tr>
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Collecting and Using Data

PREFERENCE DATA
Collecting race, ethnicity and language preference data can help hospitals to improve quality of care.

Collecting data:

- Systematically collect race, ethnicity and language (REAL) preference data on all patients.
- Use REAL data to look for variations in clinical outcomes, resource utilization, length of stay and frequency of readmissions within our hospital.
- Compare patient satisfaction ratings among diverse groups and act on the information.
- Actively use REAL data for strategic and outreach planning.
Changing Environments

South Asian Cardiovascular Center at Advocate Lutheran General Hospital
Chicago, Illinois
Partnerships

TRUST

PERFORMANCE

SUCCESS

BUSINESS

TEAMWORK

PLAN

PARTNERSHIP

WIN-WIN

COLLABORATION
Creating Strategic Alliances...
ACHI Insights
PUTTING ASIDE DIFFERENCES

Atrium Health and Novant Health
Charlotte, North Carolina
The Path Forward

- Getting to a Shared Framework
- Community and Government Partnerships
- Board Engagement and Education
- Strengthening linkages between quality with equity and disparities
- Contextual Approaches to Advancing Population Health
Thank you!

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