Public Health In The Changing Healthcare Landscape
NASHP Conference 2015

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Overview of the Presentation

• Honoring the Trust
  – Visionary Leadership
• The Past
  – Challenges
  – National Demonstration
  – Community Need Index
  – Partnership Opportunity
  – Increased Accountability
• The Present – an Update
• Evolving to the Future State
  – Challenges and Opportunities
DIGNITY HEALTH

• MISSION
  – We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:
    – Delivering compassionate, high-quality, affordable health services;
    – Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
    – Partnering with others in the community to improve the quality of life.

• VISION
  – A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees and physicians to improve the health of all communities served.

Visionary Leadership
Comprehensive Community Health Approach

• Community Benefit Program
  – Promoting community health in fulfillment of mission imperatives
  – Complying with federal/state mandates
  – Responding to identified/prioritized unmet needs

• The Community Grants Programs
  – Supporting community non-profits in response to community needs

• The Community Investment Program
  – Building capacity w/low interest loans, lines of credit, guarantees
  – Addressing the social determinants of health, including housing, jobs, access to health care services
Advancing the State of the Art in Community Benefit
A National Demonstration Project

National Demonstration Project
Advancing the State of the Art in Community Benefit
Institutional Policy Measures and Goals

**Governance / Decision-Making**
- Clear delineation of responsibilities
- Explicit criteria for decision-making
- Core Principle guidelines for recruitment
- Formal reporting on program progress
- Mechanisms for program continuity
- Senior leadership accountability

**Management**
- Clear delineation of responsibilities
- Necessary competencies for position
- Program design & reporting discretion
- Access to and support from leadership
- Mechanisms for internal engagement

**Operations**
- Develop multi-year plans
- Leverage external expertise
- Ongoing engagement of community

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**Accountability**
- Transparency
- Objectivity
- Diversity

**Quality**
- Measurability
- Competence
- Capacity

**Sustainability**
- Commitment
- Humility
National Demonstration Project
Advancing the State of the Art in Community Benefit
Programmatic Measures and Major Goals

ID communities with DUHN*
CB activities ensure access for communities with DUHN
Reduction in preventable utilization
Measurable impacts for primary prevention activities
Increased engagement of clinicians
Increased engagement of diverse community stakeholders
Evidence of increased community capacity
Cost savings produced by capacity building

Reduce Health Disparities
Reduce Health Care Costs
Enhance Community Problem-Solving Capacity

* Disproportionate Unmet Health-related Needs

Applying the Science of Community Benefit
The Community Need Index
CNI Scoring Comparison

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Indicator</th>
<th>Indicator %</th>
<th>Barrier Score</th>
<th>Indicator %</th>
<th>Barrier Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Elderly Poverty</td>
<td>3%</td>
<td>17%</td>
<td></td>
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<tr>
<td></td>
<td>Child Poverty</td>
<td>8%</td>
<td>27%</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Single Parent Poverty</td>
<td>32%</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural</td>
<td>Minority Population</td>
<td>8%</td>
<td>97%</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Limited English</td>
<td>1%</td>
<td>16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Without HS Diploma</td>
<td>9%</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td>Unemployed</td>
<td>4%</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uninsured</td>
<td>13%</td>
<td>32%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>Renting %</td>
<td>12%</td>
<td>38%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Final CNI Score</strong></td>
<td></td>
<td><strong>1.8</strong></td>
<td>(Low Need)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>4.6</strong></td>
<td>(High Need)</td>
</tr>
</tbody>
</table>

Strong Correlation with Avoidable Admissions

**Annual Admission Rate per 1000 Population by CNI Score**

Ambulatory vs. Marker Conditions

- **Preventable Admissions More Than Twice As Likely To Occur In High Need Areas; While Marker Conditions Occur At The Same Frequency**

Note: Ambulatory Sensitive Conditions if treated properly in an OP setting, do not generally require an acute care admission
Chronic Disease: A National Crisis

- Chronic diseases are the No. 1 cause of death and disability in the U.S.
- Treating patients with chronic diseases accounts for 75% of nation’s health care spending
- Two thirds of the increase in health care spending is due to increased prevalence of treated chronic disease
- The vast majority of cases of chronic disease could be prevented or managed.

www.fightchronicdisease.org
The Business Case

- Disease self-management plays an integral part in managing the risk and health of populations.
  - Fewer readmissions
  - Reduced complications/length of stay
  - Decreased utilization (free bed capacity for more appropriate inpatient admissions)
  - Decreased costs
  - Improved quality
  - Increased health/quality of life for patients living with chronic conditions

Historical Perspective - Strategic Direction

- 2006
  - To ensure sustainability, codified the processes of the ASACB demonstration in Community Benefit Administrative Policy
  - Revised Community Benefit Policy to establish accountabilities
  - Revised Finance Policy to ensure standardized calculation methodology and to establish reporting roles and responsibilities of Community Benefit and Finance staff
  - In collaboration with the California Department of Aging, California Department of Public Health, Kaiser Permanente of Southern California and Partners in Care Foundation utilizing a combination of Memoranda of Understanding and informal agreements to create a statewide partnership to advance evidence-based practice.
Partnering with Others

Partners in Care Foundation
Technical Assistance Center

Licensing & Quality Assurance
Coalition Administration

- Training
- Day-to-Day Technical Support
- Data Entry & Management
- Develop New System Partners
- Partnership Development
- Communication Materials
- Website
Cahealthierliving.org

Established Increased Accountability
Historical Perspective – Strategic Direction

• 2007
  – Integrated the five core principles in existing Community Benefit Programs
• 2008-2011
  – Implemented two long-term performance improvement metrics
    • Reduce readmissions or avoid admissions among participants in evidence-based chronic disease self-management programs
    • Increase proactive investment in Community Benefit Programs by 10% over baseline established in 2008
  – Passage of the Patient Protection and Affordable Care Act
    • Required Community Health Needs Assessments of all Hospitals
    • Required development of a Community Health Implementation Plan made publicly available

Realization of our National Goals

• Goals of Health Reform
  – Lower health care costs
  – Improve the quality of care
  – Provide coverage options for the uninsured
• National Quality Strategy
  – Better Care
  – Healthy People/Healthy Communities
  – Affordable Care
• National Prevention Strategy
  – Empower people
  – Ensure healthy and safe community environments
  – Promote clinical and community preventive services
  – Eliminate health disparities
In Patient Hospitalizations for Prevention Quality Indicators (PQI)
FY2014 Non-Commercial – Areas of Focus

<table>
<thead>
<tr>
<th>PQI Condition</th>
<th>Cases</th>
<th>Days</th>
<th>ALOS</th>
<th>Net Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina Without Procedure</td>
<td>239</td>
<td>482</td>
<td>2.02</td>
<td>($394,146)</td>
</tr>
<tr>
<td>Asthma in Younger Adults</td>
<td>991</td>
<td>2,100</td>
<td>2.32</td>
<td>($2,725,130)</td>
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<tr>
<td>Bacterial Pneumonia</td>
<td>6,068</td>
<td>26,587</td>
<td>4.38</td>
<td>($21,463,283)</td>
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<tr>
<td>Congestive Heart Failure</td>
<td>7,351</td>
<td>30,387</td>
<td>4.15</td>
<td>($21,180,408)</td>
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<tr>
<td>COPD or Asthma in Older Adults</td>
<td>5,228</td>
<td>18,724</td>
<td>3.58</td>
<td>($15,205,785)</td>
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<tr>
<td>Diabetes Long Term Complications</td>
<td>2,460</td>
<td>12,012</td>
<td>4.88</td>
<td>($7,334,486)</td>
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<tr>
<td>Diabetes Lower Extremity Amputation</td>
<td>240</td>
<td>2,607</td>
<td>10.86</td>
<td>($1,892,019)</td>
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<tr>
<td>Diabetes Short Term Complications</td>
<td>1,976</td>
<td>6,407</td>
<td>3.24</td>
<td>($7,786,247)</td>
</tr>
<tr>
<td>Diabetes Uncontrolled</td>
<td>232</td>
<td>621</td>
<td>2.68</td>
<td>($535,001)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>4</td>
<td>41</td>
<td>10.25</td>
<td>($98,596)</td>
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<tr>
<td>Low Birth Weight</td>
<td>2,148</td>
<td>40,890</td>
<td>19.04</td>
<td>($30,584,726)</td>
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<tr>
<td>Perforated Appendix</td>
<td>838</td>
<td>4,418</td>
<td>5.27</td>
<td>($5,269,729)</td>
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<tr>
<td>Urinary Tract Infection</td>
<td>3,588</td>
<td>12,299</td>
<td>3.43</td>
<td>($5,400,778)</td>
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<tr>
<td>Total</td>
<td>31,343</td>
<td>157,775</td>
<td>5.22</td>
<td>($119,670,333)</td>
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</table>
Report Outcomes – Population Health
Primary Focus on Uninsured and Underinsured

- In FY2014 facility reports reveal that more than $1.9 million was invested in Chronic Disease Self-Management Education programs by our hospitals, which served nearly 8,000 individuals.
- Ninety days following participation in the programs only 8% of the participants were seen in either the hospital or emergency department (self-reported).
- The average variable cost per inpatient case for all chronic PQI conditions was more than $10,000 for fiscal year 2014.
- Not only does the intervention reduce the burden of cost on healthcare systems, more importantly it also empowers people living with chronic conditions to better self care and improved quality of life.
- With a primary focus on vulnerable communities, this intervention effort also helps to reduce health inequity.

Evidence-Based Programming – CDSME

“I am ninety years old and this program has been very helpful in my way of life... the importance of daily exercise and less worry over my health problems... I am much more relaxed than I have been in a long time.”

“We learned to deal more effectively with anxiety, anger, pain, depression and emotions. I now have more confidence in myself...”
CDSME Programs (Stanford evidence-based curriculum) offered in:

- Bay Area (San Francisco, Santa Cruz)
- Sacramento (including Sierra Nevada and Woodland) (6 facilities)
- Southern CA (both CHMC & Inland Empire expected 2015) (4 facilities)
- Arizona (in collaboration with AZ Living Well Institute) (3 facilities)
- North State (3 facilities)
- Merced
- Stockton
- Central Coast (3 facilities)
- Bakersfield (3 facilities)
- Henderson, NV (3 facilities)

<table>
<thead>
<tr>
<th>December 2014</th>
<th>Leaders</th>
<th>Master Trainers</th>
<th>T-Trainer</th>
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<tr>
<td>CDSMP (English)</td>
<td>74</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Tomando (Spanish)</td>
<td>51</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Both (English &amp; Spanish)</td>
<td>8</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td>133</td>
<td>30</td>
<td>1</td>
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</tbody>
</table>

NEXT STEPS into the Future

- Blue Shield entered into contractual arrangements with members of the Coalition to fund CDSME for their members, with administrative support provided by Coalition member Partners in Care Foundation
- The Dignity Health Employee Giving Campaign donations to the internal Community Health Partnership Fund financed the education of new trainers in Arizona (December 2014)
- System Community Health Partnership Fund is financing consultant fees and CMS Application Fees ($900 each facility) for accreditation of Diabetes Self-Management Program for reimbursement
- In collaboration with Dignity Health IT, staff from AZ, NV, CA are building the back end for referral to the CDSME Programs through the Electronic Health Record and subsequent tracking of completion rates
- Research collaboration with Stanford’s newest program “Building Better Caregivers” was launched in 2015
Into the Future...
Challenges and Opportunities

Dissemination Strategy

HealthCare Sector
- Physician/Medical Groups & Clinic Systems
- Kaiser Permanente Sites
- Dignity Health Hospitals/MD Centers
- Veterans Health Administration Systems
- Health Care Districts

Educational Sector
- Community Colleges
- UCLA SHARP Program
- CSU Long Beach
- School Districts

Public Health & Aging
- CDPH
- County Public Health Providers
- Community Health Educators/Promotors
- Area Agencies on Aging
- Senior Centers

Community Based Organizations
- Housing Communities
- Faith-Based Organizations
- Community Centers
- YMCAs & YWCAs
- Libraries, Parks & Rec.
- Ethnic & Affinity-based organizations

CALIFORNIA HEALTHIER LIVING COALITION

ADOPT OFFER REFER HOST SPONSOR
CHAMPIONS DECISION-MAKERS
Community Benefit Expense
Five-Year Trend (in thousands)

California State Assembly Bill 1606

- AMENDED IN ASSEMBLY MARCH 23, 2010
- California Legislature—2009/10 regular session
- ASSEMBLY BILL No. 1606
- Introduced by Assembly Member Coto
- January 6, 2010
- An act to add Section 14132.07 to the Welfare and Institutions Code, relating to Medi-Cal.
- legislative counsel’s digest
- AB 1606, as amended, Coto. Medi-Cal: Stanford Chronic Disease Self-Management Program. department-approved chronic disease self-management programs. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. This bill would require the department to seek, and if obtained, to implement, all federal waivers necessary to allow for the services provided to Medi-Cal beneficiaries pursuant to the Stanford Chronic Disease Self-Management Program, as defined, through a department-approved chronic disease self-management program, as defined, to be reimbursable under the Medi-Cal program. Vote: majority.

- Appropriation: no
- Fiscal committee: yes.
- State-mandated local program: no.
Non-Medical Determinants of Health

Factors that Affect Health

- Counseling & Education
- Clinical Interventions
- Long-lasting Protective Interventions
- Changing the Context to make individuals' default decisions healthy
- Socioeconomic Factors

Examples

- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation treatment, colonoscopy
- Fluoridation, Og trans fat, iodization, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality