
Health Project

U.S. Health Care Is Moving Upstream

By ANA GARCIA, M.P.A., ANNA POMYKALA, J.D., and SHARA SIEGEL, M.S.P.P.M.

Along with providing quality health care to their patients, nonprofit hospitals often are leaders in supporting the health of the broader populations in their communities. Mobile screening units, community-based vaccination clinics and health literacy programs are just some of the resources in the health care system that hospitals often provide to community residents.

However, hospital systems cannot extend their health care services indefinitely. The costs of providing more and more treatment, albeit through innovative and lower-cost strategies, are prohibitive. Mission-driven hospitals seeking to improve the health of community members are therefore increasingly looking to community-based disease prevention efforts. Community-based prevention, particularly interventions that look upstream to stop the root causes of disease, can reduce the burden of preventable illnesses both on the population and the health care system overall. And now, thanks to changes laid out in the Affordable Care Act (ACA), hospitals have more support in making investments in prevention through their community benefit programs.

PREVENTION AND COMMUNITY BENEFIT IN THE ACA

The ACA supports health improvement and disease prevention through a variety of approaches. These include expanding health coverage, requiring insurance coverage of basic preventive services without a co-payment, and, through the creation of the National Strategy for Quality Improvement in Health Care, laying out national aims and priorities to guide local, state and national efforts for addressing disparities and improving health care quality. Each of these approaches supports better clinical prevention for individual patients.

A lesser-known component to the ACA may be its support for population health interventions that improve the health of whole communities. The $12.5 billion Prevention and Public Health Fund and the National Prevention Strategy, for example, are interesting components of health reform because they lend support to disease-reducing actions well outside the traditional health care system. They promote engaging sectors outside the health care system (business, urban planning, transportation engineers, agriculture, for instance) to take part in activities and policy changes that affect social and environmental factors — like improving air quality, enhancing access to bike paths and parks, developing farmer's markets — and can affect chronic disease prevalence.

The Community Transformation Grants (CTG) program is an example. Grantees are expected to form broad coalitions that will identify the best policy and systems approaches to improving the health of their communities in the priority areas of tobacco-free living, active living and healthy eating, and quality services to prevent and control high blood pressure and high cholesterol.[1]

This initiative has a policy orientation; for example, one specific objective is to get more state and local smoke-free air laws passed, as evidence shows these laws are associated with reductions in hospital admissions for heart attacks and stroke. The Centers for Disease Control and Prevention has committed $900 million to the grants program over the first five years. Approximately $103 million in prevention funding was awarded

in 2011 to 61 states and communities, and in 2012, another $70 million went to 40 communities with fewer than 500,000 people.

Hospitals are involved in many of the community transformation grant initiatives. The University of Rochester Medical Center in New York, for example, was awarded $3.6 million to develop Health Engagement and Action for Rochester's Transformation (HEART), which aims to create a regional food hub, establish smoke-free policies in parks and promote worksite wellness programs among area employers.

The Austen BioInnovation Institute in Akron, Ohio, is another grantee. This collaboration of Summa Health System, Akron Children's Hospital, Akron General Health System, Northeast Ohio Medical University, the University of Akron and the John S. and the James L. Knight Foundation received $500,000 to create an accountable care community (ACC). The ACC aims to "improve the physical, social, intellectual, emotional, and spiritual health of the community." It includes leaders from health and public health as well as from higher education and secondary education; alcohol; drug andmental health services; the faith and service community; and multiple community-based programs. The ACC aims to create "changes across the entire spectrum of the determinants of health."[2] Project results to date have included a 10 percent reduction in monthly costs for individuals with diabetes.[3]

The ACA also promotes broad-based community prevention initiatives through changes to the nonprofit hospital community benefit program. The ACA's legislated changes to the tax code are premised on the idea that with more Americans receiving health coverage, nonprofit hospitals will provide less uncompensated coverage — charity care — over time.

Providing charity or uncompensated care was initially the primary means by which nonprofit hospitals could qualify for federal tax-exempt status. Since 1969 — after Medicaid and Medicare drastically reduced the number of uninsured — the IRS has broadened the scope of qualifying activities beyond charity care to include programs that improve the health of the community, public health initiatives and health promotion.[4]

Some of the ways hospitals have fulfilled these obligations include providing education for health professionals, conducting community health screenings, supporting school-based health initiatives and undertaking other outreach programs that do not just treat illness, but promote wellness. But even before the recent reforms, many hospitals have used their community benefit programs as part of a strategy of supporting broad-based community prevention.

As early as 1981, for example, Montefiore Medical Center in New York City became involved in community redevelopment, rehabilitating housing stock and promoting economic development in the northwest Bronx because the hospital recognized the lack of housing and jobs in the area produced dire consequences for the health of local residents. To support this type of work, the Catholic Health Association (CHA) published its *Social Accountability Budget* in 1989. This document later became *A Guide for Planning and Reporting Community Benefit*, and it teaches hospitals how to assess community needs; set priorities; establish a sustainable infrastructure; budget for activities; and plan, evaluate and report community benefit.

The recent community benefit changes in the ACA encourage more hospitals to engage in this kind of work. Effective for tax years beginning after March 23, 2012, hospitals are to collaborate with local stakeholders to develop a community health needs assessment. The assessments are to be conducted every three years, and in between, hospitals must implement strategies to address the identified needs. The assessment must include input from community members and public health experts. The latter may, for example, be able to provide epidemiological and health systems data that can help identify local community health priorities. In addition, the ACA requires that the board of directors or other authorized governing body approve a hospital's strategy for implementing actions addressing the health needs identified in the assessment.[5]

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Improving access to care will continue to be an important finding of some hospitals' community health needs assessments, and hospitals will likely continue to need to provide charity care for some

populations, such as undocumented immigrants, who have not gained insurance coverage through the ACA. But the assessments also are likely to bring more attention to other community concerns, such as asthma incidence tied to poor housing stock, repeated pedestrian injuries related to poorly designed intersections, and the low literacy and high rates of violence that stand between some communities and real health improvement.

Wanda McClain, Executive Director of the Center for Community Health and Health Equity at Brigham and Women's Hospital in Boston, for example, says her hospital has engaged in a wide range of education-related initiatives, ranging from literacy programs in elementary schools to mentoring and health careers internships for high school students, because there is strong evidence that educational attainment will improve health outcomes in the communities the hospital serves.

WHY INVESTING IN COMMUNITY PREVENTION MAKES SENSE FOR HOSPITALS

Addressing community health priorities outside hospital walls could yield big payoffs, starting with savings in avoidable hospitalizations. Preventable hospitalizations cost billions of dollars each year. The Agency for Health Research and Quality estimated the 2007 costs for preventable hospitalizations at $29 billion, or 10 percent of total hospital expenditures, that year. Community-based prevention programs can decrease these costs.

A study by Trust for America's Health, the Urban Institute and The New York Academy of Medicine found that an investment of $10 per person per year in proven community-based disease prevention programs, such as walking programs, anti-smoking campaigns and home evaluations to address asthma triggers, could yield net savings of more than $2.8 billion annually in health care costs in one to two years, more than $16 billion annually within five years and nearly $18 billion annually in 10 to 20 years (in 2004 dollars).[6]

Moreover, as Medicaid, Medicare and other insurers' fee-for-service payments are replaced by population-based and outcome-based payments (through models like ACOs, health homes and payment reductions for readmissions), health systems will be encouraged to improve the health status of prospective patients before they seek care. A strategy that includes community-based prevention could help reduce the need for costly interventions, and it could lower readmissions.

In contrast, the costs of doing nothing are staggering. *F as in Fat*, an annual report from the Trust for America's Health and the Robert Wood Johnson Foundation, forecasts state obesity rates, new disease cases and health care costs in 2030 depending on whether obesity trends continue on their current track or whether average BMI is reduced by 5 percent.[7] Medical costs associated with treating preventable obesity-related diseases are on an upward trend expected to increase by up to $66 billion per year nationally. But with a modest reduction in average BMI, it is predicted that nearly every state could save between 6.5 percent and 7.9 percent in health care costs. By 2030, this could equate to cumulative savings ranging from $81.7 billion in California to $1.1 billion in Wyoming.

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Indeed, pointing specifically to the potential costs associated with an aging population and the onset of value-based payment structures, a recent American Hospital Association (AHA) report says reaching out into the community and prioritizing population health is a "must-do strategy" for hospitals and health systems to succeed in the evolving health care environment.[8]

In a recent AHA survey of chief executives, 98 percent of respondents agreed that, at least at some level, hospitals should investigate and implement population health strategies.[9] Echoing this, Michael Rowan, executive vice president and chief operating officer of Catholic Health Initiatives in Englewood, Colo., recently said that in an environment where "collaboration, preventive health, value-based purchasing and accountable care are the watchwords ... we're no longer focused predominantly on acute care services: instead we are managing the wellness of entire populations, which simply underscores the historic mission of Catholic health care."[10]

GETTING AT THE ROOT CAUSES

In many cases, community-based interventions are not unlike those for disease management. For example, implementing fitness programs in

a public housing development where residents have a high prevalence of obesity and pre-diabetes can prevent the onset of diabetes and mitigate other symptoms that are already present. But can community efforts move even further up the causal chain to stop risk factors from emerging in a population?

Healthy People 2020, the national 10-year agenda for improving the health of Americans, calls for precisely this. A new goal for the next decade is the creation of "social and physical environments that promote good health for all," it says. The aim to address the "social and physical determinants of health" is embraced by the World Health Organization and is also embedded in the National Prevention and Health Promotion Strategy, which is a comprehensive plan to increase the number of healthy Americans at every stage of life.[11] Decades of research show that effective economic, environmental, transportation, agricultural, social, political and other sectors play a significant role in creating the conditions that prevent risk factors from emerging.[12]

The County Health Rankings and Roadmap published by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation are a recent effort to measure the impact of social determinants. Based on the latest data publically available for each county in the country, the project ranks counties on both health outcomes (length and quality of life) and health factors, such as high school graduation rates, access to healthier foods, air pollution levels, income and rates of smoking, obesity and teen births. Not surprisingly, counties with low health outcomes rankings also have low health factor rankings. But these rankings can improve. Hospitals can use these rankings to understand which factors are in relatively poor standing for the counties they serve.

Montefiore Hospital, cited above, is one example of a hospital system that has a long history of addressing its local health determinants in an effort to promote good health. The Healthy by Design coalition in Billings, Mont., offers an example of two hospitals that recently became more deeply involved in local transportation infrastructure.[13] Led by St. Vincent Healthcare, the Billings Clinic and River Stone Health (the combined local and county health department), the coalition conducted a health impact assessment of the growth policy in Yellowstone County and the City of Billings. They found that making area roads safer for bicycle and pedestrian access had the potential to promote health by increasing physical activity, and they subsequently formulated a local "complete streets" policy encouraging street renovations to include accommodations for pedestrians and bicyclists. This policy eventually was adopted by the Billings City Council, and the coalition is monitoring its implementation.

COMMUNITY PARTNERSHIPS

Hospitals that until now have focused most of their community benefit dollars on charity care activities, or those that primarily have used hospital data to formulate prevention programs, may find it challenging to shift toward designing community prevention activities based on inputs like housing statistics, traffic incident reports, air and water quality measures and other community data. They may not be familiar with community organizations and government bodies working in these areas, or they may not have much experience in partnership activities.

But local and state health departments, other government agencies, businesses, community-based organizations, other health care providers and research institutions can help. Many will be eager to do so. In fact, consulting with outside groups is a requirement for the new community health needs assessments, and hospitals are explicitly allowed to base them on data and other information collected by public health agencies or nonprofit organizations.[14]

Can community efforts move even further up the causal chain to stop risk factors from emerging in a population?

Working with outside partners will bring new challenges, but this engagement also can present hospitals with opportunities to create partnerships to improve population health in ways hospitals would not be able to accomplish on their own. Methodist LeBonheur Healthcare (MLH) in Memphis, Tenn., is a system of seven hospitals and other providers that has developed a faith-based network of care called the Congregational Health Network (CHN). The network boasts more than 340 congregations supporting prevention efforts and out-of-hospital caregiving that the system could not offer directly.[15] Network pastors have been convened to create models for preven-

tion, education, ambulatory, inpatient and aftercare that start in the congregations, continue into the hospital system and then return back into the community. Congregation liaisons are trained to provide education on such issues as care for the dying, mental health, first aid, violence and handling suicide. Early data show significant savings to the health system for CHN members compared to nonmembers.[16]

It is important to note that programs seeking to advance population health, like those in Memphis and Akron, do not need to exist apart from a hospital's current activities. They can grow out of and support existing patient initiatives. For example, in Chicago's Humboldt Park neighborhood, Rush University Medical Center partnered with two other hospitals, an urban health research institute, a cultural center, an advocacy organization and a community health and wellness coalition to create the Community Diabetes Empowerment Center. The center is staffed by nurses and clinicians who answer clinical questions, and it offers educational programs as well as a test kitchen that hosts discussions of healthy food options. Rush Medical Center accepts patients referred from the center for ongoing care.[17]

EVIDENCED-BASED INTERVENTIONS

Community partners' guidance will be important both for completing the community health needs assessments and for creating action steps to respond to identified needs. Some key resources to help steer hospitals toward effective prevention interventions are listed on page 12.

State health improvement plans (typically prepared by governmental health department staff) also can be useful sources of information on regional and local health priorities as well as ongoing activities that hospitals and their partners may want to build upon. New York State, for example, is currently revising its state health improvement plan (known as The Prevention Agenda) for the period 2013-2017.[18] The plan reviews the current health status of New York State's population, proposes priorities for 2013-2017 and identifies strategies hospitals, local health departments and other sectors can use to achieve the priority health goals.

Philanthropic partners such as the W. K. Kellogg Foundation, the Robert Wood Johnson Foundation and community foundations across the country are funding initiatives to create healthier places and direct their applicants to sound community interventions.

TRACKING THE RESULTS OF COMMUNITY-BASED PREVENTION ACTIVITIES

Hospitals should document outcomes and evaluate the impact of their community-based prevention initiatives. It is true that demonstrating results in the short term may be challenging: Addressing the root causes of health problems can require time to yield an effect. Keeping track of process measures and interim data can therefore help justify maintaining a program from one budget cycle to another.

Dignity Health system in San Francisco and Thomson Reuters developed a standardized community need index to both identify community needs and track the impact of community benefit programming.

But data may also show beneficial outcomes sooner than expected. For example, many of Kaiser Permanente's community health initiatives, which include park refurbishment, grocery store improvement, cafeteria menu enhancements, workplace wellness programs and BMI screenings, showed positive results in only seven years. And 75 percent of the programs in Kaiser's Northern California region are likely to be sustained beyond the period of Kaiser Permanente funding.[19]

Precisely because of the challenges involved in tracking the impact of community benefit investments, Dignity Health system in San Francisco and Thomson Reuters developed a standardized community need index to both identify community needs and track the impact of community benefit programming. The index (available online for free use by communities across the U.S.) generates scores by Zip code on socioeconomic factors, such as unemployment, high school graduation and lack of insurance. and links these scores to rates of hospital utilization for ambulatory-care-sensitive conditions.[20] Using this information between 2008 and 2010, Dignity Health targeted $5.7 million of investment in preventive and disease management programs for patients who had been hospitalized for asthma, diabetes or congestive heart failure. As a result of this effort,

86 percent of the 8,917 program participants were not admitted to the hospital for the six months following their participation in the intervention program.

Dignity Health is currently developing another database to track and report service utilization for the National Prevention Quality Indicators created by the federal Agency for Healthcare Research and Quality. Their data on ambulatory care in a particular geographic area should indicate the quality of care outside the hospital setting and point to possible areas of intervention in the community while informing Dignity Health's understanding of health disparities in these areas.

Comparing and juxtaposing program data and community data can help determine whether a program extends broadly and deeply enough to have the intended impact. Successful initiatives may become models for other hospitals to adapt or be ripe for sustainable scale-up. The involvement of partners outside the health sector in community-based prevention is still relatively new, so data on the impact of new kinds of partnerships will be especially welcome to motivate and guide others.

Finally, evaluations that address both the financial and social returns on investment for hospitals and other key stakeholders involved in community health activities can help hospitals leverage limited resources for greater returns in the future.

OVERSIGHT OF PROGRAMS

Just as in the 1980s when hospitals created committees to oversee the quality of individual patient care, many hospitals are now creating similar mechanisms to oversee their community benefit programs. Subcommittees of a hospital's board of trustees, for example, can be created to provide guidance on priority setting and on the selection of evidence-based interventions. Most of the hospitals consulted in the development of this article have such committees. A board subcommittee can

THERE'S LOTS OF HELP AVAILABLE

Resources for prevention programs include:

COMMUNITY-BASED INTERVENTIONS

The CDC's *Guide to Community Preventive Service*s www.thecommunityguide.org/index.html.

The *Community Toolbox*, assembled by the Work Group for Community Health and Development at the University of Kansas. It includes links to databases of best practices http://ctb.ku.edu/en/default.aspx.

The National Prevention Strategy, www.healthcare.gov/prevention/nphpphc/strategy/report.pdf.

The New York Academy of Medicine's *Compendium of Proven Community-based Interventions* http://healthyamericans.org/assets/files/NYAM_Compendium.pdf.

Healthy People 2020, www.healthypeople.gov/.

The CDC's *Strategies Snapshot: Community Health in Action* provides specific examples of the use of Community Transformation Grant resources to promote tobacco-free living, active living and healthy eating and clinical and community preventive services, at: www.cdc.gov/communitytransformation/pdf/FINAL_CTG_StrategyReport-092012v2_TAG508.pdf.

The County Health Rankings and Roadmaps' "What Works for Health" is an online searchable menu of policies and programs focusing on factors that make communities healthier places to live, learn, work and play, at: http://www.countyhealthrankings.org/what-works-for-health

COMMUNITY BENEFIT PLANNING

A Guide for Planning and Reporting Community Benefit (2012 edition). Available for purchase at: https://servicecenter.chausa.org/ProductCatalog/Product.aspx?ID=2460.

Assessing and Addressing Community Health Needs (DRAFT) Available for purchase at: https://servicecenter.chausa.org/ProductCatalog/Product.aspx?ID=2335.

Beyond Charity Care: Mission Matters for Tax-Exempt Health Care
https://servicecenter.chausa.org/ProductCatalog/Product.aspx?ID=419.

TRACKING AND EVALUATING COMMUNITY BENEFIT

Catholic Health Association, "Evaluating Community Benefit Program Resources," www.chausa.org/evaluationresources/.

The County Health Rankings and Roadmaps
www.countyhealthrankings.org.

Dignity Health's *Community Need Index*
www.dignityhealth.org/Who_We_Are/Community_Health/STGSS044508.

provide perspective from outside the health care sector, establish target expenditure levels and incentives to senior management, help evaluate the long-term investment value of particular initiatives and propose linkages to existing efforts in the broader community.

Some hospitals may also consider providing board members with a regular opportunity to interact with community representatives. The community benefit committee of Summa Health System's board regularly consults with community residents and organization leaders to inform the board's direction on community benefit. In this way, community benefit programming can be better positioned to maximize its impact on both hospital patients and the community as a whole.

Nonprofit hospitals have the social capital to lay the foundation for community-based prevention and, now, the changes legislated by the ACA provide even more support for this work. By proactively supporting population health, hospitals and the nation stand to see great improvements in health and health system costs.

ANA GARCIA is deputy director, health policy; **ANNA POMYKALA** is special assistant to the president; and **SHARA SIEGEL** is policy associate; all at the New York Academy of Medicine, New York.

NOTES

1. Some examples of funded programs are included in the *CTG FY2011 Highlights* available at www.cdc.gov/communitytransformation/accomplishments/index.htm.
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3. PowerPoint presentation: www.cjaonline.net/events/annualConf/2012/cd2012/Files/Workshop_JANOSKY_BioInnovation.pdf.
4. See IRS Revenue Ruling 69-545, available at www.irs.gov/pub/irs-tege/rr69-545.pdf, and 2011 Instructions for Schedule H (Form 990) available at: www.irs.gov/pub/irs-pdf/i990sh.pdf.
5. IRS Notice 2011-52, available at www.irs.gov/pub/irs-drop/n-11-52.pdf.
6. Jeffrey Levi et al., *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (February 2009): 65 http://healthyamericans.org/reports/prevention08/Prevention08.pdf.
7. Jeffrey Levi et al., *F as in Fat: How Obesity Threatens America's Future 2012)* (September 2012) http://healthyamericans.org/assets/files/TFAH2012FasInFatFnlRv.pdf.
8. American Hospital Association and the Association for Community Health Improvement, *Managing Population Health: the Role of the Hospital* (April 2012): 3.
9. *Managing Population Health*, 7
10. Michael Rowan, "Radical Changes Demand New Skills," *Health Progress* (July-Aug 2012): 18.
11. For information about the National Prevention Strategy, see www.healthcare.gov/prevention/nphpphc/strategy/index.html.
12. For resources on the social determinants of health, see www.cdc.gov/socialdeterminants/.
13. See www.healthybydesignyellowstone.org/successes/.
14. IRS Notice 2011-52.
15. Teresa Cutts, *The Memphis Model: ARHAP Theory Comes to Ground in the Congregational Health Network:* 3, 5. On file with author.
16. Cutts, 12.
17. *Managing Population Health*, 15.
18. See www.health.ny.gov/prevention/prevention_agenda/health_improvement_plan/index.htm.
19. Jack Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* 27 (2008): 5.
20. Kaiser Permanente, *2010 Community Benefit Report:* 41. Available at: http://xnet.kp.org/newscenter/inthecommunity/2011/072711cb2010report.html.
21. See www.dignityhealth.org/Who_We_Are/Community_Health/STGSS044508.