Community Benefit in the Era of Health Reform

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Community Benefit Defined

IRS definition - The promotion of health for class of beneficiaries sufficiently large enough to constitute benefit for the community as a whole.

- Reference to a defined community suggests a population health orientation

- Determining the minimum size for the “class of beneficiaries” needed suggests accountability for a measurable impact.

IRS Rulings 69-545 (1969) and 83-157 (1983)
Areas for Improvement

• **Programmatic**
  - Small scale, poor design with most activities
  - Lack of coordination across programs / activities
  - Lack of infrastructure for program monitoring
  - Lack of community mobilization / leverage

• **Institutional**
  - Lack of infrastructure for governance/oversight
  - Lack of knowledge and understanding among leadership
  - Lack of formalized quality improvement mechanisms
  - Narrow, individual-based engagement
Evolution of National/State Policies

- IRS redefinition of charity 1969/83
- Local class actions in 70s
- Intermountain Health Care – 1985
- Two models of state statutes: UT & NY – 1990
- National congressional initiative (Roybal/Donnelly)
- Other state approaches TX, MA, CA, PN, NH
  - Commonalities and distinctions
- IRS Field Advisory 2001
- Yale-New Haven case (2005) – the game changer
- Congressional hearings (2006-2009)
- Illinois Supreme Court ruling on Provena
  - Next chapter - Grassley and Rush
- IRS 990 Schedule H
- National Health Reform and the coming change
Advancing the State of the Art in Community Benefit (ASACB) Standards

• Programmatic Goals
  – Improve health status and reduce health disparities
  – Strategic investment

• Institutional Goals
  – Establish CB governance infrastructure
    • Increased accountability and oversight
    • Clarity of function – transparency
  – Increase support & expand competencies
    • Attention to skills needed for quality
    • De-marginalize CB function
ASACB Goals

Shift the focus of the public debate

Ad-hoc approach represents poor stewardship.

Move from emphasis on inputs to outcomes and quality.

“It’s Christmas, Melanie. Have young Cosgrove go down to the street and give something back to the community.”
Near Term Potential Savings

• In 2002, half of Medicare beneficiaries treated for 5+ conditions, and accounted for 75% of Medicare spending.

• Estimated costs for preventable hospitalizations for 2004 were $29 billion, approximately 10% of total hospital expenditures.

• Readmissions on 18% of all hospital stays - $12B (80%) of which are potentially avoidable.
  Miller, M., Executive Director, Medicare Payment Advisory Commission, Report to Congress: Reforming the Delivery System, Testimony to Senate Finance Committee, September 16, 2008
Massachusetts: The Canary in the Coal Mine

- Charity care rolls dropping – How will NPHs fulfill their charitable obligations?
- Initial shortages of primary care physicians – examine CHT care coordination, scope of practice
- Section 44, Chapter 305 requires Special Commission on Health Care Payment “to examine alternatives to the FFS model, including, but not limited to blended capitation rates, episode of care payments, medical home models, global budgets…”
Community Benefit and Health Reform

Clinical Service Delivery

Community-Based Preventive Services

Primary Prevention
Community Problem Solving

PAYMENT MODELS
 Fee for Service
   - Episode-Based
   - Reimbursement
 Partial---Full Risk
   - Capitation
 Global Budgeting

INCENTIVES
 Conduct
   - Evidence-Based
 Procedures
   - Medicine
 Fill Beds
   - Clinical PFP
 ACOs

Expanded Care
   - Management
 Risk-adjusted PFP

Reduce Obstacles to
Behavior Change
Address Root Causes

METRICS
 Net Revenue
   - Improved
 Clinical Outcomes
   - Reduced Preventable
 Reduced Readmits
   - Hospitalizations/ED
 Reduced Disparities
   - Aggregate Improvement
 Reduced HC Costs
   - in HS and QOL

PUBLIC HEALTH INSTITUTE
New 501r Requirement: CHNA

• By the tax year that ends three years from March 2010, each hospital must “conduct” a community health needs assessment.
  
  – Must take into account input from persons who represent the broad interests of the community served, including those with special knowledge of or expertise in public health
  – Must be made widely available to the public
  – $50,000 excise tax if out of compliance in any tax year

• Each hospital also must adopt an “implementation strategy” to meet identified community health needs
Some Clarifications

• Joint Committee on Taxation:
  – The CHNA “may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more organizations, including related organizations.”
  – “To avoid the penalty, the [tax-exempt hospital facility] must have satisfied the CHNA requirements in 2011, 2012, or 2013.”
IRS 990 Schedule H

• “Describe whether, and, if so, how, the organization assesses the health care needs of the community or communities it serves.”

• Hospitals now also will need to disclose:
  - “how the organization is addressing the needs identified in each community health needs assessment and
  - a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed.”
IRS 990 Schedule H: Issues and Implications

- Gaps/Problems in CHNA requirements
- Dramatic increase in specificity in reporting
- Prohibit community building category, including
  - Youth leadership development
  - Social support systems
  - Environmental improvements
  - Physical infrastructure improvement

- Silent on priority setting; unmet needs requirement unintended consequences
- Greater transparency; opportunity for comparative analysis
- Significant implications; need for PH community engagement and advocacy
Imperative for Public Health Engagement

• **Overcome historical dynamics**
  - Negative view of hospital commitment to social mission
  - Lack of awareness of community benefit and opportunities
  - Denigration of programmatic quality/commitment
  - Doctrinaire view of hospital – public health responsibilities

• **Identify synergistic opportunities**
  - Build evidence-based framework for shared responsibility
  - Hospital investment in population health can help make the case for policy reform (e.g., shift away from categorical funding)
  - Increased leverage to secure conversion foundation support
## Key Challenges / Opportunities

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<thead>
<tr>
<th>Competitive model of CB</th>
<th>Geographic model of CB</th>
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<tbody>
<tr>
<td>- Fragmentation and inefficiency</td>
<td>- Multiplier effect</td>
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<tr>
<td>- Limited impact</td>
<td>- Shared accountability for outcomes</td>
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<td>- No sustainability</td>
<td>- Policy development opportunities</td>
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<td>- Lack of credibility</td>
<td>- Address obstacles to desired health behaviors</td>
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<td>- Minimal leverage of internal resources</td>
<td>- Build internal population health capacity</td>
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<td>- Limited ability to build population health capacity</td>
<td>- Support provider community</td>
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<td>- Threat to LT economic viability</td>
<td>- Thrive in capitated environment</td>
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East Oakland BHC and Hospital CB Programs
Opportunities for Alignment Between Public Health Quality Aims and Community Benefit
Population Health Metrics and Information Technology

• Opportunities
  – Move from institutional to geographic (population centered) approach to community benefit
  – Increased expectations for clear focus in communities with disproportionate unmet health-related needs to address disparities in access and quality (equitable)

• Challenges
  – Need in LPHAs for additional resources, internal capacity building and tools in order to be good partners
Exemplary Practices

• Regional Research Demonstration Taking CB to Scale (SF/Dallas)
  - Establish regional clearinghouse for detailed analysis and mapping of hospital utilization data* and social determinants
  - Engage FT Epidemiologist in SF DPH
  - Institute established at Dallas Hospital Council
  - Use evidence base as mechanism for shared, strategic investment by hospitals.
  - Supplement care management strategies with place-based collaborative investments in impacted neighborhoods

* With unique patient identifiers, by diagnosis, payer source, and institution
Systems Thinking

• **Opportunities**
  - Build a common platform for policy advocacy among LPHAs and hospitals
  - Secure funding for comprehensive interventions that are risk reducing and deepen local/regional collaboration
  - Increase *transparency* in decision making

• **Challenges**
  - Reductionist thinking at the federal level in funding research and programs
  - Lack of coordination across federal and state agencies
Exemplary Practices

• Bell Hill Initiative (UMASS Memorial Health System)
  – Problem solving approach to health improvement in diverse low income neighborhood adjacent to flagship medical center.
  – Central focus on affordable housing, youth leadership development, strengthening social support systems, and environmental improvements
Exemplary Practices

• Diabetes Wellness Center (Baylor Health Care System)
  - $15 million investment to renovate and expand historical youth development center in South Dallas.
  - Primary focus on creating opportunities for physical activity and nutritional knowledge and access.
  - 13% of residents diagnosed with diabetes; diabetes hospitalization 30% higher than citywide rate
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• ASACB standards, tools, and model programs available on website @ www.asacb.org