

Conference Report:

A Collaborative, Cross-Sectoral, and Local Approach to Health

On September 17, 2013, nearly 200 leaders from Minnesota organizations working in healthcare delivery, public health, hospital administration, and community services convened for a conference organized by the Institute for a Sustainable Future (ISF) to explore how the Affordable Care Act (ACA)'s requirements of deeper community engagement by hospitals can be leveraged to improve the public's health, decrease costs, and support community vitality.

The Public Health Law Center, in partnership with the ISF, has prepared these observations of some of the key lessons of the day as a tool for leaders across sectors to better understand opportunities afforded by the ACA and to consider local strategies that leverage these policy changes to promote better health across communities. The companion piece, *Perspectives and Next Steps in Creating a Healthier Healthcare System*, provides additional observations on the key lessons of the day.

"Real reform will remain zero unless action is taken close to home."

Don Berwick M.D., Former Head of Medicare and President, Institute for Healthcare Improvement

The Framework: A Commons Vision of Community Health

Jamie Harvie, P.E., Executive Director, Institute for a Sustainable Future, Cofounder of the Commons Health Network

Our notion of healthcare and health delivery is undergoing a period of significant change. Past, discrete approaches to disease treatment, health and human services, environmental protection and economic development are giving way to cross-sector strategies that consider the full range of factors that impact individual and community health. Importantly, these strategies are based on the recognition that health and healthcare is local. Underlying this framework are key "commons principles" that have gained traction as result of

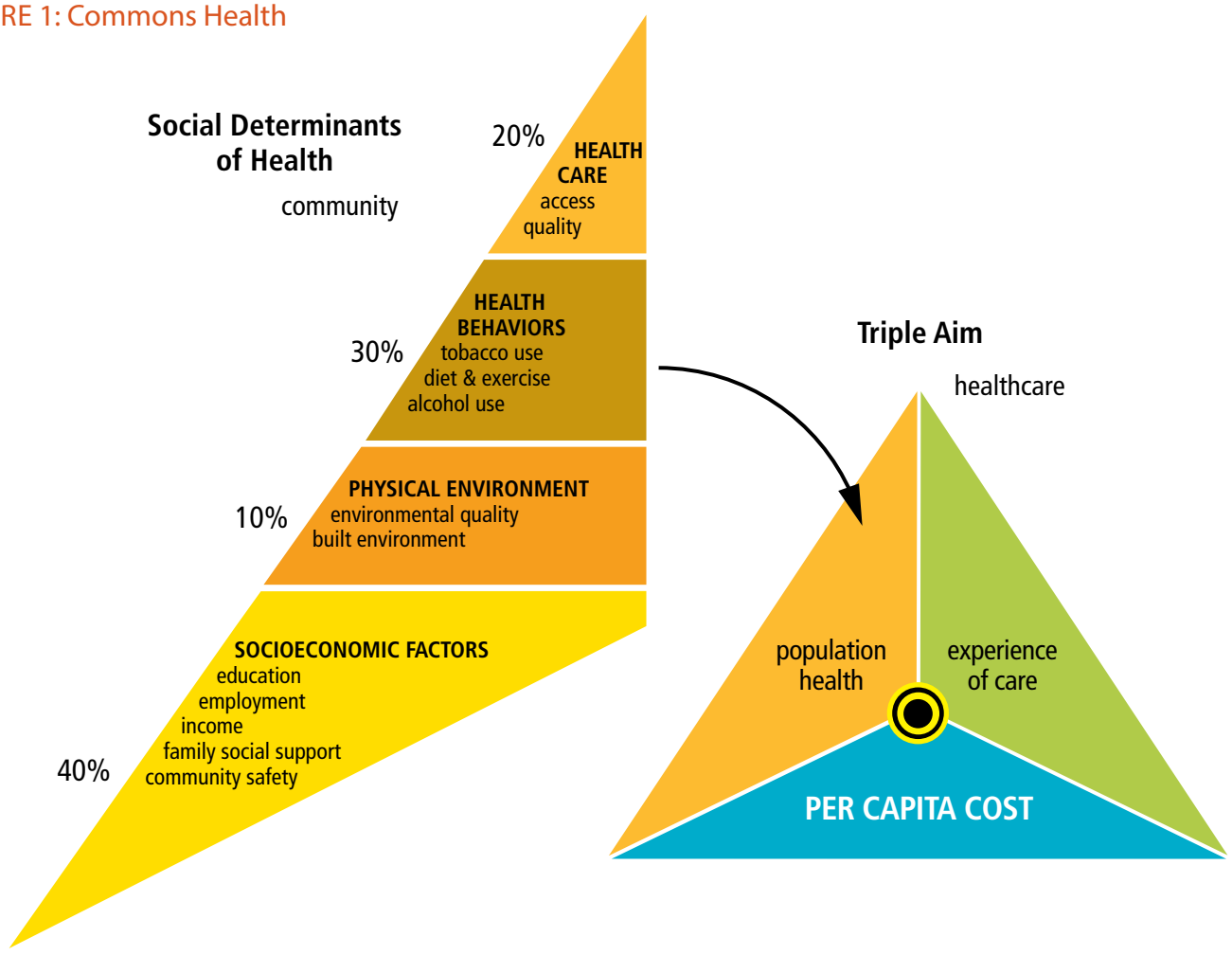
the Nobel prize-winning work of Elinor Ostrom. These principles are management rules which have proven effective in communities across the globe experiencing resource scarcity. They also have been successfully applied to control healthcare spending in a small subset of communities in an informal way.

With just 20 percent of health outcomes determined by the healthcare system,[1] leaders are recognizing that the system's "Triple Aim" of better care, healthier people and lower costs is dependent on the impact of social determinants on health. Factors such as where people live, where they work, and how they spend their time have a real and lasting impact on health outcomes and healthcare costs.

Health care leaders are recognizing that the system's "Triple Aim" of better care, healthier people and lower costs is dependent on the role social determinants play in health outcomes.

As a result, thought leaders across sectors are now beginning to look at collaborative, place-based strategies that view vital communities as a key part of health. These strategies strive to not only improve healthcare delivery, but also to promote access to quality education; healthy and affordable housing; safe, violence-free neighborhoods; healthy food; and livable-wage jobs.

FIGURE 1: Commons Health



Sources: University of Wisconsin Population Health Institute's County Health Rankings, www.countyhealthrankings.org; and the Institute for Healthcare Improvement, www.ihi.org. Figure 1 appears courtesy of the Commons Health Network.

Essential components for these place-based strategies include:

1. Clearly defining community by geography, rather than by social, consumer, or provider strata.
2. Fostering leadership for shared ownership of and accountability for health across sectors.
3. Creating integrated strategies that address the spectrum of what drives health, rather than communicating across siloed approaches.
4. Reinvesting accrued savings into future strategies that further improve community health and vitality.

The following sections are based on the presentations that were given during the conference. They are designed to be a tool for stakeholders of all perspectives to understand new and emerging opportunities to create health through a commons approach, and are not a compilation of verbatim summaries. We start with an overview of the policy environment that has created opportunities for new relationships between providers, public health, community-based organizations, and communities at large. Then, we summarize considerations and learnings about the pitfalls and potentials for data collection and sharing, the work and joys of human and institutional collaborations, and a vision of hospitals as anchor institutions for vital, healthy communities. Like the conference itself, this report concludes not with answers, but with questions and a charge to readers to continue the discussion within their communities.

Opportunities Presented by Federal Policy

1. Innovation Investments Will Pioneer New Care Models

Ellen Benavides, Assistant Commissioner, Minnesota Department of Health

Since the 2008 launch of statewide healthcare reform, Minnesota has been at the forefront of healthcare innovation with policies like Healthcare Homes and the Statewide Health Improvement Program (SHIP), which informed the ACA. Today Minnesota is building upon this history of innovation through implementation of MNSure, the state's health insurance exchange, and the State Innovation Model Initiative.

State Innovation Model Initiative

Minnesota was one of six states selected to pioneer new healthcare payment models under the federal State Innovation Model (SIM) grant program, receiving $45 million over three years to test healthcare payment and care delivery transformation models, as well as creating and supporting 15 Accountable Communities For Health. In accepting these grants, the state has committed to saving $111 million in healthcare costs over the same period: $90 million in savings is projected to come from Medicaid; $7 million from Medicare costs; and $13 million from the commercially insured market.

Accountable Care Organizations

The Department of Human Services (DHS) has contracted with six healthcare systems that are Medicaid Accountable Care Organizations (ACOs) — North Memorial Hospital, CentraCare, Children's Hospitals and Clinics, Essentia Health, the North Metro Alliance, and the Federally Qualified Health Center Urban Health Network (FUHN) (10 urban

This pioneering model is built on the vision of moving from a total-cost-of-care system to a "total investment in health" lens for improving the health of populations.

safety net clinics) — and with Hennepin Health, to implement the following elements:

- **Total-Cost-of-Care (TCOC) payments.** Under the new system, participating providers will receive a set total payment for providing treatment to an agreed upon Medicaid population. Providers will keep any savings if care costs less than the payment amount; if costs exceed the payment, providers would bear the loss.
- **Increased focus on prevention.** The TCOC model realigns providers' incentives from a focus on quantity (fee-for-service) to quality, as care delivery systems focus on improving the health of their members.
- **Integrated care and expanded care teams.** Providers will integrate primary/acute care with behavioral health, long term care and supports, public health, community and social services. They will also work as a team with a wider array of providers, such as community health workers, community paramedics, dental therapists, doulas, certified peer specialists and other types of emerging professions.
- **Data analytics and health information exchange.** Significant investments will be made to expand current information technology infrastructure to support data-sharing, health informatics and care coordination.

Accountable Communities For Health. In addition to the ACO investments, in the fall of 2014, 15 Accountable Communities For Health (ACHs) will be launched. During the fall of 2013, the Minnesota Department of Health and Department of Human Services began engaging representatives of stakeholder groups to help define "community" (through geography and/or population) and their visions of health. Ultimately, this pioneering model is built on the vision of moving from a total-cost-of-care system to a "total investment in health" lens for improving the health of populations.

TABLE 1: Shifting to a Commons Model of Health

Elements	Current system	Future system
Payment made	Fee-for-service	Total cost of care
Inherent incentive	Quantity treated	Quality of health
Population of concern	Patients seeking treatment	Communities (groups or geographies)

2. Hospitals' Community Health Needs Assessments (CHNA)

Dr. Kevin Barnett, MCP, Senior Investigator, Public Health Institute

Changes to tax-exempt hospitals' community benefit programs, which are required to sustain nonprofit status, offer another significant opportunity for cross-sector collaboration and community conversations about health. About 59% of hospitals in the United States are recognized by the Internal Revenue Service as nonprofit organizations.[2] Historically, community benefit efforts were anchored by charity care to uninsured and underinsured patients — write-offs that the ACA's insurance requirements and support are expected to eliminate.

Under the ACA, non-profit hospitals are instead expected to complete a Community Health Needs Assessment (CHNA) every three years. This federal

requirement builds off of laws in several states that required nonprofit hospitals to conduct assessments in connection with community benefit requirements. In addition, the relatively new Public Health Accreditation Board also requires local, tribal, and state health departments seeking accreditation to conduct or participate in collaborative, comprehensive, community health assessments and implementation plans at least every five years.[3] Thus, local, tribal, and regional health departments are natural partners in the CHNA process; indeed, the CHNA required by the ACA "must take into account input from persons who represent the broad interests of the community served by the hospital," including at least one state, local, tribal, or regional governmental public health department, as well as members of medically underserved, low-income and minority populations within the hospital's community, or organizations representing such populations.[4] Beyond these minimum requirements, hospitals are free to determine which partners to engage and how to define community — factors that will significantly impact what strategies are pursued and which investments are made, based on the CHNA's findings.

The real opportunity of the CHNA requirement lies in the processes of assessment and implementation: how hospitals build partnerships with local partners and how authentic collaboration is woven into the implementation process will ultimately determine its impact on improving community health.

As part of this assessment process, each hospital is required to submit a three-year plan to address the community health goals identified through the CHNA. Community partners who participate in the CHNA could contribute to the implementation strategy, and hospitals are expected to measure progress toward achieving their identified community health goals as part of annual reporting.

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Implementing Collaborative Approaches

3. Collective Impact: A Shared Vision For Public Health and Hospitals

Renee Canady, PhD MPA, Health Officer, Ingham County (MI), and Leslie Polack, Director of Health & Wellness at Sparrow Health System

Sparrow Health System and the public health departments of Clinton, Eaton and Ingham counties in Michigan offer a powerful example of how using a collective impact approach in the CHNA process can produce deep partnerships that impact community health. The integrated approach offered a win-win for the core partners managing new environments: hospitals faced a clear directive to approach community benefits from a new direction, and public health leaders sought new approaches to tackling health inequity. The collaboration, Healthy! Capital Counties, grew to more than 40 organizations under their leadership, and the process offered several invaluable lessons:

- **Collaboration takes new mindsets on all sides.** Sparrow Health System had to learn to "think outside the bed," treating people before they become patients rather than focusing on market share. Public health, likewise, had to see its work as a partnership of investment rather than seeing the hospital as an investor. These subtle distinctions meant a different relationship of parity that was new to the partners.
- **Lasting alignment is built around shared goals.** Compromise negotiations ("either/or") will not sustain shared ownership for a collective impact process. Honing in on the shared goals ("both/and") of all partners takes more work, but it ensures that the collaboration has the solid foundation needed to achieve these shared goals.
- **Reframing questions is essential to breaking new ground.** Reaching agreement on core questions is essential to creating new strategies with potential to produce lasting solutions. For the Michigan group, the vision was health equity and, as a result, questions were reframed from "Who lacks access to healthy food options and why?" to "What policy solutions would redistribute healthy food resources more equitably in our community?" New questions allowed the group to explore new strategies, and were essential to their success.
- **Engagement processes help refine quality over quantity of measurement.** In Michigan, partners held seven focus groups to gather input on the issues and measures considered for the CHNA. The results were used to hone in on which core issues to measure for the greatest impact, rather than producing a list of more questions to add to the assessment. The process of collaboration and refinement produced a CHNA that will help ensure all partners are accountable to each other for the same core outcomes, magnifying their potential for impact.

4. Hospitals as Anchor Institutions: Measuring and Contributing to Community Health and Vitality

David Zuckerman, Senior Researcher, and Steve Dubb, Research Director, Democracy Collaborative

Place plays a significant role in how long people live and how healthy their lives are. As one of the most common — and often large — anchor institutions, hospitals have the opportunity to play a leadership role in creating vital communities. For example, Minnesota's 133 hospitals employ more than 113,000 people and procure more than $7.5 billion in goods and services each year. As employers and economic actors, Minnesota hospitals are important anchor institutions for their communities.

Across the country, hospitals have leveraged their employment and purchasing power to better their communities. For example:

- **Procurement leadership: University Hospitals, Cleveland.** The health system recently completed a $1.2 billion expansion for which it voluntarily set a goal of spending 80% of project costs within 50 miles of Cleveland. Ultimately, University Hospitals exceeded its goal, making 92% of its purchases at local businesses, which in turn boosted the local economy.

- **Expanding affordable housing options: Mayo Clinic.** In Rochester, the Mayo Clinic partnered with the Rochester Area Foundation to lead the "First Homes Initiative." The effort developed 875 units of affordable housing. The units include over 200 units held in a community land trust, ensuring that Mayo's employees and the community would have access to affordable homeownership for years to come.

The Democracy Collaborative recently completed the Anchor Dashboard, a research paper derived from interviews with institutional leaders and advocates across the country. The Dashboard provides concrete measures for an institution's contributions to community health, economic vitality and environmental sustainability, with a specific emphasis on how such activities benefit low- and moderate-income communities.

The research that informed the Dashboard also yielded several important lessons for those working to measure actions of anchor institutions for community outcomes.

- **The perfect can be the enemy of the good.** Measurement is not a precise science, particularly when measuring institution-level impact. Effective community development efforts select the best possible measures among those available and consistently revisit progress on those measures over time, rather than allowing pursuit of a perfect measure to derail progress.

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- **Focus on what anchor institutions can control.** Operations (e.g. hiring, procurement), environments (e.g. safe streets and campuses), and partnerships are all actions that institutions can readily influence and have significant impacts on overall community vitality.

- **Measure what is important, not what is easiest to measure.** Anchor institutions must align benefit measurement to community goals and develop metrics that fit with these goals. In some cases, policy metrics (e.g., the presence of a community advisory board or the existence of a clear community partnership center "front door") can be as important as numerical measures.

In addition to these lessons, Dr. Kevin Barnett, Public Health Institute, also pointed out that hospitals' community benefit requirements are overseen by the same federal agency that oversees the banking industry's compliance with Community Reinvestment Act[5] requirements (the Internal Revenue Service). Both sets of requirements strive to ensure that these anchor institutions are putting their resources to work for the benefit of the communities where they are located, and could be leveraged together to amplify investments in community health and vitality.

5. Collaborative Infrastructure For Data-Driven Decision-Making

Cheryl Stevens, PhD, President and CEO, Community Health Information Collaborative

Advancing shared community health goals requires communication across partners on progress toward shared measures of health. Put simply, data sharing is at the core of managing successful integrated community initiatives.

Data sharing and electronic records management is also a significant and growing field within healthcare. The Community Health Information Collaborative (CHIC) in Northeastern Minnesota is one example of a cross-sector data-network designed to improve service and reduce cost across a network of providers. While the mechanics of data-networks are important, leaders of CHIC also noted three key oversight features that have sustained the project's success for more than a decade:

- **Founded in trust.** The partnership started in 1997 as a trust-builder for information exchange, and built participant confidence in the safety of electronic data. This foundation of relationships has been essential to creating and sustaining the CHIC network.
- **Common vision of one shared network.** The simple vision of one secure, vetted, trusted network for health information communication anchors all of the work of the CHIC network.

Anchor institutions must align benefit measurement to community goals and develop metrics that fit with these goals.

- **Shared governance.** Bringing stakeholders together for sustained trust and shared oversight keeps the technology network relevant and helps ensure quick resolution to issues that arise.

Another key issue with data collection is measurement. The process of selecting what to measure and how to do it can be as complex — or moreso — than developing the infrastructure and management systems for sharing the collected data. To help in this process, Community Commons has created a Community Health Needs Assessment tool kit to guide hospitals and community organizations through collaborative community assessments and select final, shared points of measurement, and provides readily accessible community-specific data on vulnerable populations.

Ultimately, like any collaboration, ongoing attention to the relationships that underlie information-sharing is an essential — and often over-looked — part of making data-sharing successful.

Continuing the Conversation

Communities and healthcare are both undergoing significant transformations. The challenge and the opportunity of these changes lies in the ability of leaders from public health, healthcare, community development, community organizations, social services and other sectors to come together around a shared vision for community health. The ideas, legal information and perspectives shared during the conference offer just a glimpse of what the path to achieving that vision could look like.

The conversations that took place at the conference are continuing within and across communities statewide. To further those conversations, we have created a companion "Perspectives and Next Steps" article that offers observations from the "Creating Accountable Communities For Health" convening. Slides from the presentations are available at www.commonshealth.org. We also list below some of the resources that were mentioned during presentations or that participants may find pertinent. But we know that the policy changes presented here are just a spark; it is up to leaders across Minnesota and nationwide — in hospitals, public health departments, community-based organizations, and more — to ignite these sparks with passion for new approaches to creating health.

"We share in the health of one another. Ultimately it is communities that are going to need to take responsibility to define their health commons, set goals and establish place-based solutions."

Jamie Harvie

Additional Resources

The Anchor Dashboard. The Democracy Collaborative has produced this dashboard, and companion research report, as a tool for hospitals, universities, community advocates and others to conscientiously evaluate how they direct anchor institution resources for community vitality. community-wealth.org/indicators

Commons Health. The Commons Health Network was established to grow and evolve shared knowledge, experience and communication around commons health, health beyond hospital walls. The Network recognizes that the health and resilience of individuals is intimately tied to the health and resilience of their communities and the ecosystems which support those communities. www.commonshealth.org

CHNA.org. This web-based platform was designed to help hospitals and other organizations better understand the needs and assets of their communities. The site includes health indicators commonly used, data visualization for common health indicators, and other tools for learning and comparison. www.chna.org

Community Indicators Consortium. The Consortium is an open, active learning network for people interested or engaged in the field of community indicators development and application. www.communityindicators.net/

Community Health Needs Assessment and Implementation Strategy Development. Best practices report from a public forum convened by the Center for Disease Control (CDC) in July 2011, along with expert interviews. www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf

Health Systems Learning Group. This workgroup of 43 health systems is committed to exploring how hospitals and health systems can positively impact health and community vitality. An executive summary of their learning to date is available at: www.methodisthealth.org/about-us/faith-and-health/research/learning-collaborative/

Healthy Healthcare. The Public Health Law Center has developed a series of resources to support efforts to improve the nutritional environment in healthcare and other organizations. www.publichealthlawcenter.org/resources/healthy-healthcare

Hospitals Building Healthier Communities. This Democracy Collaborative report describes how six hospitals in five cities are rethinking their economic and community engagement strategies. community-wealth.org/content/hospitals-building-healthier-communities-embracing-anchor-mission

Institute for a Sustainable Future. The Institute for a Sustainable Future is a nonprofit organization working to support and improve ecological health through advocacy, research and education. www.isfusa.org

Minnesota Healthy Communities. This project grows out of a collaboration between the Federal Reserve Bank of Minneapolis and Wilder Research. It is part of a broader partnership between the Robert Wood Johnson Foundation and Federal Reserve Banks to promote joint efforts by community development and public health workers to improve community health. www.minneapolisfed.org/community_education/mnhealthycommunities/index.cfm#about

National Association of City and County Health Officials (NACCHO). NACCHO has developed an online tool box and resource center for community health assessments and community health improvement plans. www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm

The Network For Public Health Law. The Network has created a new overview of Community Health Needs Assessments for local public health departments to learn about the law. www.networkforphl.org/_asset/fqmqxr/CHNAFINAL.pdf

On the Commons. The Commons Work webpage and online resource center showcases co-creative projects and innovative strategies for protecting the commons, such as water sources, food, farmland, and seeds. onthecommons.org/work/commons-network

ReThink Health (Rippel Foundation). The ReThink Health initiative serves as an incubator to support the emergence and application of new ways to accelerate the transformation of American health and healthcare. www.rippelfoundation.org/rethink-health/

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Endnotes

1 Adapted from University of Wisconsin Population Health Institute's County Health Rankings, www.county-healthrankings.org.

2 See U.S. Government Accountability Office, GAO-08-0880, Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements 8 (2008). The 59% does not include governmental hospitals (25%), some of which may qualify as non-profits and are required to follow relevant Internal Revenue Service regulations.

3 Pub. Health Accreditation Board, Standards and Measures Version 1.0, 9-19 (2011), available at http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf.

4 Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20,523, 20,523 and 20,541 (Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1 and 53).

5 Codified at 12 U.S.C. § 2901 et seq. (2013).