American Hospital Association™

Advancing Health in America

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35TH ANNUAL AHA RURAL HEALTH CARE | LEADERSHIP CONFERENCE

The Board's Role in Population Health Improvement and Community Health Outcomes

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SESSION OBJECTIVES

- Recognize the importance of the board in impacting community health;
- Identify key community health metrics; and
- Be informed to better engage community partners for improved health outcomes.

The Board's role is to serve as the governing body of the hospital or health system.

The board's focus should be:

- Fiduciary
- Strategic
- Generative

Governance as Leadership, Chait, Ryan and Taylor, 2005 John Wiley & Sons

High-performing boards understand the need for oversight, strategy, insight, and innovation to optimize their success

	Fiduciary	Strategic	Generative
Discussion questions of Core Work	• Is our hospital providing high quality, consistent, reliable care? • Are we financially sustainable and using our resources optimally? • Are we meeting the requirements of all regulatory and legal entities? • Do we meet our patient's expectations? • Are we functioning effectively as a board?	• Do we have a clear assessment of our strengths, weaknesses, opportunities, and threats as an organization? • Do we understand our market and what services it needs? • Do we have a medical staff development plan that ensures access to providers? • Do we have short-term and long-term goals that guide and inform our work?	• Do we have clear sense of mission, vision, and values? • Do we routinely question assumptions about the way we do our work? • Are we truly representing the organization to the community and representing the community to this organization? • Do we engage in open and honest debate and dialogue?
Key questions	What's wrong?	What's the plan?	What's the right questions?
Measures	Facts, figures, finances, reports	Strategic indicators, competitive analysis	Signs of learning and discerning

- *Sources: Hurtubise M, Goodine S. "Moving Toward a Generative Governance Model." London InterCommunity Health Centre.*
- *Brew A. "Strengthening Leadership and Governance for Nonprofit Boards." PwC Canada. February 23, 2015.*
- *"Using Generative Governance Principles for Better Boardroom Conversations." BoardSource. 2017. www.boardsource.org.*

High-performing boards take their responsibilities beyond the “four walls of the hospital,” understanding that our patients’ health depends on the population and community’s health.

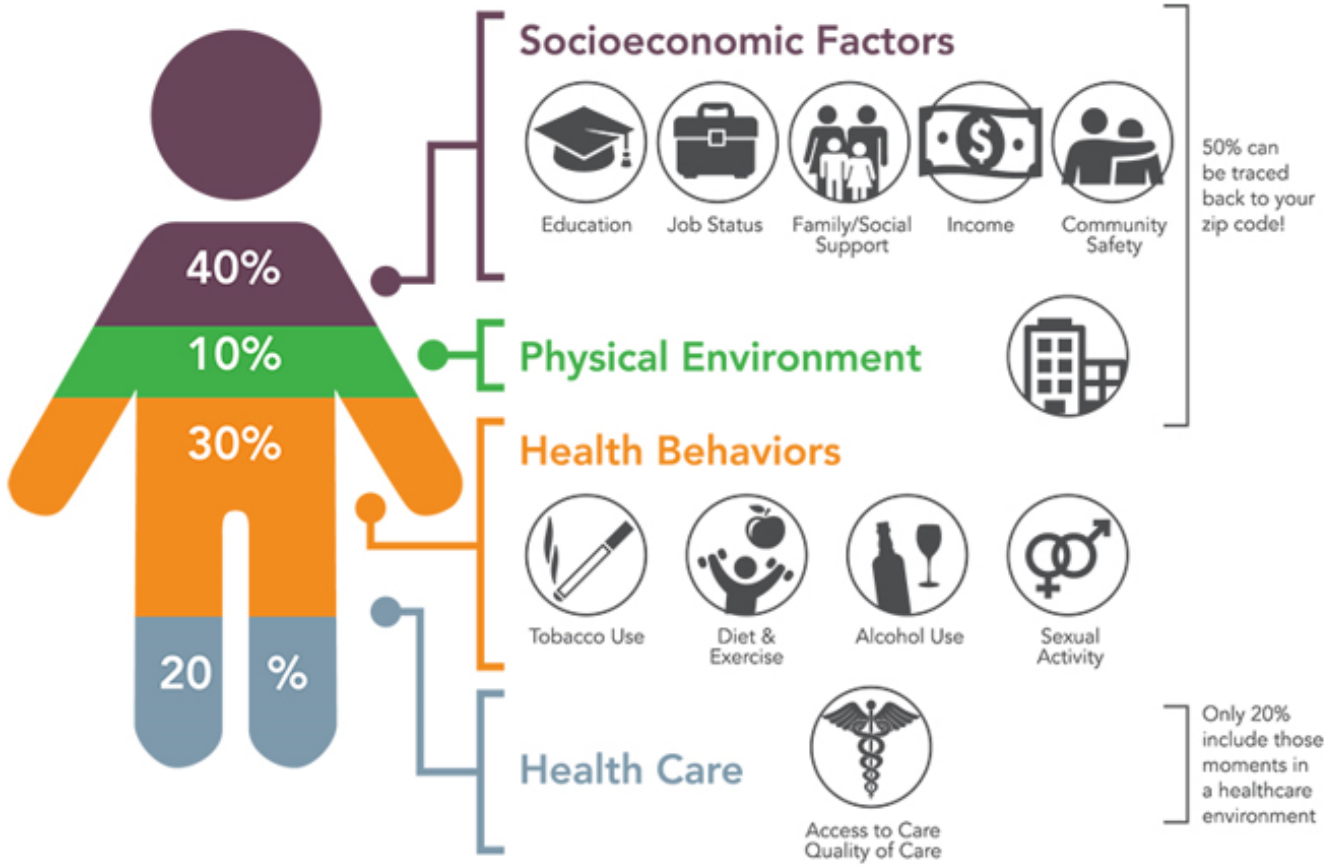
Where you live matters to your health…

Research shows that “although healthcare is essential to health, it is a relatively weak health determinant,” only making up about 20% of the factors that determine one’s health

Booske, et. al. 2010. County Health Rankings Weighting Methodology

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous effect on an individual's health regardless of age, race, or ethnicity.



SDOH Impact

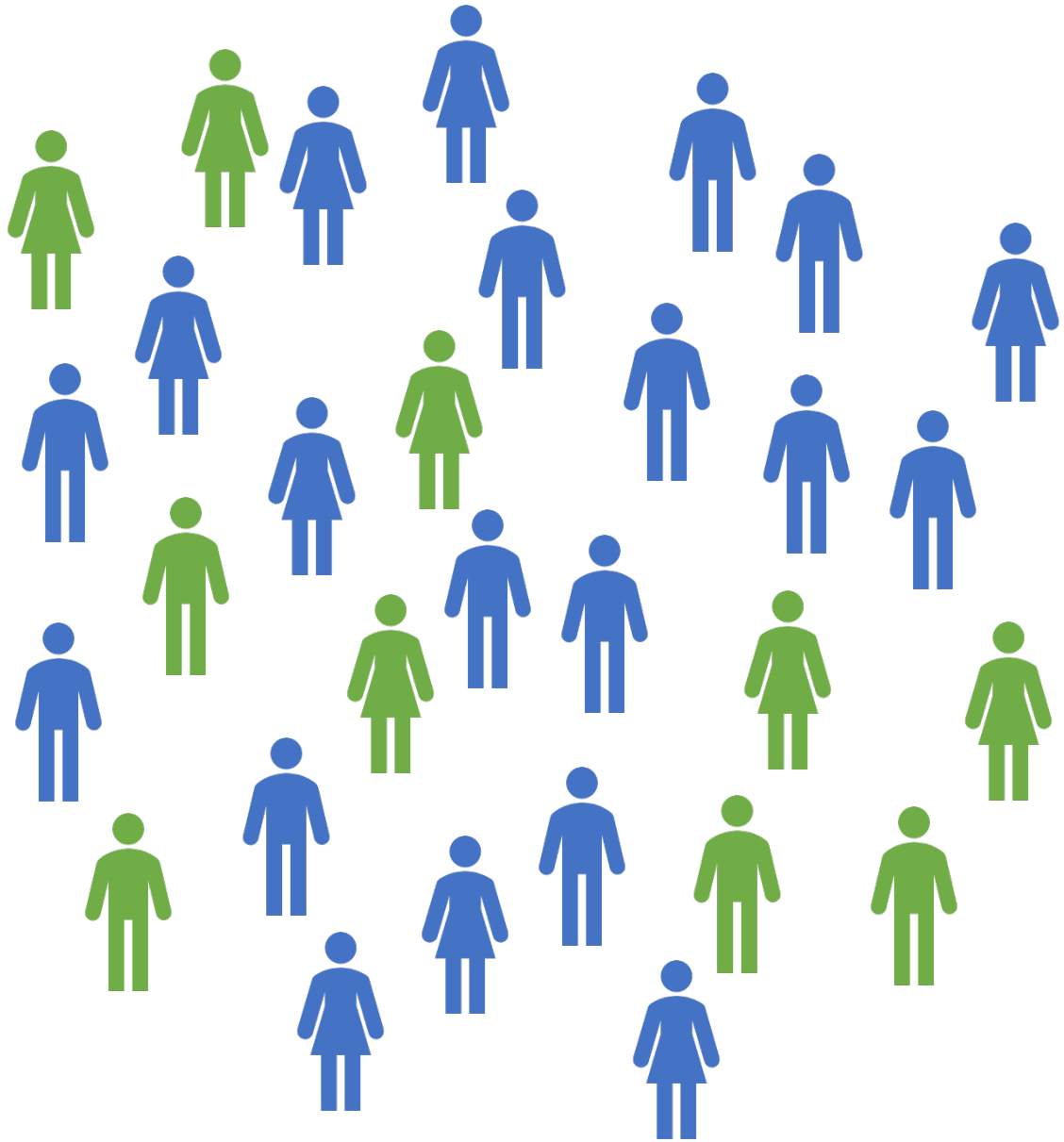
- **20%** of a person's health and well-being is related to access to care and quality of services
- The physical environment, social determinants, and behavioral factors drive **80%** of health outcomes

Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014) Graphic designed by ProMedica

Let’s start with population health…

In general, population health is defined as the health outcomes of a group of individuals distributed within the group.

- Quality of care
- Access to Care and Services
- Patient Experience
- Affordability
- Disease Management
- Care Coordination
- Prevention
- Physician Supply and Demand



Cost of COVID-19 to the state of population health

COVID CASES AND DEATHS BY RACE/ETHNICITY AS OF SEPT. 12, 2021

Race/Ethnicity	% population	% cases	% deaths
White	60.11%	51.0%	59.0%
Hispanic/Latino	18.45%	27.4%	18.2%
Black	12.54%	11.8%	13.8%
Asian	5.76%	3.1%	3.7%
American Indian/ Alaska Native	0.74%	1.1%	1.2%
Native Hawaiian/ Pacific Islander	0.18%	0.3%	0.2%
Multiple/Other, non-Hispanic	2.22%	5.3%	3.8%

"COVID Data Tracker: Demographic Trends of COVID-19 cases and deaths in the US reported to CDC," CDC, https://covid.cdc.gov/covid-data-tracker/#demographics. Accessed Sept. 13, 2021.

SINCE THE BEGINNING OF THE PANDEMIC, PEOPLE IN HISTORICALLY MARGINALIZED COMMUNITIES WERE:

- 48% more likely to have died from COVID-19.
- 28% more likely to have been diagnosed with COVID-19.
- 23% more likely to be in a COVID-19 hot spot.
- 17% less likely to have been tested for COVID-19.
- 8% less likely to have been fully vaccinated.

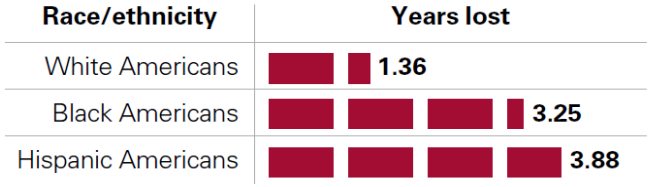
"The U.S. Covid Community Vulnerability Index," Surgo Ventures. precisionforcovid.org/ocvi. Accessed Sept. 27, 2021.

Cost of COVID-19

MAJOR DECLINE IN LIFE EXPECTANCY IN U.S.

- Life expectancy declined by nearly two years from 2018 to 2020, the largest decline since 1943.
- The U.S. mortality rate increased by 23% in 2020, experiencing 522,000 more deaths than normally would be expected.
- Average loss of life expectancy in the U.S. was nearly nine times greater than the average in 16 other developed countries, whose residents can expect to live 4.7 years longer than Americans.
- Americans died at younger ages during this period.

YEARS OF LIFE EXPECTANCY LOST



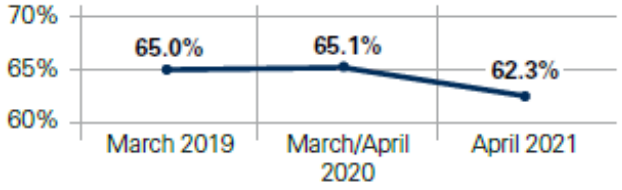
Szabo, Liz. "Black and Hispanic Americans Suffer Most in Biggest US Decline in Life Expectancy Since WWII," Kaiser Health News, June 24, 2021.

https://www.rwjf.org/en/library/interactives/whereyouliveaffectshowlongyoulive.html

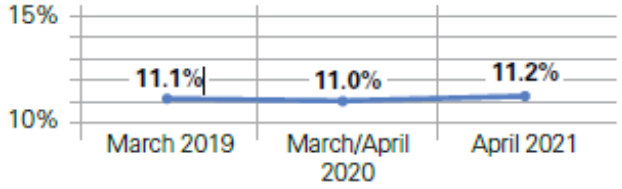
Cost of COVID-19 to the state of population health

HEALTH INSURANCE COVERAGE TRENDS AMONG U.S. ADULTS YOUNGER THAN 65

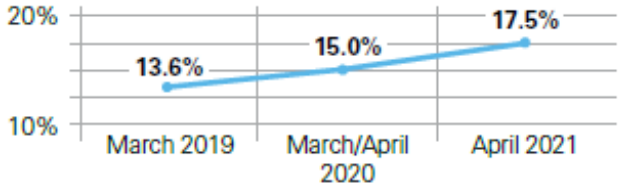
Employer-sponsored insurance coverage



Uninsured rate



Public coverage (Medicaid, ACA)



Karpman, Michael and Zuckerman, Stephan. "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased," The Urban Institute," August 2021.

PANDEMIC IMPACT ON HEALTH & LIFESTYLE

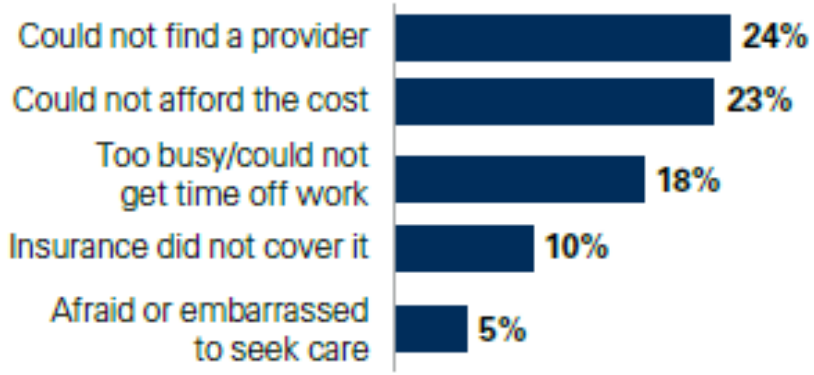
	% Increase: All respondents	% Increase: Men	% Increase: Women
Anxiety	37%	32%	40%
Stress	35%	31%	38%
Weight gain	33%	31%	34%
Nicotine	21%	28%	17%
Alcohol	20%	28%	15%
Opioids	10%	15%	7%

"The 2021 Health Care Insights Study," CVS Health, July 8, 2021.

ACCESS TO MENTAL HEALTH SERVICES

32% of adults say they needed but were unable to get mental health services from March 2020 to March 2021.

THE MAIN REASONS ADULTS DID NOT RECEIVE MENTAL HEALTH SERVICES



Kearney, Audrey. "Mental Health Impact of the COVID-19 Pandemic: An Update," Kaiser Family Foundation, April 14, 2021.

https://www.rwjf.org/en/library/interactives/whereyouliveaffectshowlongyoulive.html

Cost of COVID-19 to the state of population health

COVID-19 CUMULATIVE DEATH RATE PER 100,000 POPULATION

- All U.S. counties: **199 people**
- Nonmetropolitan counties: **227 people**

"COVID Data Tracker: Demographic Trends of COVID-19 cases and deaths in the US reported to CDC," CDC, https://covid.cdc.gov/covid-data-tracker/#demographics. Accessed Sept. 13, 2021.

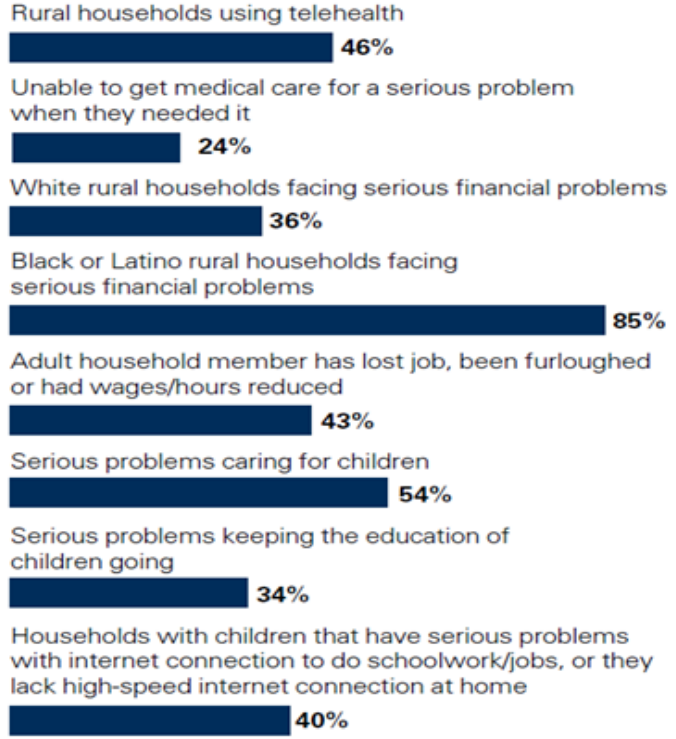
RURAL HEALTH ACCESS

- **28%** of rural Americans live in a county without a rural health clinic.*
- **6 out of 10** primary care health professional shortage areas are located in rural areas.*
- **47%** of rural hospitals have 25 or fewer staffed beds.†
- As of September 2021, **138 hospitals have closed** since 2010.‡

* "Medicaid and Rural Health Issue Brief," Medicaid and CHIP Payment and Access Commission, April 2021.
† "Fast Facts: U.S. Rural Hospitals," AHA Annual Survey Database, FY2015-FY2021, May 2021.
‡ "181 Rural Hospital Closures since January 2005," The Cecil G. Sheps Center for Health Services Research, https://www.shepscenter.unc.edu. Accessed Sept. 23, 2021.

PANDEMIC EFFECTS ON RURAL AMERICANS

Rural households were asked about their experiences during the pandemic



"The Impact of Coronavirus on Households in Rural America," NPR, Robert Wood Johnson Foundation, Harvard T.H. Chan School of Public Health, October 2020.

Cost of COVID-19 to the state of population health

CONSUMER USE OF TELEHEALTH

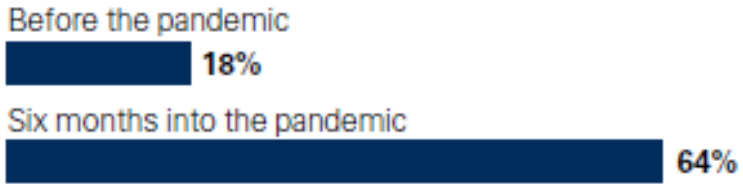
Surveyed U.S. adults who see a health care provider at least once a year (March 2021)

69% of U.S. patients report having seen a health care provider via telehealth since the pandemic began.

48% of U.S. patients would be likely to switch, or have switched, to a different provider if their current provider did not offer telehealth appointments.

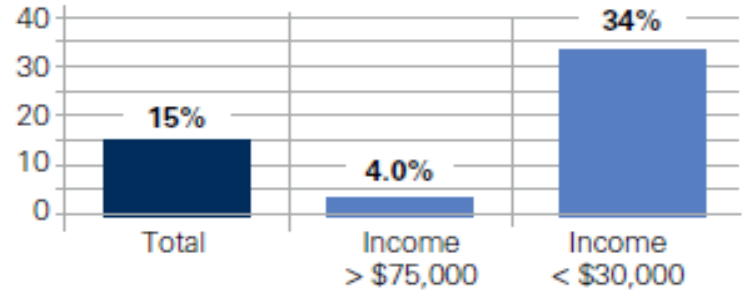
March 2021 NextGen survey conducted by The Harris Poll among 1,733 U.S. patients 18+. "National Survey Shows Online Access and Telehealth are Keys to Patient Loyalty," May 20, 2021. For further information on the survey, contact tstegmaier@nextgen.com.

MEDICARE PROVIDERS OFFERING TELEHEALTH:



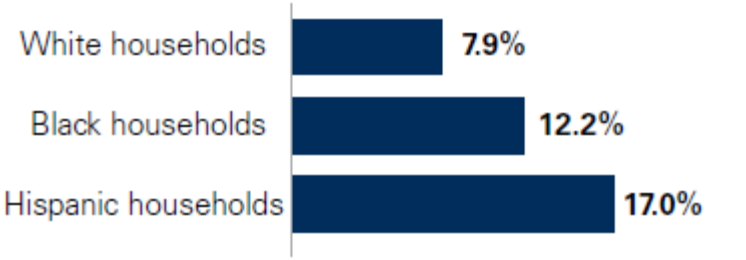
BROADBAND AFFORDABILITY

% of home broadband users who had trouble affording high-speed internet during the pandemic

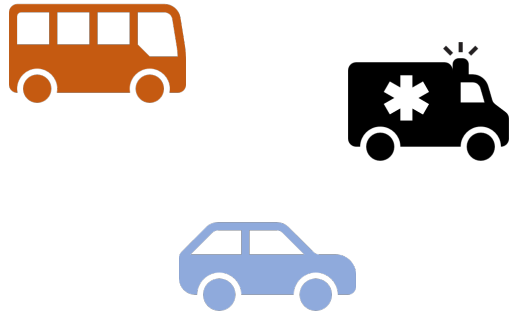


McClain, Colleen. "34% of lower-income home broadband users have had trouble paying for their service amid COVID-19," Pew Research Center, Washington, D.C., June 3, 2021, pewresearch.org/fact-tank/2021/06/03/34-of-lower-income-home-broadband-users-have-had-trouble-paying-for-their-service-amid-covid-19.

LACK OF COMPUTER ACCESS BY RACE/ETHNICITY



2021 State of Black America, "The New Normal: Diverse, Equitable, and Inclusive," executive summary, National Urban League, July 2021.



What is community health?

Community health is the collective well-being of community members. In addition to living in the same neighborhood or region, these populations often share health characteristics, ethnicities, and socioeconomic conditions.

What are the factors that impact or influence the community's health?

A Culture of Health

No one is excluded

Good health flourishes across geographic, social, and demographic sectors

Health care is efficient and equitable

Attaining the best health possible is valued by our entire society

The economy is less burdened by excessive and unwarranted healthcare spending

Families have the means and opportunity to make choices that lead to the healthiest lives possible

Keeping everyone as healthy as possible guides public and private decision-making

Business, govt, orgs, and individuals work together to build healthy lifestyles and communities

Everyone has access to affordable, quality care because it is essential to maintain, or reclaim health

Americans understand that we are all in this together

Adapted from: Robert Wood Johnson Foundation
www.rwjf.org/en/cultureofhealth/about.html


Focusing on the right things to improve health begins with understanding the population and community needs.

Moving upstream to Impact Health, Environment and Socioeconomic Drivers of Health

Public Health & Policy

Improve public health & structural determinants through policies, data, & community mobilization

Community Health

Improve access to universal primary health & social resources for defined geographic areas

Population Health

Improve outcomes for defined, usually high and/or rising risk patient/member populations

1. Manchanda, R. "The Upstream Doctors: Medical Innovators Track Sickness to Its Source," New York: TED Conferences, 2013.
2. Farmer, P. "Investigating the root causes" TED Blog, 2013. https://blog.ted.com/investigating-the-root-causes-of-the-global-health-crisis-paul-farmer-on-the-upstream-doctors/

Knowing What Our Community Needs

There are many ways to determine community needs.

Throw a broad net of assessment opportunities to ensure you are getting to the *real* needs of your community.

You are not going to tackle it all, but knowing more about the scope of needs will allow you to prioritize where to begin.

Community Health Strategies: First Generation

Community health needs assessment

Essential community partnerships

Organizational assessments and checklists

Hot-spotting

Excerpted from The American Hospital Association's report,
2016 Committee on Research: Next Generation of Community Health

Community Health Strategies: Second Generation

Collaboration with other healthcare providers

Community visioning

Predictive analytics and use of big data

National collaboratives

Excerpted from The American Hospital Association's report,
2016 Committee on Research: Next Generation of Community Health

Building Population and Community Centeredness

1. Utilize available resources and sources of information
   - Community Health Needs Assessment (CHNA)
   - State Health Plan
2. Make improving community health a focus of the board. Discuss population and community health at meetings.
3. Consider appointing a community health improvement committee of the board.
4. Support efforts to engage in conversations about community perception of health care needs and the hospital.
5. Establish relationships with social service entities and other community providers, such as skilled nursing facilities or home health agencies to support optimal patient outcomes and effectiveness of care across the continuum.

Building Population and Community Centeredness

6. Collaborate with others to positively impact legislation and regulation.
7. Champion community/population health among policymakers, elected officials and philanthropy.
8. Regularly assess clarity and “stickiness” of community benefit stories.
9. Focus on building community confidence and trust as part of the CEO’s role and regular evaluation.
10. Engage with independent medical providers and groups.

Engage in generative discussions

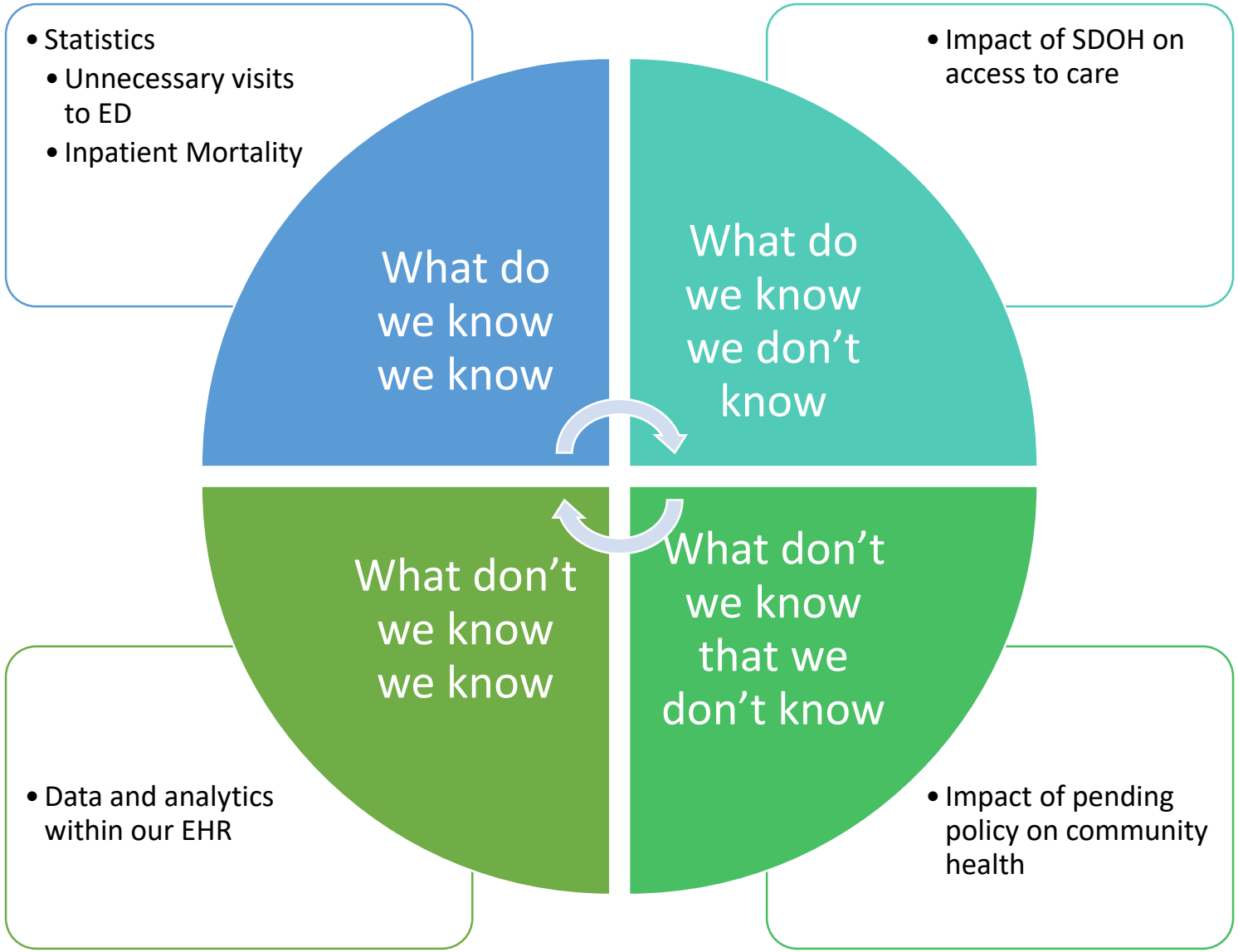
What are the drivers of good health and poor health in our community?

What needs are being overlooked?

How does our community encourage residents' health and well-being….poor health behaviors?

What other organizations or agencies in our community are doing this or similar work?

How can we partner with those groups for maximum impact to our community?



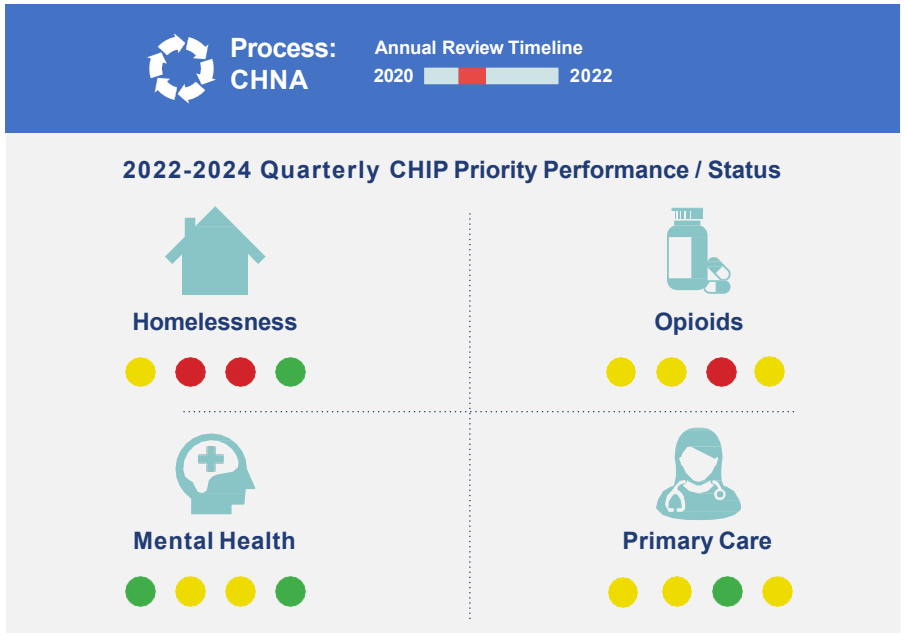
A Multitude of Potential Partners

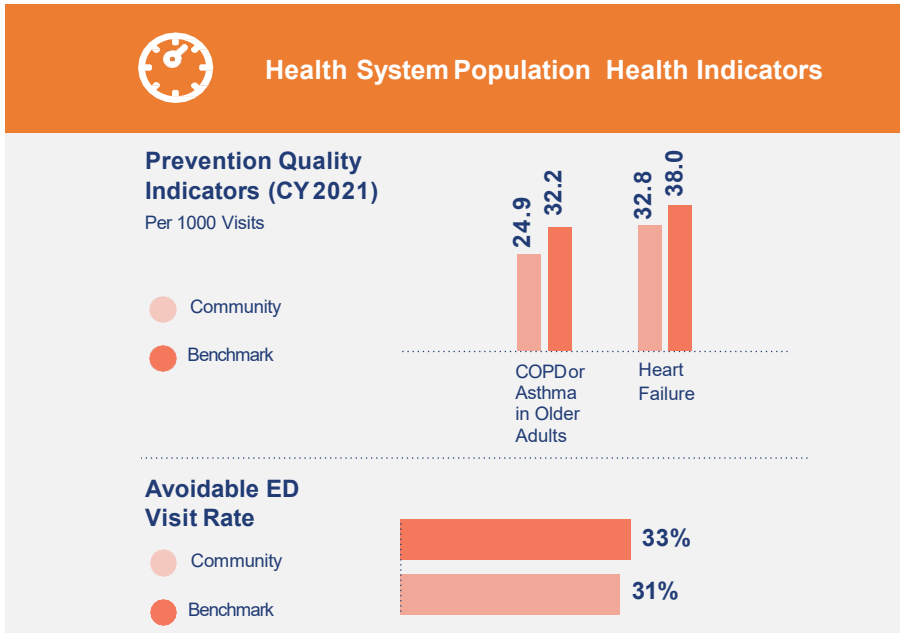
- **COMMUNITY ORGANIZATIONS**: Social services organizations, Salvation Army, food banks, parks, zoos
- **MEDICAL GROUPS**: Independent and group providers
- **EDUCATIONAL ORGANIZATIONS**: Early childhood centers (day care, foster care); primary, secondary and post-secondary (colleges, universities) schools
- **FAITH-BASED ORGANIZATIONS**: Temples, churches, mosques, other religious or spiritual congregations
- **HOUSING AND TRANSPORTATION SERVICES**: Homeless shelters, housing and land development planning commissions, transportation authorities
- **GOVERNMENT**: Local (municipal, city, county), state or federal (Dept. of Justice, Dept. of Agriculture, Dept. of Housing and Urban Development) government employees or organizations; prisons; fire and police departments; ambulance services
- **LOCAL BUSINESSES**: Chambers of commerce, grocery stores, restaurants, manufacturing organizations
- **PUBLIC HEALTH ORGANIZATIONS**: Public health departments, foundations and institutes
- **SERVICE ORGANIZATIONS**: Lions, Rotary, United Way, YMCAs, Boys & Girls Clubs
- **HEALTHCARE ORGANIZATIONS**: Other hospitals in the community, federally qualified health centers, community health centers, rural health or free clinics, mental health organizations, pharmacies, walk-in clinics, state hospital associations

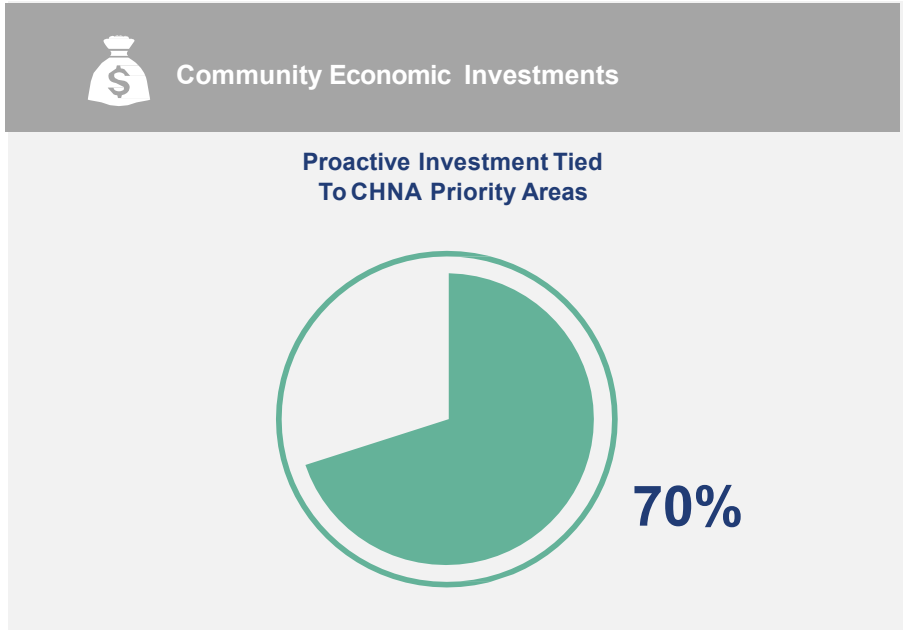
What gets measured gets done

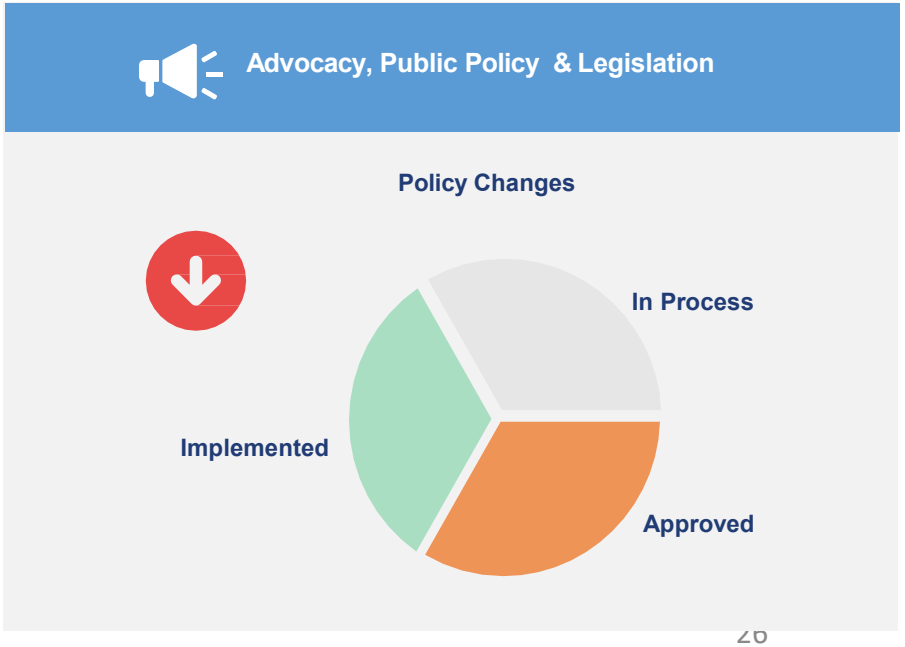
- Many boards are developing community health dashboards or integrating community health metrics into their quality dashboards
- The difference between community health metrics and the organization's quality performance metrics is often determined by the denominator (i.e., "the population" versus "our patients")
- Pay particular attention to the handful of metrics that may be included in both community health and quality oversight dashboards (e.g., avoidable readmissions, access to care/appointment wait times, avoidable emergency department visits, immunization rates, preventive care screenings)

Dashboard Monitoring









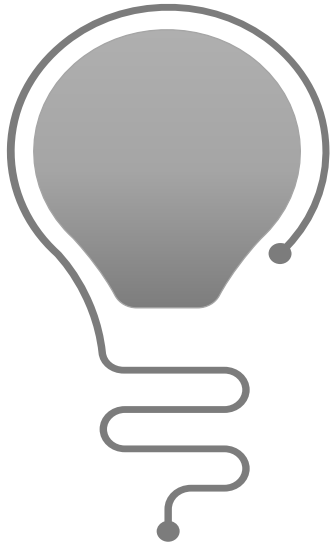
Examples of High Reach, High Impact Community Health Initiatives

Community Garden

Chesapeake Regional Healthcare, in coastal VA, created strategic partnerships to develop a community garden to improve nutrition and social interaction for low-income senior citizens.

Mobile Outreach

Baptist Memorial Health Care, in Memphis, operates a mobile health clinic and medical home to ensure free access to acute and primary health services for homeless residents.



Food Security

Nashville General Hospital opened a "food pharmacy" in February 2019. Grant funded.

Housing

Henry Ford Health System "Program of All-Inclusive Care for the Elderly" (PACE) to help low-income older adults age in the community instead of a nursing home.

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.”

Margaret Mead

Thank you

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