INSTITUTE FOR HEALTHCARE IMPROVEMENT

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SUMMARY REPORT: 90-DAY PROJECT

Population Health 3 (Part 1)
April 30th 2012

Executive Summary:

The Triple Aim is a transformational aim for our health system and now more than ever it is consistent with the needs of our country and others. We have made great progress, but no US region has yet transformed to achieve Triple Aim results. Since we can't predict where the breakthrough will come, we intend to support efforts at whatever stage they currently exist.

Based on our Triple Aim work with teams and communities, we recognize that there is a significant gap between a team's aspirational goals and what is achieved within the community around population health work. There is great potential for IHI to play a key role in helping communities identify and implement best practices to advance population health. This R&D 90-day cycle consisted of two parts: 1) Explore opportunities to work with communities on population health and 2) Develop a curriculum that can be used to support quality improvement capability in communities that are working on population health. This report consists of results from the first part. Work specifically involved reaching out to organizations that might like to partner with IHI, further developing a bridging strategy for population health in a region, and staying connected with community benefit and community assessment work.

The initial Triple Aim work with organizations was around defined populations, such as employers, or all the members of a health plan. Eventually, Triple Aim work expanded and evolved to focus on geographic regions. However, at a regional level it becomes more challenging to develop a robust set of projects that will accomplish the Triple Aim. Thus, a bridging strategy becomes necessary to move from a defined population to a geographic population. This report explores a bridging strategy, building upon a theory paper for IHI by Tom Nolan that describes three streams of work around the Triple Aim. The first stream is helping organizations develop and execute a robust portfolio of work. The third stream is focused on developing and executing a portfolio of Triple Aim work for an entire geographic region. The second stream is a bridging strategy between streams one and three, helping a community work on one area of health that is important to that community. As this report details, we recommend that the community consider three simple rules when choosing stream two work: the work must involve upstream determinants of health, health care must play a significant role in solving the problem, and the work on the specific condition must affect all persons in the community.

This report also explores community benefits, charitable obligations of non-profit hospitals as a condition of their tax-exempt status. Community benefit has recently come under greater attention through provisions of the Patient Protection and Affordable Care Act (ACA), which as of 2010 requires detailed reporting of community benefit program activities and a community health assessment at least once every three years in order to maintain tax exempt status. In an effort to

better understand the importance of community benefit reporting and how it might relate to Triple Aim sites this report includes data for a Triple Aim region derived from IRS 990 non-profit tax filings. Findings indicate wide variation in community benefit reporting across a region and the potential for better use of these resources to support sustainable progress on health in communities.

I. Research and Development Team:

- John Whittington
- Ashley-Kay Fryer

II. Intent:

The intent of this project is to continue to explore how IHI might be a help to communities that are working on improving population health. It will build off of the two preceding cycles of work that have been focused on population health.

III. Background:

The Triple Aim is a transformational aim for our health system and now more than ever it is consistent with the needs of our country and others. We have made great progress, but no US region has yet transformed to achieve Triple Aim results. Since we can't predict where the breakthrough will come, we intend to support efforts at whatever stage they currently exist. The recently completed CMMI Innovation Application process that drew more than 3000 applicants pushed health systems around the US to develop plans to improve the care and health of high-risk individuals. It explicitly required them to develop measures around the three aims: improve the health of the population, enhance the patient experience of care, and reduce per capita cost of care. In order to support this work IHI needs to continue to enhance its capability to support the Triple Aim.

Also, improving the health of a population is a key component of the Triple Aim. So far we have been engaging communities primarily around all three aims. We think there may be additional opportunities to work with communities that are not prepared to work on all three but instead would like to work on just population health. If we are going to do this we will need to connect with communities that want this help. We will need to provide technical assistance to them in a variety of ways. Based on the work we have done with communities for the last 18 months and supporting R and D work, we have developed an overall approach. This approach guides them through a series of steps down to the practical aspects of working on individual projects in a community.

Our impression at this time in talking with communities is that there is a significant gap between aspirational goals and what is achieved within the community around population health work. They generally lack: a guiding coalition that will coordinate across multiple agencies, sustainable funding, improvement skills, and a learning system among others. It is interesting that, when talking with communities, they often want help identifying best practice but seem to lack insight

on how much work it will require to implement those best practices. This is where we think IHI can be helpful, at the implementation and scale up of best practice.

During the last year we have outlined the following overall approach to helping communities work on all three aims.

Prework: This is the getting ready part where you introduce the ideas of the Triple Aim, understand the communities' readiness for this type of work, and inventory projects and resources that could be used in support of this work.
Develop a clear purpose around the Triple Aim.
Identify and possibly enhance a governance structure to support this work.
Identify a set of high-level Triple Aim measures for the community.
Identify a portfolio of initiatives and build the capability and infrastructure to support this work.
Develop an oversight and learning system to support the execution of each of the projects.

At the individual project level it is still necessary to have: leadership, sustainable funding, infrastructure to support the project work, quality improvement capability that includes knowledge about scale up and spread, project level measures, health equity issue and a clear communication strategy.

IV. Description of Work to Date:

In the initial charter for this project there were two main themes for this work:

1. Explore Opportunities to work with communities on population health.
   a. Reach out to organizations that might like to partner with IHI.
   b. Continue to stay connected with community benefit work and community assessment work.

2. Develop a curriculum that can be used to support quality improvement capability in the communities that are working on population health. This curriculum should cover at least the following topics but others will be added:
   a. Model for Improvement
   b. Development of measures for the Triple Aim
   c. Spread and scale-up
   d. Community activation
   e. Activation at the individual level

This paper is focused on item number 1. Andrea Kabcenell and her team focused on item number 2 and that is written up in a separate paper.

During this R and D cycle there were conversations or meetings with the following individuals:

1. Kitty Dana - VP of Health at National United Way
2. David Kindig - Emeritus Professor of Population Health Sciences, University of Wisconsin/ Madison School of Medicine and Public Health
3. Paul Stange and Dr Chesley Richards, both from the office of Prevention through Healthcare at the CDC
4. Kevin Barnett - CJA Board Member, Senior Investigator Public Health Institute
5. Tom Mosgaller - Director of Change Management, UW Madison
6. Carrie Marr - Director for Organisational Effectiveness, Tayside NHS
Dundee, United Kingdom
7. Greg Randolph - Director of the NC Center for Public Health Quality and an Associate Professor of Pediatrics and Adjunct Associate Professor of Public Health at UNC-Chapel Hill
8. Pennie Foster-Fishman, Ph.D. – Professor, Department of Psychology,
Senior Outreach Fellow Michigan State University
9. Steve Galen - President and CEO PCC
10. Kristen West - Vice President, Grant Programs, Empire Health Foundation
11. Site visit to Community Health Plan in Tallahassee with John Hogan, Tom Glennon and Nancy Vanvessan

Also, multiple individuals at the IHI Triple Aim face-to-face meeting.

V. Results of the 90-Day Scan:

Section 1a. Bridging strategy for Population Health in a region

When we started the Triple Aim we recognized that it would be a major challenge to bring it to success. Our initial work with organizations was around defined populations such as employers and all the members of a health plan. We eventually evolved to focusing on geographic regions. However, once we get to a region it is very hard to develop a robust set of projects that will accomplish the Triple Aim. We need a bridging strategy to move from defined populations to geographic populations. This work will discuss this bridging strategy.

A recent Triple Aim theory paper for IHI by Tom Nolan describes three streams of work around the Triple Aim. Work-stream one is focused on helping organizations develop a robust portfolio of work and executing it to manage the three aims for a defined population. Work-stream three is focused on developing a portfolio of Triple Aim work for an entire geographic region. Work-stream two is a bridging strategy between the other two streams. Its focus is to help a community work together on the one area of health that is important to that community. We recommend that the community consider three simple rules when they choose this area of work: 1. It must involve the upstream determinants of health. 2. Health care has to play a significant role in solving this problem. 3. You must plan to work on this condition for all affected persons in a community.

In that same paper Tom Nolan states, “Achieving the Triple Aim in a region is the approach that is most consistent with the needs of society.” So far we have seen great examples of Triple Aim work

accomplished for defined populations such as employees of a company or members of a health plan. We have yet to see the Triple Aim robustly accomplished at the regional level in a way that will impact all three aims. Although this is needed, our present strategies have yet to achieve it. In order to tackle the Triple Aim at a regional level, intent to accomplish this work at scale on all three aims for a significant majority of the population is necessary. That requires building a very robust coalition at the community level that can endure for many years. If that is not hard enough, you will need to change the business model of health care itself to get health care cost under control. No amount of health promotion or great chronic disease management is likely to control health care cost without the intent of the health care systems to control cost and the development of financial mechanisms to control cost.

Working at scale for a geographic region will require reaching all of the population. This is a significant undertaking for even one condition. Health care as presently designed seems to do a reasonable job of reaching a majority of the population, but there is a significant component that is missed. Even in societies that have no significant barriers to health care access there are still many other barriers to good care: language, culture, behavior, transportation and clinical variation. It is only when we take a comprehensive community-based approach that we can reach all of the population even for one health condition. That requires a new design that will involve community activation.

Therefore, based on years of work with the Triple Aim, we decided that a bridging strategy is needed to move from defined populations to entire populations based on geography. Workstream two asks a community to identify a health issue which is important to it. We suggest again that these three rules are taken into consideration: 1. It must involve the upstream determinants of health. 2. Health care has to play a significant role in solving this problem. 3. You must plan to work on this condition for all affected persons in a community. The reason that we are asking health care to be deeply involved is to help them understand the value of improving health at scale for a community and to bring their resources to the table. In many communities throughout the US, health care represents the dominant economic sector for that community. At the same time we see that the medical model cannot solve problems alone and that you need to work on the upstream determinants too.

Here are potential examples of health problems for a community:

- Hospital admissions for asthma in children
- Premature birth
- Undiagnosed hypertension
- Chronic disease with mental health co-morbidity
- Frail elderly

In talking with communities that have worked on health issues for the entire community, some have recommended working on specific populations like the very young or very old. So whether

you are working on the very young, the very old or chronic disease, for example, the idea is to improve the health status for all individuals in a community who have this characteristic.

During the last 6 months IHI has spent time exploring the issues surrounding improving health for a community. On David Kindig's Population Health Blog, Whittington and Kindig wrote the following on 11/16/2011 based on R and D research:

"Over time, the Triple Aim focus has expanded from working with small population groups and adopted a broader, more regional focus. As we move forward with strengthening our regional approach, we're asking ourselves, "What would it take to accelerate and sustain collective action on a population health project in a region that must coordinate with multiple agencies?"

We're now testing a new approach to regional population health projects that's based on what we've learned from existing Triple Aim sites, along with helpful guidance from Kania and Kramer's 2011 article, Collective Impact. We have been working with a number of developing Triple Aim regional communities in Cincinnati, Ohio; Jackson, Michigan; 14 counties in east central Michigan; and 16 counties in North Carolina. We consider the following elements to be essential, based on our research and experience to date.

** Adaptive Leadership -- Having the ability to see the big picture and galvanize that group around a set of clear aims.*

** Community assessment -- Gaining an understanding of resources and needs. Who is already working in this project space? What should we know about the needs of those who will be served by the effort, including which existing agencies and services are most utilized?*
** Infrastructure to support the project work -- Meeting demands for core infrastructure elements, including project management, data management, quality improvement advising and logistical support.*

** Unified language and approach -- Finding ways to harness, create shared meaning, and ultimately synergy among partners' diverse training and real world experiences.*

** Measures -- Selecting and monitoring a set of high-level measures that can be used to gauge progress toward aims.*

** Funders -- Working deliberately and strategically to build relationships with funders to support overall project goals.*

** Health equity -- Ensuring that the approach addresses needs of high risk populations. In our work to so far, key challenges have included patient management and care coordination, economic or social factors, and patient and family involvement (such as for chronic disease self-management).*

** Communication -- Maintaining open lines of communication among partners and with key external entities such as the media.*

The elements listed above are being employed in a wide range of initiatives addressing issues such as infant mortality, childhood obesity, adult obesity, care coordination and other population health issues. We see promise in this approach and are interested in connecting with people in communities across the country that have an interest in engaging in this type of work.

http://www.improvingpopulationhealth.org/blog/2011/11/triple-aim-accelerating-and-sustaining-collective-regional-action.html

In the end the key is whether a community can execute their project across multiple sectors to accomplish their desired outcomes. To do this they will need a learning system that uses something like The Model for Improvement, sequential learning over time or the ability to learn while scaling. In addition, they will need sustainable funding to support this work on an ongoing basis.

Section 1 b. Hospital Community Benefits and Community Health Needs Assessment in a US region.

Section 501 c 3 of the Internal Revenue Service (IRS) Code exempts organizations that are organized and operated exclusively for religious, charitable, scientific or education purposes from various taxes, including federal , state, and local income taxes, as well as property taxes. In 1969 the IRS created a provision broadening the term "charitable" to include "promotion of health," thus defining the charitable obligations of non-profit hospitals as a condition of their tax exempt status.

Community benefit has recently come under greater attention through provisions of the Patient Protection and Affordable Care Act (ACA), which as of 2010 requires detailed reporting of community benefit program activities by content category in the revised IRS form 990 Schedule H. Under the ACA, each hospital, whether independent or in a system, is required to conduct a community health assessment at least once every three years in order to maintain its tax exempt status and avoid an annual penalty of up to $50,000. The first needs assessment will be due by the end of the hospital's fiscal year 2010.

The various new reporting requirements for hospitals stem from long-held perceptions that some hospitals who are receiving tax exempt status are insufficiently charitable. Over the past two decades nonprofit accountability has come under great scrutiny, and many states have adopted state-specific reporting requirements for nonprofit hospitals.

Bradford Gray and Mark Schlesinger have written a paper delving into Maryland's experience of requiring nonprofit hospitals to submit a standardized annual community benefit report.[i] Gray and Schlesinger interviewed 20 hospitals and describe how Maryland's requirements affected hospitals

and their activities, providing a useful analysis of what issues and challenges may arise under the national community benefit requirements under the ACA. They outline a few lessons from the Maryland required-reporting-experience including, to name a few, the significant learning curve among hospitals, reports containing the potential for misunderstanding, benefits of reporting via a competitive feedback loop among hospitals, community expenditures being undercounted, and extensive variation across hospitals.

As this R&D project is part of the Triple Aim portfolio, we have sought to better understand the importance of community benefit reporting and have examined reporting among hospitals in particular Triple Aim region which we will leave unidentified. We are able to compare results among this small sub-set of hospitals within a Triple Aim region with results found across Maryland, as reported in Grey and Schlesinger's article, results found across Wisconsin, as reported in an article by David Kindig and Erik Bakken, and results reported by the IRS across 487 hospitals nationally.

Data from the Triple Aim region were derived from electronic copies of the 2010, IRS 990 non-profit tax filings from the website of Guidestar, a research organization for non-profit information. Eighteen reports were identified out of the 24 hospitals in the Triple Aim region. There are seven categories of allowed community benefit activity reported on the 990 filings. These are defined in IRS guidelines as follows:

- *Charity care at cost*
- *Unreimbursed Medicaid*
- *Unreimbursed costs—other means-tested government programs*
- *Community health improvement services and community benefit operations* include activities or programs subsidized by the organization for the express purpose of community health improvement, documented by a community health needs assessments or requested by a public agency or community group
- *Health professions education* includes the net cost associated with educating certified health professionals
- *Subsidized health services* are clinical inpatient and outpatient services
- *Research* includes the cost of internally funded research as well as the cost of research funded by a tax-exempt or government entity
- *Cash and in-kind contributions to community groups* include contributions to community benefit activities made by the organization to health care organizations and other community groups

Table 1 is a summary table and shows that, overall, $83,505,238 was reported as Community Benefit by non-profit hospitals in the Triple Aim region in 2010. This represents, on average, 4.75% of total expenses, and ranged from 0% to 9.04% across the 18 forms examined. This table also displays the total amount and percentage of expenditures reported across the seven allowable categories. It can be seen that the three largest amounts are for unreimbursed Medicaid ($55,259,052), health professionals' education ($12,210,235), and charity care ($10,431,532). Appendix 1 of this report shows the individual 18 hospitals examined in the Triple Aim region.

Table 1

Triple Aim Region Community Benefit Totals	Total (dollars)	Average Percent (of total expenditures)	Percent Range	
			Min	Max
Charity care	10,431,532	0.75%	0.00%	4.33%
Unreimbursed Medicaid	55,279,052	3.80%	0.00%	7.98%
Other means tested government programs	0	0.00%	0.00%	0.00%
Community health improvement services	3,004,739	0.29%	0.00%	1.06%
Health professionals education	12,210,235	0.22%	0.00%	1.59%
Subsidized health services	115,333	0.02%	0.00%	0.24%
Research	513895	0.01%	0.00%	0.20%
Cash and in-kind contributions	821,552	0.05%	0.00%	0.20%
Community Benefit Total	83,505,238	4.75%	0.00%	9.04%

In Maryland, Gray and Schlesinger examined the community benefit reports of the state's 45 nonprofit acute care hospitals. Results reveal that Maryland hospitals provided $1 billion in total community benefit in FY2010. Because about $380 million were included in hospital rates for uncompensated care, graduate medical education, and a nursing support program, net annual community benefit contributions were about $620 million, or 4.85% of total expense.
For a comparison within a national context, we are able to look to a study by the IRS, who in 2006 and 2007 examined the community benefits as reported in 990 forms for 487 hospitals.[ii] The mean community benefit expenditures reported by the hospitals, as a percentage of the individual hospital's total revenues, was 9%, and the median was 5%. Uncompensated care accounted for 56% and included charity, shortfalls in Medicare and Medicaid. After uncompensated care, the next largest categories of expenditures reported as providing community benefit, were medical education and training (23%), research (15%), and community programs (6%).
The new provisions of community benefit reporting under the ACA are heralding a new era of accountability for nonprofit organizations and will have an important impact on hospitals and communities that IHI may wish to further explore.

VII. Conclusions and Recommendations:

The immediate future of the Triple Aim will be the pursuit of work-streams: defined populations, regional populations and a bridging strategy that works on one health condition for all. These

work-streams have been described in this paper and are now embedded into the plan for the Triple Aim collaborative.

The focus of this R and D work has primarily been on developing opportunities for IHI to pursue our bridging strategy of work on a health issue in a region. The following opportunities are now under discussion:

1. Communities joined in action under the leadership of Steve Galen and Kevin Barnett made a proposal to IHI for working with them in their community. This is now undergoing further discussion.

2. Significant conversations occurred with Kitty Dana at United Way on the possibility of working in communities with them.

3. Early talks were held with Paul Stange at CDC around the work he has been leading on community assessment. John Whittington was invited to be part of an ongoing advisory team to support this work for the CDC. In addition there may be other opportunities to partner with the CDC in the future.

4. We will continue to connect with David Kindig and the Population Health Center at the University of Wisconsin. During this wave of work we discussed and shared work on community benefits. We developed an analysis of hospitals in one of our Triple Aim regions and may do this for other communities.

VI. Open Questions:

VIII: Appendices:

See document titled Appendix 1_Community Benefit Table (Unidentified)

[i] B. Gray, M. Schlesinger, "The Accountability of Nonprofit Hospitals: Lessons from Maryland's Community Benefit Reporting Requirements." Draft paper December 22, 2007, sent to John Whittington.

[ii] Executive Summary: Hospital Compliance Project Interim Report, Internal Revenue Service. Accessed on April 20, 2012. Available at <<http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report__execsummary_072007.pdf>>