SATISFYING NON-PROFIT HOSPITALS' COMMUNITY BENEFIT OBLIGATIONS BY TARGETING POPULATION HEALTH PROGRAMS IN PARTNERSHIP WITH DISTRIBUTED AMBULATORY PRACTICES: THE RESULTS OF A MIXED METHOD STUDY

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A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctorate of Public Health in the Department of Health Policy and Management in the Gillings School of Global Public Health.

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ABSTRACT

Lisa H. Ozaeta: Satisfying non-profit hospitals' community benefit obligations by targeting population health programs with distributed ambulatory practices: The Results of a Mixed Methods Study
(Under direction of Mark Holmes)

The findings of this study indicate that reimbursement reform will drive population health efforts by hospitals. Until there is a financial imperative to improve the health of communities, hospitals are more likely to focus on their historical business model. However, once the financial case can be made, hospitals are willing to move toward activities that seek to improve population health. Even as hospitals seek to develop population health programs, there remains many silos between hospitals and ambulatory physicians, which make effective partnerships challenging. The findings of this study include:

1) Health reform and new payment models have started discussions about population health, but have not affected reimbursement significantly enough to cause most hospitals to fully embrace population health programs.

2) Hospitals rely on community partnerships to address the community health needs that cannot be addressed in the hospital.

3) There is not an effective link between the community benefit office and community physicians that promotes cooperation in designing and implementing programs that affect population health.

4) In order for community benefit offices and community physicians to create programs that affect population health together in the future, several key requirements will need to be met.

There is a great opportunity for community health advocates to change the way that non-profit hospitals approach community benefit programs and encourage more investment in population health programs that are delivered in partnership with community physicians. There is a lot of work to be done to make these changes happen. The purpose of this paper is to be a first step in that process.

To my wife, Myra, and our four kids, Haley, John Mark, Heath and Francie, thank you for your unending support. You sacrificed many evenings and weekends to make this degree possible. I hope that I can make you proud as I work to improve our health system and the health of our communities in the future.

ACKNOWLEDGEMENTS

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CHAPTER I: PROBLEM STATEMENT

The American Hospital Association states that its vision is "of a society of healthy communities where all individuals reach their highest potential for health." Hospitals in the US, and healthcare providers generally, have not delivered on this vision. The United States continues to rank among the most expensive and lowest performing health care systems in the world ("Health - Organisation for Economic Co-operation and Development."). The US also has a significant uninsured population with an estimated 48 million people uninsured ("The Uninsured: A Primer, Key Facts About Americans Without Health Insurance, October 2012 - Issue Brief - 7451-08.pdf."). Finally, our system is wrought with socioeconomic disparities in access to care and outcomes ("Social Determinants of Health - Robert Wood Johnson Foundation."). To narrow these gaps, it will take efforts by multiple stakeholders; hospitals and health care systems will play a major role.

Meanwhile, nearly 3000 non-profit hospitals in the US receive approximately $12.6 billion dollars in annual tax exempt benefit; policymakers and the public are increasingly demanding that these non-profit hospitals make commensurate contributions to the health of the communities they serve. (Bakken and Kindig; Young et al.). Historically, the majority of this "community benefit" provided by non-profit hospitals has been subsidizing public insurance programs such as Medicare and Medicaid through accepting lower reimbursement rates (Young et. al.). Today, as recognition grows that a healthcare system organized around episodic, uncoordinated care is

inefficient, there is an expectation for hospitals to do more in preventive health, care coordination, and outcome-oriented care. Hospitals can help fulfill the American Hospital Association mission by leading this transformation.

Over the last five years, hospital systems across the country have been changing strategy by increasingly purchasing physician practices. The hospitals are creating provider networks to prepare themselves to benefit from payment reform. These doctor practices are distributed in the hospital's service area, creating multiple potential touch points within the community and providing vertical integration across the spectrum of care. Because these hospitals own physician practices throughout their service area, they can use the practices to improve population health and community building as a means of justifying the tax benefits they receive as a result of their non-profit status. However, use of the ambulatory practices to provide (reported) community benefit has been rare, likely due to the relatively nascent, co-occurring trends of increased practice acquisition and attention to community benefit. This underuse of ambulatory practices may represent a lost opportunity. This research seeks to understand how hospitals can use their distributed community physician practices as a mechanism to connect better with the community in order to provide more effective community benefit programs and ultimately affect improved population health outcomes.

Section 1.: Plan for Change Framework

The purpose of this dissertation extends beyond a didactic discussion of theory. Rather, the goal of this dissertation is to lay the framework for change to be accomplished in non-profit hospital community benefit programs. I have organized this

paper according to the 8 steps of change as outlined by John Kotter in his book XLR8 (Kotter). Figure 1 illustrates Kotter's 8 steps.

Figure 1

KOTTER'S 8 STEPS FOR CHANGE
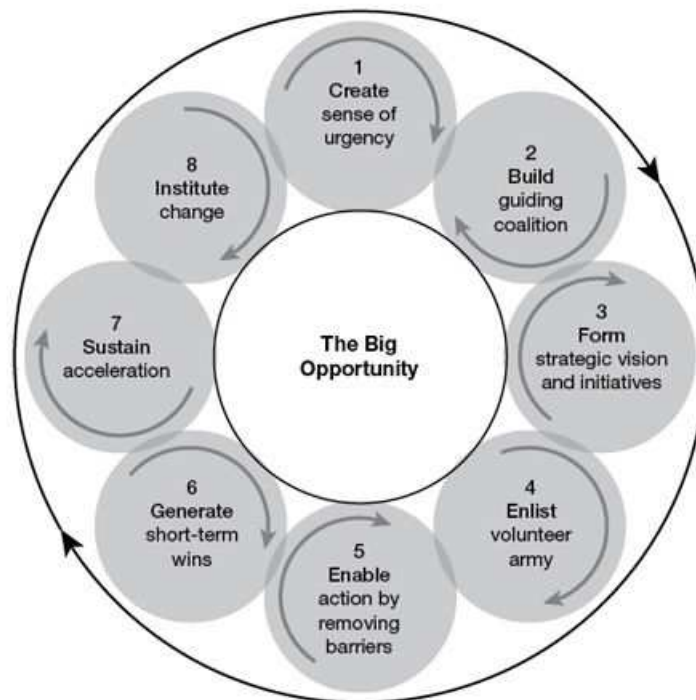
The big opportunity is to use the $12.1 billion dollars currently spent on community benefit programs to invest in impacting community health through partnerships between the hospital community benefit programs and ambulatory physicians. Each step in the Kotter 8 steps framework is discussed throughout the following chapters.

Section 2.: Background: Tax exemption and Community Benefit

Tax exemption for hospitals has a long historical tradition. From 1956 to 1969, hospitals were considered charitable because they provided care "for those not able to pay for the services rendered." (Bakken and Kindig). In 1965, Congress created Medicare under Title XVIII under the Social Security Act to provide health insurance to people aged 65 and over regardless of health history or income. At the time, there was concern that hospitals would no longer be able to provide sufficient subsidized care to justify their tax exemption since older Americans would now be guaranteed insurance (Bakken and Kindig). In 1969, the IRS expanded the basis by which hospitals could maintain their non-profit status by declaring that 'promotion of health' was a charitable purpose under the Internal Revenue Code (IRS Revenue Ruling 69-535). As a result, the Community Benefit Standard was created. The Community Benefit Standard is defined as "promoting the health for a class of persons sufficiently large so the community as a whole benefits." (IRS Revenue Ruling 69-535). This standard has continued from 1969 until today (Bakken and Kindig).

Nonprofit hospitals are able to avoid paying taxes because they attest to satisfying the community benefit standard. There have been considerable challenges to this tax exempt status of hospitals at both the federal and state levels (Bazzoli, Clement, and Hsieh). In 1991, Senator Chuck Grassley, the head of the Senate Finance Committee, expressed concern that hospitals were not earning the tax benefit they were receiving (Byrd and Landry). Since then, Congress has tried but failed to impose stricter standards for the tax exemption at the federal level. (Buchmueller and Feldstein). At the request of the Senate Finance Committee, the Government

Accountability Office reviewed data from 2005 and 2008 to examine the community benefit provided by hospitals (Byrd and Landry). It found that there was wide variation in how hospitals defined community benefit with a small number of hospitals providing a disproportionate amount of the community benefit programs (Byrd and Landry). In 2007, the IRS introduced a revision to the Form 990, Schedule H requiring hospitals to report for each community benefit activity 1) the number of people served, 2) total expenses involved, 3) direct offsetting revenues and 4) the resulting net community benefit expense (Bazzoli, Clement, and Hsieh). These public reports have given researchers the first complete data set to examine how community benefit dollars are being spent by non-profit hospitals.

In addition to federal action, some states have also enacted community benefit laws and policies. In 1993, Texas passed legislation requiring non-profit hospitals to justify their status by conducting a community needs assessment and demonstrating its value of charity care subject to rigorous mandatory minimum dollar contribution standards (Buchmueller and Feldstein). In 1994, California passed a law requiring non-profit hospitals to complete a needs assessment in their communities and to adopt a community benefit plan addressing identified needs (Ainsworth, Diaz, and Schidtlein). In the last two decades, over 20 states have adopted reporting requirements for non-profit hospitals to justify the non-profit status and resulting tax exemption (Gray and Schlesinger).

The guidance from the IRS as to what qualifies as a community benefit program is ambiguous and does not provide an explicit list of qualifying activities. The IRS Form 990 lists the following seven categories of community benefit programs:

1. Financial assistance at cost (also called charity care).

2. Unreimbursed costs from Medicare and Medicaid (e.g. the difference between cost and the reimbursed amount)

3. Community health improvement services and community benefit operations.

4. Health professional education.

5. Subsidized health services.

6. Research.

7. Cash and in-kind contributions for community health.

In addition to these 7 categories, the IRS allows hospitals to report community building programs in a separate section of Schedule H to encourage hospitals to make upstream community health investments like physical improvements, housing, economic development, and environmental support (Greenlining Institute). Not all states permit community building activities to be included in community benefit programs.

There is growing concern that non-profit hospitals are receiving a disproportionate tax break compared to the benefit provided to the community (Greenlining Institute). Recent studies have shown that hospitals are receiving a greater benefit from tax avoidance than the amount of funds that they invest back into the community. There have been six empirical studies that have examined how nonprofit hospitals are investing in community benefit programs (Young; Gray and Schlesinger; Bazzoli, Clement, and Hsieh; GAO; Congressional Budget Office ; Institute for Health and Economic Policy). A study reviewing 2010 community benefit expenditures found that California non-profit hospitals received a $3.27 billion dollars in total government subsidies and benefits in 2010, while only providing $1.43 billion dollars in community benefit during the same year (Institute for Health and Economic Policy). The most comprehensive study to date reviewed the community benefit

programs of 1800 tax-exempt hospitals during 2009 (Young). The 1800 non-profit

hospitals represent approximately two-thirds of US non-profit hospitals. Young found

that tax-exempt hospitals spent 7.5% of their operating expense on community benefit

programs during the study year. However, more than 85% of these expenditures were

devoted to charity care and other patient services. Only approximately 5% of the funds

were devoted to community health improvements that the hospitals undertook directly.

The remainder of the funds went to education of health professionals, research, and

contributions to community groups. This finding is similar to previous findings. In a

study published in 2009, Bradford Gray and Mark Schlesinger reviewed community

benefit reports for the 45 nonprofit acute care hospitals in Maryland and interviewed

officials at 20 of the hospitals to determine how hospitals were meeting their community

benefit obligation (Gray and Schlesinger). Table 1 compares the Gray and Schlesinger

findings to Young's finding on the how non-profit hospitals spend their community

benefit dollars.

Table 1: Community Benefit Expenditures

Community Benefit	Gray and Schlesinger				Young
	2004	2005	2006	2007	2009
Charity care	1.77	2.10	2.32	2.38	1.9
Unreimbursed costs for means-tested government programs	Not Reported Separately				3.4
Subsidized health services	1.20	1.28	1.39	1.52	1.1
Community health improvement and community benefit operations	0.52	0.52	0.55	0.60	0.4
Cash or in-kind contributions to community groups	0.16	0.14	0.14.	0.10	0.2
Research	0.04	0.07	0.06	0.13	0.1
Health professional education	2.93	2.72	2.49	2.45	0.4
Community Building	0.11	0.12	0.12	0.14	--
Foundation benefit	0.08	0.06	0.05	0.06	--
TOTAL	6.78	7.02	7.12	7.37	7.5

Source: (Gray and Schlesinger, Young.)

The Gray, Schlesinger and Young studies calculate the community benefit spending in the large Schedule H categories, but they do not provide insight into the types of community programs funded by these dollars. In a 1994 study of 100 California hospitals showed the distribution of community benefit programs undertaken by respondents to be heavily skewed toward community health education (Buchmueller and Feldstein). Table 2 presents the number of community benefit programs reported by responding hospitals.

Table 2: Types of Community Benefit Programs
Provided by California Hospitals (N=100)

Community Benefit Program	Count	Percentage
Community Health Education	107	36%
Health Screening	46	16%
Counseling/support groups	42	14%
Education of health professionals	32	11%
Free or subsidized clinics	23	8%
Donations to nonprofit or government organizations	19	6%
Free or subsidized immunizations	18	6%
Research	8	3%

Source: (Buchmueller and Feldstein)

This result of these studies has led researchers and lawmakers to question whether the non-profit hospitals are doing enough in exchange for the $ 12.6 billion dollar tax benefit each year. The intent of the community benefit investment is that the community health is improved. Some researchers have found that the money that is being spent by hospitals is focused on hospital-based activities and is not being used to improve the community health (Young). Thus, the prevailing wisdom of researchers and policymakers is that hospitals need to provide more community benefit, or at the very least do what they are doing differently

CHAPTER II: CREATING A SENSE OF URGENCY

Several factors are converging to make this the right time to focus on how community benefit programs can be used to improve population health. Figure 2 illustrates how regulatory scrutiny, healthcare trends, and developing new health frameworks are all providing the right external pressure to encourage ambitious community benefit programs to achieve better health. Hospitals are under regulatory pressure to demonstrate that they are providing services that are improving health outcomes in their communities. Health research has repeatedly demonstrated the importance of impacting distal causes of poor health to create a healthy population. Not only have researchers confirmed that non-clinical activities are important for improving health, they have identified several activities that can be undertaken by providers to prevent poor health outcomes. This research potentially provides hospitals and physician networks with a prescription for how to achieve to their mission. Finally, the trends in healthcare are forcing providers to think about how to work together to redesign healthcare so that patients are getting the right care at the right place at the right time. All of these factors together challenge us to seize the opportunity before us and dare to be innovative with our investments and seek to improve the health of our communities.

The US healthcare system is in a period of rapid transformation shifting focus to preventive care and health promotion (RWJF, Hospital Based Strategies for Creating a

Culture of Health). For decades, a hospital's mission was to provide excellent tertiary

care to patients that received treatment inside the hospital. Over time, this singular

mission expanded to improve the procedural outcomes of the patients that received

treatment inside the hospital. Now, with the focus on reducing overall health spending,

hospitals are being required to consider the health status and outcomes of entire

populations. This is a monumental shift in mission for hospitals. Community health

advocates must capitalize on these pressures faced by hospitals to create an urgency

for hospital administrators to make necessary changes now.

Figure 2

**DRIVERS FOR CREATING MORE ROBUST COMMUNITY BENEFIT
PROGRAMS**
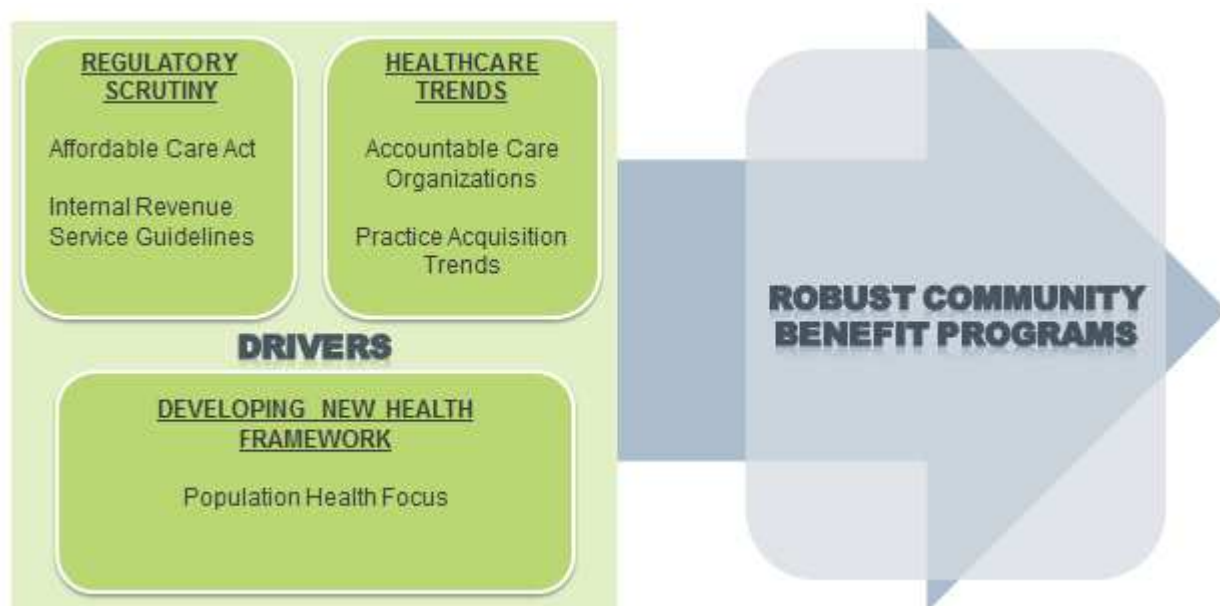
Section 1.: Regulatory Scrutiny

Section 1.A.: Internal Revenue Service

First, the regulatory environment continues to drive hospitals to look outside their walls to improve community health. In response to questions about the appropriateness of allowing hospitals a tax exemption, the IRS instituted the Schedule H to Form 990 in 2009. By requiring explicit disclosure regarding the community benefit programs, the IRS can evaluate how the money is being spent to determine if the non-profit hospitals are living up to their obligation to invest back into the community at an equal rate to the benefit. The first comprehensive evaluation of Schedule H expenditures was published in 2013. The conclusion from the study was not favorable to the assertion that non-profit hospitals invest in improving community health in similar measure to the amount of tax breaks received. In fact, the study concluded that "little was spent on community health improvements." (Young). A 2013 study in California, found that California not-for-profit hospitals received $3.27 billion dollars in total government subsidies and benefits, while only providing $1.43 billion in community benefit (Greenlining Institute). Additionally, out of the $1.43 billion spent on community benefit, only 1.1% of their overall operating revenue went to improving the community health outside of the hospital walls. The studies are confirming the fears of many who have watched the tax exemption with skepticism. Policy advocates are asking for stricter rules with defined penalties (Greenlining Institute). Community health advocates should use this threat of regulation to motivate health leaders to embrace change.

Section 1.B.: Affordable Care Act

Another important regulatory driver for creating a sense of urgency is the Patient

Protection and Affordable Care Act (ACA). The Health and Human Services Strategic

Plan enumerates six objectives of the ACA and establishes strategies to achieve each

objective including to emphasize primary and preventive care, linked with community

prevention services..

The strategic goals of HHS with respect to the ACA posits that the ACA "provides

a unique opportunity to maximize the value of America's health investment by

integrating public health approaches and health care service delivery." Going further,

HHS states that "integrating primary health care services and public health efforts,

including linking to community prevention services, can promote efficiency, positively

affect individual well-being, and improve population health." (HHS, ACA Strategic

Goals). Hospitals are in the process of creating and implementing strategic plans that

are responsive to the challenges of the ACA. Community health advocates need to use

these directives as a means to have expansive community benefit programs included in

the hospital's strategic plan.

The ACA seeks to transform health services and interventions in the community.

(Center for Study of Social Policy). To fully embrace the objectives of the ACA, the

community benefit programs need to integrate the traditional public health practices and

programs with the health care delivery system.   Section 9007 of the ACA requires non-

profit hospitals to conduct a community needs assessment every three years and adopt

an implementation strategy to address the community needs identified through the

assessment. This requirement forces hospitals to connect with their communities to

understand the needs of residents beyond those that receive care at the hospital.

When they conduct the community needs assessment, hospitals are encouraged to

engage a broad array of stakeholders including community members, schools, other

institutions, and public health professionals. Forming these collaborative relationships

can help hospitals approach healthcare planning in a new way. This collaboration can

assist in making the community benefit programs more accessible by the community

and ultimately more successful in addressing a wider range of health needs. The

community benefit programs cannot remain in a silo, but must be connected to primary

care doctors in the community and community organizations. The community benefit

office needs to create an effective link among the hospital, community primary care

physicians and community organizations. The imperatives set forth in the ACA provide

the impetus to be bold in demanding change now.

Section 2: Healthcare Trends

Section 2.A. Accountable Care Organizations

Included in the ACA was the expansion of the Accountable Care Organizations.

ACOs are an emergent model of care that are viewed by many as a promising approach

to achieving the Triple Aim (FAQ On ACOs: Accountable Care Organizations,

Explained - Kaiser Health News). ACOs are designed to move healthcare providers

away from a model where they are paid for each patient encounter regardless of

outcome to an outcome-based payment system. This reimbursement change is meant

to incentivize providers to create integrated networks that can provide comprehensive

care to patients. Because reimbursement targets outcomes, the expectation is that

healthcare networks will focus on prevention efforts; this focus requires a new approach to addressing population health needs.   As hospitals and physicians seek to improve the health of their populations, they are confronted with the social determinants of health that are not easily addressed in an episodic-focused system.   By requiring physician networks to focus on outcomes and social determinants of health, ACOs have created an environment for change that can help redefine how we approach community benefit programs.

Section 2.B.: Practice Acquisition Trends

In an effort to be ready to participate in ACOs and payment reform, hospitals have been increasing the size of their ambulatory care networks by purchasing medical practices. Figure 3 illustrates the trend of hospital ownership of physician practices. In 2003, almost 70% of physician practices were owned by physicians. By 2011, ownerships rates were nearly reversed with less than 25% of practices being owned by physicians and hospitals owning over 75% of physician practices.

Figure 3
Percentages of U.S. Physician Practices Owned by Physicians and by Hospitals
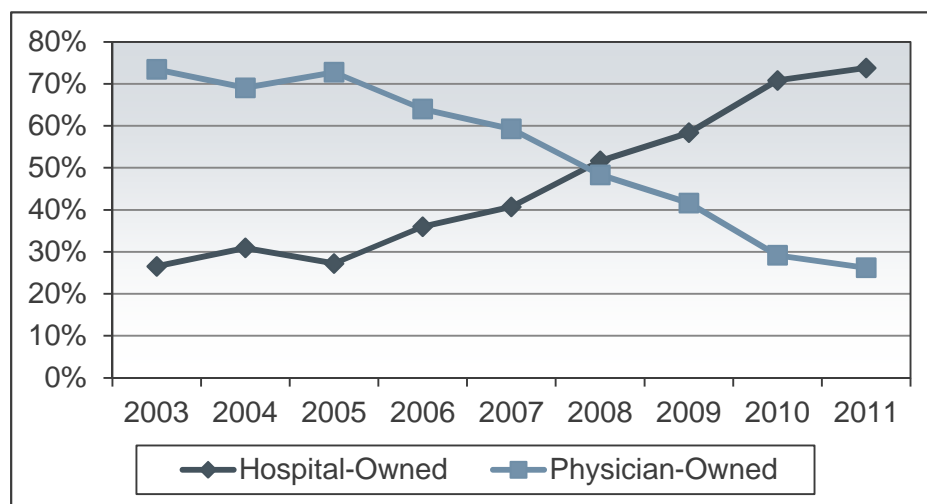
[1] Source: Medical Group Management Association (MGMA) *Physician Compensation and Production Surveys: 2003 to 2012 Reports Based on 2002 to 2011 Data.*

The aggregation of physician clinics by hospitals enables hospitals to more easily coordinate care across the care continuum, including pre- and post-acute transitional care. By coordinating care throughout the care continuum, hospitals can produce improved health outcomes over a defined population within a community. Additionally, the distributed primary care practices give the hospitals multiple points of contact with large populations within the community. Community primary care doctors hold a position of trust with their patients. They see the needs first. By integrating tightly with the community primary physicians, hospitals have an opportunity to impact the way that care is delivered in the local doctor's office. Hospitals have more resources than an individual physician's clinic. The hospital can provide the resources that a primary care doctor requires to transition to providing outcome-based care for a population of patients including an electronic medical record, panel support tools, and team-based staffing models. Additionally, if the hospital employs the physician, the hospital needs the ability to establish the financial incentives for the physician to focus on population health. This can include moving physicians from a productivity-based compensation model to a compensation plan that puts a portion of the compensation at risk for quality metrics. Additionally, the compensation plan can protect time for the physician to spend managing his panel of patients. Hospitals have the ability to partner with their primary care physicians in a significant way to impact population health by aligning the interests of the physician, the health system, and the community.

Section 2.C.: Developing New Health Framework

The American Hospital Association's 2012 Annual Survey of Hospitals found that 98 percent of CEOs believed that hospitals need to investigate and implement population health management strategies (RWJF, Trends in Hospital-based Population Health Infrastructure). Population health is measured by the health outcomes of a group of individuals, including the distribution of the outcomes within the group (Kindig and Stoddart). Population health outcomes are achieved through a myriad of determinants of health including medical care, public health, genetics, behaviors, social factors, and environmental factors (Jacobson).   Shifting from a hospital-centric mindset that focuses on providing medical care to a health system that delivers population health will require transformation in vision, organization, and coordination of care. Neal Halfon and Peter Long offer a description of how healthcare is moving into a third era. The first era was marked with the advent of modern medicine in the mid-1800s and extended through the 1950s to address infectious diseases and other immediate health threats, emphasizing acute, emergency, and rescue care to save lives. The second era started in the 1950s and has continued until today. This second era focuses on chronic diseases and focuses on prolonging life with chronic disease treatment and management with some secondary prevention efforts. We are in the beginning of the third era which focuses on life course influencers and optimizing population health development. Table 3 illustrates the 3.0 Transformation Framework developed by Halfon and Long (Halfon and Long).

Table 3: Health System Transformation

Health System Characteristic	Era 1.0 Sick Care System	Era 2.0 Coordinated Health Care System	Era 3.0 Community-Integrated Health Care System
Objective	Acute care and infectious disease focused	Patient-centered care; coordinating episodes of care across levels of care and managing chronic conditions	Population and community health outcomes, optimizing the health of populations over the life span and across generations
Organization of services	Independent health care providers; hospitals, clinics, primary care providers, and specialist operate separately	Systems of health care, such as accountable care organizations and medical homes; teams of health care providers accept collective responsibility for quality outcomes and overall cost of care	Community-integrated health system; integrated health care networks partner with public health and community organizations to both reduce community health risk factors and provide coordinated illness care
Care process	Little coordination between inpatient and outpatient medical care; dominated by an acute care treatment model	Coordinated care to better manage medical risk at each level (primary, secondary, and tertiary) of the health care delivery system	Integrated health, psychosocial services, and wellness care designed to optimize and maintain health and well-being across the life course
Payment methodology	Fee-for-service; rewards volume of services	Value-based payments: health care providers rewarded for better patient outcomes, better patient experience of care, and lower total cost of care	Recognize value with long-term horizons and capture multi-sector financial impacts outside of health care costs: sustainable financing alternatives such as population based global budgets; single budget for a broad scope of health care services combined with incentives
Health information technology	Separate paper medical records exist but are not connected	Electronic health care information exchanges connect various provider networks	Health and medical information follows the person: there is connectivity between the health and human service systems, and actors have access to real-time data on quality, costs, and outcomes for individuals and populations
Quality of care	Large variations in quality and low transparency	Consistent quality; using standard quality outcomes and improvement processes through collaborative learning	High and continuously improving quality through a learning health system
Population health improvement	Not addressed	Focused on health of patients/clients	Focused on health outcomes for geographically defined population, including upstream socioeconomic and developmental correlates of health

Source: Halfon and Long

The 3.0 Transformation Framework is more of a destination map than a conceptual framework that can assist hospitals in making the necessary transitions through each era. Today, most hospitals are working to move from a first era hospital to a second era health system. Hospitals need a framework that will assist them in understanding how to create strategies to move from version 1.0 to 3.0. Figure 4 illustrates a hierarchy of low cost/high impact strategies that hospitals can implement to affect population health.

Figure 4: Population Health Impact Pyramid
Low Cost/High Impact Interventions
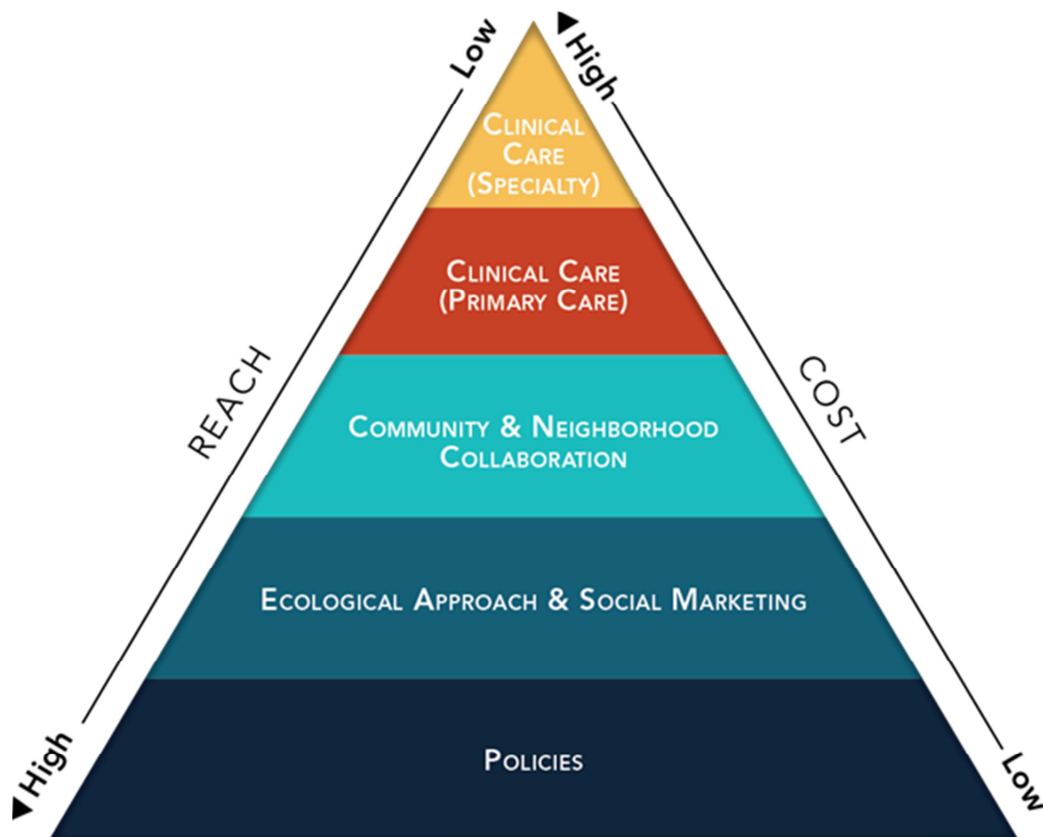
Hospitals have always focused on managing the top two wedges in this pyramid. In the 1.0 era, hospitals managed the specialty and primary care with the focus on acute care treatment. As the hospitals move into the 2.0 era, the focus on primary care shifts to patient centered medical homes, care teams with an increased emphasis on information technology. In order to move into the 3.0 era, hospitals will need to engage in the bottom three wedges of the low cost/high impact pyramid. It is in these interventions that the hospitals can make relatively low investments that can greatly improve population health.

CHAPTER III: BUILDING COALITIONS

As hospitals transform to include impacting population health into their core mission, they will need to reach outside of their walls to embrace community agencies and partners to accomplish this ambitious task. To really affect health outcomes, hospitals will need to extend beyond the ten percent of determinants managed by health care to influence and measure other determinants of health for individuals and populations (Children's Hospitals: Creating Health). In order to address upstream factors that affect health, hospitals will need to partner with a broad range of partners that can assist on various issues including urban planning, education, housing, transportation, public health, nutrition, community policing (Matterssich).   The Robert Wood Johnson Foundation Commission to Build a Healthier America found a growing appreciation of the value of collaboration among hospital administrators (Matterssich). The Association for Community Health Improvement and the American Hospital Association conducted a survey of nearly 1200 of its members to understand best practices for population health management. One of the findings was that hospitals collaborate with a wide range of community partners on population health improvement programs. The study found that on average, hospitals had 8.63 partnerships with community organizations. Table 4 lists the types of organizations hospitals partnered with most frequently.

Table 4: Community Partners of Hospitals

Organization Type	Current Partnership %
Primary and secondary school districts	78%
Public health department (local)	77%
Chamber of Commerce or other business group	71%
Community health center	70%
American Heart/Lung/Diabetes Associations	68%
City or county government	66%
Community health coalitions	61%
Faith community organizations(s)	58%
Postsecondary education (colleges, universities)	58%
Service leagues (Lions, Rotary, etc.)	55%
United Way	52%
Neighborhood organizations(s)	45%
Public health department (state)	43%
YMCA/YWCA	38%
Environmental organizations	18%

Source: Association for Community Health Improvement (2013)

Engaging in community partnerships and collaborations is not enough. The community benefit offices need to make sure that their collaborations are successful. The following table highlights the most common issues addressed through cross-sector collaborations and self-impressions of the successfulness of the collaboration.

Table 5: Self-Perceived Partnership Success

Issue	Level of Success in Cross Sector Collaboration			
	None	Incipient	Emerging	Successful
Opportunity for physical activity and active living	12%	19%	23%	46%
Promoting a culture of health and wellness in schools, workplaces, and neighborhoods	11%	17%	28%	45%
Access to health care	12%	19%	25%	45%
Providing the evidence that decision makers need to build health into policies and practices	12%	18%	28%	42%
Access to healthy food	12%	22%	25%	40%
High-quality early child care and education	17%	22%	26%	35%
Health impact assessments for community development projects	16%	265	275	31%

Source: Mattessich

The self-reported impressions from 661 respondents regarding the successfulness of the collaborative indicate that not quite half (297) of the collaborations are successful. In 2000, a study reviewing the effectiveness of collaborative partnerships found that collaborative partnerships can contribute to widespread change in a variety of health behaviors, but the magnitude of these effects may not be as great as intended (Roussos). The Roussos study found seven interconnected factors that hospitals could control that could enhance the successfulness of partnerships to create change in the community.

Table 6: Coalition Success Factors

Success Factor	Tactics
Having a Clear Vision and Mission	• Target mission statement. • Articulate outcomes. • Create awareness of the partnership.
Action Planning for Community and Systems Change	• Identify changes to initiate. • Focus attention. • Clarify ways to create change.
Developing and Supporting Leadership	• Reported as most influential factor for success. • Needed core competencies include: communication, meeting facilitation, negotiation, and networking.
Documenting and Ongoing Feedback on Progress	• Identify immediate and near-term outcomes to measure. • Develop strong measurement and evaluation methods.
Technical Assistance and Support	• Training and support for key actions. • Support can be internal or external.
Securing Financial Resources for the Work	• Availability of donations and in-kind support, competent staff, daily expenses, and technical assistance can predict sustainability of partnership.
Making Outcomes Matter	• Motivate community influencers. • Partner with grant makers. • Design reporting responsibilities to include outcome reporting.

Even if the partnerships are successful at accomplishing their goals, the question remains as to whether the partnerships are accessible to the practicing physicians in the hospital. Primary care physicians have a high degree of interaction with patients; of every 1000 people, 113 visit their primary care provider each month, and primary care accounts for 50% of all office visits annually (Green). Primary care physicians have the ability to assess patients, identify those in need, and coordinate the delivery of care (Etz). For the collaborations to have the most influence, they must be known to and

used by the physicians. In *Bridging Primary Care Practices and Communities to Promote Healthy Behaviors*, Rebecca Etz addresses *linking* or the work done to forge connections between primary care practices and community resources. Etz developed a list of necessary elements to effectively create a bridge between the primary care office and the community resources.

Table 7: Bridging Community Partners with Primary Care

Primary Care Office Characteristics	Connecting Strategies	Community Resources Characteristics
Capacity for Risk Assessment	Pre-identifying community resources — Known services and expectations	Availability of resource
Ability for brief counseling	Developing referral guides — Paper or electronic databases	Affordability of resource
Capacity and ability to refer	Engaging external intermediaries — Single-point access to resources	Accessibility of resource
Awareness of community resources		Perceived as value added

Bi-Directional Communication

Source: (Etz, 2008)

Community health advocates within the hospital must work with hospital leadership to understand the importance of engaging community partners to help address the health determinants that occur outside of the hospital. Hospitals can not affect population health working alone. The community benefit office in a hospital is typically responsible for establishing and nurturing these partnerships. As the partnerships form, the community benefit officer needs to ensure that the collaboratives are designed for success and that the necessary bridges are being made to the primary care physicians.

CHAPTER IV: RESEARCH DESIGN AND METHODOLOGY

Section 1.: Study Approach and Design

Section 1.A.: Study Overview

This study attempts to understand how community benefit offices are working through distributed physician clinics to affect community health. The study seeks to understand both current practice and identify potential improvements to the status quo. Due to the in-depth nature of the study, a qualitative design is the most desirable for creating knowledge and contributing to the body of research.

The research design and analysis addressed the study's key research questions and research aims. The two research questions are:

1.   How can nonprofit hospitals satisfy their community benefit obligation through partnerships between their community benefit office and ambulatory physician networks?

2.   How can community benefit offices, physician networks, and community organizations partner together to design and implement programs that impact population health?

The research aims are:

1.   Identify the population health goals of nonprofit hospitals' community benefit programs and physician networks

2.   Identify how hospitals (through the community benefit office), physicians, and community agencies work together to create and implement programs focused on improving population health

3.   Understand how community benefit offices connect with their ambulatory physician practices to coordinate efforts to improve population health

4.   Identify factors that enhance or hinder the development of an effective partnership between the community benefit office and ambulatory physicians' offices to create programs that affect population health

To answer the questions above, I used a two-step information gathering process. First, I conducted key informant interviews with hospital executives and community physicians to understand more about the community benefit programs used to improve population health. Second, I requested data from participants related to the community benefit program planning for the hospital and the hospital/physician network.

Section 1.B.: Study Participants and Recruitment

The study included 7 sites. At each site, I interviewed hospital executives with professional responsibility for developing and overseeing the community benefit programs, hospital executives responsible for developing the physician network, as well as community physicians who are part of a hospital/physician network. The participants were selected using purposive sampling in an effort to identify participants who can best answer how a hospital/physician network can be successful in creating impactful community benefit programs.

Participants were identified through collaborative work with the Public Health Institute. The Public Health Institute has been a leader in community benefit research

and the development of best practices. I identified 7 potential sites. I sent an introductory email explaining the research study and asking if the selected individual would be willing to participate in the an interview to discuss how hospital/physician networks can and do engage in community health initiatives (see Appendix A). I included a copy of the Fact Sheet (see Appendix B) with the email. Out of the 7 potential respondents, 4 responded that they would be willing to participate in the study. The other 3 potential respondents did not respond to the request to participate. Out of the 4 that responded, one site later dropped out of the study because of the inability to obtain consent from the physician network executive to participate in the study. I added 4 additional sites using my personal network. A total of 7 sites participated in the study. A breakdown of the participant characteristics is included below in Table 8.

Table 8: Study Sites

Index Number	Type of Hospital	Region	Part of System (Y/N)	Religious Affiliation (Y/N)
1	Children's Hospital	Northwest	N	N
2	Community Hospital	Southwest	Y	Y
3	Community Hospital	Southwest	Y	Y
4	Community Hospital	Midwest	Y	Y
5	Children's Hospital	Southwest	Y	N
6	Community Hospital	South	Y	Y
7	Community Hospital	Northeast	N	N

The study sought to interview 3 people from every site including: the executive responsible for the community benefit programs, the executive responsible for the physician network and a community physician. The job titles of these individuals varied across sites. Table 9 identifies the various job titles encountered at each site.

Table 9: Study Participants

Participant Index Number	Community Benefit Executive Title	Physician Network Executive Title	Community Physician Specialty
1	Director of Community Benefit	Chief Strategy Officer	Primary Care
2	Chief Development Officer	President and CEO Medical Group	Primary Care
3	Director Health and Wellness	Chief Physician Executive	Primary Care
4	Director of Community Benefit	Chief Medical Officer	Primary Care
5	Administrative Director Community Health	Chief Medical Officer	Primary Care
6	Vice President of Ancillary Services	Chief Medical Officer	Primary Care
7	Population Health Manager	Chief Medical Officer	Primary Care

While the titles varied at each site, I was assured that the community benefit executive was, in fact, the executive responsible for the community benefit office. Each interview was conducted via telephone and lasted between 45-60 minutes. The interviews were conducted in English. Prior to asking questions, I read the consent form to participants and received verbal consent. The consent form is attached as Appendix D. The study was fully explained to potential participants and potential participants were informed that they could decline to participate in the study. The potential participants that consented to be included in the study were enrolled and became participants.

The interviews were conducted pursuant to an Interview Guide. Both semi-structured and open-ended questions were asked of participants. There are three separate Interview Guides: one for community benefit executives (see Appendix E), one

for physician network executives (see Appendix F), and one for community physicians (see Appendix G). Key informants were interviewed until theoretical saturation was reached and no new themes or concepts emerged regarding how hospital/physician networks can best implement community benefit programs. Theoretical saturation was reached at 7 participant sites.

Section 1.C.: IRB Approval

Study approval was obtained through the Institutional Review Board at the University of North Carolina at Chapel Hill.

Section 2.: Data Analysis

Each key informant interview was recorded and transcribed. Before the interview began, I requested permission from the participant to record the interview. The transcription was compared to the audio recording to ensure that the transcription was accurate. The transcribed recording was analyzed using the qualitative software Nvivo. Prior to coding the interviews in Nvivo, I read all of the transcripts identifying potential codes. I created a preliminary code book in order to begin the process of establishing code reliability. After I read the preliminary code book, I used this code book to code the 21 interviews in Nvivo adding new codes to the codebook as new themes emerge. After coding each of the interviews, I recoded all of the interviews adding the new codes that emerged throughout the level one coding. Throughout the results and discussion section, I illustrate the findings using anonymous examples (re-worded as necessary to omit identifiable information).

Section 3: Privacy of Information

      To protect the privacy of the participants, multiple procedures were followed. To protect the fidelity of the documents, hard copies of the data and collateral materials, such as transcribed interviews, were stored separately in a locked cabinet in the office of the principal investigator. All interview data were stored in password-protected files on the principal investigator's computer. Once the study is complete (dissertation has been completed and approved by the committee), all original data will be destroyed.

CHAPTER V: RESULTS AND DISCUSSION

Section 1.: Summary of Findings

There are four major findings from this study:

1) Health reform and new payment models have started discussions about population health, but have not affected reimbursement significantly enough to cause most hospitals to fully embrace population health programs.

2) Hospitals rely on community partnerships to address the community health needs that cannot be addressed in the hospital.

3) There is not an effective link between the community benefit office and community physicians that promotes cooperation in designing and implementing programs that affect population health.

4) In order for community benefit offices and community physicians to create programs that affect population health together in the future, several key requirements will need to be met.

Each is discussed in turn.

Table 10: Summary of Findings

Finding	Summary
Health reform and new payment models have started discussions about population health, but have not affected reimbursement significantly enough to	Community benefit reports contain aspirational statements about the intention of the hospital to impact population health. The ACA has changed the way that non-profit hospitals approach community health. There is more rigor

Finding	Summary
cause hospitals to fully embrace population health programs.	applied to understanding community needs. However, many hospitals expressed uncertainty about the future of population health initiatives until reimbursement models create greater incentives. Some systems embrace addressing social determinants of health; other systems consider social determinants of health beyond the scope of the hospital's mission.
Hospitals rely on community partnerships to address the community health needs that cannot be addressed in the hospital.	Hospitals recognize the power of community partnerships. Community benefit offices work with community organizations on key priorities, which include some population health programs.
There is not an effective link between the community benefit office and community physicians that promotes cooperation in designing and implementing programs that affect population health.	Identified barriers include: • Community benefit office and physicians each operate in their own silos. • The community benefit office and community physicians do not communicate about community health needs, potential programs, or valued partnerships. • The lack of coordination results in duplicative/fragmented programs.
In order for community benefit offices and community physicians to create programs that affect population health together in the future, several key requirements will need to be met.	• Create a partnership relationship between the community benefit office and the community physicians. • Ensure a fully developed community physician network with strong primary care. • Contract with payors under a reimbursement model that pays for population health outcomes. • Align physician compensation models with focusing on population health. • Create office systems that support population health. • Provide best practices uniformly across all patient populations.

Section 2.

Finding 1:

Health reform and new payment models have started discussions about population health, but have not affected reimbursement significantly enough to cause most hospitals to fully embrace population health programs.

The community benefit reports of the study sites asserted that improving

community health was part of the hospital system goals. The statements embrace

creating significant impact in the community through programs implemented by the

community benefit office. Below is a sampling of statements from the published

community benefit reports of the study sites.

> *"…committed to improving the health and well-being of the people who live and work in the communities we serve."*

> *"…target preventative health to positively impact the health status of disproportionate unmet health needs populations, to facilitate the coordination of care (specifically prevention and disease management outreach activities) across the entire community, and provide community based activities that support and enhance hospital service lines and key performance indicators."*

> *"…system goals reflect those of health reform… so that quality can be continuously improved and patients and communities are healthier."*

> *"…our efforts make a significant difference in the health status of our community."*

While these statements are clear in the intention that the community benefit

programs affect community health and satisfy the community benefit obligation, the key

informants were less convinced that their hospitals were ready to commit fully to

population health activities at this time.   A frustrated community benefit executive

explained that hospitals are a business and that the business is not focused on

improving population health.

> *"what we're up against, as you know, is hospitals and medicine in general – are not public health. And a lot of our executives have that perspective. Their job is to run a hospital. And I would – I could see them saying, really, "What is the incentive for the hospital to do this? We're already giving millions in community benefits. Is that not enough? Why should we be concerned at all about population health?" Community Benefit Executive*

This sentiment was echoed in some measure by all participants. This is the

strongest finding in the study with almost every participant agreeing that hospitals will

not move toward fully embracing population health until the financial incentives are

aligned to that goal. It did not matter if the participant was the community benefit

executive, the physician network executive, or the primary care physician, all

participants agreed that reimbursement would drive action.

> *"people will respond to their incentives; and right now, the hospital presidents are incentivized to bring people into the hospital. Now once they're there, they want to get them out quickly, but they definitely want to bring them in." Physician Executive*

Participants agreed that the Affordable Care Act has created an interest in

understanding how healthcare delivery needs to be redesigned to improve population

health. The strong belief was that once reimbursement was conditioned on outcomes in

patient populations and/or community outcomes, the hospitals would shift not only their

rhetoric, but also their strategic plans to include community health initiatives.

> *"As the reimbursement incentives migrate toward more of a population health approach and we get rewarded for maintaining a healthier population, to be more proactive in terms of chronic disease identification and management, then I think we will see this sort of spillover into creating healthier communities, which has sort of been our mission statement for the last 25 years, but they've done precious little to really address the determinants of health." Physician Executive*

> *"Until there is a direct financial justification to pursue a public health problem, then I don't see it changing. Maybe there's more lip service. But I don't really see that changing. Not yet, at least." Community Benefit Executive*

A few study sites are participating in payment models that reward health

outcomes. Those sites had made more progress in implementing population health

initiatives in their systems. The participants at those sites credit the payment

methodologies as the impetus for their change. The Chief Medical Officer of a site that

has embraced community health initiatives explained that the system's largest payor

took a large portion of the physician reimbursement and directed into a pool focused on

primary care network development and outcome improvement.

> *" [the payor was the] chief architect who engaged with physicians in new ways to really develop the infrastructure that will drive the culture of population health management. When they [the payor] put a lot of money behind it, physicians had no choice but to pay attention. Absent significant payment reform, we're not going to see practice reform." Physician Executive*

The sites that are located in markets without pressure from payors to affect population

health are taking small steps toward delivery redesign and taking a "wait and see"

attitude.

Section 3.

Finding 2:

Hospitals rely on community partnerships to address the community health needs that cannot be addressed in the hospital.

The study sites all conducted community health needs assessments to determine

the priorities for their community benefit programs. Once the community needs were

identified, each hospital completes a community health improvement implementation

plan that lists the priorities for the next three to five years for the hospital. Table 9

summarizes the priorities identified by the study sites. I have also included a column in

Table 9 indicating what level of the population health impact pyramid the program

addresses.

Table 11: Community Benefit Priorities

Focus Area/Activity	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Pyramid Level
Access to High Quality Care								
Financial assistance to underinsured	●	●	●	●	●	●	●	▲
Health professional education	●	●			●			▲
Emergency Room assistance for indigent patients	●	●	●	●	●	●	●	▲
Enrollment Assistance in Exchanges or Medicaid	●			●				▲
Navigator Programs			●	●	●	●	●	▲
School based clinics	●				●		●	▲
Improve Primary Care Capacity			●					▲
Extend hours/Create Urgent Care Clinics						●		▲
Improve data sharing (eligibility)						●		▲
Pharmacy Assistance					●			▲
Create Referral Guide						●		▲

Chronic Disease Prevention and Management

Focus Area/Activity	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Pyramid Level
Screenings		●	●		●			(top level)
Health Education		●	●	●	●	●	●	(top level)
Immunizations		●	●		●			(upper-middle level)
Patient Navigation	●		●	●	●			(top level)
Provide Grants to Partner Organizations					●		●	(middle level)
Participate in Collaboratives			●	●	●			(middle level)
Legislative Initiatives	●				●		●	(bottom level)
Create Patient Registries	●							(top level)

Obesity

Focus Area/Activity	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Pyramid Level
Health Education	●				●		●	(top level)
Activity Classes	●				●		●	(upper-middle level)
Partnership with Community Organizations	●			●	●		●	(middle level)
Legislative Initiatives	●				●			(bottom level)

Focus Area/Activity	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Pyramid Level
Mental and Behavioral Health								
Partnership with Community Organizations	●		●		●	●		
Legislative Initiatives	●				●			
Expand ED Coverage for Mental Health	●		●					

Focus Area/Activity	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Pyramid Level
Aging								
Health Education		●					●	
Partnership with Community Organizations		●						
Grants to Partner Organizations		●					●	
Fall Prevention Interventions		●						

Focus Area/Activity	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7	Pyramid Level
Other								
Transportation			●					
Health Equity Research	●	●						
Health Equity Collaboratives	●	●		●				
Support Group in Focused Communities		●						
Homelessness/Housing Insecurity		●						

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Community benefit executives indicated that they rely on collaborative and partnerships with community organizations to implement several of these community benefit programs. Partnerships with outside organizations were used for a variety of reasons including: 1) the program objective focuses on upstream causes of poor health and requires collaboration of several institutions, 2) the program cannot be delivered within the hospital complex and/or 3) community partners are already providing the service. The quote below is from a one of the community benefit executives, however, this sentiment was shared by most participants.

> *"My approach has always been partnerships. For everything we do. It's to bring in the experts in on it and work together. Because nobody can just do it on their own."*

> *"We need to be thinking about policy changes. So it's like big picture. Your environment. What about transportation? What about the availability of food? What about these big kind of changes. So I say that that's – but it's hard. But there's absolutely no way we're going to do that kind of thing by ourselves "*

A sampling of the types of partnerships used by the study participants in included in Table 11.

Table 12: Study Site Partnerships

Community Benefit Program	Partnership Organization
Activity Classes	YMCA, Boys & Girls Club.
Nutrition and Cooking Classes	Local High Schools, Grocery Stores, Culinary Institutes, Local Farms, Churches.
Pro Bono legal services to patients to address social determinants (e.g. legal demand for landlord to change carpet that caused asthma).	Legal Aid, non-profit legal advocacy organizations.
Community building activities including safe neighborhoods, activity programs, food security, transportation, and access to care.	Health community collaboratives, public health departments.
HIV/AIDS prevention and treatment	Public health departments, pharmaceutical companies.

Work Study programs, Mentoring programs.	High Schools, Community Colleges
Development of an integrated network of home, community-based, and institutional long term care services for older adults and adults with disabilities.	Community Collaboration, Mayor's Office
Homelessness elimination projects including establishing a hub where homeless individuals and families could access primary and mental health and addiction treatment, job readiness and search training, legal services, and life skills training.	Community Collaborative

The community benefit executives, the community benefit reports, and the community health improvement implementation plans identified community partnerships as a key element of their successful community benefit program.

Section 4.

Finding 3:

There is not an effective link between the community benefit office and community physicians that promotes cooperation in designing and implementing programs that affect population health.

> *"But I would say that the communication that I have with respect to the community benefit office is zero." Community Physician*
>
> *"Whereas right now everybody's working independently, and that is sad." Community Benefit Executive*
>
> *"Certainly the physicians are not directly connected with that [the community benefit] office." Physician Executive*

The community benefit office dedicates significant resources to completing the community health needs assessment. This needs assessment creates the blueprint for the work that needs to be done in the community to improve health outcomes. A

compelling finding was that the results of the Community Health Needs Assessments

are not shared with the community physicians.   In most cases, the community benefit

executive admitted that sharing the information had not been considered previously

even though it seems like a good idea. In one case, the community benefit executive

commented that the report was shared with the senior leadership and that it was the job

of the senior leadership to determine how the report should be disseminated from there.

The Community Health Needs Assessment is the foundation to the

implementation plan prepared by the community benefit office. In all but one case, this

implementation plan was created separate from the physicians. The physicians were

not included in the planning or implementation of the community health implementation

plan. The community benefit offices have strong partnerships in the community to

address the upstream causes of poor health, however, there is not a mechanism to link

those partnerships to the community physicians. When asked how a community

physician can connect with the established partners, the most common answer was that

there was a list on the website. In most cases, there was no effective way for a

physician to connect a patient to the community resources and no feedback loop from

the community partner back to the physician.

An example of the duplication and/or fragmentation includes the patient navigator

programs that help link patients to community resources. In some cases, a patient

navigator program would be sponsored by the community benefit office but only be

available to inpatient patients. In other cases, the physician networks utilize patient

navigators, but the services are only available to a subset of patients either determined

by payor or by financial class. There were no instances where a single navigator

program was available to all patients, regardless of ability to pay and

inpatient/outpatient status. The programs were separate, sometimes duplicative and

always fragmented. In one site, the hospital had a patient navigator program for the

inpatient patients and the physician network had a patient navigator program for the

outpatient patients. The two navigator programs did not utilize the same community

partners, same databases, or electronic health record. There was little communication

between the two navigator programs. The physician executive from that site stated that

while both the community benefit office and the physician network were implementing

great programs, they were doing it in an uncoordinated manner.

> *It feels to me as though it is separate, and I'm not sure that's a good thing, but it just feels that way in all honesty.* Physician Executive

While the finding was that there was no connection between the community benefit

office and the community physicians, there were two programs that created an effective

link from the community benefit office, the community physicians' office and community

partners. One program was a Learn-to-Swim program with the community organization.

The physician would discuss water safety and exercise with a family and then prescribe

swim lessons for the child. The prescription was handled through the referral desk. The

community organization would provide the swim lessons at a discount because the

community benefit office provided a grant for the program. The referral desk followed-

up with the community organization to get updates on the patients' progress. Progress

notes were included in the electronic health record.   The second program was an

activity class that worked very similar to the Learn- to-swim case. In both cases, the

physician was aware of the community partner programs, had an established point of

referral and had a feedback loop for information.

Section 5.

Finding 4:

In order for community benefit offices and community physicians to create programs that affect population health together in the future, several key requirements will need to be met.

The respondents identified six foundational requirements that need to be in place

before the community benefit office and the community physicians can work together to

create meaningful programs that affected population health.

1. Create a partnership relationship between the community benefit office and the community physicians.
2. Ensure a fully developed community physician network with strong primary care.
3. Contract with payors under a reimbursement model that pays for population health outcomes.
4. Align physician compensation models with focusing on population health.
5. Create office systems that support population health.
6. Provide best practices uniformly across all patient populations.

These six recommendations were elicited from respondents by asking what

needed to change to allow the community benefit office and the ambulatory physicians

to work together to create and robust population health programs.

1. Create a partnership relationship between the community benefit office and the community physicians.

Respondents, whether community physicians, community benefit executives, and

physician executives, believed that there needed to be a partnership relationship

between the community benefit office and the physicians.   Some respondents

explained that this partnership was hard to establish because the community benefit

office is located in the hospital and the physician network is under separate governance.

The strategic planning and communication between the two institutions was not always

easy to accomplish. At least one respondent raised perceived legal constraints about

the ability of the hospital and the physicians partnering on community benefit projects.

Several of the community benefit executives perceived that ambulatory physicians were

not interested in population health.

> *"I think we still struggle with physicians in terms of their grasp of population health management. I think there's still – for the majority here, they're still focused on more of a disease model than a population health model. I think that's – it is different to them, and let's face it, they're reimbursed for taking care of sick people."*   Community Benefit Executive

In one case, the community benefit executive did not feel comfortable approaching the

physicians at all.

> *"I don't even want to bring up because I'm scared but shouldn't these physicians be doing Community Benefit because they're basically part of the system. I think the answer is yes, but I don't even dare bring it up right now around here."*
> Community Benefit Executive

The first step in the partnership should be the communication of the results of the

Community Health Needs Assessment. Respondents stated that it would be beneficial

if the community benefit office could share the results of the needs assessment with

specific guidelines of how a physician could impact the needs. Several respondents

discussed the irony that the community benefit office had the programs, while the

ambulatory physicians had the patients. Most respondents believed that the reach and

impact of the community benefit office could be expanded if the physicians were included in the implementation of the programs. Despite the concerns of the community benefit executives, most of the physicians were interested in creating a connection with the community benefit office to access programs offered by the community partners.

2.   Ensure a fully developed community physician network with strong primary care.

In order for the community benefit office to engage with the ambulatory physicians, the hospital needs to have a developed physician network. Respondents agreed that it was not practical for the community benefit office to attempt to work with a fragmented, uncoordinated group of community physicians. The responding sites were in different phases of developing their physician networks. The sites that had established networks were more likely to be further along in population health efforts. The sites that were still acquiring practices were focused on the building of the network infrastructure and did not have the capacity to concentrate on disseminating community benefit programs through the ambulatory practices. Respondents agreed that once the physician network was established that it could be a partner with the community benefit office to create and implement community health programs.

3.   Contract with payors under a reimbursement model that pays for population
        health outcomes.

As discussed in Finding 1, respondents cited reimbursement methodologies as a key driver for encouraging hospital and physician networks to implement population health focused programs. Respondents believed that the single biggest factor in creating an impetus for change was by having more contracts that rewarded population

health efforts rather than paying on a fee-for-service model. See the discussion under Finding 1 for a longer discussion on this point.

4.   Align physician compensation models with focusing on population health.

This point is connected to the prior point, but has important differentiation. The payor contracts determine how the hospital and/or physician network are compensated. These payor contracts create the pool of money that will be used to compensate the physicians. The physician's compensation is determined by individual employment agreements with the hospitals and/or physician network entity. Currently, most of the respondents' compensation plans are based on productivity. The more wRVUs (volume) the physician generates, the more she is paid. Respondents agreed that as long as we have a system that rewards volume of care provided, population health will not be a focus of physicians.

> *"The truth is that the way the system is designed, this is what we get. And if you change the system, which obviously I think there is a push to do, we'll get a different result, but right now, this is what we're living in."*

Below, one physician executive explains how he has been able to persuade his physicians to move to a population health mindset through compensation.

> *"You know I think they are receptive and interested. Physicians are like everybody else and they have to figure out "okay, you're changing the rules, am I going to be able to send my kids to college and do the things I've always done? How is this going to impact my compensation? Am I going to earn 20 percent less or what?"*

> *And so if you can assure physicians that they can make as much, and possibly more, in this other model, they're all in. But they honestly need that assurance.*

Physicians have, just like everybody else, have found it harder and harder to make a living over the last five to ten years.

If you say to physicians, hey, we want you to sort of care for people differently, and we think there's an upside in that, they're good to go. We kind of said to them, we're at the end of the life of your current business model, and the only way that you can think of earning more money is to earn money differently in the new population health model. And they've bought into that."

Respondents reported that they are seeing the compensation plans for physicians start to include quality metrics. The range of compensation that was at risk for meeting outcome based measured ranged from 0% to 50%. The more common percentage was around 15% of compensation being at risk for quality metrics. It was a compelling finding that the compensation of physicians would need to shift from a volume based compensation to value based compensation before physicians would be able to significantly engage in population health measures with the community benefit office in a sustainable way.

5.   Create office systems that support population health.

Physician executives and the community physicians were clear in the tools that they needed to be able to deliver on the promise of affecting population health. The needed tools included:

- Patient Registries – A patient registry is standardized information set about patients who share a medical condition. An example of a registry is a list of all patients with diabetes with available appointment, medication, and diagnostic information.
- Panel Support Tools -- Panel support tools are information systems that sit on top of the EHR and patient registries. The panel support tools allow the physician to examine trends in his entire patient portal by disease type, diagnosis code, age, gender, etc.
- Staffing models that include patient navigators and case managers – Patient navigators and case managers follow up with patients to ensure that patients are

not missing appointments, connect to community resources, and have a single point of contact within the system.

- IT that communicates across systems – Hospitals and physicians do not always share the same electronic health record. Even when the information can be shared across the systems, the quality and quantity of the shared information is lacking.

- Time built into the schedule for the physician to engage in panel management – physicians' schedules need to have time blocked off for the physician to monitor and manage the patient population health information provided through the points above.

Respondents agreed that these tools could be provided through joint programing with the community benefit office, however, the structures must be set up with guidance from counsel so that they do not violate Stark and anti-kickback laws.

6.   Provide best practices uniformly across all patient populations.

The final recommendation from respondents was that best practices should be provided to all patients uniformly. Almost all of the respondents had an example of a program that had great potential to improve health outcomes at a community level, but that the program was only available for a subset of patients. One example was a program funded through Blue Cross. The physician respondent was very frustrated that the referral process would not work for his other patients. Another complaint was that programs were often not available for patients who were not on Medicaid or on the Exchanges. Physicians expressed dissatisfaction that they could not refer their fully insured patients to programs that could be beneficial.   On the one hand, physicians were frustrated about the lack of programs available for the working poor. They recounted experiences when a patient was referred to a navigator or other program and was rejected because they were not on Medicaid, even though the patient would have benefited from the service. The other often-cited experience was the frustration of not

being able to refer patients who were middle and upper middle class to beneficial programs. There was a sense that they system was not worried about these patients because they *"had the means and ability to find resources on their own."* The physicians pushed back on this notion citing that the general public of all income levels was struggling with obesity, diabetes, and heart disease. There was a strong agreement that all patients needed access to programs that could improve their health outcomes.

CHAPTER VI: CREATING A VISION AND ENABLING ACTION

We are at an inflection point in healthcare that creates an opportunity for change in how hospitals engage in impacting population health. Hospitals cannot accomplish these changes alone. Changing the healthcare delivery system and the health outcomes of a population require active participation of the hospital, the ambulatory physicians, community agencies and the community benefit office. By moving from silos to an interconnected partnership, these actors can create a system that delivers on the promise of a society of healthy communities where all individuals reach their highest potential for health. Each actor must contribute resources to the effort to affect population health. The findings from this research establish that there is opportunity to improve the ability of hospitals to affect population health through coordination of efforts between the community benefit office and the ambulatory physicians. In developing a plan for change, the findings, taken as a whole, were used to develop a list of concrete recommendations. These recommendations strive to create an environment where community benefit offices in connection with ambulatory physicians can have maximum impact on population health. Section A. includes Table 12 with the list of the recommendations and section B has further recommendations regarding implementation

Section 1.: Recommendations

Table 13: Summary Recommendations

Recommendations for coordinated effort among the hospital, physician network and community benefit office to create and implement programs that affect population health.

Recommendation Category	Recommendation for Hospital	Recommendations for Physician Network	Recommendations for Community Benefit Office
Payor Strategy	Convert payor contracts from Fee-for-service to value based contracts.	Convert payor contracts from Fee-for-service to value based contracts.	Support the hospital and physician network in developing population health outcomes that can be effectively used in the payor contracts.
Communication	Develop a communication plan that includes the hospital, physician network, and the community benefit office.	Develop a communication plan that includes the hospital, physician network, and the community benefit office.	Develop a communication plan that includes the hospital, physician network, and the community benefit office.
Partnerships	Contribute the needed IT upgrades and personnel to provide the ability of the community benefit office, ambulatory physicians, and community partners to connect through a single referral point and have an information feedback loop.	Connect with community partners through the community benefit office using a single point of referral.	Expand the current partnerships to include a link with community physicians that includes single point of referral and information feedback loop.
Infrastructure	Contribute the needed infrastructure to allow physician offices to participate in population health activities.	Contribute the needed infrastructure to allow physician offices to participate in population health activities.	Use community benefit programs to provide some of the needed infrastructure to allow the ambulatory physicians to participate in population health activities.

Section 1.A.: Payor strategy

A compelling finding of the study showed that payor contracts had the ability to change the incentive for hospitals and physicians to focus on population health. Change agents that desire our system to focus more on population health need to keep pressure on CMS and payors to convert the current payment model from a volume

based system to a value based system. Hospitals should actively work with payors to create this change in rapid fashion. It is difficult for hospitals to survive in an environment where half of the contracts are volume based and the other half are value based. On January 1, 2015, the CMS payment modifiers for quality and cost became effective. In an effort to eliminate an environment of competing incentives, the hospitals should commit to the value based reimbursement and convert their contracts as soon as possible. This pressure will help create the focus needed for a hospital to redesign its delivery process. The incremental progress endangers success because of the inability to serve two masters. The physician network's contracts should follow the lead of the hospital. It is important that the physicians and the hospital are reimbursed for care in similar ways. The two entities need to work together as a team to improve health outcomes. The community benefit office can provide valuable guidance to both the hospital and physician network in identifying meaningful value-based metrics. The community benefit office should push the hospital and physician network to gravitate toward metrics that are measuring outcomes and not just process.

Section 1.B.: Communication

A compelling finding of the research was that there was a lack of communication between the community benefit office and community physicians. Communication does not happen without a plan. Part of any plan for change includes communicating the plan **(Kotter).** Table 13 lays out a communication plan that should be implemented by the hospital, community benefit office and community physicians.

Table 14: Sample Communication Plan

Audience	Communication Medium	Frequency	Agenda
Hospital Leadership Team	Meeting	Once a year	• Deliver results of CHNA. • Propose team structure for the implementation plan to include physician representatives.
Physician Leadership Team	Meeting	Once a year	• Deliver results of CHNA. • Propose team structure for the implementation plan to include physician representatives.
Physicians	General Meeting	Once a year	• Deliver results of CHNA. • Seek volunteers to serve on the implementation plan team.
Physician Leadership Team	Meeting	Monthly	• Monitor implementation plan and troubleshoot any barriers to success.
Physicians	Toolkit	Quarterly	• Provide physicians with a toolkit that describes the implementation plan with easy to use resources.
Physicians	Referral Guide	Twice a year	• Provide a referral guide to physicians describing the community partnerships. This guide should be electronic if possible and integrated into the electronic medical record for ease of use.
Physicians	Meeting	Quarterly	• Quarterly meeting used to update the physicians on community benefit activities, receive feedback on partnership programs, troubleshoot any difficulties, introduce community partners to the physicians.
Hospital Executives	Meeting	Twice a year	• Update hospital C-Suite/Board of Directors about the progress of the community benefit programs including the linkage between community physicians and community partners.

Section 1.C.: Partnerships

The 3.0 healthcare transformation is built on connectivity and communication. The community benefit office can be a leader in this transformation. The community benefit office needs to focus on creating meaningful linkages between the physicians' offices and the community resources. The work of the community benefit executive will be magnified when he recruits the physicians as partners. The physicians have a natural reach into the community by virtue of the connection with patients. A community benefit office cannot make this connection without the physicians. The structure of the partnership should be based on the work by Etz ensuring that the community resources are made known to the community physicians, that there is a single point of referral for the patient, and that there bi-directional information exchange allowing the physicians to receive information about how their patients are intersecting with the community partners. The hospitals can contribute to making this connection possible through development of referral resources that can serve both inpatient and outpatient physicians and the development of IT systems that can interface with outside partners.

Section 1.D: Infrastructure

Another compelling finding was that ambulatory physicians cannot participate in meaningful population health efforts without the proper tools in their offices. The respondents identified the following tools as necessary: patient registries, panel support tools, staffing models with navigators and case managers, interconnected IT systems, and protected time to devote to population health activities. These system redesigns are expensive and require a substantial investment. The required investment is beyond what the physician network can afford without subsidization from the hospital. The

hospital needs to invest in these practice tools for population health. The community benefit office can participate in funding some of these tools through community benefit programs.

Section 2.: Further Recommendations Regarding Implementation

Section 2.A.: Short-term Wins

Many of the recommendations require significant capital and time to accomplish. In order to be successful, the community benefit officers need to find ways to create short-term wins to celebrate the success of the efforts while working toward longer institutionalized changes.

Section 2.B.: Enlisting Allies

Changing the way that a system operates is not easy. Even with strong recommendations and a communication plan in place, change agents must find ways to make the change happen (Kotter). First, they must enlist others to help make the change happen. Kotter instructs change agents to surround themselves with a large force of people who are ready, willing, and urgent to drive change.   The community benefit officer needs to find allies inside the hospital who can help remove barriers that will be faced. The enlisted should include doctors, administration, and leadership. As discussed above, there are significant resources that need to be invested to help a hospital answer the call of impacting community health through their ambulatory physicians.   The community benefit officers need to understand that to make the change, they need to simply take leadership and make things happen. Helen Bevan, Chief Transformation Officer of the UK's National Health Service and leading change management practitioners teaches that one of the biggest impediments to making

change is asking for permission. She teaches that would-be change agents wait for someone in a higher position to tell them that it is okay for them to move forward with the proposed change and therefore miss the opportunity to implement their change. This is true for many of the community benefit officers included in this study. In several of the interviews, the community benefit executive relayed a reluctance to over-step their perceived boundaries. While it is true that there are organizational norms that one must consider, the community benefit executives can start this change by taking action. The community benefit executives need to schedule meetings with the leadership of the hospital and the physician network, propose collaborative teams, and develop short-term and long-term plans that include the proposed work.   Most of the work that needs to be done can be accomplished once the community benefit executive has the vision of creating a more connected program among the community physicians and the community partners.

Section 2.C.: Sustain Acceleration and Institute Change

The final two steps in Kotter's framework are to sustain acceleration and institute the change. (Kotter). Acceleration is sustained by hiring, promoting, and developing employees who can implement the vision. This step in the change process requires making the new program part of the institutional framework so that is not forgotten over time. The organizations should create a community benefit coalition that includes community partners, community physicians and the community benefit office. The purpose of the coalition is to determine what community needs can be met by each of the partners and create pathways for how to address those needs. Time spent in the coalition work should be compensated time for the physician. The structure can be

solidified by requiring that coalition report to the hospital board and the physician

network board at least twice a year. This will increase accountability of the coalition to

reach its goals. It will also create visibility into the work of the coalition creating political

support among the organizations. The coalition will become part of the fabric of the

organization and will not risk being forgotten as just another initiative. By articulating the

connections between the new behaviors and organizational success, the change will

become institutionalized. This is the final step in Kotter's 8 Steps of Change. Once the

change is institutionalized, it has become a lasting part of the organization's structure

and expected operation. This is when we know that we have been successful in our

efforts.

CHAPTER VII: CONCLUSION

Now is the right time for a change. Nonprofit hospitals can make a difference in their communities' health. Community health advocates need to work with hospital administration to create a sense of urgency regarding the need to redefine how community benefit programs target community health. Currently there are five drivers that the community health advocates should use to create a burning platform: regulatory scrutiny regarding tax exemption, the Affordable Care Act's population health priority, the advent of Accountable Care Organizations and outcome based reimbursement, market trends in network development, and the development of new healthcare frameworks. Hospitals can not accomplish this change on their own, but must build strong coalitions and embrace partnerships with community agencies in order to address upstream causes of poor health. As hospitals partner with the community agencies, they must build a bridge to the ambulatory physicians' offices so that the partnerships yield the intended results. Community health advocates must communicate the vision of fully utilizing the physicians' clinics as a touchstone of the community benefit program. Once the vision is communicated, the community benefit executives need to simply start operating in the vision. By starting the work, the community benefit executive enables the actions of the community benefit office to expand. As hospital administration and physicians begin to see the work that can be accomplished by creating vibrant partnerships, the hospital needs to formalize the new

programs by integrating the planning and implementation into the hospital's strategic

plan. Through the concerted efforts of change makers, we can continue to transform

community benefit programs from a regulatory nuisance to a powerful agent in affecting

community health through the distributed ambulatory physicians' offices.

EPILOGUE

This dissertation has focused on the work that needs to be done to redirect the $12 billion dollars that are used in US non-profit hospital community benefit programs from marketing programs to programs that can have a deep effect on community health. Throughout the dissertation, I have encouraged community benefit officers and community health advocates to take steps to make change happen. Change is personal and often starts with one person. I am committed to helping make this change happen.

I have accepted a job as the Chief Strategy Officer of UCSF Benioff Children's Hospitals in San Francisco and Oakland, California. As part of my job, I will be in leadership with the Office of Community Health and Engagement. My co-chair is the CEO of the UCSF Benioff Children's Hospital Oakland. He shares the vision of how we can work together to impact community health. Our recruited team includes ambulatory physicians, researchers, community benefit personnel, finance personnel, and administrative support. Our first retreat is planned in April 2015. We will be working together to articulate the vision of how we use our resources in a directed way to impact our communities' health. The right people are included in the coalition. We can make decisions and have the power to implement them.

Once we are able to articulate a strategic plan, develop the implementation plan, and create a budget, we will present to the UCSF Benioff Children's Hospitals Board of Directors. We have made a preliminary report to the Board to garner support for these efforts. The Board has asked us to think big and create a program that is best in class. We intend to do so.

APPENDIX A: E-MAIL REQUEST FOR PARTICIPATION

Dear [Insert Participant's Name]

My name is Lisa Ozaeta. [Insert Referral] referred me to you.

I am a doctoral student at the University of North Carolina at Chapel Hill in the School of Public Health. I am writing to request your participation in a doctoral research study I am conducting on how non-profit hospitals can engage their community physician practices to affect population health through community benefit programs. Participation would include an interview that would take place at a time and location that is convenient for you and will last approximately 45-60 minutes.

I have included a Fact Sheet regarding the research study to help answer any questions you might have.

Thank you for considering participation in this study. Please reply to this e-mail to indicate whether or not you are available to participate. I can be contacted directly at Ozaeta@live.unc.edu or 925.285.3645 if you have any questions.

Sincerely,

Lisa H. Ozaeta, JD, MBA

Attachment: Fact Sheet

APPENDIX B: FACT SHEET

IRB Study Number:_____
Consent Form Version Date: March 2014
Title of Study: Searching for Health Reform: How can non-profit hospitals utilize their ambulatory practices to satisfy their IRS mandated Community Benefit obligation and improve population health?
Principal Investigator: Lisa H. Ozaeta
UNC-Chapel Hill Department: UNC Gillings School of Global Public Health, Department of Health Policy and Management
UNC-Chapel Hill Phone Number: 919.966.7364
Faculty Adviser: Mark Holmes, PhD
Study Contact telephone number: 925.285.3645
Study Contact e-mail: ozaeta@live.unc.edu

What are some general things you should know about research studies?

You are being asked to take part in a research study. To join the study is voluntary.

You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study. There may also be risks to being in research studies.

Details about this research study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study.

You will given a copy of this consent form. You should ask the researchers named above any questions that you have about this study at any time.

What is the purpose of this study?

The purpose of this study is learn innovative ways that non-profit hospitals can redirect their community benefit dollars to affect population health through programs in partnership with their distributed ambulatory clinics.

You are being asked to participate in the study because you have professional responsibility related to community benefit programs, physician networks, population health or strategy.

How many people will be interviewed for this study?
If you decide to be interviewed for this study, you will be one of approximately 15-20 people interviewed for this research study.

How long will your part in the study last?

If you decide to interviewed for this study, you will be asked to meet in-person or by telephone for a 45-60 minute interview. If you agree, you may also be contacted by e-mail or telephone to address follow-up questions or clarifications if needed.

What will happen if you participate in the study?

Participation in the interviews for this study will involve the following steps:

- Read this fact sheet and the information enclosed to determine your interest in participating in this study.

- Contact the researcher listed on the first page of this form with any questions or concerns regarding your participation.

- Schedule a time to participate in a 45-60 minute interview (interviews may be conducted in-person or over the telephone).

- Participate in a 45-60 minute interview either in-person or over the telephone.

- Address follow-up questions or clarifications if needed after the interview.

What are the possible benefits from being in this study?

You may benefit from participating in this study by discovering new ways that community benefit dollars can be used to benefit public health through your distributed ambulatory practices. The research is designed to benefit the greater healthcare system and population health by gaining new knowledge. You may not benefit personally from being in this research study.

What are the possible risks or discomforts involved from participating in this study?

There are no known or expected risks to participating in this study.

How will your privacy be protected?

The researcher listed on the first page of this form is the only person who will have access to information that links individual participants to the responses from the interviews.

- Participants will be asked for permission before being identified in any report or publication about this study.

- Records of the interviews will be stored electronically in password protected files.

- At the time of the interview, participants will be asked for permission to record the interview for transcription. If an interview is recorded, a transcript will be made and the audio recording will be destroyed.

- Any hard copy information linked to an individual's responses to interview questions will be stored in a locked file cabinet in the principal investigator's office.

Although every effort will be made to keep research records private, there may be times when federal or state law requires the disclosure of such records, including personal information. This is very unlikely, but if disclosure is ever required, UNC-Chapel Hill will take steps allowable by law to protect the privacy of personal information. In some cases, your information in this research study could be reviewed by representatives of the University for purposes of quality control and safety.

Will you receive anything for being in the study?

You will not receive anything for participating in the study.

Will it cost you anything to be in the study?

Other than your time, there will be no costs for participating in the study.

What if you have questions about this study?

You have the right to ask, and have answered, any questions yu may have about this research. If you have questions or concerns, you should contact the researcher listed on the first page of this form.

What if you have questions about your rights as a research participant?

All research with human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research participant, you may contact, anonymously if you wish, the Institutional Review Board of UNC at 919.966.3113 or by email to IRB-subjects@unc.edu.

APPENDIX C: CONSENT FORM

Interview Consent Form

Title of Study:
Searching for Health Reform: How can non-profit hospitals utilize their ambulatory practices to satisfy their IRS mandated Community Benefit obligation and improve population health?

Investigator:
Lisa H. Ozaeta, JD, MBA, DrPH (candidate) Department of Health Policy and Management, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.

Purpose: The purpose of this study is learn innovative ways that non-profit hospitals can redirect their community benefit dollars to affect population health through programs in partnership with their distributed ambulatory clinics.

Potential Benefits: You may benefit from participating in this study by discovering new ways that community benefit dollars can be used to benefit public health through your distributed ambulatory practices. The research is designed to benefit the greater healthcare system and population health by gaining new knowledge. You may not benefit personally from being in this research study.

Potential Risks: There are no known or expected risks to participating in this study.

Privacy Protection: The researcher listed on the first page of this form is the only person who will have access to information that links individual participants to the responses from the interviews. Participants will be asked for permission before being identified in any report or publication about this study. Additional information about privacy protection is available on the Study Fact Sheet.

Consent

I, _____, understand that I am being asked to participate in a University of North Carolina study to answer question relating to the use of community benefit dollars to affect population health through distributed ambulatory practices/

I understand that it is my voluntary choice to participate in this study, and I also understand that I may refuse to answer any question during the interview and/or withdraw from the study at any time without penalty.

A summary of the results of my interview will be made available to me upon completion of the study, should I request a copy. I understand what this study involves and I freely agree to take part. A copy of this written consent form will be provided to me upon request.

I understand that my verbal consent after having this form read to me shall constitute my consent as if I had signed this consent below.

_____

_____

Signature of participant   **Name of participant**   **Date**

If you have any questions or concerns, either prior to or following your participation, please do not hesitate to contact me.

Lisa H. Ozaeta at 925.285.3645 or by email at Ozaeta@live.unc.edu.

PROVIDING COMMUNITY BENEFIT
THROUGH COMMUNITY PHYSCIAN PRACTICES

INTERVIEW GUIDE COMMUNITY BENEFIT EXECUTIVE

I.   Introduction

A.   The objective of this project is to understand how non-profit hospitals can engage their community physician practices to affect population health through community benefit programs.

B.   This interview is in support of my dissertation which is a partial fulfillment of the requirements for my doctorate in public health at the UNC Gillings School of Global Public Health at Chapel Hill.

C.   The purpose of the interview is to:

- Receive feedback regarding specific challenges and priorities faced by the hospital in undertaking a community benefit program.

- Obtain a better understanding of the hospitals' effort to use offsite community benefit programs with regard to strengths and weaknesses, opportunities, strategic plans, and previous and future plans to use physician practices as part of the community benefit program.

- Obtain feedback regarding potential efforts to use physician practices as part of community benefit programs.

D.   All interviews will be kept confidential.

II.   Background Information

- Please give a brief description of your background and role at the hospital.
- Please describe the community benefit (CB) program at the hospital including:
    - What kind of activities/services are included in your CB program?
    - How much is spent or allocated on CB programs?
    - What is the goal or what do you hope to achieve through CB?
    - How do you monitor the effect of the CB programs?
        - *Prompt: Patient/Doctor/Donor satisfaction, outcomes, other analytics (ER use, re-admission)*

- Is implementing the community benefit program easy or hard at the hospital?
  - Why? What are the obstacles or what makes it easy?
- How are priorities for the CB program set? Who decides where money will be spent or which activities will be undertaken?
  - *Model Intent: Is the Community Needs Assessment or Community Advisory Group used to help set priorities. How responsive are the Community Benefit Programs to the needs identified through these two resources?*
- If there is one thing that you think the hospital should do regarding its community benefit program, what would that be?
- What are the greatest needs that could be addressed through a community benefit program?

III. Community Benefit administered with Physician Practices

- Has the hospital pursued any community benefit programs off-site? What are they?
- Have any programs been administered through or in conjunction with community physician practices?
  - What were the outcomes?
  - What were the barriers?
  - What helped make the project successful?
  - What else would have been needed to make the project more successful?
- What kind of programs could the hospital administer through the physician practices?
- What would the barriers or obstacles be to providing these services through the physician practices?
- What resources would be needed to make providing CB through physician services successful?
- Have you found community physicians interested in participating in community benefit activities?
  - If not, why? If so, why?
- Are community physicians integrated into community benefit planning? Could they be? How? What could that look like?

IV. Community Benefit administered with Partners

- Has the hospital pursued any community benefit programs with other partners? What are they?
- What were the outcomes?
- What was hard about implementing the CB program with an outside partner?
- What helped make the project successful?
- What else could have helped make the project even more successful?

- Have you found other agencies or providers reaching out to you to create joint CB programs?
- Has your hospital/health system reached out to others? Why or Why not?

IV. Closing

Do you have any questions or comments on issues that we did not cover? What else should I be thinking about?

APPENDIX E: PHYSICIAN NETWORK EXECUTIVE INTERVIEW GUIDE

PROVIDING COMMUNITY BENEFIT
THROUGH COMMUNITY PHYSCIAN PRACTICES

INTERVIEW GUIDE PHYSICIAN NETWORK EXECUTIVE

I. Introduction

A.   The objective of this project is to understand how non-profit hospitals can engage their community physician practices to affect population health through community benefit programs.

B.   This interview is in support of my dissertation which is a partial fulfillment of the requirements for my doctorate in public health at the UNC Gillings School of Global Public Health at Chapel Hill.

C.   The purpose of the interview is to:

• Receive feedback regarding specific challenges and priorities faced by the physician network in undertaking a population health program.

• Obtain a better understanding of the hospitals' effort to use offsite community benefit programs with regard to strengths and weaknesses, opportunities, strategic plans, and previous and future plans to use physician practices as part of the community benefit program.

• Obtain feedback regarding potential efforts to use physician practices as part of community benefit programs.

II.   Background Information

• Please give a brief description of your background and role at the hospital.
• Please describe the physician network the hospital including:
    o How is it organized?
    o How many physicians are included (employed, other affiliation, independent)?
• How is the physician network involved population health efforts? Payment reform?
    o What are the incentives for the physician network to undertake population health efforts?
• What are the greatest needs that could be addressed through a population health program through the physician network?

III. Community Benefit administered with Physician Practices

- How does the physician network learn of the needs of its community?
- Review the population health preparedness checklist. Which of capabilities do your physician offices currently have?
- How are population health priorities set for the network?
- Have any programs been administered through or in conjunction with community physician practices?
  - What were the outcomes?
  - What were the barriers?
  - What helped make the project successful?
  - What else would have been needed to make the project more successful?
- What kind of programs could the hospital administer through the physician practices?
- What would the barriers or obstacles be to providing these services through the physician practices?
- What resources would be needed to make providing CB through physician services successful?
- Have you found community physicians interested in participating in community benefit activities?
  - If not, why? If so, why?
- Are community physicians integrated into community benefit planning? Could they be? How? What could that look like?
- Does the physician network work with the community benefit office in any way?
- Have any of your population health initiatives been funded as pilot projects through the community benefit office?
- Is it desirable? Why or why not?

IV. Community Benefit administered with Partners

- Has the physician network pursued any community benefit programs with other partners? What are they?
- How did the physician network make connections with the community providers? How did CB office play a part in the connection?
- What was hard about implementing the CB program with an outside partner?
- What helped make the project successful?
- What else could have helped make the project even more successful?
- If the physician network does work with community agencies, is there a feedback loop of information back to the physician.

IV.   Closing

APPENDIX F: PHYSICIAN INTERVIEW GUIDE

PROVIDING COMMUNITY BENEFIT
THROUGH COMMUNITY PHYSCIAN PRACTICES

INTERVIEW GUIDE COMMUNITY PHYSICIAN

I.   Introduction

A.   The objective of this project is to understand how non-profit hospitals can engage their community physician practices to affect population health through community benefit programs.

B.   This interview is in support of my dissertation which is a partial fulfillment of the requirements for my doctorate in public health at the UNC Gillings School of Global Public Health at Chapel Hill.

C.   The purpose of the interview is to:

- Receive feedback regarding specific opportunities for hospitals to affect community health through activities conducted in conjunction with its community physicians.
- Obtain a better understanding of how community physicians can assist their hospital partners in improving community health.
- Obtain a better understanding of what challenges exist for hospitals and community physicians in seeking to positively impact population health.
- Receive feedback as to what additional resources or assistance is needed from hospitals to allow community physicians to improve population health in the communities in which they serve.

II.   Background Information

- Please describe your practice.
    - What is your specialty?
    - How long have you practiced?
    - Is your practice part of a health system or hospital network?
    - Which one?
- Please describe the community in which your practice is located.
- Are you aware of the health needs of the community in which you practice?
    - If yes, what are they?
    - How do you learn of the health needs of your community?
    - If no, would you like to know?
        - What would you need so that you would know?

III. Community Benefit administered with Hospital Partners

- Are you integrated into community benefit planning with your hospital partner?
    - Could you be?
    - How?
    - What could that look like?
- Are you involved in any community health project in partnership with your hospital partner?
    - If so, please describe.
        - What were the outcomes?
        - What were the barriers?
        - What helped make the project successful?
        - What else would have been needed to make the project successful?
    - If not, would you be interested in participating in a community health program with your hospital partner?
- What do you think are the greatest needs that could be addressed through a community benefit program?
- How can hospitals work with their community physician partners to affect population health?
    - What is needed to make that successful?
    - What are the obstacles?
    - Do you know of any examples?
        - What are they?

IV. Closing

Do you have any questions or comments on issues that we did not cover? What else should I be thinking about?

REFERENCES

"ACA Strategic Goals."Web. <http://www.hhs.gov/strategic-plan/goal1.html>.

"FAQ On ACOs: Accountable Care Organizations, Explained - Kaiser Health News."Web. 1/19/2014 <http://www.kaiserhealthnews.org/stories/2011/january/13/aco-accountable-care-organization-faq.aspx>.

"Health - Organisation for Economic Co-operation and Development."Web. 1/17/2014 <http://www.oecd.org/health/healthataglanceeurope.htm>.

"IRS Revenue Ruling 69-545."Web. <http://www.irs.gov/pub/irs-tege/rr69-545.pd>.

"Patient Protection and Affordable Care Act of 2010."Web. 2/8/2014 <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>.

"Social Determinants of Health - Robert Wood Johnson Foundation."Web. 1/17/2014 <http://www.rwjf.org/en/topics/search-topics/S/social-determinants-of-health.html?c=content-type:issue-briefs>.

"The Uninsured: A Primer, Key Facts About Americans Without Health Insurance, October 2012 - Issue Brief - 7451-08.pdf."Web. 9/8/2013 <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7451-08.pdf>.

Ainsworth, D., H. Diaz, and M. C. Schmidtlein. "Getting More for Your Money: Designing Community Needs Assessments to Build Collaboration and Capacity in Hospital System Community Benefit Work." *Health promotion practice* (2012)Web.

Association for Community Health Improvement. "Trends in Hospita-Based Population Health Infrastructure: Results from an Association for Community Health Improvement and American Hospital Association Survey." (2013)Print.

Bakken, E., and D. A. Kindig. "Is Hospital 'Community Benefit' Charity Care?" *WMJ : official publication of the State Medical Society of Wisconsin* 111.5 (2012): 215-9. Web.

Bazzoli, G. J., J. P. Clement, and H. M. Hsieh. "Community Benefit Activities of Private, Nonprofit Hospitals." *Journal of health politics, policy and law* 35.6 (2010): 999-1026. Web.

Buchmueller, T. C., and P. J. Feldstein. "Hospital Community Benefits Other than Charity Care: Implications for Tax Exemption and Public Policy." *Hospital & health services administration* 41.4 (1996): 461-71. Web.

Byrd, J. D., and A. Landry. "Distinguishing Community Benefits: Tax Exemption Versus Organizational Legitimacy." *Journal of healthcare management / American College of Healthcare Executives* 57.1 (2012): 66,76; discussion 77-8. Web.

Child Health Advocacy Committee. *Children's Hospitals: Creating Health.*, 2014. Print.

Etz R., et al. "Bridging Primary Care Practices and Communities to Promote Healthy Behaviors." *Am. J. Prev. Med.* 35 (2008): 5S. Print.

GAO. "U.S. GAO - Nonprofits Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements."Web. <http://www.gao.gov/products/GAO-08-880>.

Gray, B. H., and M. Schlesinger. "The Accountability of Nonprofit Hospitals: Lessons from Maryland's Community Benefit Reporting Requirements." *Inquiry : a journal of medical care organization, provision and financing* 46.2 (2009): 122-39. Web.

Green LA, Fryer GE, Yawn BP, Lanier D, Dovey SM. "The Ecology of Medical Care Revisited." *N.Engl.J.Med.* 344 (2001): 2021. Print.

Greenlining Institute. *Community Benefit and Missed Opportunities.*, 2014. Web.

Halfon N., Long P., Chang D., Hester J., Inlelas M., Rodgers A. "Applying A 3.0 Transformation Framework to Guide Large-Scale Health System Reform." *Health Affairs* 33.11 (2014)Print.

Health Research & Educational Trust. "Hospital-Based Strategies for Creating a Culture of Health." 2014Print.

Institute for Health and Economic Policy. *Benefiting from Charity Care: California Not for Profit Hospitals.*Web.

Jacobson, R., Rutten, L.,. *Building Capacity for Population Health Intervention: Research in Primary Care*. Washington DC: Institute of Medicine National Academies Press, 2013. Print.

Kindig D., Stoddart G. "What is Population Health?" *Am.J.Public Health* 93.3 (2003): 380. Print.

Kotter, John P. *Accelerate: Building Strategic Agility for a Faster-Moving World*. Harvard Business Review Press, 2014. Web.

Mattessich P., Rausch E. "Cross-Sector Collaboration to Improve Community Health: A View of the Current Landscape." *Health Affairs* 33.11 (2014): 1968. Print.

Roussos S., Fawvett S. "A Review of Collaborative Partnerships as a Strategy for Improving Community Health." *Annu.Rev.Public Health* 21 (2000): 369. Print.

Young, Gary J. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals." *The New England journal of medicine* 368.16 (04): 1519; 1519,1527; 1527. Web.