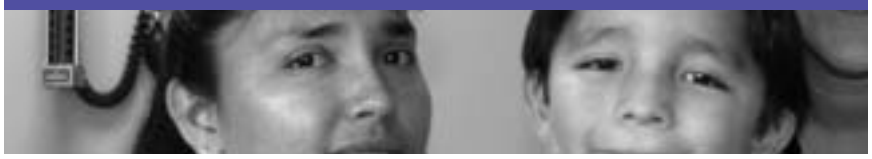
Report of the National Steering Committee

On Hospitals and the Public's Health

September 2006

Prepared by

The Health Research and Educational Trust



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Photos: top, by Margaret Molloy, courtesy of Venice Family Clinic; third from top, by Doug Haight; bottom, by Doug Haight

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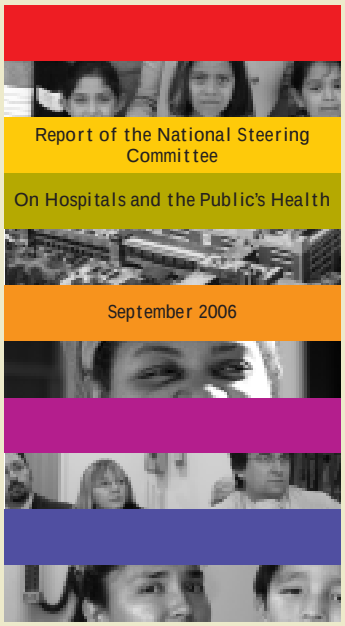

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Photos: top, by Margaret Molloy, courtesy of Venice Family Clinic; third from top, by Doug Haight; bottom, by Doug Haight

About the National Steering Committee on Hospitals and the Public's Health

Designing a strong and cohesive system to attend to the public's health requires an understanding of both the status quo and the future potential for the system's various parts. Since 2002, HRET has worked with the support of the Centers for Disease Control and Prevention to understand and inform hospitals' unique contributions to public health improvement. To this end, the National Steering Committee on Hospitals and the Public's Health is a critical endeavor.

HRET convened the National Steering Committee to guide us in our examination and identification of the role of hospitals in health promotion and disease prevention. Our specific aim was to illustrate why and how hospitals and health systems can be better integrated with the public health system. In return, the National Steering Committee charged HRET with issuing a call to action directed at policymakers and practitioners to incite fundamental change—to guide hospitals' and health systems' engagement in improving the public's health and to eliminate the barriers that systemically preclude this engagement in standard practice.

Members of the National Steering Committee on Hospitals and the Public's Health include hospital leaders, public health directors, and academics. Individuals were selected because of their thought and practical leadership in enhancing population health and meaningful collaboration between public health agencies and private health care. Steering committee members worked with HRET from July 2005 to September 2006, reviewing current recommendations and research about hospitals' connections to the public health system and highlighting missed opportunities for joint planning and practice. This process was designed to lay new groundwork for understanding how private health care can work with a public health system for the shared goal of improved health status.

While the immediate result of the committee's work is this report, it is the intent of HRET and the Steering Committee that together the current state and recommendations sections of this report provide a substantive starting point for discussion and strategic planning for health promotion and disease prevention at every level—organizational, community, regional, and national.

"In days past, if the rate of asthma shot up in a community, the local hospital might ask itself how it could become a center of excellence for treating asthma. Today, the same hospital has the responsibility to ask: Why do we have so much asthma and what can we do about it?"

Paul Hattis, Concentration Leader in Health Services Management and Policy, Tufts University School of Medicine

Executive Summary

The U.S. health care system is broken. Many hospital executives face nearly insurmountable challenges with respect to limited reimbursement, overburdened emergency departments, treatment for the uninsured, onerous regulations, patient safety and medical liability concerns, reporting and community benefit requirements, and staffing shortages. The year 2006 may not seem an opportune time to ask more of hospital leaders, yet that is precisely the goal of this report.

"Almost any way you look at the status of the U.S. health care system and the health of Americans today, it is clear that something has to give. The U.S. has the human, financial, and technological resources to turn this around. We also have the knowledge to more fully integrate prevention, health promotion, and health protection into our lives. What are needed are the will and the focus to make it happen. It's time for a change."

Georges C. Benjamin, Executive Director, American Public Health Association

The National Steering Committee on Hospitals and the Public's Health is calling on hospitals to fulfill a critical role as collaborators and leaders in recreating the U.S. public health infrastructure and capacity. Why should hospitals participate in this endeavor? The short answer is that they have a vested interest in their communities' health, and frankly, they cannot afford to maintain the status quo.

The old models of medical care and public health delivery no longer work. Our nation spends $1.8 trillion a year on health care, yet ranks 37th out of 191 countries on eight health outcomes tracked by the World Health Organization.[1] Seventy-five percent of health care spending is on preventable diseases that rob millions of Americans of quality life-years and deprive society of productive citizens. As Americans become sicker, we are not receiving an acceptable return on our investment in good health. We can save billions of dollars that we currently spend treating avoidable communicable and chronic diseases, if we invest instead in illness and injury prevention.

The public health system is the totality of public health departments, emergency response organizations, governmental agencies, hospitals and health care providers, pharmaceutical companies, social service organizations, religious institutions, and many other entities whose common goal is ensuring a healthy population. Until the terrorist attacks on the United States on Sept. 11, 2001, public health departments suffered from a near-fatal lack of funding. In response to the attacks, the federal government has spent

[1] Benjamin, G. 2006. "PERSPECTIVE: Putting the Public in Public Health: New Approaches" *Health Affairs* 25 (4): 1040-3.

billions of dollars during the past five years to resuscitate specific components of the public health infrastructure needed to fight a looming new threat: bioterrorism.

Public health services are best delivered locally, at the community level, but the majority of public health departments lack funding, information technology, and staff to adequately provide disease surveillance and protection to their constituents. Moreover, despite huge infusions of targeted funding from the federal government, public health agencies are ill equipped to respond to extraordinary bioterrorism and natural disaster threats. With decreasing annual budgets, many cannot perform traditional public health functions. Finally, determinants of disease include environmental, economic, and social factors that originate outside the purview of public health agencies.

It will take a multisectoral effort to improve population health at the community level. Business and labor have economic interests in improving workers' health. Schools are interested in improving the health of children, and thus family and community health. The public pays directly and indirectly for increasing health care costs attributable to declining population health status. Americans pay taxes to support Medicaid and Medicare. Those who are fortunate enough to have health insurance pay higher insurance rates due to cost shifting to cover medical treatment for the uninsured and underinsured. For these and other reasons, we all have economic and personal interests in improving the health of our communities.

The National Steering Committee is calling for change and innovation—for hospital leaders to help public health leaders define and develop a new public health system to improve Americans' health. Mutual respect and cooperation must guide efforts to recreate the public health infrastructure. The ideal is a partnership in which each member does the work for which it is best suited and supports the other in its work. Private and public health must engage in active dialogue and joint action to ensure the public's health. Rather than act in isolation, they must do a better job collaborating to advance the mutual goal of improving the health of people in local communities.

Most hospitals have already participated in bioterrorism preparedness planning and preparation with public health and emergency medical services partners. Hospitals collaborate with these and other agencies and organizations to meet the challenge of planning for and responding to a mass casualty event such as terrorism, a natural disaster, or a pandemic. Despite all the planning efforts, hospital CEOs recognize that many linkages are still missing with respect to disaster planning, as revealed before, during, and after Hurricane Katrina.

"What has become clear to me is that the story of public health is not simple to tell. Public health is so broadly involved with the biologic, environmental, social, cultural, behavioral, and service utilization factors associated with health that no one is accountable for addressing everything."

Bernard J. Turnock, Clinical Professor of Community Health Sciences, School of Public Health, University of Illinois at Chicago

This report calls for a new paradigm: Hospitals must look beyond their walls and the immediate sick. This new system of American health care requires a realignment of financial incentives—in both the public and private sectors. What follows is a more detailed introduction to the American health care crisis and a discussion of the role hospitals can and must play in changing the system and improving Americans' health. The National Steering Committee makes seven recommendations in areas where hospital leadership and involvement are urgently needed:

1. **Eliminate health disparities**
2. **Coordinate care**
3. **Promote primary prevention**
4. **Optimize access to care for all**
5. **Advocate payment for prevention**
6. **Build the community's capacity to stay healthy**
7. **Support recreating the public health infrastructure and expanding capacity**

Under each recommendation, guidance is provided on how hospital leadership can focus on and deliver new strategies for institutional involvement in these critical areas that affect the public's health. This report is intended to be used by hospital senior management and hospital trustees to:

- Assess current hospital practice with regard to the seven recommendations;
- Provide concrete actions that hospital leadership can take today;
- Identify issue areas for hospitals and health partners to advocate needed change; and
- Provide resources for hospitals to use to improve the public's health.

Introduction

U.S. Health Care: A Broken System

The U.S. health care system, both public and private, is in imminent danger of collapse. On the private side, more than 46 million[2] Americans lack health insurance, payers continue to slash reimbursements and cut coverage, and providers seek profitable services to counteract losses from uncompensated and under-compensated care. Waste, excessive administrative expenses, and excessive profits siphoned from health insurance premiums divert essential resources needed to provide medical treatment for all. Compounding these access, payment, and cost issues are concerns about quality of care.

The public health system is faring even worse than private health care. For decades, public health funding has been woefully inadequate. Traditional public health agency functions are not performed in many parts of the country that lack funding, a public health workforce, or both. SARS, 9/11, Hurricane Katrina, bird flu, anthrax attacks, and fears of an influenza pandemic are among recent public health crises that have made manifest the critical need for radical improvements in the public health infrastructure. In response to 9/11, the federal government significantly increased public health funding to states for bioterrorism preparedness, yet total U.S. spending on public health still amounts to less than 2.5 percent of total health care spending for Americans. Public health funding is severely deficient for meeting the demands and expectations of an aging population threatened by an alarming increase in chronic disease rates, terrorism, and natural disasters.[3] Long-term, systemic under funding is shocking in light of the most significant health achievement of the 20th century: Twenty-five of the 30 years of additional American life expectancy are attributable to public health; only five years are due to medical breakthroughs and improvements in medical care.[4]

Objective: Improve the American Public's Health

Americans believe in investing the lion's share of health-related spending in medical care and biomedical research, despite strong evidence that behavior and environment are responsible for more than 70 percent of avoidable deaths. The ultimate goal of the U.S. health care system, to improve the health of the American public, is all but forgotten by most medical providers, payers, and consumers. The loudest and most powerful health care constituencies champion pay-for-performance, medical error

[2] United States Census Bureau. 2006. "Income, Poverty, and Insurance Coverage in the United States: 2005" accessed on Oct. 11, 2006. Available at *http://www.census.gov/prod/2006pubs/p60-231.pdf*.

[3] Beitsch, L.M., R.G. Brooks, N. Menachemi, and P.M. Libbey. 2006. "Public Health at Center Stage: New Roles, Old Props" *Health Affairs* 25 (4): 911-22.

[4] Forums Institute for Public Policy. 2000. "New Jersey Public Health Financing in a Changing Environment—Implications for Policymakers" accessed on Oct. 11, 2006. Available at *http://www.forumsinstitute.org/publs/nj/ib35.pdf*.

reduction, evidence-based care, hospital report cards, and available low-cost health insurance and health care. The overwhelming focus is on treating illness, not promoting wellness. Lately, prevention, health screenings, and behavioral change have attracted increasing numbers of proponents and scientific inquiries, recognizing the need to target effective and efficient population-level interventions that will reduce the incidence of disease, or greatly mitigate its effects.

Death, disease, disability, quality of life, and reduction in harm are key health status indicators used to examine and compare aggregate rates of morbidity and mortality for community, state, and national populations. Comparing these measures of population health with results for similar populations, earlier results from the same population, or predetermined benchmarks reveals how well a health care system works. America spends more money on health care than any other country in the world, yet ranks 37th out of 191 nations on eight health outcomes tracked by the World Health Organization.[5] Current U.S. results are unacceptable and have reached a state of crisis.

Financing: Expenditures Uncorrelated to Outcomes

Photo by Margaret Molloy, courtesy of Venice Family Clinic

Annual expenditures on American health care total $1.8 trillion, nearly 75 percent of which is spent treating preventable diseases.[6] The cost of overweight and obese conditions ($98 to $128 billion annually), for example, is so great it jeopardizes the fiscal stability of every state and territory in the nation.[7] The National Governors Association charges that,

> *"The consequences of inaction [in eradicating preventable diseases] for Americans, states, and our nation are incalculable. States cannot afford to ignore these trends if they want to remain globally competitive, diminish catastrophic health care expenditures, and invest in a healthy, productive future for our nation."* [8]

U.S. health care is organized around its reward system: Financial incentives reward treating the sick, not wholesale improvement of the public's health. As one health care official put it, "We get paid for what we do, not what we accomplish."[9] Until population outcome measures are rewarded, we will not solve the 21st century challenge of maximizing health outcome improvement, given the resources available.[10] Within our country,

[5] Benjamin, "PERSPECTIVE" p. 1040.

[6] National Governors Association. "NGA Report on Healthy Living Investing in Illinois' Health" accessed on Aug. 16, 2006. Available at *http://www.subnet.nga.org/healthy/facts/IL.pdf*.

[7] Ibid.

[8] Ibid.

[9] Philip Lee, Former Asst. Secretary of HHS, quoted in Kindig, David. 1998. "Purchasing Population Health: Aligning Financial Incentives to Improve Health Outcomes" *Health Services Research* 33 (2): 223-42.

[10] Kindig, David. 1997. *Purchasing Population Health: Paying for Results,* p. 175. Ann Arbor, MI: University of Michigan.

the large variation in health outcomes across states and communities has no correlation to state health care expenditures.[11]

Improving Health Outcomes: Shifting Focus to Prevention

So, how can the U.S. health care system improve the health status of Americans? The focus must shift from treating illness to preventing illness. The payoff for disease prevention is increased productivity, increased states of well-being, and decreased health care expenditures for treating preventable illness. Our health care system, both public and private, must recognize and ameliorate determinants of preventable diseases. All sectors must play a role: employers, labor, medicine, hospitals, public health, community organizations, schools, faith communities, housing, governmental agencies responsible for environmental safety, workplace safety, and traffic safety, architects, engineers, urban planners, and others too numerous to mention. To date, regrettably, little integration has been developed across the boundaries of other potentially health-enhancing regulated sectors, such as education, housing, and the environment.[12]

The public health sector continues to address disease prevention at the population level in order to improve Americans' health. Programs such as Healthy People 2010 and the Task Force on Community Preventive Services take a specific disease—for example, cancer—and use a reduction of incidence and mortality approach to improve population health. Additionally, programs of this type have adopted a modification of risky behaviors approach to prevention. Yet a concerted and coordinated multisectoral effort is urgently needed to tackle determinants of disease in tandem with scientific research demonstrating the most efficacious and efficient actions that should be taken to improve population health.[13]

The reality, however, is that unless Americans' attitudes toward government involvement in public health fundamentally change, the federal government is unlikely to adopt, much less implement, a coordinated approach to ameliorate negative—and enhance positive—determinants of disease. Moreover, at the state and local levels, multisector population-level prevention and wellness efforts are unlikely to receive comprehensive public funding.

[11] Ibid., p. 2.

[12] Kindig, "Purchasing Population Health: Aligning Financial Incentives to Improve Health Outcomes" p. 225.

[13] Swedish National Institute of Public Health. 2003. "Sweden's New Public Health Policy National Public Health Objectives for Sweden" accessed on Aug. 7. 2006. Available at *http://www.fhi.se/shop/material_pdf/newpublic0401.pdf*.

The Hospital's Role:
A New Commitment to Improve the Public's Health

The Health Research and Educational Trust has assembled top hospital and public health leaders to consider how hospitals can optimize their signal role in improving the public's health and recreating the public health infrastructure. The National Steering Committee on Hospitals and the Public's Health has examined ways that hospitals can improve Americans' health and support public health efforts, given their capabilities and missions. Hospital participation must be substantial, extending far beyond providing acute care.

The American Hospital Association report titled *Trust Counts Now* analyzes the American public's eroding trust in hospitals. The report urges hospitals to strengthen their bonds with their communities. Hospitals need to change, and to do so they need to clearly comprehend the challenges ahead.[14] The hospital mission, according to *Trust Counts Now*, includes the challenge of balancing community health vs. the bottom line.[15] Ideally, hospitals will adopt a public health model that complements their finance and business models.[16] Hospitals are de facto community leaders, and optimally, they serve as agents of social change.[17] The 10 characteristics that model hospitals share, according to this American Hospital Association report, include:

1. They have a tradition of energetic, visionary, and innovative leadership.
2. They relate their own well-being to the health of the community.
3. They stay true to their core values while changing and improving.
4. They place patients and principle first.
5. They are good at their business, but business isn't all they do.
6. They see beyond their limited role as providers of acute care.
7. They collaborate with others to solve basic community problems.
8. They dedicate fiscal and human resources to improving the community's quality of life.
9. They communicate with the community—and they listen to the community.
10. They are respected locally and nationally.[18]

These trust-building ideals can be realized with a new commitment to community benefits—especially community health. Media accounts are constant reminders that hospitals need to take serious action to rebuild public trust. Nationwide, local

[14] American Hospital Association. 2006. "Trust Counts Now" accessed on Aug. 24, 2006. Available at *http://www.caringforcommunities.org/caringforcommunities/content/trustcounts.pdf#search=%22American%20Hospital%20Association%20Trust%20Counts%20Now%22*.

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] Ibid.

newspapers are asking what hospitals are doing for the community's good. Critical inquiries about hospital profits and surpluses and government scrutiny of insufficient charitable care are putting hospitals on the defensive. There are calls for excess hospital funds to be allocated for community investment. *Trust Counts Now* strongly endorses a public health mission to guide hospital strategic planning, including allocation of resources.

It takes joint collaboration to create a healthy community with partners such as local public health agencies, social service agencies, businesses, government, schools, the faith community, and even hospital competitors. In fact, collaboration among multiple partners is essential to every public health endeavor. The first step for collaboration between hospitals and public health is performing a community assessment to determine population health status and identify areas with health needs. An assessment, for example, might identify particular neighborhoods with higher than average incidence of diabetes, barriers to health care access, or disparities in health care based on ethnicity, sex, and economic status. This allows public health, hospitals, and other partners to shift resource allocation to areas that will reap greater benefits and to modify approaches to medical care to produce better outcomes.

One area of public health in which hospitals and public health agencies have already joined other partners is emergency preparedness planning. When natural and manmade disasters strike, it becomes all too obvious that hospitals and public health must collaborate, but in reality this need is ever-present. Since 2002, the federal government has devoted considerable financial and administrative resources to aid states and localities in emergency preparedness planning. Federal funding from the National Bioterrorism Hospital Preparedness Program and CDC Public Health Emergency Preparedness Cooperative Agreement is distributed by the states to community hospitals and local health departments. A recent study finds that key results of bioterrorism preparedness efforts at the local level include an upgraded public health infrastructure, improved communication networks, and better collaboration among hospitals, health departments, and other emergency response agencies.[19] The benefits of preparedness planning inure to the public health system as a whole. For example, local bioterrorism preparedness efforts have aided responses to infectious disease outbreaks and distribution of flu vaccine.

Emergency preparedness cannot be achieved without a strong public health infrastructure, adequate financing, and contributions from all sectors of the public health system, including hospitals. There are many gaps and inadequacies in emergency preparedness planning and responses as evidenced by Hurricane Katrina and a number of recent

[19] Center for Studying Health System Change. 2006. "Bioterrorism Preparedness Efforts Strengthen Public Health Capabilities" accessed on Aug. 21, 2006. Available at *www.hschange.com/CONTENT/859/?PRINT=1*.

public health disasters in other parts of the country. Hospital leaders can bring a unique perspective to identify missing emergency preparedness linkages and work toward adding them. Likewise, hospitals can fulfill a similar role in improving the public's health through their insights, contributions, and advocacy for increased public health funding in recreating the public health system.

"[F]or health care reform to capture what is possible in improving the health of Americans, it must embody a population-based public health perspective."

J. Michael McGinnis, Senior Scholar, Institute of Medicine

Finally, there are also financial reasons for hospitals to lead and participate in collaborative efforts to improve the public's health. The Centers for Disease Control and Prevention estimates that 96 percent of Medicare spending and 83 percent of Medicaid spending is for people with chronic conditions.[20] According to the CDC, health care costs attributable to those with a chronic condition average five times more than costs for those without such a condition.[21] Federal and state response to steadily increasing costs of health care for Medicare and Medicaid recipients is to reduce reimbursements to health care providers, including hospitals.[22] This means that as the number of people with chronic diseases grows, hospitals can expect to receive lower payments for treating more cases of increasing severity. The financial impact of chronic disease on providers—lower reimbursement from both public and private payers' misguided cost control efforts—does not bode well for hospital budgets. Now is the time to address and reverse alarming and increasing rates of chronic disease. It is in every hospital's economic interest to reduce chronic disease incidence in its community by developing, in collaboration with other partners, a population-based method of disease prevention.

Hospital leadership is urgently needed to advocate for and help create a "rational, coordinated, comprehensive, and better-financed public health system."[23] This new system will face many hurdles. Every locality must have access to functional public health services. Laws and regulations that promote good health outcomes must be enacted. More public health research must be funded to determine accurate and appropriate ways to measure population health outcomes and targets, and to monitor progress. Health impact assessment, systematic review, and community fit and feasibility analyses are essential to provide evidence-based public health to efficiently and effectively improve community health outcomes.[24] Future federal funding must be assured.

[20] National Center for Chronic Disease Prevention and Health Promotion. 2006. "Global and Domestic Health Priorities: Spotlight on Chronic Diseases" accessed on Aug. 25, 2006. Available at *http://www.wbgh.org/opportunities/webinar052306chronicdiseases.pdf*.

[21] Thorpe, K.E., and D.H. Howard. 2006. "The Rise in Spending among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity" *Health Affairs* 25 (5): w378-w88. Accessed on Oct 10, 2006. Available at *http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w378*.

[22] Ibid.

[23] Baker, E.L., and J.P. Koplan. 2006. "Strengthening The Nation's Public Health Infrastructure: Historic Challenge, Unprecedented Opportunity" *Health Affairs* 21 (6): 15-27.

[24] Fielding, J.E., and P.A. Briss. 2006. "Promoting Evidence-Based Public Health Policy: Can We Have Better Evidence and More Action?" *Health Affairs* 21 (6): 969-78.

How To Use This Report

These and other matters requiring redress are addressed in the following seven recommendations. These recommendations are neither sequential nor all-inclusive, and they involve considerable overlap. Under each recommendation, guidance is provided on how hospital leadership—CEOs and trustees—can target and deliver new strategies for institutional involvement in critical areas that affect the public's health. This report is intended to be used by hospital senior management and hospital trustees to:

- Assess current hospital practice with regard to the seven recommendations;
- Provide concrete actions that hospital leadership can take today;
- Identify issue areas where hospitals and health partners can advocate needed change; and
- Provide resources for hospitals to use to improve the public's health.

Definitions Used in This Report

- **Improving the public's health** is broadly defined by the National Steering Committee, which subscribes to the World Health Organization's 1978 expanded definition of health: "complete physical, mental, and social well-being, and not merely the absence of disease or injury."
- **Public health** is used to refer to local public health agencies or public health functions performed by other governmental entities where local public health agencies are not available. These are activities undertaken at the federal, state, regional, or local level to assure the conditions in which people can be healthy and include organized community efforts to prevent, identify, and counter threats to the health of the public.[25]
- **Public health infrastructure** refers to the systems, competencies, relationships, and resources that enable public health's core functions and essential services in each community. These include human, organizational, informational, and financial resources.[26]
- **Private health care** is used to distinguish the work of non-public hospitals and health systems and other forms of non-public health care delivery from government-sponsored public health efforts.

[25] Turnock, B.A. 2004. *Public Health and How It Works,* p. 398. Sudbury, MA: Jones and Bartlett Publishers Inc.

[26] Ibid., p. 393.

ELIMINATE HEALTH DISPARITIES

Recommendation 1

"Martin Luther King Jr. once said, 'Of all the forms of inequality, injustice in health is the most shocking and inhumane.' Yet we continue to tolerate its existence. Forty-six-plus million individuals in this country without health insurance, and we talk about a compassionate nation."

Lovell A. Jones, Director, Center for Research on Minority Health, University of Texas M. D. Anderson Cancer Center

IDEAL STATE

There are no differences in health care received by patients based on sex, race, ethnicity, economic status, level of education, or any other classification. There are no differences in access among different populations. Similarly, language barriers do not affect health outcomes. Hospitals and health systems are able to keep pace with changing U.S. demographics by providing culturally competent care to people of diverse cultures, and communicating effectively to all populations to promote health and prevent or reduce the severity of disease and disability.

CURRENT STATE

Studies of health care quality that include data on patient sex, race, ethnicity, income, and other social and economic characteristics indicate that in general, people who are members of racial and ethnic minorities, who have lower incomes, and who are less educated receive poorer quality care.

Factors contributing to disparities in health care operate on both the individual and systems levels. On the systems level, these factors include fragmentation of care, financial and physical barriers, information barriers on the part of both providers and patients, and differential access to high-quality hospitals and other health care facilities. On the individual level, these factors include lack of trust between practitioner and patient, lack of understanding of patients' culturally based health beliefs and behaviors, problems of health literacy and English language proficiency, as well as bias and prejudice on the part of providers and practitioners.[27]

Using the most recent data from 2003, a study published by the federal Agency for Healthcare Research and Quality (AHRQ) examined the rates of preventable hospitalizations among different racial and ethnic populations. The study shows significant differences in the hospitalization rates for whites, blacks, and Hispanics. The disparities were greatest for those with chronic conditions such as asthma, hypertension, and

[27] The Commonwealth Fund. 2006. "Health Care Disconnect: Gaps in Coverage and Care for Minority Adults: Findings from the Commonwealth Fund Biennial Health Insurance Survey (2005)" accessed on Oct. 11, 2006. Available at *http://www.cmwf.org/publications/publications_show.htm?doc_id=386220*.

diabetes. Compared with whites, rates of admission for these conditions were three to five times greater among blacks and two to three times greater among Hispanics. These differences raise questions about disparate access to timely and effective preventive and primary care.[28]

ACTION PRINCIPLES

- ***Health disparities are unacceptable and must be eliminated.*** Care must not vary in quality or accessibility on the basis of gender, ethnicity, geographic location, or socioeconomic status.
- ***Providers must at all times demonstrate respect for patients' values, preferences, and expressed needs.*** Hospitals must train culturally competent health care staff and constituents.
- ***Providers should hire management and clinical staff who reflect the racial, ethnic, and cultural diversity of the communities they serve.*** Similarly, providers should partner with organizations with diverse staff.
- ***Culturally competent providers offer better care.*** Health practitioners who understand the varying susceptibility of different populations to diseases can more quickly diagnose those conditions and give patients better care. For example, diabetes prevalence is 100 to 200 percent greater among Hispanics than among non-Hispanic whites, placing Hispanics at greater risk for renal failure, congestive heart failure, and blindness. African American males experience a 300 percent higher mortality rate for prostate cancer than white men.
- ***Culturally competent staff increase patients' satisfaction with health care encounters.*** Increased satisfaction is associated with racially and ethnically diverse staff. Hospitals with a reputation for cultural expertise attract people who value culturally attuned services for themselves and their families.
- ***Hospitals must ensure staff are culturally competent.*** They can offer training to enable staff to understand how patients of different cultures act in a clinical setting and to communicate with minority patients to ensure the best possible outcomes. This includes understanding the prevailing cultural preferences, values, and attitudes of diverse groups, providing professional medical translators, and being willing to take additional measures to assist limited English proficiency patients.

"Disparities in health and health care illuminate weaknesses in the health care and public health systems. Interest in better understanding the causes of these differences and formulating strategies to ensure the highest quality of care for everyone has generated significant attention to disparities across racial and ethnic groups."

***Eliminating Health Disparities*, National Research Council**[29]

[28] Ibid.

[29] National Research Council. 2004. *Eliminating Health Disparities: Measurement and Data Needs*, p. 22. Washington, DC: The National Academies Press.

"Promising Practices for Patient-Centered Communication with Vulnerable Populations: Examples from Eight Hospitals."

Matthew Wynia, M.D., M.P.H., and Jennifer Matiasek, M.S., of the American Medical Association's Institute for Ethics identify hospitals with a demonstrated commitment to communicating with their vulnerable patients. Through site visits and focus group discussions, the authors draw out nine "promising practices" used by the selected hospitals. These practices include:

1. Encourage passionate champions throughout the organizations
2. Collect information to demonstrate need
3. Engage communities
4. Develop work force diversity and communication skills
5. Involve patients every step of the way
6. Be aware of cultural diversity
7. Provide effective language assistance services
8. Be aware of low literacy and use clear language
9. Evaluate organizational performance over time

- ***Effective communication between health care providers and patients is essential.*** It facilitates access to care, reduces health disparities and medical errors, and increases the likelihood that limited English proficiency patients will comply with treatment plans. Incorrect diagnoses and treatment instructions that result from misunderstandings can have serious consequences for patients.

IMMEDIATE ACTIONS FOR HOSPITAL LEADERS

- **Provide staff with cultural competency training by qualified cultural competency educators.**
- **Periodically test all staff, including leadership, about cultural competency principles and behaviors.**
- **Implement quality improvement processes to assess the adequacy of language services used when providing care to limited English proficiency patients.**
- **Collect race, ethnicity, and primary language data accurately to monitor quality of care for different populations treated in the hospital.** Efforts to stratify quality measurements by race and ethnicity will help the health system provide three critical functions for all populations served by the hospital or system: 1) ensure the health of the population, 2) ensure equitable access to care, and 3) ensure quality of care.

CURRENT PERFORMANCE ASSESSMENT

1. Is your hospital systematically collecting race/ethnicity and primary language data to measure quality of care, reduce disproportionate health outcomes, and provide patient-centered care?

2. Does your institution track patient satisfaction from diverse patient groups in order to understand how to improve care processes and health education for these populations?

3. Is your institution in step with the latest concepts of cultural sensitivity? Do you periodically conduct self assessments on cultural proficiency? [See self assessment resources listed below.]

4. Are you collecting race, ethnicity, and primary language data accurately? Are you using recommended and standardized processes—for example, self report by patients or their designees and standardized methods of data collection? [See HRET resources listed below.]

RESOURCES

1. Issue Brief *Collecting Race, Ethnicity, and Primary Language Data: Tools to Improve Quality of Care and Reduce Health Care Disparities*, HRET, 2005: http://www.hret.org/hret/publications/content/isbr1105.pdf

2. *A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients*, HRET: http://www.hretdisparities.org/hretdisparities_app/index.jsp

3. *A Diversity and Cultural Proficiency Assessment Tool for Leaders*, American College of Healthcare Executives, American Hospital Association, National Center for Healthcare Leadership, and Institute for Diversity in Health Management:http://www.aha.org/aha_app/issues/Disparities/index.jsp

4. *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*, HRET, 2006: http://www.hret.org/hret/languageservices/content/languageservicesfr.pdf

5. *Quality Health Care For Culturally Diverse Populations*, Diversity Rx: http://www.diversityrx.org/CCCONF/06/index.html

Photo by Margaret Molloy, courtesy of Venice Family Clinic

COORDINATE CARE

Recommendation 2:

"One of the greatest health threats facing our nation is the fragmented model that we have for health care in this country, because you can't do any disease prevention or health promotion in a fragmented system."

Patricia A. Gabow, CEO/Medical Director, Denver Health

IDEAL STATE

The ideal health care system seamlessly delivers the full range of health and social services to patients with complex, chronic conditions. System hallmarks include a patient-centered approach to care in which a patient receives coordinated care regardless of his or her point of entry into the system. The health care system has an integrated organizational structure that links hospitals, physicians, community health centers, nursing homes, and other caregivers and payers for the purpose of sharing clinical, financial, and administrative information to plan and coordinate care. In this system, patient inconvenience, over-utilization of drugs, medical errors, repeat hospitalizations, and other inefficiencies are eliminated or minimized.[30]

CURRENT STATE

The health care system is currently fragmented into many independent and uncoordinated provider sectors: hospitals, physician groups, pharmacies, and other provider organizations. By 2010, 50 million Americans will be over the age of 65. The health care delivery system is increasingly challenged to address the chronic conditions of this aging population. Two-thirds of Medicare beneficiaries have two or more chronic conditions and see an average of seven physicians a year.[31] Per capita expenditures are significantly higher for individuals with one or more chronic conditions than for those who have no chronic conditions.[32] Furthermore, chronic physical ailments can be exacerbated by mental health problems, which often go undiagnosed.

ACTION PRINCIPLES

- ***The care delivery system should be easy to navigate and user-friendly.*** Improve and simplify the often difficult and inefficient process of obtaining care.
- ***The right care is delivered at the right time in the most appropriate setting.*** Good quality care is less likely to occur in fragmented systems of care. Patients with one or more chronic conditions typically need to interact frequently with multiple medical, nursing, and other caregivers.

[30] Partnerships for Solutions. *http://www.partnershipforsolutions.org/*.

[31] Ibid.

[32] Ibid.

Stages of Care Coordination Process

(Adapted and reprinted with permission from the Care Coordination Work Group: Massachusetts Consortium for Children with Special Health Care Needs)

1. **Conduct and update community and environmental scan**
   a. Develop consensus of community programs and agencies
   b. Acquire or develop community resource guide
   c. Gather written and electronic descriptions and applications
   d. Establish person-to-person contact with agency staff
2. **Enhance capacity for early and ongoing screening and identification**
   a. Collect and synthesize screening tools reflective of different conditions, needs, languages
   b. Establish mechanisms for referral including self-referral by families
   c. Conduct outreach and education regarding availability of care coordination (CC) services
3. **In-depth needs assessment**
   a. Interview family to determine full array of needs related to care of patient
   b. Identify family strengths and resources
   c. Review family circumstances, needs, and concerns on an ongoing basis
   d. Conduct home visit as setting for needs assessment
4. **Development of individualized family support plan**
   a. Review needs, concerns, and strengths with family
   b. Define priority issues
   c. Identify resources, programs, benefits to address priority issues
   d. Provide or carry out referrals to relevant services and programs
   e. Intercede with or for family if systems fail to respond
5. **Implementation and monitoring of care plan**
   a. Carry out activities with or for family as prioritized
      i. Identify family vs. CC tasked
      ii. Contact referrals
      iii. Initiate meetings as needed
      iv. Send information to family
      v. Identify resources to meet specific family needs
      vi. Follow up with services and family as needed
      vii. Act as proxy/advocate for family as needed
6. **Review and revision or completion of plan as needed**
   a. Conduct regular, periodic global review of plan with family
   b. Revise plan as needed and return to stages 4 and 5
7. **Link information on unmet needs and continuing barriers to system-level assessment and planning efforts**

Providing all care in one location increases patient satisfaction and compliance with treatment.

- ***Care is coordinated across settings and time to prevent, reduce, or halt further progression of disability and disease, and to enhance quality of life for patients, families, and caregivers.*** When possible, sites of care for patients with multiple chronic conditions are provided in the same location or in close proximity.
- ***New linkages are created across health sectors including medical care, mental health care, dental care, public health, and social services.*** These linkages provide important support to vulnerable members of society.

IMMEDIATE ACTIONS FOR HOSPITAL LEADERS

- **Provide guidance to patients on how to access needed resources.** A simple step is to create a comprehensive list of available resources and referral sources to help patients navigate the health care system and find appropriate providers, caregivers, and social services. A more comprehensive approach is to adopt and implement a patient navigator system, such as the one developed by the American Cancer Society.
- **Utilize community health records and interoperable health information technology systems to support continuity of care.** A single, comprehensive, electronic patient health record that is regionally accessible by treating physicians and ancillary health care providers facilitates the most efficient care. Dangerous drug interactions, missed diagnoses, and duplicate testing and treatment are significantly reduced when complete information concerning a patient's medical history is available.
- **Advocate for financing structures and incentives that facilitate coordinated and effective chronic illness care.**

CURRENT PERFORMANCE ASSESSMENT

1. What chronic care programs does your hospital have that can be made seamless and user-friendly?

2. What resources do you have for patients who need social support to deal with chronic disease? For example, is a nutritionist available for patients who are obese and/or have diabetes? If so, is the nutritionist trained to take into consideration patients' culturally based food preferences?

3. How might your organization advocate for health policy that supports better care coordination?

RESOURCES

1. *Check List for Chronic Care Reform*, National Chronic Care Consortium, Aug. 8, 2003: http://www.nccconline.org/

2. Care Coordination Work Group: Massachusetts Consortium for Children with Special Health Care Needs: http://www.neserve.org/maconsortium/mac_about.html

3. *The Connecting for Health Common Framework: Overview and Principles*: http://www.connectingforhealth.org/commonframework/index.html. Provides a road map for how different communities with different hardware, software, and structures can share information in a secure and private way over the Internet using the Common Framework

4. "Community-oriented Primary Care in Action: A Dallas Story," Pickens, S., P. Bomboulian, R.J. Anderson, S. Ross, and S. Phillips, *American Journal of Public Health* 2002, Vol. 92, No. 11

5. Denver Health: http://www.denverhealth.org/portal/

PROMOTE PRIMARY PREVENTION

Recommendation 3:

"Some people believe that it's the doctor's job, not theirs, to keep them well... But those in the next generation could be persuaded to form healthier habits and attitudes from the beginning. Over time—by which we mean years—it should be possible to persuade a growing fraction of people to join the ranks of 'adherers.' Education and public health campaigns may make it so."

James H. Bigelow[33]

IDEAL STATE

Most U.S. residents receive appropriate preventive screenings and vaccinations; refrain from abusing alcohol, tobacco, and recreational drugs; maintain a healthful diet; engage in regular physical activity; have access to mental health services; and maintain proper dental hygiene.

CURRENT STATE

The twin epidemics of obesity and diabetes demand greater health promotion efforts to prevent or halt the progression of chronic disease. Current and future implications of these epidemics, which affect everyone, not just those with the disease, are worrisome. Increasing rates of diabetes will have serious negative economic impacts on schools, employers, and the economy.[34]

Unhealthy lifestyle factors such as smoking and obesity have prompted both medical and public health professionals to investigate ways to encourage health-enhancing behaviors, yet there is still much work to do.[35] Private and public health care providers must work in concert with community organizations to reduce risky behaviors that lead to disease, disability, and death in the United States.

ACTION PRINCIPLES

- ***Americans must embrace the wisdom and practice of preventive health measures and be taught to pursue health-enhancing behaviors throughout their lives.*** Popular beliefs are unrealistic and contribute to our chronic disease epidemics. For example, high-technology medicine cannot "fix" every illness, nor can it compensate for sedentary lifestyles, over-consumption, and other unhealthy behaviors and environmental exposures.
- ***Children should be a major focus of intervention efforts.*** Many of the risk factors observed in adults, such as

[33] Bigelow, J.H., K. Fonkych, C. Fung, and J. Wang. 2005. "The Patient's Role in Disease Management and Lifestyle Changes," *Analysis of Healthcare Interventions that Change Patient Trajectories.* (Report) RAND Corporation.

[34] Kleinfield, N.R. 2006. "Diabetes and Its Awful Toll Quietly Emerge as a Crisis" *The New York Times,* Jan. 9, 2006, online edition.

[35] McGinnis, J.M. 2006. "Can Public Health and Medicine Partner in the Public Interest?" *Health Affairs* 25 (4): 1044-56.

high blood pressure, overweight, and asthma, can be detected in childhood. Strong evidence suggests that early interventions can change the health trajectory of children.[36]

- ***Behavioral and social influences on health are complex and require multiple interventions.*** No single intervention is likely to make a difference. Hospitals and their public health partners need to look beyond efforts to simply reduce the prevalence of specific diseases. Rather, they need to focus on the fundamental behavioral and social causes of disease. Furthermore, they should work together to fashion multi-layered strategies that are complementary yet not duplicative.
- ***Successful prevention interventions involve communities as partners in the design, implementation, and evaluation of health promotion and disease prevention interventions.*** The best results are achieved when beneficiaries of the intervention work closely with researchers and practitioners to ensure that health messages are meaningful and understandable to community members.

IMMEDIATE ACTIONS FOR HOSPITAL LEADERS

- **Promote healthy lifestyles to employees and their families by providing wellness programs and adequate health insurance.**
- **Counsel patients who smoke not to do so.** Smoking should be a vital sign that is taken at all points of entry into the hospital system.
- **Instruct staff to discuss lifestyle issues with patients, particularly those who are overweight.**
- **Track and analyze preventable hospitalizations to indicate priorities for health promotion and disease prevention efforts.**
- **Establish cooperative health resource centers for education, screening, and other prevention activities staffed and funded by hospitals, public health entities, and local corporations.** With public health and local employers as partners, hospitals can reach more diverse populations and can pool resources to initiate long-term change.
- **Target specific at-risk populations with comprehensive strategies that address the root determinants of their illnesses or disabilities.** Work with community residents and community-based organizations to fashion appropriate outreach strategies and programs.
- **Engage community members and local organizations as partners to address social, economic, cultural, and ecological factors that contribute to health risks.** Support within the community is imperative. Interactions of this nature encourage continued collaboration and set the stage for lasting change.

"You need visionary leadership at the hospital who realizes that population-based health care is a role for the hospital."

Michael A. Mortimore, Health Officer, Berrien County Health Department

[36] Institute of Medicine, *Promoting Health: Intervention Strategies from Social and Behavioral Research*, June 2000.

"Health promotion and disease prevention activities have been viewed as outside the traditional realm of health care. By asking health care providers to provide proactive health, we are asking them to engage in health promotion and disease prevention efforts to a greater degree than they have in the past. Health promotion is about the difficult task of attempting to modify human behaviors known to create disability and ill health."

Bernard J. Turnock, Clinical Professor, Community Health Services, University of Illinois at Chicago

CURRENT PERFORMANCE ASSESSMENT

1. What is your hospital doing to avoid unnecessary hospitalizations? For example, do you offer hospital-sponsored or supported community efforts to promote healthy lifestyles? Do you help patients take advantage of available community resources?

2. Does your hospital adhere to evidence-based prevention guidelines, such as the clinical preventive guidelines or community preventive guidelines listed in the Resources section below?

3. Do you use nurses and lay health educators to extend outreach and enhance effectiveness of health promotion efforts?

4. Does your hospital employ clinicians and lay educators from racial, ethnic, and cultural backgrounds similar to those of hard-to-reach populations within your community?

RESOURCES

1. *Guide to Community Preventive Services*, CDC: http://www.thecommunityguide.org/

2. "Priorities Among Effective Clinical Preventive Services: Results of a Systematic Review and Analysis," Coffield, A.B., M.V. Maciosek, J.M. McGinnis, et al *American Journal of Preventive Medicine* 2006, Vol. 21, No. 1

3. *Integrating Prevention into Health Care*, World Health Organization: http://www.who.int/mediacentre/factsheets/fs172/en/

4. *Put Prevention Into Practice—A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach*, Agency for Healthcare Research and Quality: http://www.ahrq.gov/ppip/manual/

OPTIMIZE ACCESS TO CARE FOR ALL

Recommendation 4:

"A society of healthy communities, where all individuals reach their highest potential for health."

Vision statement of the American Hospital Association

IDEAL STATE

The United States is a society where all individuals can reach their highest potential for health. Everyone has access to needed care, whether it is prevention services, acute care, mental health services, dental care, rehabilitation services, or long-term care, and to all non-health care resources necessary to live a healthy life.

CURRENT STATE

Lack of access to care is the font of a cascading succession of health-related problems—for patients, families, health care providers, communities, and society at large. Many factors beyond the cost of health care determine a population's access to health services. The biggest predictor of access to care is whether an individual has health insurance. Escalating costs of insurance and out-of-pocket expenses, a steady decline in the availability of employer-based insurance, denial of coverage decisions, and pre-existing condition exclusions threaten the adequacy of insurance coverage. Other barriers to access include the availability and location of health care services, lack of transportation, inconvenient scheduling, and lack of community awareness about available services. Language and cultural barriers are formidable obstacles to obtaining appropriate health care. Addressing economic and non-economic barriers to access to care is critical for both individuals and communities.

A recent study by The Commonwealth Fund finds "increasing instability in insurance coverage for a wide cross-section of Americans," and consequently, "a host of [related] problems accessing care, managing health conditions, and paying for care."[37] Racial and ethnic disparities confirm the significant effect that lack of insurance coverage has on access to health care and health outcomes. The rate of uninsured Hispanic and African American adults is one-and-a-half to three times greater than the rate for white adults.[38] Hispanics are much less likely than whites to have a regular doctor or to feel confident about their ability to manage their health problems.[39] African Americans are much more likely to use emergency departments for non-urgent care and experience significant problems with medical bills and medical debt. The Commonwealth Fund calls for expanded insurance coverage and policies that promote stable medical homes for patients to reduce disparities in access to medical care.[40]

[37] Collins, S.R., K. Davis, and M.M. Doty, et al. 2006. *Gaps in Health Insurance: An All-American Problem.* (Issue Brief) New York: The Commonwealth Fund.

[38] Ibid.

[39] Ibid.

[40] Collins, Davis, and Doty, et al., *Gaps in Health Insurance: An All-American Problem.*

"Access to care is associated with statistically significant and clinically meaningful changes in health related quality of life in children enrolled in California's Children's Health Insurance Program."

Michael Seid, RAND Corporation[41]

"No community can be truly healthy if a significant portion of the population is excluded from basic health care services. In the absence of a national health policy that includes health care for everyone, concerned citizens need to find other ways to provide the medically under-served with the health care services they need. Sick people can't wait!"

Volunteers in Medicine Institute[42]

ACTION PRINCIPLES

- ***Health and health care are basic human rights.*** Everyone wins when community residents are healthy. Healthy individuals are more productive and can better contribute to the commonweal.
- ***Health care utilization is a function of affordable health insurance and the availability of accessible services.*** Any barrier to health care diminishes the ability of a population to improve its health.

IMMEDIATE ACTIONS FOR HOSPITAL LEADERS

- Learn from community members about the barriers to care that they face.
- Identify neighborhoods that have a high prevalence of poor health or a high concentration of health-related risk factors. Develop outreach mechanisms that inform community members of available services.
- For uninsured patients without medical homes, partner with state and local medical societies, other hospitals, and medical groups to identify ways to provide them with medical homes.
- Undertake actions to reduce barriers to access to care. For example, keep clinics open on evenings and weekends and provide patients with needed transportation services to health care appointments.

CURRENT PERFORMANCE ASSESSMENT

1. What problems with access to care have community members identified? What is your institution doing about them?

2. What is your hospital doing to ensure that community residents have medical homes—a regular place to go for care? Is primary care accessible to all members of the community? Is specialty care also accessible?

3. How can the impact of your efforts to improve access to care be measured? What outcomes measures can be used to evaluate efforts?

4. Do community members know your hospital is addressing access to care problems? Are they responding to your efforts?

[41] Seid, M., J.W. Varni, L. Cummings and M. Schonlau. 2006. "The impact of realized access to care on health-related quality of life: A two-year prospective cohort study of children in the California State Children's Health Insurance Program" *The Journal of Pediatrics* 149 (3): 354-61.

[42] Volunteers in Medicine Institute accessed on Oct. 12, 2006. Available at http://www.vimi.org/challenge.shtml.

ADVOCATE PAYMENT FOR PREVENTION

Recommendation 5:

"It is confounding enough that there is little finance that goes to promote prevention, but the real tragedy today is that the chronic care needs of the population cannot be paid for until the condition deteriorates into an acute manifestation. This means substandard care, poor use of resources, and confusion for the patients."

Ed O'Neil, Director, Center for the Health Professions, University of California, San Francisco

IDEAL STATE

Financial incentives are realigned so that hospitals are paid for preventive health services targeted to the needs of their communities. Hospitals and their community and public health partners are rewarded for improving population health outcomes, such as reducing mortality and the incidence of formerly prevalent chronic diseases. Evidence-based interventions enable cost-effective allocation of scarce medical resources.

CURRENT STATE

Paul Krugman, a noted Princeton economist, recently observed, "The U.S. system of paying for health care doesn't let medical professionals do the right thing."[43] In January 2006, *The New York Times* published an alarming investigative series on the growing diabetes epidemic in New York City, which exposed the tragic consequences of current U.S. health care reimbursement policies. The *Times* reported that appropriate diabetes management is not a paying proposition. Insurance companies refuse to pay for daily test strips and other comparatively inexpensive disease management activities that fail to demonstrate short-term cost savings. Ironically, years later, when health care complications inevitably arise, insurance plans willingly make large payouts for diabetes-induced limb amputations and other avoidable and costly outcomes. Traditional insurance companies typically do not pay for preventive medicine; instead they pay for treatment of acute illness and extreme remedies.

Decades ago, when reimbursement policies were established, little was known about the root causes of chronic illnesses, or the effectiveness of health promotion and disease prevention interventions. While there is clear evidence today that many health-promoting interventions work, the U.S. health care system is hampered by fee-for-service reimbursement policies established half a century ago.

Reimbursement is central to how the U.S. health system operates. Medical care payment policy should reflect a better balance between prevention and treatment. Investments in

[43] Krugman, P. 2006. "First, Do More Harm" *The New York Times*, Jan. 16.

health promotion and disease prevention have long-term health benefits that need to be more widely recognized and promoted. Evidence now indicates that disease prevention produces economic savings and averts premature disability and death. Unfortunately, new insurance mechanisms, such as high-deductible major medical plans and health savings accounts, are a step backward because they provide further disincentives for patients to seek preventive services and primary care.

The failure of the system to adequately fund preventive care has a ripple effect of reducing access to prevention and primary care, causing patients to use emergency rooms for basic needs. Although emergency department use is growing, fewer physicians are willing to "take call" for ED duty because of another reimbursement problem: Often physicians do not receive any reimbursement for such work. With fewer physicians covering the ED, there is more overcrowding and service suffers.

A new health care trend, the specialty hospital, threatens preventive care and disease management by emphasizing high-reimbursement, episodic acute care and discouraging a holistic, continuum of care, health-promoting approach to the delivery of health care.[44] In addition, studies have found that specialty hospitals provoke medical technology arms races, which increases health care spending. They skim high-paying cases from community hospitals, which are forced to further cost shift to compensate for low-reimbursement cases and uncompensated care. This raises the cost of health care for everyone and ultimately reduces access to care for the uninsured.

"If a hospital charges, and can get reimbursed by insurance, $50,000 for a bariatric surgery that takes just 40 minutes, or it can get reimbursed $20 for the same amount of time spent with a nutritionist, where do you think priorities will be?"

Diana K. Berger, Medical Director, Diabetes Prevention and Control Program, New York City Department of Health and Mental Hygiene

ACTION PRINCIPLES

- ***Upstream, preventive interventions consume fewer resources in the long run and promote a better quality of life for individuals and populations immediately.*** Failure to pay for prevention is swelling the ranks of the chronically ill, whose care will not be paid for until their chronic conditions deteriorate enough to conform to current reimbursement policies. Everyone loses: Affected individuals and their families experience diminished quality of life; the public pays for uncompensated care through cost shifting; and society at large loses both human capital and resources that could have been productively invested for the good of the entire community.
- ***Medical care payment policy needs to be restructured to support health promotion, disease prevention, and primary care.*** In health care as elsewhere, what gets paid for gets done. Health care reimbursement must be structured to ensure the delivery of preventive services.[45]

[44] This discussion excludes nationally renowned cancer research institutions, children's hospitals, mental health facilities, and similar institutions. Local specialty hospitals for the purposes of this article are defined as single specialty hospitals created and owned by the specialists who utilize them.

[45] McGinnis, "Can Public Health and Medicine Partner in the Public Interest?" p. 1044.

- ***Disease affects everyone, even those who do not get it.*** "There is an underappreciated truth about disease: It will harm you even if you never get it. Disease reverberates outward, and if the illness gets big enough, it brushes everyone. Diabetes is big enough."[46]

IMMEDIATE ACTIONS FOR HOSPITAL LEADERS

- **Work with local business coalitions such as chambers of commerce to advocate rational payment incentives for health promotion and disease prevention.**
- **Collaborate with health clinics in your community on mutual referral systems so patients receive preventive and other necessary treatment in the most economical and efficient setting based on level of care needed.**
- **Lobby government for changes to reimbursement policies.** Medicare and Medicaid reimbursement policies and rates are frequently adopted by private insurers. If government reforms payment policies to pay for prevention, private payers are likely to follow suit.
- **Pay yourself for prevention. Implement a work site health promotion program at your own hospital.** A 2001 analysis of 32 studies showed that the average savings vs. program cost yields a return on investment of $3.48 for every dollar spent.[47] Next, create a community connection by introducing work site health promotion programs to community businesses.
- **Create a community benefit program that invests in prevention with a secondary goal of reducing your hospital's charity care burden.** Consider collaborating with your competitors to achieve improved community health outcomes.

POLICY QUESTIONS TO EXPLORE

- What are the necessary ingredients in a rational reimbursement scheme predicated on improving the public's health?
- Should hospital systems create their own community-rated insurance plans that pay performance incentives for improved population health outcomes?
- How can Medicare and Medicaid reimbursement schemes be reformed to reward improved population health outcomes?
- Would a single-payer health care reimbursement system be sufficient to institutionalize payment incentives for markedly improved preventive care and chronic disease management?
- Does Medicare Part D disincentivize the development of disease prevention and management strategies by rewarding expenditures on drugs used to treat illness?

[46] Kleinfield, "Diabetes and Its Awful Toll Quietly Emerge as a Crisis."

[47] Aldana, S.G. 2001. "Financial Impact of Health Promotion Programs: A Comprehensive Review of the Literature" *American Journal of Health Promotion* 15 (5): 296-320.

BUILD THE COMMUNITY'S CAPACITY TO STAY HEALTHY

Recommendation 6:

"Institutions that have often achieved excellence in medicine, medical education, and research now need to enter into the community where they are no longer experts. They have to risk being the student and give up command and control and share resources to build a new accountability with the community."

Ron Anderson, President and CEO, Parkland Health & Hospital System

IDEAL STATE

Every community in America has the potential to produce good health for its inhabitants. Government and the public health system recognize that root determinants of health include employment opportunities, good housing, availability of fresh foods, opportunities for recreation, interaction with neighbors, safe neighborhoods, excellent public schools, and a clean environment. The health system supports public and private providers of social services, invests in sustainable community development, and empowers local businesses and leaders so the community has the foundation to be healthy.

Each community has productive linkages and partnerships among health care providers, community residents, and community employers, agencies, and other resources. The community is not just a passive recipient of health care but a real partner in identifying needs, establishing priorities, developing programs, and promoting effective and equitable health care for all.

CURRENT STATE

Genetic and biological processes, individual behaviors, and the social, economic, political, and physical environments interact to influence health and well-being. For example, gene expression can be affected by environmental exposures or personal behavior patterns. Social circumstances affect our behavioral choices. To make populations healthy, the public health system must address all of these factors. Failure to consider these factors deprives community members of the opportunity for optimal health and quality of life, and further stresses the health care delivery system.[48]

Investing resources to address population-level factors that affect health outcomes improves the long-term health status of communities across the nation, particularly those with disproportionate unmet needs.[49]

[48] McGinnis, J.M., P. Williams-Russo, and J. Knickman. 2002. "The Case for More Active Policy Attention to Health Promotion" *Health Affairs* 21 (2): 78-93.

[49] Barnett, K., and G. Torres. 2001. "Beyond the Medical Model: Hospitals Improve Health through Community Building" accessed on October 11, 2006. Available at http://www.hret.org/hret/programs/content/Fall01.pdf.

Factors contributing to premature death

Current evidence estimates that the relative impacts of various factors on premature death are:

- Genetic predispositions 30%
- Social circumstances 15%
- Environmental exposures 5%
- Behavioral patterns 40%

"In order to effectively deal with the health problems facing the country, we have to recognize that the community is both the independent and the dependent variable. It is both the treatment and the disease. In other words, one needs to build community in order to heal the community."

Stephen M. Shortell, Dean, School of Public Health, University of California, Berkeley

Growing scrutiny and criticism about non-profit hospital performance in fulfilling community benefit obligations heightens the imperative for hospitals to participate in community building. A moral expectation that hospitals should fulfill charitable obligations extends beyond the provision of charity care. Strategic investment of resources to address the underlying causes of persistent community health problems may be the best expression of a non-profit hospital's charitable mission.[50]

ACTION PRINCIPLES

- ***Non-profit hospitals are accountable to the communities they serve.*** Hospitals and health care organizations are part of the public health system, which is responsible for ensuring the public's health.
- ***Improving health and quality of life extends beyond the delivery of medical care.*** Stakeholders in the community must be active and engaged partners in defining, promoting, and delivering population health.
- ***With respect to the public health system, the sum is greater than its parts.*** Cross-sector collaboration enables partners to pool expertise, resources, and influence to achieve what each cannot accomplish on its own.
- ***We can only manage what we measure.*** Measurement and evaluation are essential elements of tracking community health, identifying Community health priorities, and addressing community needs.

IMMEDIATE ACTIONS FOR HOSPITAL LEADERS

- **Help create a shared vision and approach to addressing health improvement in your community.**
  1. Engage in routine and comprehensive community needs assessments with all major community stakeholders to understand both the symptoms and the underlying causes of ill health.
  2. Offer a collaborative forum to meet regularly and share issues.
  3. Use trained facilitators to bring about a shared vision of health and needed action steps.[51]
- **Educate community members to be a powerful voice for policy changes needed to improve population health in your community.**
- **Build interoperable information systems that measure and track progress on priorities identified in needs assessments.** Measurements should track health status, chronic disease management, health manpower competency and availability, and general quality of life. Information systems should also measure progress in meeting the needs of the medically underserved.

[50] Ibid.

[51] Ibid.

- **Initiate progress on community-set health priorities by starting and continuing short-term actions that lead to quick wins, yet be prepared for the long haul.** While quick wins build momentum, there are no quick fixes to improving the multiple determinants of poor population health.

CURRENT PERFORMANCE ASSESSMENT

1. How does improving community health status factor into strategic planning at your hospital?

2. Do you have a resource for assessing, measuring, and tracking community-identified health priorities? What aspect of this system needs to be improved?

3. What are the top three drivers of health status in your community?

4. Are you addressing consensus high-priority problems in your community? Where do public health partners invest their efforts? What is falling between the cracks?

5. What hospital resources are used to promote positive drivers of health and abate negative ones? Are resources currently being allocated to existing, promising efforts in the community? What would happen if these efforts were to disappear today?

6. Have you involved community members in strategic decision making about where to invest community health improvement resources? Have you considered important contributors who may be missing from this discussion?

7. Visit the American Hospital Association's *Community Connections: Making Communities Healthier* Web site to determine whether case examples suggest actions you can take in your own community.

RESOURCES

1. *Community Connections: Making Communities Healthier—Case Examples*, American Hospital Association, May 2006: http://www.caringforcommunities.org/caringforcommunities/hospitalsaction/index.html

2. *Community Connections: Measuring the Community Connection: A Strategy Checklist for Leaders*, American Hospital Association, May 2006: http://www.caringforcommunities.org/caringforcommunities/content/strategychecklist.pdf

3. *Trust Counts Now: Hospitals and Their Communities*, John King and Emerson Morah, American Hospital Association, May 2006: http://www.caringforcommunities.org/caringforcommunities/content/trustcounts.pdf#search=%22%22trust%20counts%20now%22%20and%20aha%22

"We tell our residents, 'We care for 100 percent of you.' That means rebuilding communities, which means rebuilding neighborhoods. We have rebuilt 10 neighborhoods in 12 years. That means everything from reducing high-risk behaviors and outcomes, to economic development, to leadership training for the residents."

John Benz, Chief Strategic Officer, Memorial Regional Hospital

SUPPORT RECREATING THE PUBLIC HEALTH INFRASTRUCTURE AND EXPANDING CAPACITY

Recommendation 7

"Hospitals should actively become involved in rebuilding our public health enterprise and make public health a priority for the communities they serve."

Gail Warden, President Emeritus, Henry Ford Health System

IDEAL STATE

The United States has a health system in which public and private providers, payers, and practitioners have an adequate work force; information, data, and communications systems; and organizational and systems capacity to jointly reduce the overall burden of preventable illness. This ideal system is able to maintain sufficient shared resources to prepare and respond to illness and events that cannot be prevented, and invests in research and development for continued improvement in health care and quality of life. In this system:

- Community-based health status assessments are regularly performed to determine the health needs of the community;
- Population-based surveillance tracks changes and trends in health status to highlight significant shifts;
- All health providers access, use, and contribute to this information to ensure its completeness;
- The public health system is responsive to public health threats in a timely manner;
- Primary and behavioral health care is provided in the most appropriate outpatient setting to prevent avoidable and costly hospitalizations;
- Emergency department overcrowding and avoidable hospital admissions are reduced to ensure that resources are available for true emergencies; and
- Injuries and environmentally caused illnesses are eliminated or minimized.

CURRENT STATE

The Public Health Foundation describes our public health system as "made up of a complex network of people, systems, and organizations working in the public (local, state, and national levels) and private arenas."[52] It is the first line of defense against routine and unusual threats, ranging from infectious diseases and water- and food-borne illnesses to natural disasters and bioterrorism. We think of infrastructure as "all the parts within the public health system that work to help health professionals carry out the

[52] Public Health Foundation accessed on Aug. 23, 2006. Available at http://www.phf.org/infrastructure/.

"Health security threats and increased attention to public health preparedness have exposed the fault lines in the public health infrastructure brought about by decades of neglect."

Eileen Salinsky, Principal Research Associate, National Health Policy Forum and Elin A. Gursky, Principal Deputy for Biodefense, ANSER[53]

10 Essential Public Health Services"[54] (see sidebar). Clearly, hospitals and private health care are integral to the public health system, contributing a competent work force, resources, and capacity to its infrastructure.

The current public health system is underfunded, undermanned, and woefully inadequate to meet the challenges of protecting and promoting all Americans' health in the 21st century. Basic and extraordinary funding for providing routine public health services, combating new infectious diseases, and preparing for health security threats continues to be inadequate. The changing nature of the types of diseases and threats that compromise Americans' health calls for recreating and expanding the capacity of the public health infrastructure.

It is important to bear in mind that strengthening the public health system will not happen all at once; however, the system can be strengthened one part at a time. Infrastructure components requiring overhaul include the work force, laboratories, physical plants, laws, education, training, and health promotion programs.[55] Each part of the public health system must work both collaboratively and within its purview to change, even if incrementally, this broken system. To effect the needed expansion of the public health infrastructure, political leaders and the public must be educated about the essential nature of the public health system. America's future depends on improving the public's health, which can be achieved only through major public health expansion.

10 Essential Public Health Services

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care work force.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

[53] Salinsky, E. and E.A. Gursky. 2006. "The Case for Transforming Governmental Public Health," *Health Affairs* 25 (4): 1017-27.

[54] CDC, National Public Health Performance Standards Program accessed on Oct. 12, 2006. Available at http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm.

[55] Institute of Medicine. 2002. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press.

ACTION PRINCIPLES

- ***Improving the public's health requires all players to advocate for adequate financial support to rebuild and maintain the work force and organizational and systemic capacity of the U.S. public health system.***
- ***Active dialogue between hospitals and local public health agencies is a necessary starting point.*** It builds trust and mutual appreciation of resources and perspectives and leads to effective joint action.
- ***Players in the public health system will achieve shared community health improvement goals if they collaborate.*** The benefits of collaboration have been well documented in emergency preparedness planning.

IMMEDIATE ACTIONS FOR HOSPITAL LEADERS

- **Meet regularly with your public health counterparts to learn about each other's priorities, services, and constraints.** This will engender trust and understanding about what services are available and what gaps exist with respect to community health needs.
- **Provide support**—financial and/or in-kind—to local public health agencies and relevant community-based organizations, depending on community need and service gaps.
- **Identify a public health intervention that can be a routine service provided by the hospital.** Test the possibility and impact of working with public health. Chronic disease screening and management, HIV testing, and injury and violence prevention are a few examples of possible actions. Hospitals can lend clinical expertise and physical space to efforts. If adequately funded, local public health may be able to provide staff, funding, and technical assistance to prevention, counseling, and screening efforts. Public health is also a proven neutral convener when competition impedes inter-hospital collaboration on joint efforts.
- **With public health, sponsor and conduct routine community needs assessments biannually, if possible, to track your community's progress on key community health indicators.**
- **Devote a portion of your board meeting to reviewing community health indicators quarterly.**[57]
- **Recruit board members with community health expertise.**[58] **In addition, hospital leaders should be willing to serve on local public health governance boards.** Hospitals need to actively engage in the public health process.
- **Serve as a conduit of health promotion and disease prevention education.** This will link hospitals, clinicians, patients, social service agencies, and the community at large.

"For public health, no partner is more important than health care; for health care, none is more important than public health."

J. Michael McGinnis, Senior Scholar, Institute of Medicine[56]

[56] McGinnis, "Can Public Health and Medicine Partner in the Public Interest?" p. 1044.

[57] Size, T., D. Kindig, and C. MacKinney. 2006. "Population Health Improvement & Rural Hospital Balanced Scorecards" *Journal of Rural Health* 22 (2): 93.

[58] Ibid.

"We need appropriate representation on our board—including the public health department—to make good, community-based decisions."

Joseph Wasserman, President and CEO, Lakeland HealthCare

- **Actively promote the value of public health.** Begin by educating the hospital board of directors, and then reach out to community members and elected officials.
- **Join public health partners in advocating for redesign and adequate funding of the public health enterprise.**

CURRENT PERFORMANCE ASSESSMENT

1. What is your hospital's relationship with local public health partners? How can a collaborative relationship be initiated and strengthened?

2. If there is no local public health authority in your community, who is responsible for public health and for environmental protection? How are you working with responsible officials?

3. At your institution, does the board of directors include local public health representatives and community members?

4. In what priority health areas do hospitals and public health in your community share or exchange expertise, staff, space, and resources for mutual benefit?

5. In what ways is your hospital supporting the public health infrastructure beyond the walls of the hospital?

6. Are you doing all you can to support the health of your community? Take an inventory of what you are doing in this area.

RESOURCES

1. "Public Health: What It Is and How It Works," B. Turnock, 3rd edition, 2004, Jones and Bartlett Publishers

2. The New York Academy of Medicine, Division of Public Health, Center for the Advancement of Collaborative Strategies in Health: http://www.nyam.org/initiatives/ph.shtml

3. Public Health Foundation, Public Health Infrastructure Resource Center: http://www.phf.org/infrastructure/phfpage.php?page_id=20#2

4. National Association of County and City Health Officials: http://www.naccho.org/

5. The Association of State and Territorial Health Officers: http://www.astho.org/

6. National Association of Local Boards of Health: http://www.nalboh.org/

"We need to build capacity around what creates health. Then there is collective responsibility."

Tyler Norris, President and CEO, Community Initiatives

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