Population Health Matters

Spring 2017
Vol. 30, No. 2

SE PA "Collaboratory" to Address Social Determinants of Health

Health policy experts have identified multi-stakeholder collaborations as effective — indeed necessary — strategies for improving population health, especially in communities with socioeconomic challenges.[1,2] In southeastern Pennsylvania, COACH—Collaborative Opportunities to Advance Community Health—seeks to test a "collaboratory" approach to addressing the underlying social needs that give rise to poor health. COACH's ultimate goal is to achieve measurable improvements in the population health of vulnerable local communities, thereby reducing the incidence of preventable medical interventions—such as hospital readmissions—caused in part by patients' social circumstances.

Toward the end of 2014, final Internal Revenue Service (IRS) regulations[3] authorized by the Patient Protection and Affordable Care Act (ACA) provided for greater collaboration in nonprofit hospitals' community health needs assessments (CHNAs) and strategies implemented to address unmet population health needs. These regulations led hospitals, public health agencies, and community organizations in Greater Philadelphia to explore how they could work together to improve community health. As described in 2016,[4] Department of Health and Human Services (HHS) Region III, along with The Hospital and Healthsystem Association of Pennsylvania (HAP), convened the initial meetings to consider opportunities for such collaboration. The official launch of COACH in September 2015 was the end result.

During 2015, HAP formally recruited hospital and health system participants, invited the participation of public health department representatives, and engaged The Health Care Improvement Foundation (HCIF) to facilitate the collaborative effort. Community organizations and stakeholders began joining COACH in mid-2016 (see Table 1 for current list of participants and stakeholders).

COACH participants view the effort as a "collaboratory"—a respectful, evidence-driven environment where relevant research findings, outcomes from new models of care, and emerging best practices can be identified, tested, and evaluated. COACH provides an opportunity for participants to:

- Engage in shared learning
- Strengthen the partnerships necessary to address social determinants of health
- Build stronger relationships with patients and communities
- Align with the population health vision of thought leaders and policy makers, as well as local, state, and federal public health improvement efforts

In addition to revised IRS regulations supporting hospital and health system collaboration on joint CHNAs and implementation strategies, recent policy approaches have promoted more coordinated, multi-stakeholder approaches

CONTINUED ON PAGE 2

Table 1. COACH Participants and Stakeholders

Hospital and Health Systems	Public Health Stakeholders	Community Stakeholders
Children's Hospital of Philadelphia	Montgomery County Health Department	Benefits Data Trust
Einstein Healthcare Network	Pennsylvania Department of Health	Center for Hunger-Free Communities, Drexel University
Holy Redeemer Health System	Philadelphia Department of Public Health	Coalition Against Hunger
Jefferson Health (including Abington Jefferson Health and Aria-Jefferson Health)	U.S. Department of Health & Human Services, Region III	Delaware Valley Regional Planning Commission
Mercy Health System		The Food Trust
Temple University Health System		Health Federation of Philadelphia
University of Pennsylvania Health System		Health Partners Plans
		Keystone First
		Philabundance
		Philadelphia Association of Community Development Corporations
		Share Food Program
		United Way of Greater Philadelphia and Southern New Jersey

Thomas Jefferson University®
Jefferson College of Population Health

to community health improvement. Widespread dissemination and adoption of collective impact[5] and the Robert Wood Johnson Foundation's "Culture of Health" have provided partners with common language and frameworks to guide collaborative planning and action.

In response, hospitals in communities as diverse as the Lehigh Valley in Pennsylvania, King County in Washington, and Washtenaw County in Michigan have worked together on joint CHNAs. However, pursuit of joint implementation strategies to address shared community health needs have to date been much less common. Drawing on the example provided by the Healthy Chicago Hospital Collaborative, COACH sought to be an "early adopter" of implementation strategies shared among a group of hospitals and health systems, in partnership with public health and community stakeholders, in southeastern Pennsylvania.

As the COACH facilitator, HCIF developed and implemented a yearlong structured process for exploring collaborative strategies to address unmet needs emerging from local hospital and health system CHNAs. HCIF support included:

- **Facilitation.** Preparation, delivery, and follow-up for collaborative convenings, including 10 in-person meetings.
- **Outreach and Engagement.** Regular one-on-one communication with participants to gather information and elicit feedback. Engagement of community stakeholders as collaborative participants.
- **Prioritization.** Development and implementation of methods and matrix tools for prioritizing health needs to address collaboratively.
- **Research.** Comprehensive research on best practices to inform development of shared implementation strategies.
- **Synthesis.** Development of a draft implementation strategies document and a specific proposal for a healthy food access pilot.

Through this process, participants identified healthy food access as a high-priority need for vulnerable populations in the region. In late 2016, COACH hospitals and health systems collectively adopted this strategy:

> *In coordination with partners in the region, implement a healthy food access pilot that 1) institutes screening for food insecurity through a validated two-question survey tool administered in the clinical setting; 2) tests interventions to improve healthy food access and processes for referral to community resources; and 3) tracks and shares common impact measures.*

Key reflections on the first year:

- Synthesis of hospitals' first-round CHNAs and discussion of the health impact pyramid helped participants realize the importance of pursuing "upstream" strategies with potential for greater impact.
- Building trust among hospital and public health participants and identifying areas of focus before engaging with community stakeholders provided for effective group dynamics and more targeted stakeholder recruitment.
- Getting the right mix of consensus-building versus timely progress was a tricky trade-off. Meetings sometimes focused on participant-driven decision-making at the expense of moving more quickly to conclusions and a plan of action. By more aggressively leveraging participants' mutual respect, HAP and HCIF likely could have helped the collaboratory settle sooner on its shared implementation strategy.

Nearly 18 months into the COACH collaborative, results include:

- **Sustained engagement.** HAP and participating hospitals and health systems recently committed to the resources and staff support need to support the next 18 months of collaboration.
- **Better relationships.** Strong attention to process and transparency created an environment that fostered open sharing of questions and concerns. As a result, hospital, public health, and community participants have a better understanding of and respect for one another's expertise, experience, and challenges, which serves as a strong foundation for collaboration.
- **Shared implementation strategies.** COACH hospitals and health systems have documented their intent to implement the food access pilot in selected clinical practices.
- **The start of COACH's first collective action.** COACH has established initial workgroups to develop the food access pilot's framework for food insecurity screening and referral, facilitate better identification and connections to appropriate food resources, and explore interventions for directly addressing food needs in clinical settings to be tested through the collaboratory.

COACH has provided hospital, health system, public health, and community stakeholders with an efficient, cost-effective method of evaluating emerging models and best practices aimed at improving population health for vulnerable, lower-income communities.

Poised to undertake its first effort in this arena, the group will commit the resources and energy necessary to give the healthy food access pilot its best chance of

CONTINUED ON PAGE 3

achieving an impact. At the conclusion of the 18-month pilot, the COACH group will evaluate its return on investment.

For COACH hospitals and health systems, this first foray into adopting and pursuing a shared strategy as part of ACA-required community health implementation plans has sparked potential interest in conducting one or more joint CHNAs and implementation plans when planning for the next cycle begins in 2018.

Our city, state, and nation must improve the population health of vulnerable communities if we are to have any hope of advancing overall well-being while, at the same time, reining in health care spending. Collaborative population health efforts such as COACH hold promise for achieving this difficult but necessary goal. Policy makers should encourage and evaluate such initiatives and related best practices to assess their effectiveness and promote successful models.

Susan Choi, PhD, CPHQ
Senior Director, Population Health
Health Care Improvement Foundation
schoi@hcifonline.org

Priscilla Koutsouradis
Director, Public Relations
The Hospital and Healthsystem Association of Pennsylvania
priscillak@dvhc.org

Bradley Moore, MPH
Project Manager
Health Care Improvement Foundation
bmoore@hcifonline.org

Robert G. Shipp III, MSHSA, RN, NEA-BC
Vice President, Population Health Strategies
The Hospital and Healthsystem Association of Pennsylvania
rshipp@haponline.org

REFERENCES

1. Prybil L, Scutchfield FD, Killian R et al. Improving community health through hospital-public health collaboration: Insights and lessons learned from successful partnerships. http://www.uky.edu/publichealth/sites/www.uky.edu.publichealth/files/Research/hospital-public%20health%20partnership%20report_12-8-14.pdf. Published December 8, 2014. Accessed April 16, 2017.
2. Health Research & Educational Trust. Creating effective hospital-community partnerships to build a Culture of Health. http://www.hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf. Published August 2016. Accessed April 16, 2017.
3. New requirements for 501(c)(3) hospitals under the Affordable Care Act. Washington: Internal Revenue Service. https://www.irs.gov/charities-non-profits/charitable-organizations/new-requirements-for-501c3-hospitals-under-the-affordable-care-act. Updated July 29, 2016. Accessed April 16, 2017.
4. Brawer R, Plumb J. Non-profit hospitals and community benefit – what's next? *Pop Health Matters*. 2016; 29(1):3.
5. Kania J, Kramer M. Collective impact. *SSIR*. 2011; 9(1):36-41.