

Panel 3: Data Platform: Scope and Transparency

Our first panel is going to focus on an essential element that we couldn't help ourselves. We began to get into yesterday, which is the assessment and what are the data that we need to do an effective assessment?

You'll see there are a number of questions that they're going to address. We have two large systems that are going to share some terrific work that they are doing. And then we're going to get a broader perspective. Let me just introduce to you who will get us started this morning. Eileen Barsi, on the right, is the Director for Community Benefit for Catholic Healthcare West, a large system, 40 plus hospitals based in California but serving California, Nevada and Arizona. Winston Wong is the Medical Director of Community Benefit for a small little system called Kaiser Permanente that happens to be all over the country. And Julie Willems Van Dijk is the Associate Scientist at the University of Wisconsin Population Health Institute and the Community Engaging Director for the Match program across the country, and will share where they're going. Just before we get started, I wanted to do a quick recap and reminder on ground rules. I think we had a great discussion yesterday. I want to try to fine-tune things a little bit more by asking our panelists to do their best to stay within the 10 minutes. Their charge is to put the issues out there and to get you engaged. And my charge is to help them do that.

So I've already spoken with our first panel and asked them to model good behavior for our subsequent panels. I also want to encourage, if not plead with, each of you to really do try to keep your comments and questions to a minute. Our folks with mics will quickly get to you. And we've fine-tuned our system a bit further so we can get to you quickly, and also ask our panelists -- panelists to be concise in their response. We're still going to go three, get three questions and comments, and then go to the panel and continue.

So we'll see how many cycles we can get in per panel so we can get all the issues on the table. With that, I'm going to turn it over to Eileen Barsi. It is such a privilege to be among you. I'm very eager to share with you our work. Let me acquaint myself with this first. How do you turn it on?

Thank you. A little bit about us first. Catholic healthcare West is the fifth-largest health system in the United States. And what I think is important for our meeting today is that in fiscal year 2010, our contributions through community benefit exceeded \$1.3 billion. I would love to be able to say to you that every bit of that was in proactive investment and community benefit programs. But with the current economy, much of it was in reaction to the demand for healthcare services. I think it's critical to begin our presentation with a definition of health. We've talked several times yesterday about the importance of being with the right definition or the same definition.

So I wanted to be sure our definition for health was what was in your mind as you listen to the presentation. And it is the World Health Organization's definition. And the two questions that I want to focus on for this morning are in what ways we can collect data on social determinants and in what ways we can identify concentrations of unmet need. Our board of directors asked us in 2005 if we could take a look at the ways we were doing community needs assessments across our 40 hospitals. We had been part of the California law that was enacted in 1994 to do a community health needs assessment every three years. And every one of our hospitals did it a different way.

Some would hire an outside agency, some would hire consultants, some worked with the consortium of hospitals in their community to reach their needs assessment goals. Our board asked us, is there any way that we could do an at-a-glance of each of our hospital's communities and understand their needs simply?

So they wanted us to provide with each of our hospitals a little bit more science and a little bit more rigor into the community needs assessment process.

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So we partnered with Solucient, which has become part of Thomson Reuters. We convened an ad hoc group comprised of community board members and community benefit staff, including those with public health backgrounds, to talk about what would we look at. And we chose these five socioeconomic barriers that put people at the highest risk of needing health services. They include income, culture and language, education, insurance, and housing. Solucient then took that and became engrossed in a method that would calculate indicator values at the zip code level. They assigned a barrier score from one to five based on those socioeconomic barriers in aggregate. And then they assigned the score to each of the zip codes. I apologize for the smallness of this, but it will show you the comparison between two of our communities, one in Inglewood, California and one in Scottsdale, Arizona. For each of the five primary barriers, we had indicators.

So you can see under "income" we were also looking at elderly poverty, child poverty, and single parent poverty, etc. We then assigned a score for each of those in aggregate and came up with that average score.

So in Inglewood, California there was a very high need based on those socioeconomic barriers. I'd like to say there was a very high risk in those neighborhoods; and in Scottsdale, Arizona, quite the contrary. We then color-coded all of our community maps based on those scores for our service areas. And we provided them with information in detail about each of those subcategories. CHW owns the community need index to give you that type of information. But Thomson Reuters owns the detail and does offer it for sale at a nominal fee. There were some surprises in some of our communities. In one in particular in Stockton, they were stunned when one area was considered a high risk when they thought that they were quite well-to-do in that neighborhood. They then found out that more than half of the children in the school district qualified for the lunch program. And so they diverted the health mobile van to that area. This is just a glimpse of the United States just to share it with you. Notice the border states. Texas was number one with the community need index with the highest risk. California ranked number four. What we've learned in the methodology was that admission rates were twice in those high-risk neighborhoods than they were in the more privileged neighborhoods.

And we found as well that for marker conditions, it was pretty much the same. But people who lived in those high-risk neighborhoods, when correlated with utilization data, were in the hospital twice more frequently than their more privileged neighbors for ambulatory care sensitive conditions. Things like asthma, diabetes, congestive heart failure, chronic obstructive pulmonary disease, pneumonias. It became a very compelling bit of information for us at our system. And we realized that there was a face of the poor unlike any we'd seen before. For me personally, it became a cry of the poor unlike any I had heard before. And so we looked at what was the real demand for services and created demand management maps for each of our communities showing our hospitals where the access to acute care services was, where there was primary care services, and then where the demand was coming from. We took it a step farther and went into detail about what were the conditions, by zip code. You can see at least the dollar amount in one area. But we could also see concentrations of great numbers of people coming in for ambulatory care sensitive conditions by zip code. This was so compelling that for the first time in our history, we announced a system initiative. We usually allow autonomy for each one of our service areas to address the unmet needs that they have identified and prioritized. But we announced a system initiative that became financially incentivized for our leadership, asking them to reduce the admissions or readmissions to our hospitals for these conditions, focusing in these high-risk neighborhoods with people who had no insurance, or people who were underinsured, and try to drive down that demand. From a mission perspective, it was our belief that we were looking at where the burden of cost that was both human and financial was greatest.

So between 2008 and 2010, our hospitals invested \$5.7 million in preventive and disease management programs. I'm very proud to say that at an average, 86% of the participants in our program were not

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readmitted to the hospital or avoided an admission altogether. The very conservative estimates of that cost savings was in excess of \$49 million, based on the cost of care, not the charges. Those were our reactive responses to the need that was being demanded in our service areas and the needs we knew existed. Our program, however, is comprehensive. And we offer both a grants program and a community investments program as well. In our community grants program in fiscal year 2010, more than \$4 million was awards to our community partners for other projects, most importantly improving access to care. And our community investment program works at those underlying causes of risk, those socioeconomic barriers. The community investment program allocation is \$70 million for loans and \$10 million for guarantees. In the current year, the community investment program provided loans for the construction of 16,324 unit of housing, eight non-profit facilities serving children, youth, and women. Emergency loans were provided to 28 community health clinics during the California budget crisis. And CHW's community investments leveraged over \$160 million of capital.

So, not only are we reacting to the demand, but we are also proactively working on reducing that demand by addressing the socioeconomic barriers. I want to stress that the community need index, while it is a very valuable tool for us to focus in on those high-need areas, we also do a more formal community needs assessment utilizing the tools that have been developed for us with the Association for Community Health Improvement and the new guide from the Catholic Health Association.

So, it is a complement to the more formal needs assessment, and a complement as well to the relationships we build in the community. This is just an indication of what one project looked like with the community investment program with housing. You can see a far more dignified housing development on the right side of the slide than on the left. And I'm also proud to say that the community need index has now been made available for your use. This is the website, if you have an interest. Put in your own city zip codes and see what comes up. We will be working on adding different things to it, but it will at least give you the basis of where the socioeconomic barriers exist and where the need may be greatest.

Thank you. I'm going to ask our panelists just to help themselves to the mic, so I won't come up here and interrupt every time. I'm going to actually go back a little bit here. Good morning, everybody. I'm Winston Wong, Medical Director at Kaiser Permanente. I was here for a portion of the afternoon yesterday, and I felt that I should probably reflect as to why I stumbled into this job. I'm a relative newbie. I've been at Kaiser Permanente for eight years. And I recall my first conversations with my perspective employer, Ray Baxter, at Kaiser Permanente. I had actually been a commissioned officer for HRSA working on the chronic care collaborative.

Some of you know that the FQHCs had been embarking on Ed Wagner model chronic disease management for several years. And in that work in the western region, I came across these Kaiser Permanente folks, very intriguing group of physicians and health planners. And I mused with them. I said, "You know, if we're really talking about population management, I can't just talk about the FQHC population, I really need to think about what we can do with partners like Kaiser Permanente". And lo and behold, that actually become a job where I was able to talk about with my perspective employers what does population management really mean in terms of a cohesive set of plans and mechanisms in which we can really elevate the health of a community?

And thus, I was introduced to the big, wide world of Kaiser Permanente, which exists indeed outside of California as well. We reported a community benefit portfolio of \$1.8 billion just last year. Inclusive of many specific activities around community health investments in terms of improving our social determinants with regards to environment, healthy eating, active living. The safety net partnerships, of which I'm principally directing in terms of supporting our public hospital and FQHCs as well as other systems that

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support access to care for uninsured populations. Our commitment to research and development of the workforce in terms of developing and disseminating knowledge.

So, it's a pretty robust portfolio. And what I want to do today is to share with you a little bit of some of the work that we've been doing relative to some of the mapping. I think Eileen just introduced some aspects of mapping. I think today, this morning is a geography lesson and I'm going to ask you to think about looking at some of these slides forthcoming with your best photographic memory.

So let's look at this first slide, if I can advance it. Probably some of you are familiar with this kind of mapping. This particular slide shows three sets of maps. Successively on the left side is the per capita income of where Kaiser Permanente members live in the greater Bay area. The middle shows mapping relative to diabetes prevalence. You can just take a flash with your eyes and see these darker areas represent increased prevalence of diabetes. And on the right side, the prevalence of obesity. Now we're able to do a lot of this work relative to some great data analytic folks that we have within our organization, as well as harnessing the power of KP Health Connect, which is the largest private electronic health record system in the country, arguably perhaps in the world. And, as you can see, up above here we're looking at many different things in terms of employment, educational literacy, early childhood, etc. Now, if we really look at some other interesting aspects, this is childhood obesity relative to park space. And there's a pretty interesting correlation between the lack of park space relative to the prevalence of obesity. This gives us a sense of where some of our investments might go in terms of really upstream investments to address obesity, rather than just looking at what we see within the clinical space. Now I think as a physician, as I mentioned to you, I had been working on chronic care collaboratives. Diabetes was our number one focus. And when I came to KP, we were able to generate some of these really interesting maps. I think it's fair to say that diabetes prevalence can't be thought as a proxy for the overall health of a community. And again, if you just take a flash in your memory banks here with regards to where the intensity of color is, you can see with regards to Kaiser Permanente's folks where we see the most diabetes in the greater Bay area, at least in the East Bay here. Now, if we focus a little bit more and start to divide the membership in terms of Caucasian members in this case, you can see this pattern. And I would ask you to maybe look at these red spots where we see the greatest intensity of prevalence of diabetes as compared to the next slide which shows non-white members and where their prevalence is.

So let's go back and look at where the white prevalence of diabetes is as compared to non-white members. And you can see it's actually different. And this is really important information when we think about addressing diabetes and addressing health disparities. Now I did want to alert those of you that are interested in the methodology relative to the preceding slides, this is a long explanation to consider other ways of cutting the data beyond just prevalence. But relative to looking at the cases in any given geography and looking at the standard deviation. It's kind of saying the same thing but with a little bit more methodological precision. But again I will point to you some of the ways that you can look at these slides. Again, all members, red means a greater standard deviation of the prevalence that would be predicted otherwise, all members as compared to Caucasian members. And then, if you look a non-white members again, you can see that the pattern is somewhat distinct between non-white members and Caucasian members. Now, the next few slides I'm actually probably most enamored with, and I'll go to this slide. And this is the East Bay of our Bay Area. And this gives you a snapshot relative to the membership of Kaiser Permanente in various communities. And the green bars here give us an eyeball sense of the percentage of Kaiser Permanente members relative to the overall adult population. And then you'll notice too that there's various stars such as here that recognize that we're not the only provider in a given area. We have safety net partners in these areas that have high prevalence of diabetes and dare say high disparities with regards to diabetes. And in addition, I don't know if you can tell but at least the slide set that I had, there are concentric circles indicating a 10 mile radius. I don't know if you can see it on this side, but there would be about three concentric circles.

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So that in any given area, we know geographically that there's an important set of providers that provide care for chronic disease, address disparities beyond Kaiser Permanente. And it behooves us as a population management thinking organization, what do we do in collaboration with safety net partners.

So the next few slides will actually address that. This just focuses on one of those counties.

So if you take Contra Costa County, which is one of the largest counties in the Bay Area, you look the total population here of total folks that are insured and total folks that are uninsured, there's 925,000 folks in Contra Costa County that are insured and 87,000 who are uninsured. Of those 925,000 individuals in Contra Costa County, you can see the big bite that Kaiser Permanente takes. The Contra Costa healthcare system, which includes their own managed care situation and hospital, as well a MediCal members the are covered by the FQHCs, between these three sections of providers, it's well over two-thirds of the population.

So the question really is, what can you do together as a group of providers that care for the vast majority of insured folks and have responsibilities certainly for the uninsured folks in terms of thinking about elevating the health of the community, particularly around diabetes?

One of the things that we've done, and this gives you a sense of some of our activities around the safety net partnerships as well as thinking about population management, is to develop a cardiovascular disease risk reduction program, which we call PHASE in northern California, and we have its counterpart in other parts of the country known as AOL. These are the various partners that are really partaking in this collaborative effort to reduce cardiovascular risk. What does the reduction of cardiovascular risk really mean?

It means around thinking about capacity building in the safety net to address things as putting together a risk reduction program that comprises of a very aggressive means of getting therapeutic drugs into the hands of the underserved and in the uninsured. This just gives you a sense of how these kinds of programs can really replicate across the spectrum, including those grants that we have in northern California and inclusive of southern California as well. I think this is very consistent with our overall strategy at Kaiser Permanente in terms of recognizing that what we see in the clinical setting is certainly only in this first circle of individual and family. But our members are part of a larger community, part of school systems and worksites, part of a community that has assets as well as challenges in it, certainly in terms of being impacted by the social determinants. For us to think about our role as a provider, we have to consider the spectrum of where we touch patients across their lives, inclusive of the clinical setting; but perhaps more importantly, increasingly more importantly, in the broader community setting. This is one way that we've addressed obesity, for example.

If you can think about this model -- that you can do a lot of things in the clinic with regards to BMI screening, talking about self-management goals, etc.; but what we do outside of the physician/patient interaction includes these group programs, individual counseling; and also, most importantly in terms of looking at the overall environmental changes including policy, work site programs, also modeling the kind of work that we think is important in terms of changing the kinds of food that we have in our systems and engaging our own staff and physicians in healthy lifestyles. This is a map of some of the 40 different communities that we have initiated across the board with regards to what we call healthy eating and active living coalitions, which addresses the previous model that I shared with you, which indicated this interaction between the clinical setting, the care management system and then a policy and environmental community collaboration. It's something we're very proud of. It's existed for about five years and really is consistent with a lot of the activity that's occurring nationally. I think finally, I think the future is quite promising if we think about all the ways that we can really start to associate community and social determinants of what we

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see in the clinical setting. As this was the first slide that you may recall seeing when I first began, I want to suggest that there's a lot of opportunity to even go beyond typical education and literacy. Let's look at what happens with regards to adverse childhood events, since we know that adverse childhood events are strongly correlated with the bad outcomes for adults as they age. Economic sustainability in terms of how income within a community stays within a community instead of being exported outwards. This whole question of violence prevention, looking at open space per capita. I think some of the things that Eileen perhaps mentioned, these are all opportunities for us to really push across the spectrum of how to consider the overall determinants of what we ultimately see in the clinical setting. I think that's it.

So thank you very much. Good morning. I've had the opportunity to learn from my great colleagues from California and they've shared with us how to apply data at that local level. I'm going to widen the angle of the lens a little bit and talk about how the County Health Rankings and the model we use can be used to support your efforts in community health needs assessment. I'm going to give you a few cautions about how we'd encourage you not to use this work in moving forward; and as Kevin said, talk a little bit about where we're heading with the mobilizing action toward community health project to assist you in these efforts in your community. How many of you have been to the countyhealthrankings.org website?

Okay, most people in the room. I'm not going to go into the details of the rankings, the specific data that's in there. But I think what this tool has provided is the opportunity for everyone in the nation to be able to come to this website, click on their state, click on their county and get a snapshot of their county's health -- an ability to look at what the strengths and the challenges are within their community. The rankings are built on this model. And I often tell people, in fact, I always tell people, that this is the most important slide that I will show you and the most important product of the County Health Rankings. People often think it's that county snapshot with all the data on it. I love my data colleagues and I respect what they do and there's reliable and valid data there, but what I have heard from people around the nation is that this model has been an incredibly powerful tool when you enter into a conversation with many partners from many different sectors. Everyone from community members to business leaders, to healthcare leaders, to faith leaders, to education leaders because people can understand how the different factors fit together. And they can see themselves in this model.

So, for those of you who have not had as much time on the County Health Rankings website, let me just tell you that at the top of the model, which is usually in green but not showing up very well there, is health outcomes. And we do -- we look at five different measures of length of life and quality of life, and measure the current health outcome in the community or a picture of today's health. The boxes that look like they're in gray there but are usually in blue, describe the health factors or the determinants of health, the things that drive whether people are going to live long and healthy lives.

So we look at 23 different measures in the area of health behaviors, access to and quality of clinical care, social and economic factors and the physical environment. And you can see that we weight each of those health factor areas a little bit differently. 40% for social and economic factors, 30% of health behaviors, 20% for clinical care and 10% for physical environment. This model helps people think through what's most important, where they're doing well, where they're not doing well, and also guides people, we hope and we encourage, to look beyond just the 23 measures that are on their county snapshot. But think about what else do we need to know about education to fully understand the needs, the strengths and the challenges in our community?

What else do we need to know about these different health behaviors, about access and quality of care?

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And so, it's a model that can help drive further data analysis. The rankings are intended to be a tool to raise awareness in the community. They are not intended to be a comprehensive community health needs assessment. And I caution you on this and we'll talk with you about work we're doing to make sure we caution others in the nation around this. I have heard the stories, and I have actually seen community health needs assessments that were based on printing the county health ranking snapshot and thinking we've done everything we need to do. That is not where we want to see this go. The rankings are intended to raise awareness because one of the things they do is put this data in context in a summative fashion so you can see how your county compares to a neighboring county and other counties in your state. And this puts an element of relativity and competition into the mix, as you talk about community health needs assessment. But the whole purpose of this major project, which is funded by the Robert Wood Johnson Foundation and produced by the University of Wisconsin, is not merely the data. It's what you see on the right hand part of that screen, which is that this is a tool that can speak to many different sectors in our community, have them come together and enter into the process of not just looking at data, but thinking about what do we do next.

So, most of you have been to the County Health Rankings website. How many of you have been to the action steps page of the County Health Rankings website?

Okay, it's a little better than I get in most audiences, so I commend you and thank you for visiting this portion of our website. And I encourage you, if you have not, to take a look and visit here especially in months to come. Because we'll be doing a lot of work to expand this.

So when the rankings were first released for the first time in 2010, I talked to many, many reporters and many community leaders. And they said, Okay, we get it. We don't rank where we want to rank. We want to do better. We know we can make health improvement. What do we do next?

. And so, I would refer them to this take action model, which, if you look at it, would be what most of us I think would describe as a fairly common set of steps for doing strategic planning or community health improvement planning or community health needs assessment and planning. And I would say that the first thing you need to do is do a deeper dive into the data. You need to look at more data about your community so you understand more fully what is happening in your community. You need to look at that first step in the process, assess needs and resources. And what reporters would ask me is, Well, how do you do that?

Or what mayors would say to me is, How do we do that?

And so, we reference many of the other tools and resources that are available such as the map process and the community toolbox and the ACHI toolbox. But we also knew people were starting here at our website and looking at these data.

So, when we released the rankings in the subsequent year in 2011, we produced this data drill-down guide, so that people could start with their rankings and think further about where they needed to go next.

So if you go to the site and take a look at the data drill-down guide, what you'll find first is some steps in how you look at your county's snapshot and think about that data that's there before you. And then, if you page down this drill-down guide on the website, you'll come to a place that highlights a variety of other national data sources that describe data at the local level. Now yesterday, in the excellent presentation about geography, we certainly heard that the county level data is inadequate for many, many communities. And I will fully concur with you about that. But the challenge is that data often is not available at a lower level within the community, which we also talked about yesterday and is a great transformational challenge for us. But what we've strived to do here is put in one place where community members can quickly get to the

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major national resources that would be available to them. They don't have to go out and find these and search for them. It's all right here and it describes what it is, what type of data are available, what geography you can find it on, and what specific types of data is relative to the rankings is present.

So, the US Census Bureau, CDC Wonder, the community health status indicators, the food atlas, the Annie Casey Kids Count report, and the new health indicators, the new data warehouse health indicators. In addition, there is also data available at the state level. We've customized this so that we direct people to further data that's available primarily through their state health department. And so if you're in Washington, you can click and get to data from the state of Washington. If you're in Maryland, there's a link there, whichever of the 50 states you're in.

So, what I want to summarize is about data on the County Health Rankings is it is a starting point, not an ending point. It is a great conversation stimulator. If you use the county health ranking snapshot, please pull the model out and have the model be a driver of discussion within your collaborative or your partnerships within your community. Other sources of quantitative data are available and we've strived to link you to them. But we concur with many of the challenges that have been discussed here, that often data is available at a state level or a county level but not at a neighborhood or zip code or more disaggregated level that would really help hone in. We also feel very strongly that quantitative data must be balanced with qualitative data. I often tell people, I'm a clinician, I'm a nurse and was educated as a nurse practitioner. And when a patient would come into my office, I never sat and looked at their vital signs and their lab data and made a diagnosis off the numbers alone. You always start by listening to the patient, hearing his or her story, what are their signs and symptoms, what do they feel, what's aggravating them, what's helping the situation. And we must do the same thing with our community and not treat qualitative data as lesser than or second class data. Because it is critical data in terms of fully assessing the needs of the community.

So, that's the data drill-down of the County Health Rankings but let me conclude my comments with the last few moments to talk about what's coming next. The Robert Wood Johnson Foundation saw the attention that the County Health Rankings generated and said, We now need to put our money where our mouth is and further support action in regard to this. And there's a wide variety portfolio of new resources and initiatives that are coming forth in regard to this, including we're in the final stages of selecting local community grantees to take action around policy and systems change in the area of social and economic factors. But we are also working on further developing tools and resources to support communities in action. And one of those is really thinking through, okay we know, we've looked at the data, we've set priorities, we know what's wrong with our community, now help us find the best policies and programs to effect change in our community. And so, there is a beginning of this work on the County Health Rankings website. And in the months to come, this will blow up into a searchable database, where you'll be able to look for the latest evidence. This will be ongoing review around how you can take policy and systems change to make change in your community and really how you focus on those systematic changes so that it is sustainable in terms of change over time.

So, you can click on any of those hyperlinks. And here's an example in the area of education of the kinds of policies and programs that are there now. But this, again, watch this site. It will become much more robust. And, one of the things we're hearing from communities is they not only want to know what the evidence is, but they want to know who's tried it, how'd it work, where are the procedures, what were the challenges. And so we'll be linking you much more to a practice-based approach to evidence-informed policies and practices.

So, I thank you for your time. These are my great colleagues that I work with at the University of Wisconsin, the Robert Wood Johnson Foundation and our federal partners, without whom this work would not be done.

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Thank you. Just a quick note for folks that may have noticed on the lower right hand of this slide, as Julie presented, that there was Kaiser Permanente. And Kaiser Permanente is not the sponsor of the Match program. We'll take responsibility for having put that on and accidentally left that transposed on the other presentations.

So with that, I want to pose a couple of questions to the panelists before we open it up. And what I'd like to do is to go to that first question that is posed, which is, what are and should be viewed as the essential data sources in an assessment. Winston, both you and Eileen shared some great work on utilization data. Now the Agency for healthcare Research and Quality has a tool on their website where you can actually download utilization data and look at what we have called ambulatory care or sensitive conditions that they call prevention quality indicators, in essence the same kinds of measures. Should utilization data be considered an essential data source?

Should demographic data be considered an essential data source?

And what else should we be thinking of?

Oh, okay I'll be the sacrificial lamb. Well, you know I think it's actually a very intriguing new world with regards to the advent of the electronic health record because I think basically the momentum is in the next 10 years, every large system, including hospitals and health plans, are going to have a substantial amount of data. The question is, how much the data will be socialized for general consumption as well as the transparency and the sharing of data through data pools. But I'm, at the heart as my other panelists, I'm a clinician.

So I think about ways that data that is kind of historically or traditionally thought of as disease-related data can be more broadly related to social determinants. And to understand how things like diabetes or things like asthma are merely proxies for other underlying reasons as to why we see the prevalence and the intensity of a disease process.

So, I'm hopeful that through this process over the next five to 10 years, as we harness data across delivery systems, that that will be part of the calculus between public health as well as primary care and chronic disease management. I would like to add to that by simply echoing something that I learned from our godfather of community benefit, who's here in the audience, Bob Sigmond. He said to us years ago, You know, you're always looking out there about what's going on and what the needs may be out there, when in fact the community is in your hospital every day telling you one of their needs or more of their needs. And so, it was very valuable for us to take a look at the utilization data, especially when the development of the community need index indicated to us that people from those high-risk neighborhoods were in the hospital twice more frequently for the ambulatory care sensitive conditions. We were stunned when we did take a look at the data for our hospitals and learned how many people actually that represented and what that expense also represented. It was in excess of \$47 million the first time we looked at it. And so, the ambulatory care sensitive conditions and utilization data become very, very important. The socioeconomic barriers gave us a glimpse into where do you live, what are your health conditions, what are the contributing factors to that.

So we now know where you live, what those issues are. But we also know how to help you. And so it has helped us to become far more strategic in our community benefit program planning to address those unmet needs. Great. I want to just add a little evolutionary idea about this piece about data. In my former life I was a local public health officer. And when you mention demographic data, Kevin, for years when we did

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community health assessments we collected demographic data. And we considered it background data. I think the evolution now is that same demographic data, the socioeconomics, the educational level of your community and data such as that are now actionable elements of your community health needs assessment. And so I think it's really important because I still see people collected as kind of here's the profile of our community. And I think, as we talk about what we know drives health outcomes, we need to think about that data in a way that those, again, are actionable and core pieces of the assessment, not just background. Great. I want to emphasize, in asking that question, I think there's something we all have to grapple with, folks may recall in Becky Slifkin's presentation yesterday. We have to acknowledge that a significant proportion of our hospitals are smaller rural hospitals, many critical access hospitals. And we have to consider their capacity in ways in which we collaborate and support those efforts in the assessment process.

So look forward to all of your questions and comments as that acknowledges that diversity of hospitals. A couple of quick questions, one for Eileen and one for Winston. Eileen, I was impressed with the Lecowza example of investment in affordable housing and an improvement, as we've discussed, and I think will be discussed and raised on a number of occasions throughout today's panels is the current exclusion of -- in the IRS reporting for community building activities, of which housing renovation is certainly one of those, and a concern raised that, for example, hospitals may use that if, in fact, it were permitted, would use that permission to renovate and otherwise gentrify neighborhoods around the hospital. I wondered if you can address how, and in the ways that you approached that ensure that it is not misused in that manner. At this time, our community investment program is primarily low-interest loans and lines of credit. And, as such, they are not countable as community benefit. If anything, there would be interest foregone, but that's an opportunity cost that we're not counting at this time. And in those investments, they are clearly focused on creating housing opportunities and improving housing opportunities explicitly for low-income populations?

That's correct. We're also involved in southern California with permanent housing for the homeless, who are frequent utilizers of one of our hospitals in the heart of Los Angeles. Also, with the California endowment for fresh foods for our communities. Great. Winston, I'd be remiss if I didn't note that your system is -- in many ways reminds us the direction that, in fact, we're going. You're basically a system that is financed in a manner that incentivizes the investment in prevention and keeping people out of our hospitals and as a way of encouraging this work. I'd like to get your perspective on ways in which Kaiser is looking at going to the next level. What are your quality improvement objectives, particularly as it relates to improving health of populations in the context of their communities. Well, I think yes, historically our model is really predicated on prevention and recognizing that the health of our members is only as good as the health of our communities.

So I think the brand new world is really broadening the definition of what is within the purview of Kaiser Permanente as a big system in terms of how do we cultivate healthy lifestyles as well as wellness in communities and how we think about the ways that we touch communities sometimes beyond just a direct delivery of services, but also in terms of how we partner with different organizations to model a sense of population management and outcomes. I mean, we've been actually a fairly strong proponent of how accountable care organizations can come into play. We don't believe that Kaiser Permanente is going to be in 50 states, but we do believe that some of the models of how we think about prevention and population management can perhaps be emulated or replicated in some of the models that are coming out of the innovation center at CMS. As you look at accountable care organizations, I think it's a missed opportunity if the ACLs don't actually -- actively integrate into their thinking around how does a healthcare provider think about ways that it intervenes or provides support for a community that's outside of the medical model and thinks about investments back into the community. That's great and we'll hear more on that in panel five with Brad Gray and Paul Hattis. I want to now go to questions, and our folks will get to you right away. Start over here.

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Thank you.

Thank you. Lets make sure we're on.

Thank you. Okay, Allen Lomax, Community Indicators Consortium. It's not really a question but really a comment that we also need to think outside of traditional health organizations with information and data. I know a number of the school systems collect data on youth that are highly important such as your first behavior survey, development assets. In addition, when we start talking about special populations, a number of communities one day a year in January collect a point in time count for the homeless. And so there's a number of data points there that are outside of the normal realm. One of the things that I think that we often tend to forget is actually identifying who are the data owners and providers and however we define the community, and bring them together first to start talking about what are they, as a major resource, and bringing them together and how those resources can be leveraged as you move forward. Great. Great point. Next, Reggie?

Mic folks need to get to folks so we're ready to go. Folks, please raise your hand or stand up so we can get to you. I want to emphasize also that we are going to do our best to make sure that we get to the full spectrum of folks. Not that we're not going to come back to you a second time if we've already come to you, but we want as much as possible to get to everybody. Ron, please. Ron Bialek with the Public Health Foundation. A lot of the data that we have been talking about are sort of looking at the part of the glass that's half empty, you know the problems. And I'm wondering about the efforts to do comprehensive asset mapping. And what I mean by that is not just the looking at the institutions but really looking at the community connectors, the gifts and talents individuals bring, the loosely knit associations. Because at the end of the day, it's those community assets that really do need to come into play where the institutions, the health departments, the hospitals, etc., can support and work with. But I'd like to know what you're doing with the community assets mapping part. Great, great point, Ron. And we have -- do we have our third?

And, it's kind of building on what Ron was just sharing. I think that the data that's typically looked at with community health is probably more the 20% of the information needed to address community health improvement. And Julie touched I think on the other 80% at the very end of her presentation. It's valuable to do more and more sophisticated analysis about utilization and socioeconomic factors and everything. But the real challenge is how do communities come together to make improvements. And that means not only being aware of the assets but how do you leverage the complex information to manage who's doing what?

What are the obstacles?

The kind of things that Judy mentioned in her introduction say to do that.

So, if you're looking at data and information management capabilities, I think it's valuable to keep getting better and better at the analysis. But we've been getting better and better at the analysis for the last 30 years and the problems continue to grow. I think it's important to focus on how do you help communities manage information not only looking backwards on how we've been doing, but rather how do we do better. I'm just wondering if you have thoughts or comments on that. See, our audience is pushing us forward. Three issues, how do we engage non-health data sources and use them more effectively, assets identification mapping and not just mapping but mobilization which moves into Bill's point -- how do we really bring folks together?

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Oh I'm sorry. I wholeheartedly agree in terms of the untapped resources of asset mapping. And one of the things I mentioned at the last slide was whether we can capture, as I call it, economic sustainability. You know, as some of you know, in my background I worked a lot in Asian immigrant communities. And Asian immigrant communities are interesting in that if you look at the dollar flow within an Asian immigrant community, it actually is generated inside the community about six times over because of language and cultural historical patterns as opposed to perhaps other communities where dollars actually leave the community in terms of not being able to support businesses and small employers and such. I think we at KP are starting to understand this relative to our position not only in terms of a healthcare plan but also as a generator of jobs. We are starting to really look at when we establish a medial building or a medical office, what is the impact in the community in terms of really generating good-paying jobs, how we think about our open space, how we think about our green environment kind of responsibilities, and looking at how that relates to the strengths in the community. One of the other things that we've done recently is to really up our ante with regards to supporting minority vendors, which we associate with basically job generation within communities that have been underserved. Really it's pushing the envelope with regards to how you think about yourself as a healthcare provider and less so in terms of providing medical services, but more so in terms of being an economic driver to provide good-paying jobs for communities that have been underserved. Other panelists?

I would simply like to add that the topic for our conversation this morning was about the tools that we use in the needs assessment. And I understand that and the agenda coming forward will be more information about the assets and partnerships that we'll be engaged in within our communities. But simply know that, as part of a comprehensive community benefit program, along with the health needs assessment, we also do an assets assessment in every one of our communities and insist upon that as well as the competencies of staff to engage in relationships with community partners because we recognize it as something we cannot address alone. Ditto. But I would say, we made one change in the rankings this year that goes to that whole element, which is we're looking at educational levels. And we had in the 2010 rankings looked the percentage of the population with a college education. And then we realized, looking at further data, that you actually see a significant improvement in health outcomes when people have some college education not just graduates. And that's much more modifiable to get adults to go back for some post-secondary education than, say, you're only going to have an improved health outcome if you get a bachelor's degree.

So it's an example of a way to continue to look at assets and how you use data from other sectors to further the conversation. Great. Next set of three questions, comments, please raise your hand. I'll jump in. Good morning, this is Dennis Lenaway from CDC. I have a question for all three panelists. And I think, Julie, this goes back, harkens back to your days as a local health official perhaps. As an epidemiologist in a county health department, I conducted several community health assessments. And one thing that we noticed right away when we brought a collaborative of the hospitals and leaders in the community together was we didn't have all the data we wanted. And I noticed your very first prompting question was what are the essential data sources. And I think we all struggle with, well, what are they?

Because if we don't measure it, it's not going to get the attention it deserves.

So I'm curious as to your experiences, and I really enjoyed your presentations. Have you gone out and tried to seek out some primary data on your own?

In other words, you're surveying or you're gathering data to fill a gap or perhaps to drill down in a neighborhood or community sense, something along those ideas. Because I think one thing we'd want to promote is the end-all is not the existing data you go out and go get. I think oftentimes to really nail it in a

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community, for all the reasons we've been talking about, you might have to get your own primary data occasionally to fill some of those gaps.

Thank you. Next?

Hi, Julie, Joella Griss with NACCHO. I do want to emphasize, Julie, you made a brief comment about qualitative data. And I know that it's often seen as the ugly step-child to quantitative data, but we see a lot of limitations in kind of understanding the causation. I think that good correlation between things like income, education and some of the health outcomes that we're seeing. But to really understand why conditions are the way they are and how that results in outcomes, we really need to do qualitative data or collect qualitative data.

So when we talk about data sources, it's not just about what data we have. I mean I think the data sets that you have are excellent but it really doesn't tap into what's going on in communities. And if we're really think about social economic determinants, it's not enough just to have some of those indicators but understand why those disparities exist. And in order to do that, we need to have conversations with communities. Great. Number three?

I just want to emphasize a point that Julie made, that qualitative data, especially at the beginning, maybe much more important than quantitative data. My own experience is you want to gather whatever data you can to find out what are the low-hanging fruit in terms of changes in the health system to make it more -- really an improvement system. And that involves finding anything that the community feels it wants to see changed. And there are providers that are interested in that kind of change. And I think that kind of information, which is I believe what she was talking about when she talked about qualitative information, is the most important thing for getting started while you go into all this fancy data collection. The real question is what will bring the community and the providers together around getting something done right away. And that's low-hanging fruit. Okay, the last three questioners are really helping us with a segue to the next panel, as I'm sure those panelists will agree.

So we have, what are forms of primary data collection that we should be thinking about?

And in particular as it relates to qualitative data as a means and doing it on the front end, as a means of really getting a sense from our communities. What are the issues?

If we want to engage our communities, how do we make sure that we are engaging them and listening to them on the front end?

Well, if I can start in responding to Dennis's question, I think one of the things that makes local data and qualitative very important is if you want to engage local policy makers, they want to know what their community says. And I remember when I was working on tobacco control, we'd have state survey after state survey about how people want to clean indoor air. And it did not matter until we could bring it down to township and city and my represented district about what people want about clean indoor air, if they were going to take action at a local level.

So I think that's another element about why local data is really important to drive action. The second thing, though, going to the second two comments about the importance and the value of qualitative data, I have a great example from when I was a local health officer. I come from Wisconsin. We're huge binge drinkers. In fact, we're always number one in that except when North Dakota beats us. And, as a local health officer, I knew my community was worse than the state in terms of binge drinking. When the county health rankings

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came out in my state, I was able to say we were 64th out of 72 counties. And that made us the worst of the worst. Now, that's quantitative data. But when we went out and talked to the community about that, and started and we had some tragic events, and we heard people's angst, and we began to talk about our culture of drinking and how people argue with the definition of binge drinking because five beers at a Packer game is normal behavior. And how are we going to change that and what does it mean in people's lives and how had it affected people's lives?

It went to a whole different place where people were willing to say this is something we have to change in our community now, versus just a cultural thing we can't do anything about. And if it hadn't been for the qualitative conversations, that wouldn't have moved.

So, it's just an example reemphasizing the power of that. Five beers for a Packer game, we have a good team even.

So that's kind of interesting. Well, one of the things that I'm sorry we didn't have a chance to show, is it's very interesting. We have this part of our HEAL initiatives that includes photo voice, which enables communities to take snapshots of their community in terms of what is happening in their community that really strikes at the heart of what they see every day, and then through the process of the collaboration and coalition building to engage in those folks that have cameras, young people, older people, to take a snapshot, you know what they want to see as the desired state and what actually occurs. This has really been a powerful tool in terms of communicating what really resonates with people at literally the street level and how we can incorporate that into a broader sense of planning. We need more vehicles to really engage patients at the very level where they see their community and bring that into the consciousness of how we plan. In our system across the 40 hospitals, the qualitative data has been invaluable to us. It has taken us from prioritizing in one way to switching gears altogether to address what is really important to the people in the community.

An example of that would be in our San Bernardino area where, lo and behold, one of the most important things was the worry parents had about their children after school. And so a homework club was developed in that area. Another area was the values enhancement for the children when the parents were not at home, worried about what would happen after school in Bakersfield. And so a values enrichment program was founded. The insight that we're able to gain from the qualitative data is so very important. And it happens across the system. It may be that a community advisory group representative of the community is sharing information from the street with the folks who are at the hospital board level. Or it may be in those open forums in a local church where people are talking about their embarrassment, about some of the health issues that they have or their socioeconomic conditions. Helping find jobs, helping find homes. It's an amazing insight into community when you do an assets assessment as well to learn who is doing what and who can help you so that they too can be at the table with you as you communicate with your community. One quick anecdote to emphasize the point of community engagement. Our health officer in Contra Costa County, California tells the story of approaching community members in Richmond, which is low income, very ethnically diverse community in the Bay Area; and proposing to them that he wanted to establish a new community health center in their neighborhood. The initial response was, well you know I suppose that's okay but our priority is speed bumps. In our neighborhoods, the kids are racing up and down the street. We've had people injured, at least one kid killed in this last year. This is what we want to have done. And he decided that if he wanted to engage the community, he had to be responsive to these issues.

So, he engaged the appropriate departments and got the speed bumps put into the neighborhoods and had the kind of engagement subsequently that he was seeking.

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So we have time for two more quick questions, comments. I think we have up here first.

Thank you. I'm a physician at Emory University and have been working. I used to work with the state health department in Georgia in setting up community clinics throughout. Oh I'm sorry. I'm a physician at Emory University and worked with the state health department in setting up community clinics in rural areas throughout the state, and had an opportunity to also get involved in another area that I think relates to all this. And it has to do with the entire area of medical literacy. The way I sort of see the picture is it would be like not teaching people to read and then having a whole group of people who, if you need something to be read, you go to them and they read for you. In medicine, people are medically illiterate, grossly medically illiterate. And they're starving and they're excited about getting involved in things where they can become literate. For instance, we had a program that was adopted by the American Heart Association to teach fifth graders to take blood pressure. And they went home, took their parent's blood pressure and referred them for care. And the guy who came up with that program got an award from President Ford in the White House. But the program is now not in existence. I think that if consumers can -- personally, if I can learn medicine, anybody can learn medicine. And I think, you know the basics of a physical exam, I've been very obsessed with this. We did a book teaching the basics of a physical exam. And we put it free on the Internet so anybody could look at it. And kids like it, you know. And if you went into the communities and found out what knowledge base they have and got doctors and nurses who have these skills to start sharing that information, I think you'd find an incredible outpouring. We did another book of symptoms that were life-threatening and also made that available free on the Internet.

So when Random House wasn't excited about that. But instead of people having to buy it, just make it available. And I think through community efforts that sort of activity can go a long way. The other thing I'd say -- I'm going to have to stop you there and take it to the next commenter. But great point. We have opportunity for one more question, comment. Hi, Paul Epstein, Results That Matter team. And I want to go back to Kevin's question to Eileen before about housing assistance as a community building-activity. You can't count it. And I'm kind of astounded. I mean I've heard that many times. It came up yesterday, it came up before. When you got -- the way I would look at it, hey we got the data, we chose the need, the need correlates with bad health, we got the plan, it's on the plan. Hey, we have a picture of it. We have a strategy map. We have a logic model. Here's a picture of it. Here's our housing assistance, our homework clubs, all these other alleged community-building activities. They're not community-building activities, they're health improvement activities because we got it on a picture and look at the top: better health outcomes. You put it all together. Its community health improvement activities go away. I think with that point, we're going to end this panel and bring the next panel up.

Thank you very much.