

## Panel 8: Monitoring and Evaluation

Welcome back, folks, to our final panel of the day. There is a sheet of paper being passed out to you. There was some discussion at the end of our fifth panel about the Community Benefits Standard and Implementation, and whether or not it included Charity Care as part of that standard. What you have in front of you is an excerpt that is an appendix to a monograph that Larry Prybil has done that we excerpted and scanned and expanded so you would have that at your fingertips. We have one panel and I wanted to draw particular attention to at the end of this panel, we are also going to get some closing reflections on the day from Dr. Leonard Syme who for those of you who weren't here at the beginning in recognizing him, he is Professor Emeritus at the UC Berkeley School of Public Health and a mentor for many of us, and the father of social epidemiology. Needless to say, we've been talking a lot about social epidemiology and he is going to offer some of his reflections before we close and we go to our reception for the evening. Without any further deliberation, I'm going to introduce our panel. Again, they are going to model good behavior on 10 minutes presentations and we'll go very quickly to questions. Monitoring and evaluation -- we've talked about this meeting being covering the Community Health Improvement Cycle. I want to note that while this panel is number eight of 13, that doesn't mean that's we think it fits on the Community Health Improvement Cycle. In fact, it's something that has to start from the very beginning of the process. We have three terrific panelists who will address this issue, Jim Walton is the Vice President of Health Equity and Chief Health Equity Officer at Baylor Healthcare System. Catherine Kinney, a longtime friend and colleague is Principal, Kinney and Associates and has worked with hospitals all over the country for the last twenty years and Christopher Fulcher is the Co-Director for the Center for Applied Research and Environmental Systems at University of Missouri at Columbia. Jim, do you want to start us off?

At this point in the afternoon my job in 10 minutes is to tease you a little bit and entertain a lot. I see that most of you are still awake and that's good. I took a different approach. I'm an internist by training and work for a major healthcare system in Dallas, Texas and had the opportunity to provide leadership across our system around the notion of health disparities and how to create more health equity in our community. My approach to my comments today in the 10 minutes I've been given is to kind of take a stab at this larger concept of strategy implementation around health disparities, specifically just to give you a snapshot of what current practices are looking like in Dallas, Texas with no real expectation that you would think that that's really great or significant other than just give you some points of reference in time. What I want to cover in the next few minutes is this idea that; kind of three ideas, is that we're going to identify health disparities and monitoring progress, one of the bodies of work that I'm going to work on and describe for you. The second part I'm going to talk about is the potential roles of community members as we see it and how we're implementing that in our community.

Then third, the potential impacts of advancement in technology and how we see that we can kind of start to move in that particular space. In this slide here, this identifying health disparities and monitoring progress, probably the big three bullet points that you need to take away is that we've really gotten serious about this point of service collection of race, ethnicity, and primary language variables at the point of service in the ambulatory space and in our inpatient side of the house. We monitor for quality of collection by the excess services folks as they collect that and put that into the electronic health record because only then can we actually pull that information back out of the electronic data warehouse and do some analysis on it with regards to clinical performance analyzed by dichotomous variables of race, ethnicity or language. We can also look at our payers. We can also look at age. We can also look at gender. But right now, we're kind of focused a little bit in this space of race, ethnicity and language disparities. We take that information and we report to our Best Care Committee, our Quality Improvement Committee for some of other organizations, both at the healthcare system level, which is mostly our hospitals and our hospital presidents and also within the primary care and specialty care employed physician group called Health Texas. That's both organization, both inpatient and practice level. What I've provided for you here and I think that shows up fairly well is this slide that shows you just a snapshot of one of the reports that we actually produced and reflect for our

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physician group. This specifically looks at diabetes and it looks at the question of I think you're doing okay in diabetes management overall, but are there disparities within the population that you're taking care of?

What I would point out to you is that we calculate mean differences, and we test that for statistical significance to make sure it's not a random difference. We've tracked that over four quarters or even eight quarters and then we show that to the committee. In this particular illustration, there is five metrics that we could look at from the database within our ambulatory primary care sites. The one that I circled for you just for illustration purposes shows you significant disparities in A1C control as measured by a hemoglobin A1C less than 7% favoring the majority population, or what we would call the historically advantage population in our community. You can see in other areas that it's both in the race when we look at white versus non-white, ethnicity when we look at Hispanics versus non-Hispanics, and in English-speaking. That is our trend in 11 of our pilot clinics that we've been working with. When you look at the trend for one of those clinics in that pilot site, you can see a -- if you graph that out over time, you can see a fairly dramatic picture that says something's not right with the practice in that particular site. In fact, that black dotted line is the average for the entire medical group of several hundred physicians, and this particular blue line; the bottom line, is basically a group of about three or four primary care providers in a particular site serving a predominantly minority population. That illustrates kind of what we've been able to do to give that quarterly feedback back to a provider group. What is interesting within our organization, is that we have created if you will thresholds for payment -- financial rewards and financial penalties to the provider community once they identify these problems in quality that if they don't make improvement over a certain number of quarters, then they actually would experience a financial penalty. When we look at those type of problems; kind of what you've been chatting about here I just heard a couple of your lectures earlier, in that there is this kind of question that you've been tossing around is what is the community's role?

We have kind of identified that in our space with regard to clinical integration between the formal and the informal healthcare delivery system. The informal being community entities that are out there at the local level trying to improve health status for people that are experiencing disparities. One of the tactics; one of the levers we've identified in the literature and have actually been implementing is this notion of expansion of care coordination's role in expanding the definition of care coordination and pushing the edge if you will for our organization of what care coordination might look like. In fact trying to apply what Prahalad talked about with the base of the pyramid's knowledge and what they've been able to do with social engineering if you will within the community to help folks consume if you will a healthcare resource that they really don't quite really understand very well.

Finally, this notion of using new health IT data systems to capture and report in multiple directions. At the point of service, pushing that information collected at the community level back out to the formal healthcare system. That is what we're trying to accomplish. This particular slide shows you a graphic that illustrates some success with this strategy. On the right, we have two benchmarks. We have the state of Minnesota that is working on diabetes control and they report this at the state level and it's been fairly robust at performance at 55% of the people with diabetes are under control with an A1C calculated at less than 7%. Our physician organization that basically takes care of privately-insured people is performing at 51% last year, and then you can see that two-thirds of the population is Latino, low-income and Spanish-speaking only and their experience in what's called a Diabetes Equity Project that is trying to move the needle with regard to control of diabetes using a community health worker, hiring folks from the community and placing them within community hubs that are trusted by the community. Very simple, nothing real creative here, but we've seen in the path here is a fairly significant improvement in the number of percent of people achieving A1C control.

So we are feeling fairly bullish on this and we kind of like that strategy. Finally, let me just go to this. This next thing is this potential impact of advancement of technology. We have got this health IT geo-mapping

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idea that kind of following on Gawande's article that appeared in the New Yorker with regards to hot spotting of outliers that basically come to the hospital ER or get admitted for problems that are potentially avoidable. We have talked a little about this mobile primary care clinical data transfer so that we have this idea where we use Health Information Exchanges when our staff are out mobile making house calls to certain populations that that information can be exchanged in real time back with the primary care physician so we're not necessarily dependent on physicians doing all the house calls. We can do Med Rec with the hospital continuing care documentation. And then we can basically achieve higher capture rates within 14 days of hospital discharge. And then finally the integration of an ROI analysis. At the bottom line, we have to achieve some degree of ROI for our organization in order to sustain the initiatives and to keep the hospital system making more and more investments in our work. This map shows you kind of an illustration of our hot spotting strategy. This is basically what any organization can do probably you say where do my patients come from?

So this is just the high concentration of where people come from is denoted in red. What I'm going to show you is a community -- I think there's a button here -- it's right in the middle there is a city called Irving where the Dallas Cowboys used to play football. They tore that place down. What we did, we hot-spotted it and what we've done with this is -- and this is just a simple map for you to show. We hot-spotted, this particular hot spot is basically a census tract evaluation using Medicaid and self-pay ER visits that ultimately ended up at in an inpatient. We've done this with heart failure, pneumonia, CV disease, whatever. You can see basically by the shades of green basically we know where we need to go work. We now have a mobile strategy that could basically address that particular hot spot. Finally, our ROI approach is very simple. By doing our hot-spotting, we can actually illustrate what a patient's direct costs have been for several years before we actually started an intervention, develop a cost curve for that hot-spotted population, develop a trend of where we think those costs are going to go without any intervention, and then do an intervention. What we've been able to demonstrate to our financial people is that obviously post-intervention we have a pretty significant diminishment in hospital-based costs, but we also have added additional costs. For example, we would call the care coordination -- the specialty care as well as the ambulatory services that we have to do for those patients additional costs that we then have to cover. I think what we've experienced at Baylor has been this ability to get our financial people to make greater investments to reduce disparities by virtue of having a robust ROI calculation that takes into account bending of the cost curve plus the costs that it takes to actually bend that curve.

So I think I'm going to stop there and I'll talk when we have questions. Good afternoon and thank you all for hanging in there. We asked Kevin if we could just move the reception down here starting when we talk so that you all would have an incentive, but he wasn't quite ready to do that. I'm Cathy Kinney. I'm really privileged to be here. A little bit about my background because I'm sort of changing a few things that I'd say based on the enormous richness of the discussion over the last couple of days. I've spent time operating community health programs. I've spent time starting quality improvement in two healthcare systems, have worked with IHI on community health and public health and so on, so I'm kind of a Johnny Appleseed. I've gone different places and done different things. Over the last two days, we have heard extraordinary examples of innovations and I think Baylor's is a very good example of that. I also hear people saying yes, but what about the rest of us?

How do we basically move the whole playing field?

And as we know from the literature about diffusion of innovations, people don't change based on innovators alone. There are other issues that we need to deal with if we are going to change the whole field of practice. As I've been thinking about this, I've been thinking more about what we did we learn about institutionalizing quality improvement, and a CQI approach from where hospitals were 20 years ago and how does that apply to this today?

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That thread will be going through my comments as we talk and as I talk about the monitoring and improving issues because I think we are at a critical window and if we don't deal with some of these issues now, we will be having these same kinds of discussions in the next five or 10 years; some great innovative examples and then we still haven't moved the overall playing field. Many of you talk about silos and we've seen silos. I just wanted to make a few comments about this in terms of the work we're seeing today. We have the IRS putting some specific requirements on hospitals. We have public health accreditation standards that are coming down and dropping down in to the silo right now of Public Health with a capital P and a capital H. If you think about living in a silo, you look inward or you look up. You don't look sideways. There aren't usually windows in silos and so even this conversation is a chance to have some windows; but as Don Berwick taught us a system is perfectly designed to achieve the results that it achieves and silos create and reinforce silos. The other thing that people have raised again and again is how do we systematically engage our communities?

Unless the silos change how they work, our communities will still experience the United Way asking for input. Perhaps Public Health and hospitals asking for input together, but the system is not designed to make that happen. One of our challenges in going forward is do we want to intentionally look at a different kind of system. In order to be concrete about some of these, but also to not go back again to just the best practices, I'm going to use as an example a system that I've worked with over the last ten years and Dory is one of the leads in one of the nine divisions for that system. Just as an example that innovation does not necessarily and naturally diffuse, she's been doing this work for 10 years and I've known her for about eight and a half. It is not diffused in the system. If it hasn't diffused in a system that is owned by the same entity that supports this kind of work, we as a collective with the privilege and responsibility of being here need to be much more intentional about how we are going to move forward in terms of institutionalization which is way beyond diffusion. You all know this. We've talked about it a lot. If we have silos, what happens?

We had multiple measures whether it's ambulatory care sensitive admissions for the hospitals and epidemiology in public health and United Way has other approaches to do things; we all do it in our own culture to meet the needs of our own silo. These are my comments generally and again I'm not talking about the best practice, I'm talking about the central tendency in terms of the theme of this panel, which is monitoring and evaluation. There is a lot of inspection. There is not a lot of improvement. I think when you talk about state reporting systems and so on, that is really where in many places the minimum level is inspection. Staff competencies and time to use data and to look at improvement are very limited. I have been working with one of the large hospitals in the St. Joe's system over the last five years on establishing outcomes that are jointly owned with community collaboratives, gathering data across the collaborative, bringing that data back to the collaborative for them to use that for improvement purposes. Program people in community benefit have not been trained in the basics of data nor are they comfortable with it and so they need nurturing and they need support and, in many cases, they need allocations of time that were not there five years ago. There is not only a competency issue, there is a resource issue and an understanding of how best to do that. If that exists in hospitals and they talk to epidemiologists in public health, there may be two different cultures about data. And then many other organizations are funded on other kinds of data needs.

So we don't have a common set of competencies around data. When evaluations are done, and I would emphasize when because it's not always, most often they are tied to a grant and it's a retrospective evaluation done by an outside evaluator. Those of you that have done them, you do what you can with the data that is there and the scope of the project. In most cases, there are projects pretty modest process goals. Did people say that they learned about how to manage their diabetes?

Did the family tell you that they were going to go to the community park?

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That is not a criticism of the evaluator or the project. All you can measure is what that program is intended to do. There's very weak potential for meta-analysis across programs; looking across programs. We've all been talking about childhood obesity and all of us have probably gone to groups and talked about well, what do we know makes a difference in terms of working on childhood obesity?

The Cochran Collaborative, which is sort of a national best practice for synthesizing what's been known, can tell you some basic things. Reducing screen time helps, etc., but they've said because of the nature of the evaluations that have been done so far, they cannot yet tell us what are the key elements of an effective program because all of the evaluations look at things differently. Well how does that help you using the scarce resources you have?

Again, it's the state of where we are. Finally, and we've talked about this a lot, sometimes we bring in community groups for community asset assessments and sometimes we don't. I've really got to speed up. Okay. The opportunity that I see and this group is a prime one to do it; is to be very intentional about a paradigm shift to look at what I would call a virtual system. We can call that virtual system public health with a small p and a small h, whatever; but the basics of a virtual system are that the pieces are interdependent and reaching a shared aim. We also need to use shared logic models rather than having different models come out of different professions. We need to move to a continuous improvement perspective in terms of using data, and we'll talk some more about the measurement and data gaps. Quickly, building readiness for the alternative paradigm. I think we have a challenge if we have public health accreditation going in one place, IRS going in another, and the Joint Commission; it's not on their radar. Bob Sigmond said before he designed criteria for Joint Commission on community benefit 20 years ago. If the power structure does not send cohesive messages about working as a system, we will naturally revert to silos. We need to do that. We need to identify a few topics for shared systematic pilots across oversight entities, what you would call in quality improvement a practice field; maybe it's childhood obesity, maybe it's one state, but to very deliberately design and implement something that does not mean you're cramming the silos together, but that you're redesigning the system. We've talked about community building as essential foundation work. We will not engage community members successfully if we don't both engage their skills but also teach us how to work with them, build collaborative governance structures, and we've talked about the collective impact models. I won't repeat that.

You all know what those messages are. Then we ought to be looking at specific projects, not in terms of whether or not we like them, but how do they fit in terms of that overall goal. Another step is to use outcome-based collaborative logic models. There are several out there in different kinds of ways. I have a strong opinion that we need to start with the long term result rather than starting with these are the projects we would like to do and we hope that it will impact this and then we hope they'll impact that. We need to use evidence. We've talked about that. Describe the relationships of processes and outcomes and agree on useful and feasible measures to track progress. We can't wait until we have the perfect measure. We need to start learning about how to use measures and use measures that are relevant, and monitoring and evaluation is grounded in that. This is one example. This is a logic model I've used in many places. The advantage of it is that again you start on the left with an outcome. The other thing that has been very useful in very diverse groups is the metaphor of a root and branches and leaves. The leaves may change, the projects may change but the fundamental root of the tree stays intact. The next one is embedding the continuous improvement approach and I've talked about that a little bit. We need to add consistent expectations about improvement and measurement to our accountability agenda. I don't think continuous quality improvement really was embedded in organizations until the Joint Commission started changing their expectations about accreditation because that was money, Medicare money. We need to develop new skills at both governance leadership and staff levels.

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Governing boards, whether it is the Public Health Board, the County Commissioners or hospital board, need to understand what the difference is between an outcome in a process and how long it takes to get there. Reflective learning and realistic target setting, the California Endowment has -- a very interesting project has chosen 10 years to see, in selected communities some progress on outcomes rather than saying we're going to get there overnight. Then on-line learning communities, this is a rare opportunity for many of us to come together. If we have an intentional model that integrates it, we need to start connecting across California and Massachusetts and Texas -- small and big and not in the spirit of I've done it one way. Simplifying measurement mechanics, select and fund useful measurement tools across sectors. The IOMs just came out with some recommendations about a subset of the Healthy People 2020 measures. There are other short lists and I think if we're going to set up practice fields, they should be tied to testing some of those areas. The National Priorities Partnership that is going to be driving the National Quality Forum's measurement; they're coming up with measures. Let's find a few and get better at using them, not just have them be used on a periodic basis. We need frequent reporting cycles. The collaboratives that I'm working with, quite often you can get a BRFSS maybe once every two years, but the sample sizes aren't adequate and during that two years, you're flying blind and you can't get data at the community level.

We also need to start figuring out which data we're going to use to track improvement and use that in our assessment. I see disconnects. They use one set of data for assessment and then an evaluator comes in and looks at something else. In a quality improvement mode, you pick a measure, you get a baseline, and you track progress. Then also, another reason to choose a subset; we need to learn from each other, not just on anecdotes, but on really effective database benchmarking. We have a lot of work to do to develop and test measures in new process areas. A couple of examples, I'm working with an affordable housing coalition and the cities and the advocates agreed on a scoring system for what was an appropriate affordable housing policy. It took a lot of work to develop it and get buy in, but it was from scratch. It would be really nice if for issues like that especially in the social determinants area, we started to working together to test measures and see which ones were reasonable representations, but also most importantly were ones that both governing boards and community residents could utilize to help understand the challenges they were addressing and also agree on reporting expectations. This is sort of a reiteration of the first point of how many different documents need to be filled out by the members of a collaborative and how then that pulls them back into their silos and wastes a lot of time and effort to be honest. With that, I'm actually done.

Thank you very much. Good afternoon, everyone. My name is Chris Fulcher and I serve as a Co-Director of a center at the University of Missouri called CARES or Center for Applied Research and Environmental Systems. I am the last panelist standing and I'm separating you all from the next great activities. What we're doing here is I'm not doing a PowerPoint, I'm actually going to a live demonstration of different technologies that are available, and I'm going to take what I would call three 30 minute presentations and lump them all into 10, and sticking with that.

So bear with me as I go through some of the applications. Who are we?

CARES was founded about 20 years ago. We're a systems-based center that focuses on using geographic information systems or GIS and building applications on top of them, whether it's around the health sector, education, early childhood development, etc. We work with a number of federal agencies, foundations, local government, state governments, etc. Our mission is to make public data publicly accessible at no cost to all communities in the United States and we do that through funding also with looking at the rural urban differential; really looking at the continuum of urban America but also rural America. The issue of small numbers and being able to put the data in the policy context and I'll show you that through the presentation here. What I'm going to go to first. I have three microphones here. Should I turn this off and go to the other one?

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I feel like a piano player. We couldn't put the laptop up here because the technology wouldn't stretch it up to the podium. We had to go down here, but they had to record this on the webinar. They want my face close to the microphone. I think you get the point. Let's go ahead first to one of the applications. It's CARES. It's our center and what I am going to go to first is our national mapping system. It is publicly available. You can go on the website and do everything that I'm showing you right now. What I will not show you is our recording environment where you can record across different regions of the country and build these dynamic reports and use them for many different purposes. What I'll first go to is the map room, our national interactive mapping area. What you see here are over 7,000 national source GIS data layers in our system. What we've done is amassed over many years based on all of the grants and contracts that we've received is making public data publicly accessible in one commons area rather than just reaching the objectives for each grant and building unique portals, because we have about 60 grants ongoing at any one time; but rather than focus on that, I appreciate the term siloed approach, how do we build a more ecological approach to the issues we're dealing with in communities?

It's not just around health or education or economic development, but the intersections across all these different areas. If you look at this, we have over 7,000 GIS layers here. Let me go first to administrative areas. We have all the cities, towns, counties, etc. Let me just start simple and I'm using somebody else's laptop and it's like driving somebody else's car. I'm going to try to muddle through. What we have in this section here are what we call broad community themes. We've looked at a number of websites around the country and you have administrative areas, children and youth, community resources, economic, education, food environment, health, etc. I'm going to drill down deeper in a minute. Let's just make a simple map from food environment. We've integrated all of USDA's food atlas data into our system. Let me first look at access to food, scroll down here to food deserts and let's make a national map here. When we make a map what's going to come up is a map of the United States. We could also choose to zoom into one state or to one city, etc.

So while the map is loading, there are a number of tools and functionality available that I will not go into in 10 minutes.

So suffice to say that this is just a national map of food deserts. Let's go ahead and zoom in to Chris, where do you want me to go?

New Orleans. Okay, let's go to New Orleans. About right here?

As I zoom in closer here. Am I down too far?

Okay. For folks that are geographically challenged like I think I am not, we could bring up for example the cities and towns. Let's go ahead and bring up cities and towns and we'll update the map and what we'll have on top is another layer of data, cities and towns. Then what we can do is use this other tab here to turn on and off GIS layers, bring up attributes. I'll bring up the labels for cities and towns and bring it in to the New Orleans area right here. I'm going to go ahead and zoom in a little closer here. Let's start diving deeper into the engine. Let's go ahead and bring up other data. I'm going to be just very, very brief, I'm not going to go through all the categories. For example, civic engagement boundaries -- we have all the legislative and congressional district boundaries in the US that we can report on looking at economic income data, unemployment rates, we update monthly, etc. The American Community Survey -- how many people are familiar with the ACS data?

This will literally change the face that we really look at the broader social determinants around all the data that we're looking at. With the ACS, the Census Bureau has gotten rid of the long form approach, has gone instead to a one-year, three-year and five-year rolling average. A one year rolling average for urban areas

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around the US, and a three to five year rolling average for more rural areas. We have integrated at our center all of the ACS data for the one year, three year and five year. Let's just look at the five year here under age, gender, household income -- we have all these different levels of geography. Let's go down to the finest level of geography, block group level. Let's also bring up poverty and we'll bring up poverty down to the census tracked and bring that up. Let's bring up other data such as education -- education facilities. Let's bring up middle schools, elementary schools, and high schools here. I've already mentioned the food data. There is a lot we have in the food atlas. Under the health data, we've really worked quite a bit in this area here. The community health status indicators, I now acknowledge our colleague in the audience here, who really is making this data publicly available and that's really great as we work and focus on, for example the community health status indicator, we can go into all of the depth that is provided here. Likewise with our colleagues in Wisconsin, we worked with them on the appropriate way you can reflect this data in a mapping format, not a national comparative ranking but really only being able to go to that state level so their guidance was quite helpful. We've integrated their data as well in terms of the factors, etc. The health facilities, looking at CMS POS data, hospitals, FQHC's, etc. Let's just go ahead and make another map. There is going to be a lot of stuff coming up right now. I can turn on and off different layers as that comes up. We're bringing up the block group level average household income and let's go ahead and move that water a little higher so we actually know where New Orleans is in respect to this.

So what we have in this area right here and zooming in, we have -- what you're seeing right now are the elementary, middle, and high schools, the hospitals. We're looking at populations below poverty -- the darker the green color, the higher the poverty level. Let's start simple and just bring up that data. We're going to zoom in to an area of New Orleans so we have the poverty right here. Let's go ahead and zoom in right here and let's bring up some data. Bring up poverty levels instead or average household income. You're looking at track level data. For folks who want a reference point, we can move that up to the top here in terms of highways and roads. We're now looking at average household income. Let's go ahead and look at other data sets like high schools, middle schools, elementary schools. I'll refresh the map. We can actually look at identifying the different schools. For example, right here I'm going to look at a high school. I think I have to look at the legend here and those are elementary schools. I'm clicking this right here. What you're seeing here are ways; and all the underlying attribute data, you're looking at 70% of the student population is eligible for free or reduced lunch. We can do a lot of Boolean algebra searches. I want to look at all of the schools in this area where the percent of the student body eligible for free or reduced lunch is 80%. It will highlight all those points in red. In the interest of time I'm not going to delve deep into the tools. This is one application where there is a wealth of data. The one thing I didn't mention as I went into health data is all of the Health Data Initiative, looking at for example health profession shortage areas and clicking on health profession shortages, all of the meta-data is tied to this data. We update data monthly, quarterly, annually or as often as it becomes available. Let me move now to another application. This is where we go beyond the mapping interface to what we call our collaborative management systems. We're working with Robert Wood Johnson Foundation, with YUSA, with Public Health Institute on Public Health Data

Solutions. A number of organizations have said to us just having the public data publicly accessible is not good enough because it's around the dialogue, it's around the conversation. It's around the tacit knowledge of people who live in those communities who understand the issues; and furthermore when they say here's your national data, they'll say it's pretty out of date. We have local data that's more current.

So we have tools to automatically upload and integrate local and regional data. We have what we call issue notebooks that help frame issues. Here in Lehigh Valley, Pennsylvania, we look at Access to Care. We're not in the broad mapping engine now. We are now in our collaborative management space.

So in this notebook right here, on Access to Care, each of the communities are able to create these notebooks. In this case it's around a partnership between Lehigh Valley Health Network and various health

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providers who are collaborating to provide better access, etc. You can save maps and reports. You can also upload a hyperlink to documents and other types of media. It's about the blending -- from what I heard before about the qualitative and the quantitative. You have the quantitative, you have the maps, reports, the underlying data, but it's about the belief system, perceptions of the issues we're also addressing. Let me move quickly to another tool called the Comprehensive Community Needs Assessment Tool. I'd like to acknowledge my colleague at Community Initiatives, Monty, and I would like to talk about what we've done with community needs assessment. In the state of Missouri, they said Chris all of our regional offices are creating their needs assessments. They have to do it every year and there is varying qualities of needs assessment results. Can you create a statewide template?

And we have this ability to do it nationwide. Let me just click on a community agency action area. I'm going to select the content. I want to create a complete needs assessment, but under each one you have like education or if you're looking at healthcare, etc.

So we worked with a group of organizations to really help us identify what are the key factors they wanted to look at here in terms of a needs assessment.

So I'm going to make a report. What it's doing is it is drilling across our engine, pulling across the education, healthcare, employment, etc. to create a Word document. It's the starting point for these folks who are doing these needs assessments because what has happened is for a long time is it's taken them weeks and weeks of time in pulling together federal databases and local databases. I'm going to go ahead and open it, but in the interest of time for downloading a 69-page Word document, I've just saved it here to the desktop. What we have is the needs assessment.

So what we have are 69 pages that was just generated. The first page here was -- each page has got the same attributes, the title, population, the subtitle, population change. This paragraph is what we call a stem paragraph. It's basically, as our data is updated in our engine, it recalculates the numbers and percentages. Likewise the graphics are automatically generated so you're looking at a series of counties. The next component here is looking at the tabular data, and the final section is the source. Every page has the same in terms of the content -- age and gender demographics, looking at race demographics, going to households, going to families, poverty, poverty rate change, households in poverty, seniors in poverty.

So the list goes on and on in terms of the broader social determinants. And keep in mind this was created for community action agencies focusing more on a human services environment. Our public health folks saw this and they said we need to do the same thing from a public health standpoint because of our mandated community needs assessments as well. What we have is employment and the list goes on and on. I'd be happy to talk more later. Our good man here is telling me my time is up. But the final point here that I would like to make is what does this all mean?

We're pulling in all of this together in what we call -- it's interesting, it's kind of breaking off here for some reasons, what we call our community commons. How are we looking across all of these national initiatives around the country of being able to change the conversation from a funder-centric view of community to a community-centric view of all the funding activities going on?

If you just go for example to Philadelphia, we're looking at a series of different initiatives going on in that, whether it's Robert Wood Johnson, CDCCPPW site, etc. There are many different initiatives. You can bring this up and it's a profile and it is basic information about the initiative, but it is the opportunity to delve deeper into the CARES engine and also do a crosswalk between different systems. We're collaborating with Transtria, which is an evaluation group where you can actually do a crosswalk from a community commons to the deeper dives where we have these collaborative management systems in place. What I've done is

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shown you a lot in a very short period of time. I didn't do any one of these activities justice, but I think the main thing I would like to point out in summary is that there a lot of technologies out there. Technologies are always evolving. We're often distracted by those technologies and the data. I think the most important part is really thinking through what are the questions and really focusing on the process, around the community engagement, the stakeholder engagement, how do we work with this data internally, how do we drive down costs. Because we can deal with data in very different ways now than we did 10 years ago.

So there is a lot of opportunity for helping us to focus on the question and not get distracted by technologies. Because at the end of the day, the technologies will not help us make more informed decisions alone. It's through that process and thinking together with that.

So with that, thank you very much. Okay.

So we heard from Jim Walton on the use of data systems and an expanded model of care management as a way to achieve measurable reductions in disparities. This is one area for in particular where there is a particular interest across the country around monitoring and evaluation. Cathy shared with us some of the practical realities and areas in which we need to begin to build capacity for monitoring and evaluation. And Chris laid out a set of tools for us that, while he didn't address it explicitly, really addresses something that Cathy also referenced, which is how we begin to drill down in doing the assessment in a way that provides the starting point, the evidence base for effective monitoring and evaluation. The assessment is not and shouldn't just be a snapshot; something we do at one point and walk away from for three years, but really something that is live, that is the starting point for ongoing evidence-based work; work that validates our efforts. I should also note that particularly in watching a 69-page report being generated in a matter of seconds, how that frees the time up that we need to actually build relationship, to establish the kinds of working relationships and trust with a broad array of stakeholders and community members that we actually need to focus on and that needs to be the focus of our work.

So with that summation, once again I am going to defer to questions for the broader audience in the interest of time. I'm Abby Atkins from HRIA. I do community needs assessment on a regular basis so listening to you talk about the community needs assessment process and the use of data, I now have used all of my iPad extra screens to go to other websites that you had suggested and they're now full.

So I've got to figure out how to save all of those for tomorrow. One of the things I'm hoping that you can talk about is some specific examples of how after completing the needs assessment using existing data systems or strategies to regularly update that data or to keep that in mind as you go forward. I can give you one. The BRFSS is a very valuable tool as we all know and one of the hospitals I work with bought a new Hospital, and we used that in the priority setting process, first in the needs assessment, the priority setting and one of the areas of focus was substance abuse, no surprise, and the classic question about use within the last 90 days. We used a community collaborative group including parents and ministers and so on to go through a systematic planning process looking at evidence; and then also used the presence of a caring relationship with a parent, which the evidence shows is important in terms of preventing and then youth perception of the ease of getting alcohol as another measure if you will. That was a branch of the tree. That's a very good example of where that data will be available every two years but because funding is shifted it won't be for exactly the same population.

So we wanted, we will continue to monitor that, but it's only going to be available every two years and we're going to need to switch population groups because we want that to be our ongoing metric.

Thank you, Kevin, for really talking about how I implicitly really refer from assessment to ongoing monitoring. What I've really looked at here, for example, this community needs assessment tool for

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community action agencies is changing the conversation from assessment to an ongoing monitoring. Or, for those folks that don't like the word monitoring, taking a pulse of the community, or a region on an ongoing basis. The technologies are there, the databases and how we link the databases provide that kind of framework for an ongoing monitoring of what we're doing. With the system here that I showed you, we're updating databases on an ongoing basis. Not every section will be updated or new, but different sections will be depending on the frequency of updates. One of the key things about when Monte Roulier and I presented this work in Missouri at their state conference, we did the three clicks of the button and to your point about the 69 page report pops up, this one lady got up and she said, our work is done. And so the executive director said no, your most meaningful work is about to begin because all that time, the resources it took to get across the finish line to slap that full report in there is now basically used to think more deeply about, does it make sense?

Does the data make sense that we're working with?

What primary data can we collect and how do we better address needs in the regions that we're working in. It was really changing the conversation from getting all the data and just rushing to much more around making meaning of data in that context. Cathy got the jump on me before I could get more points in, so I'm going to go back and let's get two or three points in before we let the panel respond. Okay, hi, I'm Charlotte Kent and I'm with the Division of Community Healthcare at CDC and I think there are some other opportunities for aligning community assessments, priority settings and evaluation in addition to the non-profit hospital and public health accreditation. Now there's going to be the community transformation grants, which are funded by the Affordable Care Act and we want to align these community assessments and evaluations for the community transformation grants with the work that's being discussed here. There is three priorities for the community transformation grants, which include to implement policy environmental and programmatic initiatives, which are very similar to some of the community building discussion that's been ongoing. The second is health equity and the third is to increase the evidence base. Now, my question is because of one of our funded mandates by the Affordable Care Act is to increase the evidence base, how do you suggest we get to common measures and evaluation so that we can do meta-analysis to build the evidence and is there a value to some common metrics?

Great, I've got it down. Next point. I'm Megan Wise with the

South Carolina Institute of Medicine and Public Health. As of a week and a half ago, we were the

South Carolina Public Health Institute, so depending on which name you recognize. Actually my point follows very closely with a comment that you just made. I won't bother going into the community transformation grant side of it, but also with the Affordable Care Act and the use of the prevention fund, both of the community transformation grants taking a revolutionary approach to working on problems with them. There's also the current RFP that's out about coordinated chronic disease programs within state health departments.

So as we're talking about the different silos, I know for example in

South Carolina we have a diabetes state plan, we have a cardiovascular plan, we have the obesity state plan. I think everyone here knows -- I guess some of the ridiculousness behind that.

So in terms of some of the silos being taken down, I think there are other forces that are going to help with that. It's also being able to manage the fact that that will happen very rapidly and just with the grant application the amount of stress and craziness and fear people have within the Health Department and all the different coalitions around the state, that's going to be something to work around. Then also, yes, that is a

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first step, but that does not also take down some of the silos between working with our colleagues in mental health with DJJ and with some other areas.

So it's a start, but managing that change process while also continuing to reach out to be fully integrated.

So I'd like to hear your thoughts on that as well. Great. One more question/comment.

So, Paul Hattis, Tufts Medical School, I'm going to be slightly provocative. My observation is that hospital community benefit folks have had challenge, and perhaps even non interest for the most part working with health department people often over the years.

So now were taking the data piece, which is an attractive piece that the hospitals often look to health departments for, we're making it more accessible so that the hospitals can skip over the health departments. Now the hospitals who want to be more relational with community groups don't need the health departments to do that because the health departments have their own challenge about being relational at a community level.

So, am I right about that ,or am I wrong?

Getting access to this data is only going to give the reasons for the hospitals to have even less interaction with the health departments going forward. Okay, so panel we've got to address the community transformation grants, which are rolling out which have their own set of priorities, policy, program, health equity, increasing the evidence base. How do we align this with what you're talking about?

A variation on that, which is how do we deal with our fragmented approach with RFPs coming out all over the place on an array of issues; how do we make sense and begin to harness all these resources and energy in a way that makes sense?

This issue, Paul, help me, I'm not sure I captured all of what you were saying. What I'm saying is most hospitals historically had difficulty, or not that much interest necessarily working with health departments, but one area where they had some interest is around data.

So, to the extent that we take the data expertise or the availability out of the health department, and make it more generally available okay; am I going to create a reason now for the hospitals not necessarily to be all that engaged with the health departments where they've had challenge working with anyways. Health departments often don't offer that much in terms of being closer to community groups that you know the hospitals can sort of do that on their own.

So I'm trying to be provocative here, but I'm wondering whether people agree or disagree that making the data more easily accessible without having to go through the health department is actually going to work with hospitals less engaged with health departments. I think your provocation is partly what I was trying to get at too. I think with the kind of people we have in the room and the moment that we have, if we are not ready to challenge collectively in a very discontinuous way our current sets of relationships of how does one silo move to the next silo, we will be here again in 10 years and the money will be in different places and we'll continue to be fragmented. I think Steve Fawcett opened with a very important idea, which is we need ecumenical language because I think we get into our own lingos. But underneath that is also why we need to figure out what are our common outcomes or what outcome do we collectively in a very United Nations kind of way want to focus on?

Then, what are the core competencies to get there and where do they exist?

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I think if you looked at the growing list of core competencies for community benefit people, the growing core competencies for public health people; then you look at these resources, we're competing for who gets to be called competent too rather than saying we need collectively to have those resources. I've been around too long to know we don't wave a magic wand and that happens automatically. I'd suggest that that's why we need to get very intentional about it. What do we want the system to look like in the future and then where are some safe practice fields that will enable us to not only learn how to do it but then move and disseminate that more broadly. Many of you probably have read the framework for spread by the Institute for Healthcare Improvement. There's been extraordinary additional work, many of it from learning in third world countries about how do you diffuse effective innovations. One of the things you do is you are very intentional about which pilots you pick. We have a lot of innovators here but they weren't chosen, they chose themselves really. They weren't chosen to help us diffuse and I think that's the challenge we've got, or the struggles of what happens when the next grant cycle comes in. We will continue to sort of play on the same hamsters wheel. It's going to take shared work and a readiness to let go of our individual professional identities and in some cases be ready to move into shared governance with folks that we've sat next to but we haven't been ready to do. I think that's our challenge and our opportunity. Other panelists want to take that issue on?

Just the issue on we talk about the word silos and my background starting out was in agricultural engineering and silos were the best thing since Swiss cheese for me.

So, the thing about silos and if you look at food distribution systems and silos, you have these pipes that go out to trucks that transport the grains, etc. The problem with our silos is we don't have any pipes. The information flows are rotting in our silos because we're not dealing with them in the ways that we can. Technically, we can, it's institutionally and the way we have that broader governance framework is key. We don't want to break down any more silos. Let's improve the silos, create those pipes where the information flows really get us to where we want to be. We have a panel tomorrow that's going to deal more with this notion that's been brought up by at least two of the questioners on how do we deal with the kind of fragmentation and approaches of RFP's. Jim, you may have something to say about ways in which you've dealt with that at the regional level. A different perspective, because the Accountable Care Act has some embedded opportunities for curiosity seeking grants that maybe pushes the envelope with understanding a little bit about how to make some of the silo walls put glass in the silos I suppose. But the truth of the matter is inside of a major health care system in Texas, this story is not terribly relevant. We have value based purchasing and joint commission around disparities and class standard. We're functioning fairly far behind the curve and there is some huge financial hurdles to get over moving forward. Not to mention what's looming on 2014 and then adapting to the new Accountable Care opportunities.

So I'm not sure where this conversation, this intersection is; I'm not sure that there's been enough healthcare system leaders, hospital leaders in this audience to kind of create the type of meaningful dialogue that would bring the science of behavioral health and primary prevention, which we know can in fact assist healthcare systems in controlling the controllable costs that will help them be successful into the future especially under the future Accountable Care Act legislation. I'm having some kind of intellectual dissidence here, thinking I'm not sure, I think a lot of healthcare systems are really trying to punch the ticket with regard to community benefits and rounding the bases to make sure they touch all the bases to get that done; but there's not been some really intentional connections made between what the real financial challenges are confronting healthcare systems in major metropolitan and rural areas in America and what we're doing with public health space. You know our public health system is woefully underfunded and terribly irrelevant in what we're facing as a healthcare system in Dallas Texas, it's a major metropolitan area. I struggle with this conversation.

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So, let me push back a little bit with you Jim because I know in particular the leadership in your own system despite the financial challenges, you are investing for example, in a diabetes wellness center. That moves well upstream beyond the issue of clinical care because as your health system CEO indicated to me, we're being hit by a tsunami of diabetes and we can't deal with this just in the clinical arena. And they are. Okay. I'm going to be nice. I think we're going to have a break at 5:15 that we're going to have an opportunity to have wine it would be a fun conversation over wine. Yes. Aren't you taping up there?

I do have one comment because I think Jim points out another silo within the silo of healthcare. I think the question is, Can we be relevant?

We being the community benefit arm or semi-silo in healthcare. I have seen in multiple places where the strategic development to deal with ACOs and to move into population health is going on in one arena and the community benefit planning and measurement funding is going on in another.

So again, diffusion of innovation is not happening. It doesn't mean that all of it fits exactly, but I think we haven't learned how to leverage those even within our own individual hospitals so that we if you will have one set of processes of care, one set of initiatives to prevent obesity, etc., adapted for appropriate community needs which is Jim's expertise. It's another place where we haven't made that connection meaningful. Right. Kevin?

Mary Pittman from the Public Health Institute and I wanted to build when I heard Paul's comment, he kind of triggered in my mind that it's obviously much more than the data, the data is important, but I think this last conversation really lifted up a couple of key issues. One is leadership and the absolute imperative that we have leadership to be able to carry out the actions that get lifted up from the data and from the community engagement and the community processes. I've worked on both sides of the aisle, I've worked in public health, I've worked in hospitals, not just both, I've been a community organizer. And what we have, when you look at those silos, we have these concentric circles that don't always overlap at the critical places where they need to, and I would hope that at the end of this conversation that we've had for three days where you've had the who's who in the various sectors and the folks who have been doing this work for a long time as your exemplars, I would hope that there is some sort of consensus statement that we can come out with, something that we can take forward to the leaders who need to understand that this work has been going on for a long time, there is a lot of progress that's been made; but now is the time to have public health, community, hospital and well beyond that, all of the leaders that are represented in effective community engagement strategies to make a commitment to moving this agenda forward.

So, I was trying to be quiet, but I couldn't help but respond to that conversation. And there are a lot of folks that have been doing this work for a long time who I'm sure we could tap into to be champions. We all know that to get a movement going you have to have leaders, you have to have champions and then you have to have all the folks who toiling in the field and join in as part of that movement. I think we have to think of this as a concerted campaign so that we put all of the pieces in place so that we actually end up with that quicker diffusion of not only the ways to do a community health improvement and community health assessment, but so that it becomes the fiber of what we do day in and day out. And I spoke too long, thanks.

Thank you Mary and what's just transpired highlights the reason that we came together, which is to get the issues on the table, to acknowledge the challenges, to celebrate as some have said, the things that we have accomplished, and to be clear eyed about what we need to do to move forward. We're getting there, we have another day to have discussions about other aspects of this and I appreciate our panelists as well as those in the audience for being sober about what we have to deal with. It's very important if we're going to make the progress and I think we need to think about what it is that we can do in the wake of this to continue to build on the momentum that's been established. With that, I want to thank our panel. Before we go to the

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reception, as I'd indicated earlier, we're going to get some reflections from a colleague that's been around the ball field a few times and he's going to share with us some of his reflections after a day and a half of these proceedings.

So please join me in welcoming Professor Emeritus Leonard Syme.

Thank you very much. A couple weeks ago I was sitting in my office minding my own business when I get a phone call from Kevin asking me to come to this meeting, and when he told me that it was the link between acute care interests and community social factors -- social determinant issues, I told him he was crazy and that these were two different worlds and they didn't talk to one another.

So he convinced me to come anyway, so I came with all kinds of wonderful things to say. And very frankly, I've been blown away by what's gone on here for the last couple days. The level of conversation has been far more sophisticated than anything I could have contributed. I think he was completely wrong and he should have left me alone. You guys are way down the road, it's been very -- I've been in awe.

So as I've been thinking about the last couple days, the words that come to mind are inspirational, creative, innovative, breathtaking in vision. I mean, it's really been something else. But he wanted me to say something, so the only thing I can really add is to add some words about context about framing the issue, about really emphasizing the need for change to make this issue more urgent than I think many people out there realize. One of the things that makes these issues important is of course the IRS. The other thing that makes it important is as John Bluford said, is doing the right thing. But there are four other issues it seems to me are really important and we ought to all recognize. The first is, and I hesitate to say this, but I think we all recognize the limits of medical care. To me, the most important document of our time is the Black Report from the United Kingdom.

So the United Kingdom after the second World War, as I'm sure everyone here knows, decided that the level of inequalities in the United Kingdom were unconscionable. and they developed the National Health Service. Free high quality medical care for everyone. Then, in 1980 Sir Douglas Black was asked to form a committee to review the impact of that National Health Service on reducing inequalities in the United Kingdom, and as I'm sure everyone knows the results were basically very modest. The health of everyone improved a little bit, inequalities didn't budge. In 1998 Sir Donald Atchinson did another review, this is now 50 years after the creation of the National Health Service, same results. The Canadians have looked at the impact of their National Health Service on inequalities, same result.

So, we understand that medical care can only do so much. There are a few things medical care really does well, cares for heart disease, cataract surgery, hip surgery, antibiotics, pain control, but it's a limited sort of impact.

So that's one really important issue that we need to think about the social environment as a really important issue that needs to be taken very seriously. The second issue is the ranking of the United States in the world tables. We all know that we spend a lot of money on medical care and that we rank 35th, 38th, 39th in almost every marker of health and this is very uncomfortable. One of the arguments about that is to say, well, we have so many poor people, if we could just get rid of those poor people, our results would be much better. And it turns out as I'm sure many of you have seen, a comparison of health in England and in America in the top 10% of our society, we still rank low.

So there's something going on that we really need to pay attention to that goes beyond medical care. The third issue is the baby boomers. Again, as I think we all know, starting this year, the number of people over 65 in our population has begun; and before they are finished, the number of people over 65 in our country

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will have doubled. When we considered, we all know our medical care system is under strain now, when the number of people over 65 doubles, we are in big trouble.

So we really have to begin to think about the prevention of disease earlier in life in order to have people enter the over 65 population healthier than they do now. Otherwise, we're in big trouble. The fourth issue is one I mentioned yesterday, is the fact that there is some people in our community that are in difficult living circumstances, living in underprivileged settings. It's too bad but I think we really need to understand the toxic impact of that kind of inequality on all of us. The inequalities really have an impact on our nation and we really need to begin to deal with that. To do all that is moving beyond the hospital, to the community and it really takes on a sense of urgency that I think everyone in this room at least understands.

So, that's my sense of it, we're talking about really important stuff. I'm in awe at the level of discussion that we've had the last few days; and in the end, thank you for inviting me. I hope you join us in the garden terrace for our reception this evening.

Thank you very much.