Engaging Communities in the Redefinition of the H Tools and Resources
Tools and Resources

Tool 1 – How-to Toolkit

Tool 2 – Individual Community Conversation Overviews

Tool 3 – Community Case Examples
  Western Maryland Health System
  Allegiance Health
How-to Have Community Conversations: A toolkit for advancing health in America

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Dear Colleague:

The American Hospital Association (AHA) has been working with hospitals and health systems to explore different paths for transformation as the future of health care is rapidly evolving and moving from a volume-based system to one now grounded in value. It is very likely that the shifting business model will mean significant changes for many hospitals and communities, which is why it is important to identify possible scenarios for change and paths to redefine the hospital of the future.

As our health care system changes over the coming decade, collaboration and partnership will be crucial to providing quality health care and cultivating healthier communities. The AHA’s Committee on Performance (CPI) Improvement was tasked with exploring ways for hospitals to engage with their communities as an essential part of such transformation.

The CPI oversaw the development and implementation of six Community Conversations across the country; the purpose being to provide a venue for diverse community stakeholders to convene and discuss what is happening in their individual communities, why it is happening and what it will mean for the health of the community. The events were very well received and served as an important listening opportunity to better understand community expectations and needs as the hospital field looks to redefine the “H”.

Moving forward collaboration will be more diverse than ever before, as hospitals are willing to try new things to promote the best health for the most important stakeholder of all: the patient. We encourage you to use the resources included in this toolkit and consider hosting your own Community Conversation. Listen and learn from all stakeholders in your communities, particularly those you may not work with often. When working together with the best interest of the patient as the primary focus, silos of care that exist within a hospital or health system, as well as with other stakeholders, can begin to be broken. Hospitals and communities alike will have a better chance to weather our nation’s changing health care system.

Rich Umbdenstock  
President and CEO

Dr. Tom Burke  
Chair, CPI Committee
Introduction

With health care rapidly evolving, hospitals and health systems are exploring different paths to transform their organizations during these changing times. Across the United States, hospitals are considering a variety of options such as:

- merging with a local, regional or national health system;
- affiliating or establishing a joint venture with another health system without ownership or asset change;
- partnering more closely with health plans for payment redesign;
- considering what clinical services may best serve the community, which may include discontinuing certain services; or
- converting a full-service facility to one that focuses more on an area of specific need, given the community’s resources and the region’s other capabilities—such as, emergency care, urgent care, rehabilitation care or long-term care.

Current economic pressures, delivery and payment system reforms and the shift from a volume-based business model to a value-based model will necessitate that the hospital field consider redefining the “hospital” of the future. During this time of transformation, hosting conversations where community and health care stakeholders can come together and discuss a shared future and explore the future role of the hospital will be essential to ensure a successful process of transformation.

Need for Community Conversations

Relationship building and open communication will be vital for hospitals as they look to transform. While the materials included in this toolkit will guide users in hosting a community conversation event, we first encourage hospitals to consider their goals for such an event and thoughtfully consider what “type” of group they would like to convene and around what topic. Current conversations have been focused on transformation and redefining the hospital “H,” but this framework could certainly be used as an ongoing listening, learning and partnership tool with a wide variety of community stakeholders.

Objective of Hosting a Community Conversation

The purpose of the community conversation event is to convene community stakeholders, health care and non-health care, to initiate a dialogue about the changing health care environment and about the transformation hospitals are likely to undergo; whether that be integrating, specializing, partnering, experimenting or redefining themselves in some manner. Participants will have the opportunity to begin to develop strategies for change that the community can further build upon.

The primary objectives of the community conversations are to:

- Engage in a robust discussion on emerging health care trends
- Gain a shared understanding of changing community health needs
- Consider how changes and trends might impact the hospital and, more broadly, the health of the community
- Encourage further dialogue and collaboration among all care stakeholders on the changing role of hospitals in community health
1. Timeline

Timelines will likely vary based on event location, designation of speakers, etc. But the timeline below offers an outline for optimal event planning and execution.

- Select date – 4 months prior
- Build invitation list – 3-4 months prior
- Send out save-the-date notice – 3 months prior
- Send out invitation – 2 months prior
- Send out reminder invitation – 3 weeks prior
- Send out pre-survey to attendees – 2 weeks prior
- Send out post-event survey – 1 week post event

2. Audience

Audience makeup will likely change based on the individual community, but included below is an outline of how to build a audience that will prompt a robust, productive conversation.

Community Conversation events are intended to be structured dialogues, not open to the public, and designed to initiate conversations regarding the challenges and opportunities to redefine the hospital “H.” Events should be planned to accommodate roughly 25 to 40 attendees. To ensure a group of that size, invitations should be sent to at least 60 individuals.

Think strategically in determining the goal of the community conversation as well as identifying which community stakeholders should attend – for example, who could offer important insights and open doors for ongoing partnership. As most hospital leaders have opportunities to speak with one another, we suggest that the invitation list for community conversation events be representative of the local community and also include a variety of non-health care stakeholders. Those who convene community conversations are encouraged to think beyond their comfort zone to invite a full spectrum of community stakeholders, including consumers and other public representatives they may not normally solicit feedback from. Ideally, the audience would be close to 75 percent non-health care participants. The audience could include:
- purchasers, large employers and local businesses
- city, county or state departments of health and public health officials
- health plan representatives
- local elected officials
- consumer group representatives (AARP or other local consumer group chapters)
- community stakeholders representing the chamber of commerce, banking/finance and educational institutions
- social service organizations (YMCA, mental health clinics, health centers, etc.)
- health care stakeholders (medical societies, nursing home associations, home health associations, rehabilitation facilities, etc.)

Identifying a member of your hospital’s governing board also may be a helpful addition to the community conversation audience; these individuals provide an important connection with community stakeholders and the opportunity to listen to such conversations will bring new insight to the hospital boardroom. Additionally, for small and rural communities, there may be value in joining together and learning from one another, particularly those at different stages of transformation. Doing so can allow for important insights and add to the diversity of the audience and conversation.

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### 3. Invitation

A sample invitation is included below. AHA partnered with state and metropolitan hospital associations in hosting these events and would encourage the use of co-logos with any key event partners to broaden interest. Initial save-the-date invitations were sent out a month or more prior, with a follow-up invitation sent two weeks before the event.

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### 4. Logistics

**Venue:** Ideally, community conversation events, which are scheduled to run for three and one-half hours, would be held in a centrally located and easy-to-access venue for all attendees. Recognizing that participants are committing a significant amount of time to participate, we suggest providing a working lunch.

**Room setup:** The suggested room setup is a hollow “U” to help facilitate dialogue and open exchange of ideas. Additionally, if the venue permits, secure two or three additional rooms adjacent to the main event room that have flip charts and can be used for the small group breakout discussions.
Speakers: The community conversations should be just that: conversations with the invited stakeholders and not solely a hospital-centric discussion of hospital challenges. The events held by the AHA in partnership with a number of state and metropolitan hospital associations employed a model that consisted of using a moderator who was not directly connected with a hospital to serve as a knowledgeable third-party entity and who could keep conversations moving in a productive manner. In addition to the moderator, the community conversation events included a hospital/health care representative to give a brief overview of the national health care landscape and touch on key aspects of the local environment and community challenges. When inviting a moderator and other guests to join such an event, we encourage a pre-event prep call to walk through the intended flow of the event, talk through any specific state or local considerations and answer any questions that would help the guests feel more comfortable with their role.

Community Conversation Checklist:

- Articulate the reason or goal for convening a Community Conversation
- Select a date
- Select a venue
- Strategically build an invitation list
- Identify guests (moderator and other speakers)
- Send a save-the-date invitation when possible
- Send invitation
- Hold prep calls with moderator and speakers
- Confirm logistics with venue (room setup, food, AV, etc.)
- Send reminder notices as needed
- Send pre-event survey and materials to registered attendees
- Convene event (bring needed materials: agendas, any handouts, tent/name cards, flip charts, etc.)
- Follow up after event (send participants thank-you, post-event survey or evaluation, key findings and any next steps)

5. Pre-event Survey/Materials

Please find a sample survey included below. Once your attendee list is confirmed, you may decide to send pre-event materials. Such materials should be refined to provide you with needed insight and/or educate attendees but should not appear as cumbersome homework for attendees.

The AHA, in conjunction with the state and metropolitan association partners, opted to share some basic background materials with participants to give some perspective on the changes the health care system is undergoing. Additionally, all registered attendees received a brief survey to complete as part of an event reminder that was sent out one week prior to the event. The survey responses helped to gauge the basic understanding, perceptions and expectations of the attendees and was used to help guide the moderator in determining key topics for discussion.
SAMPLE SURVEY QUESTIONS

1. What are the biggest health care challenges your community is facing today? (Click all that apply)
   a. Access to care
   b. Chronic illness
   c. Affordability of health services
   d. Preventive services
   e. Mental health services

2. As the health care system continues to transform, what do you see as the largest obstacles your community will face over the next five years?
   a. Cost or price
   b. Access to hospital care in your community
   c. Access to other health care services in your community
   d. Surplus of specific services
   e. Better coordination of care
   f. Need for preventive care

3. What services does your community need MORE of in the future to improve your community’s health? (Click all that apply)
   a. Primary care physicians/providers
   b. Urgent care services
   c. Home health services
   d. Nursing home or other long-term care services
   e. Social services (such as Meals on Wheels)

4. Do you agree that, compared to today, in five years most patients in your community will have primarily electronic health care interactions (i.e., schedule appointments online, have online medical visits, receive test results online, use social networking for collecting information)?

5. Should hospitals partner with business and others in the community to impact health challenges?

6. Over the next five years, do you foresee any changes in the current hospital or health system makeup within your community as it relates to possible mergers, acquisitions or affiliations with other health care organizations?

7. In your community, do you envision having more or fewer hospital inpatient beds in the next five years?

8. Compared to today, in the next five years will health care be more integrated and providers paid based on a fixed price for all care that is delivered versus reimbursed based on each service provided?

9. Compared to today, in the future, do you believe hospital payments will be based on the value or performance of the services provided, rather than the volume or number of services provided?

10. What one question or topic would you like to ensure is discussed at the upcoming Community Conversation in terms of health care services in your community?
6. Agenda

Included below is a sample agenda that can be adapted as needed based on the speaker lineup. Please note that each of the AHA Community Conversations included breakouts during which small groups were able to discuss topics in greater detail before reporting back to the larger group.

SAMPLE AGENDA

Welcome and Introductions with Lunch (12:00 – 12:30)
State Executive
- Brief overview of the state/community landscape
- Introduce moderator

Moderator
- Quick outline of how afternoon will flow (tee up questions, point of discussion)
- (Before we jump into the “meat” of today’s discussion, let’s hear from XXX to share a little national perspective/ set-the-stage for why we are all here…)

National Health Care Landscape (12:30 – 12:50)
American Hospital Association representative
- Changing landscape
- Top issues coming at us/top challenges
- Need to adapt to survive

Moderator
- (Ask a few questions of the AHA speaker … regarding top strategies for success in future, areas of focus for hospitals, any key deadlines, etc.)

Local Health Care Trends, Challenges and Opportunities (12:50 – 1:30)
Moderator (Example: State executive shared a little, but let’s delve in a bit deeper and get thoughts from all of you on local health care challenges and opportunities)
- Key questions for attendees (asked by moderator)
- What key considerations need to be addressed proactively regarding health care/ redefining the “H”

Health Care Transformation and Redefining the Hospital “H” (1:30 – 2:45)
Moderator
- Tee up key aspects of transformation
- Ask questions of participants/ solicit discussion around key topics and local challenges

Small group breakout discussions
- Each small group will have an appointed leader and scribe and receive several questions to discuss

Wrap-up and Next Steps (2:45 – 3:30)
Moderator
- Small-group sharing
- Moderator recaps common themes and recognizes areas of differences – attendees can add/amend the list
7. Moderator’s Guide

The moderator’s guide below was prepared and shared as a tool for the individuals who moderated the AHA events. The guide was used as a general framework to keep the event and discussions moving but can be adapted as needed based on each community and who steps into the role of moderator for the community conversation events.

SAMPLE MODERATOR’S GUIDE

1. Background/Introductions (12:00 – 12:30)

MODERATOR WILL:
- Introduce self
- Share agenda/objective slides
- Keep the agenda moving
- Introduce speakers

SUGGESTED TALKING POINTS:
- We have a lot to cover in a few hours today, and our biggest goal is to have a lively discussion. We want to get this group’s reaction to the current health care challenges our community faces, as well as how national pressures may impact the future of health care and where challenges as well as opportunities may exist.
- We are interested in hearing all opinions, not simply those that agree with others.
- My role is to keep the discussion focused and within our time frame.
- We will be audiotaping today’s discussion to ensure we don’t miss any comments, but we will not attribute any quotes to specific individuals so you can be assured confidentiality beyond this room.
- Before we set the stage for today’s discussion by hearing about the national perspective, let’s quickly run through a few “housekeeping” items – respectful of one another and of time (no phones), restrooms are, drinks back of the room, etc. On that note, let’s get started by introducing yourselves. We’ll go around the table.

2. National Health Care Landscape (12:30-12:50)

MODERATOR WILL:
- Introduce AHA presenter
- Ask questions of AHA speaker
- Facilitate group discussion/ questions for AHA speaker

SUGGESTED QUESTIONS:
- What major trends do you envision playing out over the next 5 to10 years in health care in general?
- What top strategies are hospitals considering to manage these changes?

**GROUP QUESTIONS/ DISCUSSION**

3. State/Local Health Care Trends, Challenges and Opportunities (12:50-1:30)
Moderator will walk through key concepts/ topic areas for discussion.
MODERATOR WILL:
- Briefly outline topics up for discussion
- Pose question to participants about key topics/concerns that should be addressed but are not on our list
- Lead robust group discussion through these topics
- Facilitate discussion that solicits feedback from participants on each key topic area

SUGGESTED TALKING POINT:
Let’s delve in a bit deeper and get thoughts from all of you about local health care challenges and opportunities. (NOTE: WHEN APPLICABLE, MODERATOR CAN SHARE RESULTS OF SURVEY, TICK THROUGH A LIST OF PRIORITY TOPICS, PROMPT PARTICULAR ATTENDEES TO WEIGH IN)
- Access to care
- Health care costs
- Behavioral health
- Workforce
- Community needs assessment/community partnerships
- Appropriate primary/preventive care
- Payment inadequacy

SUGGESTED QUESTIONS:
- In the survey, this group identified X, Y and Z as the top health challenges we face. How do you think those will change in the next five years?
- How will such changes impact each of you? (prompt feedback from … business/insurer/health provider)
- What unique challenges are you facing based on the “type” of organization you are … i.e., rural, urban, etc.?
- Does anyone have particular insight on how any (or all) of these challenges/concerns can be addressed in your community?

**GROUP QUESTIONS/DISCUSSION**

4. Health Care Transformation and Redefining the Hospital “H” (1:30-2:45)
Moderator will walk through key topics for discussion and facilitate breaking into small groups for discussion. (Groups will be predetermined.)

MODERATOR WILL:
- Tee up key aspects of transformation with some general background (topics will be provided to moderator)
- Move group discussion to how health care services are changing/expected to change
- Introduce breakout groups (assign groups, explain assignment, hand out small group worksheet)

SUGGESTED TALKING POINT:
As touched upon throughout our discussion so far, the health care landscape is changing. Some aspects will be more universal for providers, like payment reform that shifts from volume to value. Other aspects of transformation may play out differently in different communities and areas of the country … whether it be mergers or new affiliations among hospitals and health systems; partnerships between hospitals, health plans, physicians or stronger collaboration with community stakeholder groups; or reassessing the type of clinical services that are offered in certain communities.
SUGGESTED QUESTIONS:
- Here in XXX, what do you see as the key areas of health care transformation your community will have to address?
- Are there specific changes/challenges you anticipate based on your location?
- What might that mean for the hospital and other providers?
- What role can all stakeholders play in ensuring that needed health care services are available for the community?

**SMALL GROUP QUESTIONS/DISCUSSION**

MODERATOR WILL:
- Convene groups back together
- Facilitate small group reporting

5. Wrap-up and Next Steps (2:45-3:30)
Moderator to facilitate

MODERATOR WILL:
- Initiate wrap-up, including teasing out common themes – key takeaways, major challenges and opportunities
- Solicit any other topics not addressed or issues that should be addressed in the future

SUGGESTED TALKING POINTS:
- Let’s identify common themes from what we’ve heard today. I’ve heard X, Y and Z. Is there anything I’m missing that someone wants to add?
- I’ve also heard A, B and C are major challenges and 1, 2 and 3 are key points of disentension that provide opportunities for us to explore further at another time. Is there anything I’m missing?
- One topic we briefly discussed that I’d like this group to talk a bit more about is XXX. (Use this to circle back to any of the priority areas that were not discussed or issue/discussion you feel needs further clarification.)
- Thank you all for your participation today. The goal of this conversation was to begin understanding how together we can improve our community’s/state’s health. I know we have learned from all of you and will look to this discussion to help inform the association about how best to tackle future health challenges. Thanks again!

8. National Perspective Slide Deck

Following is a slide deck developed by the AHA in June 2014 that outlines the changes the field is seeing and the potential paths for transformation that hospitals and communities may be experiencing in the coming years. These slides may need to be updated with time and, depending on the speaker lineup for state and local events, could be woven into the presentation given by a state/metropolitan association executive or hospital CEO.
What Is Different Now?

How is the current health care landscape changing? How is it different? Are these changes a good thing for me and my family?

- Economic/financial pressure
  - Health care is a significant portion of our national economy (18% of the GDP)

- Aging population and rise in chronic conditions

- Technology and medical advances
Is Health Care Transformation Good?

Explaining the Affordable Care Act

- **The Good:** expanding insurance coverage, insurance reform and helping to drive and accelerate change
- **Areas of Concern:** reimbursement constraints
- **Unanswered Questions:** the next decade may be spent testing and experimenting with new payment and care delivery models

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Health Care Transformation

- **Volume** → **Value**
- **Fragmentation** → **Integration**
- **One Provider** → **Multidisciplinary teams**
- **Episode** → **Population health**
- **Passive Purchaser** → **Consumerism**
- **Buildings (Bricks & Mortar)** → **Health information technology**
Community Challenges

Hospitals are economic engines and cornerstones of health in many communities, but must continue to:

- Understand the needs of your community through a needs assessment
- Identify obstacles to good health
- **Engage all stakeholders in improving the overall health care of a community**
- Partner to meet community needs
- Solicit feedback and community impressions

Hospital Challenges-Nationally

- Hospitals will be paid differently, and money will be tight
- Risk will be moving from those who pay for health care services to those who provide the services
- Hospitals and caregivers will be caring for more people, with greater health problems
- Consumerism will be experienced at a higher level than ever before… price transparency, quality comparisons, etc.
How Hospitals Are Responding—Nationally

- Redesigning care to improve quality and reduce costs
- Developing strategic partnerships
- Engaging in new delivery models of care
- Experimenting with risk-based payment
- Educating and engaging hospital trustees
- Redefining the “H”
**Hospitals Need to Adapt to Survive**

- Hospitals will start in different places and take different paths
  - Specialize
  - Partner
  - Redefine
  - Experiment
  - Integrate

- But all will become more integrated, more accountable and more financially at-risk

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**Moving Ahead…**

- Hospitals must engage with their communities and various stakeholders to understand national and local trends.
- Hospitals and communities should continue to keep lines of communication open as health care continues to change and hospitals look to redefining themselves.

*Hospitals must work collaboratively to meet community health needs and achieve the triple aim; better health, better healthcare, lower cost.*
9. Breakout Group Questions

Sample breakout group questions are included below. Based on the six events hosted by the AHA and our state/metropolitan hospital association partners, these questions were general enough to guide discussion but allowed for time to explore key topics relevant to each small group. These can be adapted or refined if it is desired to focus the breakout discussion on more concrete topics or concepts.

SAMPLE SMALL GROUP DISCUSSION QUESTIONS

1. How do you envision health care in your community changing in the coming five years?
   a. Are there any positive changes?
   b. Any potential negative repercussions of change?

2. As a community (all stakeholders) how can we best adapt to this type of change, making it work for the unique needs of our community?
   a. What challenges need to be addressed/discussed further?

3. What can policymakers do or implement that would increase flexibility and/or support communities rather than hinder them?

4. How do we convey to our neighbors that it may not be financially feasible to support a full-service hospital in our community? Hospital may be redefined.

5. Stakeholders need to collaborate together to meet health needs. But who does what? What role should hospitals play?

(Answers to those questions can be captured on small group worksheet and highlighted on whiteboard/flipcharts if helpful.)

10. Common Themes to Date

Overall, the balance of improving access to health care services and insurance coverage, while maintaining hospitals’ financial viability, was a major theme in every Community Conversation held thus far. There was uniform agreement that the health care system is approaching a time of rapid change that will impact the current infrastructure of community health. Cost and coordination of care were identified as two of the biggest obstacles in health care transformation. Behavioral health, preventive services and social services were identified as most in need. While every community had its own characteristics and populations to consider, the concept of collaboration being crucial to transformation emerged during each conversation as a common recommendation to solve the bigger challenges around changing the health care environment. Additionally, there was a belief that transformation and change would begin first and could be most successful when occurring locally.
11. After the Conversation

*Included below is the basic survey the AHA sent to participants. In addition to the basic survey, you may opt to send a more comprehensive follow-up.*

In addition to thanking participants for their time and sharing basic themes and takeaways from the event, take the opportunity to send a post-event evaluation to help capture additional thoughts and possibly direct future activity and collaboration among community stakeholders. This could be accompanied with a thank-you note to participants, a meeting evaluation form, a summary of key insights and next steps when applicable. Remember this is an opportunity for relationship building.

**SAMPLE POST-EVENT EVALUATION**

1. Please indicate what type of organization you represented at the Community Conversation event:
   a. Hospital/ health system
   b. Health care (other than hospital)
   c. Non-health care

2. What was your biggest takeaway? What did you learn?

3. What next step(s) would you like to see happen in your community?

4. Please provide any additional comments.
Tool 2

Individual Community Conversation Overviews
Colorado (Cortez, Alamosa/Rio Grande and Yampa Valley/Steamboat)

While the Community Conversation in Colorado was comprised of representatives from three rural communities, there was universal concern among all attendees over the general economy and how it impacts health care. With that in mind, participants felt that efforts to transform must center on keeping communities whole, not just on implications for the hospitals.

Top Areas of Discussion:
- Behavioral health services
  - Hospitals are spending money they don’t have to provide behavioral health services.
  - 25 percent of readmits are due to mental health, substance abuse; there are not enough psych beds, psych-trained staff to accommodate patients.
  - There are not enough alternative community resources/settings to access behavioral health services.
- Lack of primary care providers
  - Older physicians are retiring, others are leaving rural areas and younger doctors do not necessarily stay in one place.
  - Additionally, many small and rural communities cannot support specialists so rely on primary care physicians.
  - The group felt that the graduate medical education (GME) path is broken, with no incentives for primary care training.
- Reimbursements
  - Reimbursement for care should be focused more on value, but there is a concern among rural hospitals, with low volumes, etc. that the current incentives don’t fit and, without a safety net for small hospitals to try new payment or delivery systems, the current system is not sustainable for rural, non-critical access hospitals.

Key Observations:
- While the payment system is not likely to improve, hospitals need more:
  - Mental health access/services
  - Primary care
  - Social service needs
  - IT/virtual care
- Competition, even in rural communities, is becoming bigger and more global with large health systems, corporate clinics, etc. entering the market.
- The number of hospital beds may stay the same in the coming years, but there will be a shift in who is in the beds and the type of beds available.
  - Older population, coming to hospital sicker, staying longer

Recommendations:
- Hospital, health care leaders and community leaders must have the discipline to have difficult conversations as collaboration is going to be essential.
- There will be a need for funding streams to support collaboration, and “resources” may need to be pooled together to truly address the breadth of services needed in a community and then redistribute funds to where the needs are.
- Silos of care, even within one setting, need to be eliminated, allowing for better coordination of care so patients can more smoothly move from one setting to another.
The attendees at the New Orleans event all shared a similar commitment to improving the health of their communities, but with several social service and public health representatives present, the focus of the discussion was broader than transformation in health care or hospital care. Much time was spent discussing the social determinants of health and how many “good” plans for improved health will be derailed if these determinants are ignored.

Top Areas of Discussion:
- Social determinants of health
  - Must get “upstream” to address hunger, smoking, obesity or other health improvement efforts won’t be effective.
  - In this area, health outcomes can be determined as much by ZIP code as by care process.
  - Transportation has been a barrier to access for many residents which has led to an expansion of federally qualified health centers (FQHCs) or neighborhood health settings.
- Role of hospital versus role of community versus role of government
  - Personal accountability was discussed in the context of making good/poor health choices and then corresponding consequences.
  - Much of the discussion focused around public health issues and what the appropriate intersection is between hospitals and, for example, the local food bank … need to consider how these entities can work together to improve health.
  - The state’s handling of the tobacco tax was discussed as an example of a major local/state challenge and how politics can run counter to improving health outcomes.

Key Observations:
- While certain issues/challenges may be amplified in New Orleans, they are not unlike those occurring nationally, just with different emphasis.
- Concern that the recent growth of hospitals and number of beds increasing in New Orleans has created a perfect storm and could create an over-capacity issue in the wrong settings. ED beds will need to be redeployed as health care transforms and as care moves to outpatient settings.
- New Orleans has many well-intended organizations doing good things to promote health, including the hospitals, but they do not seem to communicate well or coordinate around common community goals.

Recommendations:
- Consider children as change agents.
  - Education and prevention initiatives must be linked closely to get the best “upstream” impact on health.
- Consider opportunities for “medical managed care” where people most at risk are identified and social and health interactions are employed.
  - Public and private partnerships need to be strengthened with more integration of services and patients.
- Need to strengthen strategic coalitions where parties who have the same interest can come together and have a stronger voice on health and public health policies.
Maryland (Annapolis)

Maryland has an opportunity to be a national leader since it is the only state in the United States in which all hospitals charge Medicare the same price (set by an independent commission) for the same service and operate under global budgets. A new waiver will apply this approach to all payers and the entire episode of care (inpatient, outpatient and care delivered in other care settings). Essential to the success of Maryland’s waiver is the education, engagement and collaboration of the broader community, particularly consumers.

Top Areas of Discussion:
- The state’s new, five-year “all payer” demonstration waiver
  - It’s never been tried or tested before now.
  - There is a blurring of the ACA and the Medicare waiver for the public.
  - Even for those well versed in health care topics, the waiver can be daunting.
- Lack of access to primary care
  - There is a shortage, or uneven distribution, of primary care providers available to meet the current demand for care.
  - Recruitment of primary care providers is challenging when specialties are more lucrative.
  - Patients without a primary provider use the ED — the highest cost setting.
- Better coordination will give patients the right care in the right place at the right time
  - Absence of EHR that can be shared across provider settings results in inefficiencies such as higher costs, duplication of services and readmissions.
  - Restrictions of staff privileges can prevent patients from being cared for close to home.

Key Observations:
- The public is highly confused about, or unaware of, the changes Maryland’s hospitals are undergoing.
- The public is skeptical of messages from large organizations like some hospitals.
- In the public’s eye, global budgets = rationing of care.
- The public is acutely aware of, and frustrated by, the disconnect between providers along the continuum of care.
- There is a thirst for greater outreach, communication and partnerships between hospitals and communities.
- Patients care far less about how their service is provided as long as the quality is high, the cost is low and the experience is positive.
- Case studies/anecdotes of successful population health management, community partnerships, readmission reduction efforts, etc. resonate well.
- There must be real substance/infrastructure behind any messaging/outreach effort.

Recommendations:
- Launch public education/awareness campaign, starting from within the health care community. Messages will need to be tailored for different audiences with compelling reasons why this issue is important to them. Messages should answer questions such as:
  - What is a global budget?
  - What is this waiver all about?
  - Where and how do I access different types of care?
  - How can I be part of the solution?
- What can I do to achieve a healthier lifestyle?
- What’s in it for me?
- Bring pharmaceutical companies to the table to be part of the solution.
- Define the “community,” and identify partners/roles to be filled.
- More physician assistants and nurse practitioners should be utilized in order to better allocate limited primary care resources.
- Partnering with faith-based organizations and social services groups is key in addressing the issue of transportation, in order to expand access to community-based primary care services while decreasing health costs.
- Build awareness in the community of care access points and when and how to use them, with support from community partners.
- To attract more primary care physicians, their image needs to change, along with their level of income.

**Pennsylvania (Harrisburg)**

There is a common interest in working toward a healthy Pennsylvania, where families and individuals secure affordable health care coverage, receive quality primary care, improve overall well-being, and eliminate disparities in access to care and outcomes. All conversation participants spoke passionately and strongly on the side of patients, emphasizing the need to empower patients to make health care decisions based on solid information.

**Top Areas of Discussion:**
- Transitions in care
  - Coordination of care is essential, and care will extend beyond the walls of the hospital into other health care and even community settings.
  - Patients must be able to transition seamlessly.
- What resources do patients have and need to do this?
- Are patients’ records easily accessible if they have to access EHR?
- Consumerism
  - Is there a danger of information overload? Related concern that consumers can’t separate good information from bad.
  - Patients have a responsibility for their own health ... provide incentives for them to take it on.

**Key Observations:**
- The shifting of risks in health care delivery triggers survival strategies among hospitals and health systems. Could that overshadow the goals of transformation and collaboration?
- Changes in health care are perceived to be forced onto hospitals, causing resentment, which is not a good theme for collaboration.

**Recommendations:**
- Think creatively! Looking for unconventional partnerships could yield positive results (the state hospital association is partnering with libraries to disseminate information related to being healthy. The program’s success likely will lead to similar collaborations in other communities around the state).
- Honing in on the “one size doesn’t fit all” theme, conversation participants suggested looking to universities (medical schools and business schools) for solutions or to tap
into work universities are doing in the area of community health.
Ensure that policy changes include input from community stakeholders so that it’s more of a grassroots versus top down approach.

**Texas (Dallas/Ft. Worth)**

The number of Texans who are uninsured — about 5 million — exceeds the total population of some states. That’s why affordable, accessible health care coverage is so important to the economy and quality of life in Texas. Understanding that different regions of such a large state require different strategies for transformation, there is general agreement that collaboration is an essential piece of any scenario. The existing model of regional health partnerships was acknowledged as successful.

**Top Areas of Discussion:**
- Collaboration
  - Organizations and providers need to break out of their silos as collaboration can reduce costs.
  - Diverse community partnerships will benefit both patients and providers.
- Funding challenges
  - There is not enough money to fund every potential solution, yet still need to find a way for every individual to have access to quality health care.
- Coordination of care
  - Care coordination will be truly successful when health information is portable and accessible by all.

**Key Observations:**
- Consumerism will be a big factor as health care evolves, and it will be interesting to see how much of health care interactions will move to online platforms.
- There are untapped resources among providers. Nurse practitioners and physician assistants provide excellent, quality care, and the IOM “Future of Nursing” report supports this concept, as does HHS when considering expansion of care in the community.
- The Dallas-Fort Worth area is one of the fastest growing regions — growth and prosperity delay the transition from the fee-for-service model because volume helps sustain the current model.
- One million people in Texas are in the insurance gap … these are people who can’t afford coverage and don’t qualify for Medicaid

**Recommendations:**
- Collaboration should include advocacy and not focus only on individual agendas.
- Establish increased access to data — HIPAA is an unintended barrier; successful communication between providers depends on access to information and portability.
- Embrace telehealth, especially for rural hospitals and providers.
- Address changes in patient population — demand for services, transportation issues, socioeconomic status.

**Vermont (Bennington)**

Vermont is a small but progressive state. There’s general understanding that change won’t come from the state or from Washington quickly enough, therefore communities
and hospitals must begin transformation at the local level. Integration is a key component, but it needs to mean more than mergers or affiliations. It must include enhanced lines of communication and flow of information.

**Top Areas of Discussion:**
- Aging population
  - Vermont is the second oldest state in the nation, and the expectation is that care will shift from surgical care to medical care as baby boomers live longer with more chronic conditions.
- Behavioral health services
  - Partnerships are essential to adequately address behavioral health needs, with different social service entities in the community needing to come together to connect medical care and behavioral health care.
- Service areas that cross state lines can be barriers to partnership.

**Key Observations:**
- The decision to collaborate needs to be a strategic decision. When conversations are held as part of a strategic planning process, they are more likely to get done.
- Hospitals and communities cannot wait for legislation to make collaboration easier; rather, they must begin now and need to hear from consumers as they begin to transform.
- Look for education/discussion opportunities and begin with existing community forums as the community owns a piece of health care transformation.
- Cost versus value
  - Health care stakeholders are doing themselves a disservice when they only talk about costs; they need to emphasize messages on value and outcomes. Clearly identify why these paths of transformation are good for patients.
  - All stakeholders must identify the silos that currently exist within health care and within the community and work to remove them with the patient and value as the focus.
- Vermont embraces experimentation and innovation.
  - Hospitals need to realize that they may not be able to be everything to everyone and might need to “repurpose.” This insightful quote was shared by a hospital CEO who attended the Community Conversation: “I used to feel like the hospital was the only kid on the block, then realized I was just the most expensive kid on the block, and now I am just another kid on the block.”

**Recommendations:**
- Key partners should include social service organizations, schools and law enforcement.
- Particularly for small states, there is a need to build an interstate exchange to alleviate barriers to collaboration.
- All stakeholders need to move away from “protectionism” where different entities are only thinking about their own challenges; rather, they must think about the health challenges of the entire community.
- More ongoing outreach by hospitals must be done. This is a learning process – a time of change for all – and it will be vital that open communication continues between community stakeholders. Hospitals must be the convener for such discussion and collaboration, but not necessarily the leader.
Western Maryland Health System and Allegiance Health Case Examples
About: The Western Maryland Health System (WMHS) consists of physician practices; outpatient services; urgent care centers; primary care centers; home care; the Frostburg Nursing and Rehabilitation Center; an 88-bed skilled nursing facility; and Western Maryland Regional Medical Center, a 275-bed hospital that offers a full range of medical services. With a workforce of more than 2,300 employees, WMHS is the largest employer in the region and cares for a community with 75 percent of patients enrolled either in Medicare or Medicaid.

Objectives: In 2009, WMHS was presented with the opportunity to participate in a total patient revenue/capitation model demonstration project. After reviewing both financial and patient data, the hospital decided it would be a good approach to try a model that pre-determined reimbursement rates and strongly emphasized efficiency – ensuring that initial admissions, length of stay and then any readmissions are well managed and appropriate for a particular patient and setting. Participation in this program changed the hospital overnight — one day it was looking for opportunities to increase volume and the next looking to contain volume. Participation in this project put the hospital on a path of early transition from the first, volume-driven business model to the second, value-driven business model. WMHS set goals to better coordinate care, improve efficiency and improve the quality of care provided to patients.

Strategies: As the hospital made this dramatic shift in both philosophy and in business model, the focus on achieving the IOM’s Triple Aim became a guiding principle. All change and all education was done with the patient as the central focus. Hospital leaders recognized that education and engagement of staff would be critical for adoption and acceptance among the hospital employees, physician community and within the general community.

Education and outreach began first with physicians and staff. Given that physicians are reimbursed under a different payment model, WMHS needed to help combat concerns about reducing the number of patients seen and explain how care coordination can actually open opportunities for new ways of caring for patients, as well as repurpose staff responsibilities.

Initially, the leadership team held a meeting to share this new approach with staff but then realized that more in-depth training would be needed. All staff at WMHS now participate in mandatory three-hour training sessions each year that help educate staff about changes to the delivery system and reimbursement models and how the new reforms allow WMHS to provide better, more effective and more efficient care.

Community outreach followed closely once staff had been educated, and the focus of all communications was to explain how the patient was central to all that was being done.

Community education began with the hospital’s community advisory board and spread to the local chamber of commerce, rotary clubs, churches, and economic development councils, among others. The hospital developed a presentation and proactively identified opportunities to present to different community groups, helping the community feel more...
comfortable about seeking care in different settings. Shifting locations of care, even if to a more appropriate care setting, was a change that needed to be clearly explained to the community. The health system also created new primary care centers within neighborhoods most in need. It created the Center for Clinical Resources to help provide treatment to community members with chronic diseases, and also enhanced existing relationships with home health and nursing home settings to ensure better transitions of care.

In addition to small group education and outreach to diverse stakeholders like parish nurses, Lions clubs and local AARP chapters, the health system also employed more traditional communication and marketing tactics, like revamping the hospital website, running ads around the theme “Meeting the Challenge of Health Care Change” and explaining the shift to value-driven care.

**Lessons Learned:** Education and outreach don’t stop. While many communication and education vehicles were initially put in place to share the change that was beginning, these same vehicles still exist and in many instances, have expanded and are now used to enhance collaboration and coordination among partners. The U.S. health care system is a complex one, and even many working in health care may not understand the changes that are occurring, which is why education can be key. Additionally, educated staff can become ambassadors within the community and help underscore that better coordinated care is best for patients. Educational sessions are ongoing as new concepts and approaches are introduced. Identify and build mechanisms to help promote positive change. An example at WMHS is the establishment of the President’s Clinical Quality Council, which includes a group of 12 physicians who are considered leaders as well as early adopters. This council has helped bring others along when changes are being rolled out. Additionally, establishing coalitions or strong collaboration among neighboring hospitals and communities can offer learning opportunities, as well as improve overall coordination of care as patients move across service areas.

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**Allegiance Health**

**About:** Allegiance Health is a community-owned health system in Jackson, Mich., consisting of a full range of inpatient, outpatient and emergency services, including a 480-bed acute care hospital; 60-bed long-term acute care hospital; 20-bed hospice residence; primacy care centers; home care and private duty nursing; chronic care services; and cancer center. The largest employer in the region, Allegiance Health has more than 3,800 staff members and 400 physicians with a range of medical and surgical expertise, from primary care to advanced surgical specialties. Allegiance Health provides services to a population in which nearly 70 percent are covered by Medicare or Medicaid, and the health system incurs $15 million (at cost) bad debt annually.

The Jackson community and surrounding areas have historically rated poorly on comparative health indices. The data reflects lower levels of post-high school education and many other socioeconomic factors that inhibit wellness.

**Objectives:** In 1999, the focus of the Executive Committee of the Board was a pending risk to the health maintenance organization (HMO) that Allegiance then owned. An annual actuarial
rate increase averaging 40 percent threatened the viability of the health plan and affordability of coverage for local employers, ultimately reinforcing the cycle of poor health and high cost in the community. Since the data reflected that the hospital’s price transfer to the plan was not the issue, the committee concentrated on the cost of demand for health services. A board member asked a key question of hospital leaders: “Why do we want to be an HMO when the current levels of health are so poor?” This question ultimately changed the organizational focus to one of health improvement, as the health system recognized that the cost of health care follows health status. In 2000, Allegiance Health created its health improvement organization (HIO), and embarked on a path of population health improvement.

Transforming the health system focus from a “sick care” model to one of “well care” required significant groundwork, including a key decision about how to start such a monumental undertaking. Allegiance Health concluded that local employers, comprised mostly of smaller manufacturers, were the most adversely affected by the consequences of poor health and were “intact groups” with the greatest potential to effect change. This made employers a logical group to begin Allegiance Health’s health improvement efforts.

**Strategies:** Improving the health and well-being of the community became Allegiance Health’s mission, with a vision of creating Michigan’s healthiest community. The health system created the employer-based program, “It’s Your Life,” which assists individuals in monitoring their health while encouraging wellness activities. Participation by Allegiance staff members and others in pilot employer groups grew slowly, even with financial incentives offered. Allegiance Health remained focused. Websites and other materials were created to educate and engage employees, employers and the community to make lifestyle changes that would improve health outcomes.

As the HIO effort grew, Allegiance Health recognized the need to partner with community stakeholders given the breadth and depth of work required to create a community culture of health. Allegiance adopted the role of “integrator,” bringing the Jackson County Health Department and the local United Way chapter together for the collective advancement of their community’s health. The Community Health Needs Assessment (CHNA) was jointly funded, and the findings of the assessment created common priority goals for health improvement endorsed by leaders across the community. After 14 years, Allegiance Health now collaborates with more than 30 other health and community service organizations on a single community action plan to prioritize and address pressing health needs, particularly for people who are underserved. In addition, Allegiance Health and the Jackson County Health Department have a unique relationship in which the Health Department’s medical director and health officer both hold comparable leadership positions at Allegiance Health.

**Lessons Learned:** Transformation began at Allegiance Health because of a visionary board that worked in co-leadership with executives. Leaders were committed to improving the health and wellness of the community and did not settle for status quo when it came to the health of patients, employees and the community. Beyond delivery system changes and reimbursement system changes, Allegiance Health views population health as its core mission.

A process of inclusiveness helped to align the work of the health system with the broader community, creating commonly agreed upon goals, tracking improvement and engaging
a broad array of stakeholders to enhance momentum and build an infrastructure that addresses the complex issue of poor health. This collective work in health served as a model for local education and financial sectors, which have recently adopted similar structures, creating a strong platform through which to focus on social determinants of health. As the delivery system evolves, alignment of value-based payment incentives with this work, as well as the health system’s clinically integrated network (a partnership with community physicians) and key hospital services, such as case management, health navigators, emergency physicians and hospitalists, will be key to achieving Triple Aim objectives of population health, experience and cost. Engaging in open dialogue at the community level and sharing balance scorecard metrics are critical to success.

For a delivery system steeped for decades in a model that incents caring for sick people, a goal of creating a healthy community can be seen as heretical. And, doing the right thing in the absence of aligned payer incentives results in financial challenges. Allegiance Health has learned firsthand that the journey to population health is enormously messy work requiring a willingness to partner broadly, a focus on community need and a tenacious spirit required of marathons.

Our Vision for Transformation

1.0 Acute Health Care System
- High-quality acute care

2.0 Accountable Care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance

3.0 Community Integrated Health Care System
- Population-based health outcomes
- Care system integration with community health resources

Source: Allegiance Health, 2014