



HEALTH SYSTEMS LEARNING GROUP (HSLG) MONOGRAPH

*Prepared from shared learning for use at
Strategic Investment in Shared Outcomes:
Transformative Partnerships between Health Systems and Communities*

Washington, DC, April 4, 2013



April 4, 2013

Dear Colleagues,

Whether overlooking the skyline of Detroit, or the Alaska Range and sprawling Mat-Su Valley beneath it, what we see is, in many ways, precisely the same. We see the lives of people – in communities that are not “out there,” but are intrinsic to our organizations’ respective missions and visions:

- Our communities, home to people with ponderous health challenges – chronic disease, infant mortality, health disparities and more. Our communities, home to environmental drivers that can profoundly shape health issues – lack of access to care, jobs, education, fresh food and other factors we know to be social determinants of health.
- But also, our communities, home to rich, largely untapped assets. People who are natural leaders mobilizing neighbors to improve quality of life ... practitioners of time-honored cultural practices that positively impact health behavior ... school and faith-based initiatives that are changing lives ... the list of potential health partners goes on. Not to mention the treasure troves of knowledge and wisdom that can inform sustainable community partnerships fueled by shared responsibility, where everyone wins.

That’s why, as leaders of the two health organizations honored by 2011 Malcolm Baldrige National Quality Awards, we are pleased to welcome you to the promising, precedent-setting work of the Health Systems Learning Group. This group of 43 organizations, including 36 non-profit health systems, has gathered in Washington, D.C. and in regional locations from Loma Linda to Detroit for the past year and a half, with the shared goal of making a positive impact on population health through innovative practices and community partnerships.

Funded by a generous grant from the Robert Wood Johnson Foundation and by participating health systems, their efforts have been sparked by a series of stakeholder meetings at the White House Office and Department of Health & Human Services Center for Faith-Based & Neighborhood Partnerships, and are administered by a secretariat housed at Methodist Le Bonheur Healthcare’s Center for Excellence in Faith and Health.

The Health Systems Learning Group aspires to identify and activate a menu of proven community health practices and partnerships that work from the top of the mission statement to the bottom line – a platform that our own organizations’ leaders for community health present to us in the following monograph. What these practices and a burgeoning body of other evidence-based initiatives show us are new pathways to transform unmanaged charity care into strategic, sustainable community health improvement.

It is highly significant that today’s convening takes place on the 45th anniversary of the death of Rev. Dr. Martin Luther King, who said, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” Dr. King, we will never forget your galvanizing words. And, together as the Health Systems Learning Group, we believe the moment is now – as perhaps never before – to leverage the learning, and to act.

Sincerely,

Katherine Gottlieb

Katherine Gottlieb, President and CEO
Southcentral Foundation
Anchorage, Alaska

Nancy M. Schlichting

Nancy M. Schlichting, CEO
Henry Ford Health System
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On Our Cover:

A pregnant mom discusses infant car seat safety with an exhibitor at a community kick-off event for Sew Up the Safety Net for Women & Children (SUSN), a \$2.6-million project of the Detroit Regional Infant Mortality Reduction Task Force. The project has engaged and trained community health workers in three Detroit neighborhoods to improve opportunities for mothers and families to succeed – and babies not only to survive, but to thrive. SUSN is demonstrating place-based population health management; innovative, sustainable service delivery models; high-tech/high touch social marketing; provider education on the health equity framework; and institutional alignment – even amongst competing health systems.

Chapter 1

Introduction and Acknowledgements

Introduction

The Health Systems Learning Group (HSLG) brings together 36 health systems to take advantage of the opportunities presented by national health reform to re-examine health system practices. The HSLG:

- ▶ Deliberately embraces a **‘learn-in-the-open’ approach**—sharing transparently, while harvesting lessons from promising practices in the field,
- ▶ Promotes proactively **managing charity care and leveraging community benefit requirements**, not only to assess community health, but to invest in community health with a true integrative strategy,
- ▶ Documents its learning in this starting monograph in order to challenge leaders in the field to be the **early adopters of an ensemble of practices that will improve health status**, both inside and outside of their health systems.

Acknowledgements

Without the insights, generosity and open spirits of all HSLG contributors, it would neither have flourished nor been funded. All those who have participated at any level are listed below.

Further, the HSLG would not exist without the leadership and support of the Health and Human Services **Center for Faith-Based and Neighborhood Partnerships**. The Office’s initial interest in programs that seek to create different models of healthcare—like the Camden Coalition’s ‘hotspotting,’ Methodist Le Bonheur Healthcare’s Congregational Health Network, and Southcentral Foundation in Alaska—sparked the HSLG’s formation at a **White House** meeting in September 2011. Here, particular thanks go to Joshua DeBois, Mara Vanderslice-Kelly, Alexia Kelley, Kimberly Konkel, Acacia Salatti and, especially, Heidi Christensen, whose concise and brilliant leadership, writing, momentum and passion for this work have been pivotal.

Robert Wood Johnson Foundation, through its Program Officer, Abbey Cofsky, has graciously subsidized our work, funding meetings, writing groups and professional material production and dissemination.

The support, leadership and seed funding from key health systems that make up the *Provisional Integration Team* have been critical to our movement—they are **highlighted** in the *full health system partnership* listing below:

Adventist Health Central Valley Network, CA	Loma Linda University Health, CA
Adventist HealthCare, MD/NJ	Lutheran Healthcare, Brooklyn, NY
Adventist Health Ministries, North American Division, FL	Methodist Le Bonheur Healthcare, Memphis, TN
Adventist Health System, Orlando, FL	Nemours, DEL, FI
Advocate HealthCare, Chicago, IL	OhioHealth, Columbus, OH
Aurora Health System, Milwaukee, WI	Penrose-St. Francis Health Services, Colorado Springs, CO
Baptist Health (Northeast Florida & Southeast Georgia)	People Improving Community by Organizing Network (PICO)
Bon Secours Health System, Inc.	Pinnacle Health Systems, Harrisburg, PA
Bon Secours Baltimore Health System, Baltimore, MA	ProMedica Health, Toledo, OH
Camden Coalition of Health Care Providers	Providence Hospital, Washington, DC
Catholic Health Association	Public Health Institute, California
Carter Center (The)	Robert Wood Johnson Foundation
Centers for Disease Control and Prevention	Shawnee Mission Medical Center, Kansas
Centura, Englewood, CO	Sibley Hospital, Washington DC
CHRISTUS Health, Irving, TX	St. Joseph Health System, Sonoma County, CA
Dept. of Health and Human Services	Southcentral Foundation, Alaska
Dignity Health, San Francisco, CA	Summa Health System, Akron, OH
EMORY Interfaith Health Program	Texas Health Resources, Dallas/Ft Worth, TX
Fairview Health Services, Minneapolis, MN	The California Endowment
Henry Ford Health System, Detroit, MI	Trinity Health System, Livonia, MI
Howard University Hospital, Washington, DC	UMASS Memorial Health System, Worcester, MA
Indiana University Health	University of Illinois Health and Hospital System, Chicago, IL
Inova Health System, Fairfax, VA	Wake Forest Baptist Health, Winston-Salem, NC
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Kettering Health Network, Dayton, OH	

Among key individuals, Kevin Barnett at the **Public Health Institute**, serving as content consultant, graciously held together, captured, and collated intelligence from a very bright, but eclectic, group of trans-disciplinary thinkers and practitioners. Gary Gunderson, as co-Primary Investigator, brought invaluable energy and brilliance, pushing to keep the group out of its comfort zone, and creating new language for an innovative paradigm of healthcare delivery in the process. Kimberlydawn Wisdom became the unofficial co-investigator, complementing Gary's insights with her logic, experience and inventive ideas from her deep well of experience at the intersection of medicine and public health.

Special thanks go to **all presenters** for their content shared at our early and regional HSLG meetings: Elliott Attisha, Bobby Baker, Dora Barilla, Kevin Barnett, Eileen Barsi, Regina Benjamin (US Surgeon General), Jeffrey Brenner, Ameldia Brown, Sean Cavanaugh, Heidi Christensen, Doug Clark, Jaye Clement, John Clymer, Mandy Cohen, Rima Cohen, Nancy Combs, Bonnie Condon, James Connelly, Kelly Craig, Teresa Cutts, Loretta Davis, Bill Davenport, Chris Dawe, Joshua DuBois, Nancy-Ann DePaule, Doug Eby, Dory Escobar, Ruthita Fike, Jim Galloway, Kathryn Gottlieb, Pierce Graham-Jones, Nancy Gray, A. Hugh Greene, Gary Gunderson, Yvette Harris, Richard Hart, Doug Hawthorne, Sally Howard (Chief of Staff, HHS), Erin Inman, Steve Ivy, Carole Johnson, Alexia Kelley, Maureen Kersmarki, Michael Knecht, Howard K. Koh (Assistant Secretary for Health, HHS), Shawn Levitt, Cynthia Luna, Audrey Moran, Jeremy Moseley, Farzad Mostashari, John McConnell, John O'Brien, Todd Park, Kirsten Peachey, John Popovich, Rick Rawson, Trudy Raymundo, Mike Rodgers, Melissa Rogers, Carolyn Rowland, Wilma Ruffin, Margaret Sabin, Acacia Salatti, Nancy Schlichting, Herb Schultz, Karen Gray Sheffield, Jim Skogsbergh, Fred Smith, Leslie Smith, Paul Stange, Don Stiger, Thomas Strauss, Fahad Tahir, Steve Tierney, Evelyn Trevino, Aaron Truchil, Mara Vanderslice-Kelly, Keith Vesper, Cleve Warren and Kimberlydawn Wisdom.

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ARTS OF ALIGNMENT: TRANSFORMATIVE PARTNERSHIPS

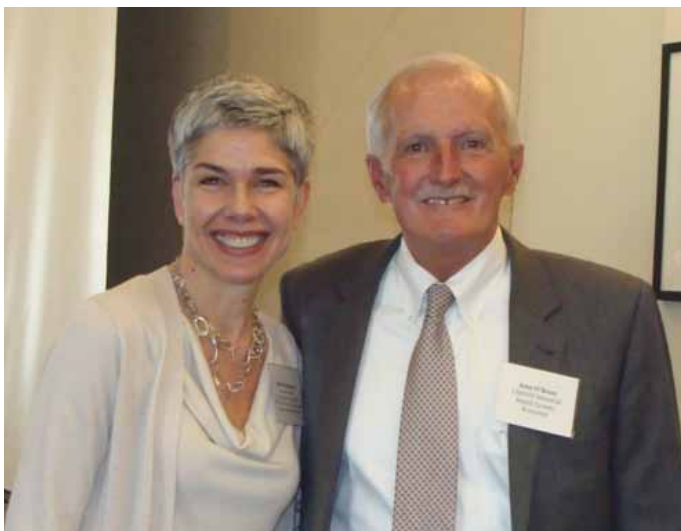
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Heidi Christensen of HHS and John O'Brien of UMASS at April 4, 2013 Leadership Summit

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Chapter 2

Executive Summary

Strategic Investment in Shared Outcomes: Transformative Partnerships between Health Systems and Communities

Overview

The Health Systems Learning Group (HSLG) is a self-organized group of 43 organizations (including 36 non-profit health systems) that have engaged in a series of meetings across the country over the past 18 months. We are inspired by the passage of the Patient Protection and Affordable Care Act (ACA), and motivated by the recognition of the need to transform our organizations and our communities. Collectively, we have made a commitment to accelerate this transformational process through ongoing sharing of innovative practices that improve population health and the development of coordinated strategies that take innovation to scale.

The creation of this learning collaborative was sparked by a series of stakeholder meetings at the White House Office and Department of Health & Human Services Center for Faith-Based & Neighborhood Partnerships. The HSLG is administered by a secretariat housed at Methodist Le Bonheur Healthcare's Center for Excellence in Faith and Health in Memphis, Tennessee and at Wake Forest Baptist Health System in Winston-Salem, North Carolina. The HSLG partners have contributed substantial financial and in-kind resources to support the 18-month developmental phase. In addition, a generous grant was provided by the Robert Wood Johnson Foundation to support the dissemination of findings and lessons learned during this period.

The Health Systems Learning Group aspires to identify and activate a menu of proven community health practices and partnerships that work from the top of the mission statement to the bottom line — a platform that our own organizations' leaders for community health present to us in the following monograph. These practices and a burgeoning body of other evidence-based initiatives show us new pathways to transform unmanaged charity care into strategic, sustainable community health improvement.

The first phase of development for the HSLG culminated with a convening on April 4, 2013 co-hosted with The White House and HHS Center for Faith-Based and Neighborhood Partnerships, along with the Chief Executive Officers from many of our health system partners. The purpose was to review findings from the past 18 months of inquiry and dialogue and to consider a call to action on a specific set of recommendations. This inquiry, dialogue, and call to action are captured in this monograph. HSLG partners affirmed their commitment to move forward at the April 4 meeting, in recognition of the important work ahead. As noted by Assistant Secretary for Health Howard K. Koh, MD, MPH in his opening comments, "We are all interconnected. We are in a moment of opportunity with health reform to do this work in new and innovative ways."

Background

Health care and the health of populations and communities in the United States are impacted by many forces, with substantial inequities in access to care, living conditions, and social, educational, and economic opportunities. The resulting disparities in health status produce many direct and indirect costs that are difficult to control, much less reduce. As a community of providers, we have failed to fulfill the promise of 21st century science and our own long-held charitable mission. The ACA creates a policy context that challenges us to move beyond inpatient care delivery—to link clinical services to community health improvement activities outside the walls of our inpatient institutions.

While far from perfect, this new policy direction is consistent with our mission and fundamental belief that doing the right thing medically and socially is doing the right thing morally. Decent and efficient are the same thing. New and hopeful for us as health care organizations is realizing that we now know enough to extend that mission logic to engage the social environments from which our most complex patients come. *Decent, efficient, and effective* is possible, if we join partners at community scale. This calls for operational changes that align with the profound changes occurring in all aspects in the provision of health care and partnering with diverse stakeholders in our communities to address the underlying causes of health problems. This shift in focus was well articulated by Henry Ford Health System CEO Nancy Schlichting at the April 4 convening of leaders in Washington, DC in her statement that "We're changing the center of gravity from the hospital to the home and the community."

Our hospitals are conducting the first generation of federally mandated Community Health Needs Assessments (CHNAs) and developing implementation strategies to improve the health of the communities we serve. The assessments confirm the profound health disparities in our communities, where inequities in policies and practices yield social, economic, and physical conditions that present immense obstacles to improved health. These issues are driven by determinants that are beyond the capabilities of health care provider organizations.

The HSLG partners share a commitment to the optimal fulfillment of our charitable mission, focusing our efforts in communities where health disparities are concentrated. This starts with good stewardship in the allocation of charitable resources, working with diverse stakeholders to deliver the right balance of services and investments that improve health, reduce costs, and contribute to overall economic vitality.

Return on Investment

Good leadership of our organizations requires ongoing attention to return on investment (ROI); in the delivery of health care services, internal investments in infrastructure and expertise, and in broader external resource allocations that help to create the conditions for longer term benefit. While the use of traditional ROI models to evaluate the impact of clinical interventions may be appropriate, they are not readily applicable to evaluating our investments in comprehensive approaches to community health improvement. As the regulatory and financial context of care provision changes, we must provide new language and develop analytic tools to better evaluate, guide, and build upon activities already underway or newly envisaged. We must work together to develop tools that identify, calculate, and demonstrate financial and non-financial returns that accrue not only to our own institutions, but to other stakeholder partners, and the broader society through shared investments in community health improvement.

Current models are inadequate, primarily because they do not effectively integrate external factors that may significantly impact clinical outcomes. While our accountability for quality in clinical settings is vitally important, our models for evaluation of investments and interventions must evolve to reflect the complex interaction of factors that contribute to changes in utilization, improved health outcomes, and improved conditions in the broader community.

ACA helps create an environment where prevention is understood to be central to successful health care system transformation. The Signature Leadership Series report, *Managing Population Health: The Role of the Hospital*, notes that the ACA identifies ‘creating healthier communities’ as a population health management strategy, and identifies several relevant issues, such as housing conditions, open space and the availability of parks for physical activity, and health literacy (a proxy for level of education).¹ The Joint Commission recognized root cause analysis would identify these causal factors. For example, the proximate cause for a diabetic patient’s hyperglycemia may be failure to take medication as directed and/or poor self-management skills; a root cause may be lack of safe and convenient locations for a daily walk.

The ACA goals to improve access, improve quality, and reduce costs can only be achieved through shared ownership for health among hospitals, providers, and the full spectrum of stakeholders and sectors. Together, we must build a balanced portfolio of investments that views health in a broader context, one where equity in opportunity, the quality of living conditions, and meeting basic needs is understood to be fundamental to optimal health. This approach aligns well with the longstanding missions of not-for-profit hospital systems, and pushes us to extend our thinking beyond ROI to social returns on investment (SROI). As we work collaboratively within communities to address the determinants of health, we will see changes in the community—returns on our and others’ investments—that go beyond the financial. Developing the tools to identify, assess, and measure these social returns, along with more conventional ROI, enables us as mission-driven organizations that are also committed to financial stability to make the best application of our investments.

Transformative Ensembles

The HSLG has identified *three points of high leverage* that can begin to dissolve the walls between health care and health, hospital, and community, and produce both cost savings and improved outcomes in place-based terms. We see promise where others may see only problems: the complexity of the causal factors in community health presents us with a rich tapestry of potential partners to improve health.

The passage of the ACA has driven home the need to think and act more broadly. Yet, we still labor under the perverse incentives in the current system of fee-for-service financing. In this light, the HSLG proposes to identify what we can do now, and to map what we should plan for in the near future. One important challenge will be to keep the attention of leadership on these issues in the context of growing complexity, changes in functionality, a requirement to build competencies in new areas, new constraints on reimbursements, and the need to keep bond ratings strong.

At the core is the recognition among HSLG partners that in order to transform our communities, we must transform ourselves. This will involve attention to the roles and contributions of each and every department, function, and structure, on an institution-wide basis. HSLG member Henry Ford Health System (HFHS) has taken important steps in this direction, as recognized in its receipt of the Malcolm Baldrige National Quality Award. A focus on community health is a core Pillar in the organizational strategic plan, with associated metrics that are board-reportable and institutionally aligned—as weight-bearing and accountable as any finance target. The HFHS Community Pillar Team convenes high-ranking leaders from the health system’s seven business units on a quarterly basis to review metrics on strategic objectives in key areas of infrastructure, wellness, access, equity, and new and emerging programs/partnerships. Working groups in each of these areas meet regularly for greater alignment.

¹ Health Research & Educational Trust, April 2012, *Managing Population Health: The Role of the Hospital*. (Accessed 12, May 23).
From http://www.hpoe.org/resources-and-tools/resources/Population_Health.pdf

Charity Care

The ‘Triple Aim’ concept has been developed for the Institute of Healthcare Improvement (IHI) to improve the experience of care, improve the health of populations, and reduce per capita costs of health care. The HSLG agrees that these three aims are critical to transforming our health delivery system, but contends that ***it is not possible to achieve these aims without focusing on a fourth dimension that is embedded in all three—to reduce and ultimately eliminate the profound health disparities in many of our urban and rural communities.***

With an increasing focus on a more planned, proactive approach to charity care aimed at reducing preventable emergency room and inpatient care for the uninsured, the basic issue has been good stewardship—making optimal use of limited charitable funds. A more proactive and strategic allocation of resources enables hospitals to help low income populations avoid preventable pain and suffering; this, in turn, allows the reallocation of funds to serve an increasing number of people experiencing health disparities.

To this end, a growing number of hospitals across the country are engaged in efforts to address ambulatory care sensitive conditions (ACSC) as framed by John Billings² or more recently, as described by the Agency for Healthcare Research and Quality (AHRQ) via Prevention Quality Indicators. ACSCs are diagnoses resulting in hospitalizations that are judged to have been preventable had there been timely and appropriate access. In a study published in 2007, the AHRQ estimated the costs for preventable hospitalizations at \$29 billion, or 10% of total hospital expenditures.³ Numerous studies have documented higher concentrations of these conditions among uninsured, underinsured, and/or underserved racial and ethnic populations.^{4,5}

Monitoring what is actually happening within the community at large, and linking it to clinical care that is actually being delivered, is a major analytical activity. It requires a vastly different view of how we use information technology to inform and support our activities. Administrative information systems, (ADT, discharge abstracts, decision support), until now, have largely been used as historical data repositories tapped for episodic community and institutional analysis (e.g., strategic planning, retroactive QC). The business imperatives of the ACA require something much more timely, and they require analysis that is more finely grained in its geographic specificity.

To create new sustainable models of care will require real-time capacity to monitor and understand the health needs of communities, including understanding how our interventions are making improvements in the lives of families and in neighborhoods we serve. New tools, and a different lens to look at community health, are essential in developing the missing analytical capacity that health systems need, such as examining geographic variability, location analytics, or predictive modeling. We recognize that there is much to be done to build this capacity. As noted by Wake Forest Baptist Health CEO John McConnell, “We have the data, but we don’t have information. Our ability to pull out and analyze what we want is the immediate challenge.”

Developing the tools to identify, assess, and measure these social returns, along with more conventional ROI, enables us as mission-driven organizations that are also committed to financial stability to make the best application of both our charitable and non-charitable investments. Our advancement of these strategies is informed by the work of HSLG partners the Camden Coalition and Dignity Health. Between 2008 and 2010, Dignity Health hospitals invested \$5.7 million in preventive and disease management programs for patients deemed at risk for hospitalization for asthma, diabetes, or congestive heart failure. This resulted in 8,917 individuals participating in disease self-management programs, and 86% of these individuals were not seen in the emergency department or hospital within the six months post intervention.

² Billings, J., Teicholz, N., 1990, Uninsured patients in District of Columbia hospitals, *Health Affairs*, (Millwood), 9(4); 158-65.

³ Russo, Allison, et al, 2007, Trends in Potentially Preventable Hospitalizations Among Adults and Children, 1997-2004, Statistical Brief #36, Healthcare Cost and Utilization Project, Agency for Healthcare Research & Quality.

⁴ Oster, A., and Bindman, A., 2003, Emergency department visits for ambulatory care sensitive conditions: Insights into preventable hospitalizations, *Medical Care*, Vol. 41, Issue 2, 198-207.
Russo, Allison, et al, 2007, Trends in Potentially Preventable Hospitalizations Among Adults and Children, 1997-2004, Statistical Brief #36, Healthcare Cost and Utilization Project, Agency for Healthcare Research & Quality.

⁵ Laditha JN and Laditha SB, 2006, Race, Ethnicity, and Hospitalization for Six Chronic Ambulatory Care Sensitive Conditions in the USA, *Ethnicity and Health*, Vol. 11, Issue 3

Integrated Care for Socially Complex People in the Community Context

Place gives us a point of entry. It makes visible the concrete and specific social and physical contexts of our patients' lives, pinpoints social work needs and interventions, and helps us begin to identify, assess, and measure the social determinants of their health. Understanding patients as place-based gives us a foothold into understanding many factors and circumstances that complicate their medical conditions. Perhaps more importantly, place helps us begin to identify assets, stakeholders, and potential partners that we can engage, and join with, to help address those issues that lie beyond the scope and expertise contained within our walls or professional arenas. By expanding our view, we begin to grasp the social complexity that is a crucial factor in differential health outcomes.

The new paradigm that health care providers are being asked to embrace asserts that our patients will be best served by not only attending to their individual bodies, but also to the communal assets (including relationships) they might hold, and to the social determinants of their health—to the health of the community as a whole. The ACA not only requires tax-exempt hospitals to conduct Community Health Needs Assessments and develop Implementation Strategies to address identified needs, but asks the hospitals to track the five-year impact on broader community health trends. We are being asked, in essence, to be accountable for improving the health of our communities.

Affecting health trends across a community requires a deeper understanding of the communities in which our patients and families live and intervention strategies that are grassroots-oriented, collaborative, and focused on root causes. This more comprehensive approach is exemplified in the work of HSLG member Advocate Health Care, whose Christ Medical Center, a Level 1 Trauma Center in Chicago, partnered with CeaseFire to develop the region's first hospital-based gun violence prevention project. The program works in five 'hotspot' communities to employ trained 'violence interrupters' and 'community-based outreach workers.' The violence interrupters—often individuals who were previously in street gangs—use cognitive-behavioral methods to mediate conflict between gangs, and intervene to stop the cycle of retaliatory violence that threatens after a shooting. They are able to work effectively with highest-risk individuals to change thinking around violent behavior. The community-based outreach workers provide counseling and services to high risk individuals in communities with high violence rates.

The extension of team-based patient-centered care into the community to link marginalized and lower income residents to support systems, medical and non-medical, has been shown to be a powerful intervention for those with chronic disease. This requires the engagement and mobilization of community "assets" that can produce powerful results. HSLG member Methodist Le Bonheur Health System demonstrates the potential with the establishment of a formal covenant relationship with over 500 congregations in the city of Memphis. The Congregational Health Network (CHN) hired 10 congregational navigators who work both in the hospital and the community, and has provided culturally competent health education, literacy and promotion training in 12 condition areas for over 2,000 CHN members to date. Annualized data indicate a drop in readmissions for any reason from 24.24% to 18.18%, and a drop in DRG readmission rates for heart failure from 18.18% to an astounding 2.27% (>90% reduction) from 2011-2012, in one target zip code.

Engaging community health workers, pharmacists, home health and parish or faith community nursing, among others, has been repeatedly shown to improve the health of residents as well as 'the bottom line.' For example, an intervention in Chicago where community health workers make 3 to 6 home visits over a 12-month period for children with asthma resulted in a 62% reduction in asthma related ED visits and a 67% decrease in asthma related hospitalizations and a 7 to 1 return on investment.

The ACA and our business stewardship provide us with a mandate. Our faith-based and non-profit missions drive us to serve socially complex and underserved communities. Before us lies a responsibility to ensure that our efforts effectively 'move the needle' in community and population health and are sustainable over time. In order to accomplish this, we must move beyond small-scale innovations. As indicated by Loma Linda University Health System CEO Rick Rawson, "We need to fully integrate and take to scale what we have historically done as a separate community benefit function."

Transformative Partnerships

One of the great opportunities in this new landscape is to identify new partners who are already working to improve community well-being. Addressing the social determinants of health puts us into conversation with partners in housing, transportation, education, agriculture, public health, economic development and business. Health care providers do not need to carry the freight of solving complex social issues on their own, but they can strategically align their resources and efforts with those of others who specialize in these areas. For example, Florida Hospital partners with United Global Outreach, a small non-profit in Bithlo, a semi-rural, low income community of 8,200 people, to engage the full spectrum of stakeholders in addressing education, housing, transportation, food, and other basic needs. At the core of this effort is the development of a three-acre 'Transformation Village' in the center of town, with a school, a coffee shop, a hydroponic community garden, larger community events, a library and computer lab, adult education and social services.



Gary Gunderson and Kimberlydawn Wisdom at the April 4, 2013 Leadership Summit

Transformative community partnerships move beyond public relations, outreach, and a short term programmatic approach where to there is shared ownership and commitment to community problem solving. This is the kind of relationship where there is a level playing field and where all participants learn from one another, recognizing the strengths and assets each partner brings to the table. In many cases, the hospital may not take the lead, but will provide strategic support in a defined area. This approach is exemplified by HSLG member Loma Linda University Health (LLUH), which works in partnership with municipal governments, school districts, health care providers, community-based organizations, and business in 22 low-income communities in the Inland Empire.⁶ Stakeholders are engaged in an ongoing agenda of dialogue and action that moves well beyond programs to build communities 'where we all have a purpose and a sense of belonging'.

Transformational community partnerships also involve shared commitment to a set of outcomes that are agreed upon by all partners at the start of the process. A central focus is on how to optimally leverage the time, treasure, and talent of all stakeholders, and to test innovations that offer the promise of replicability and scaling. This approach is culturally competent in the broadest sense, using the tenets and tools of equity, cultural humility, and health literacy. It is well demonstrated by HSLG member St. Joseph Health-Sonoma County, which employs a team of community organizers who engage residents at the neighborhood level through grassroots leadership development programs. Residents and organizers set their own priorities, and take action with the support and engagement of the hospital and other stakeholders who are brought to the table.

John Kania and Mark Kramer identified the features of partnerships that enable them reliably to achieve what they call 'collective impact.' The five conditions of collective impact include a common agenda; shared measurement; mutually reinforcing activities; continuous communication; and an independent 'backbone support' project management organization with the appropriate set of skills.⁷ The HSLG embraces this approach as fundamental to the achievement of measurable and sustainable improvements in health in our communities. The framing by Kania and Kramer builds on much prior work on partnerships and collaboration, and outlines a clear path for the advancement of the HSLG transformational vision. There is much hard work ahead, but there is a clear imperative to engage both our communities and our colleagues in dialogue and in action. As noted by Methodist Le Bonheur CEO Gary Shorb, "Collaboration is a core competency. We need to share ideas that help us get to collective impact."

⁶ The Inland Empire is the title for two geographically large, contiguous counties northeast of Los Angeles with over 4 million residents. The Inland Empire is one of the fastest growing and most ethnically and culturally diverse regions of California.

⁷ Kania, J., & Kramer, M, Winter 2011, 'Collective Impact,' Stanford Social Innovation Review, Vol. 43. Retrieved from http://www.ssireview.org/articles/entry/collective_impact; also Spring 2013, 'Embracing Emergence: How Collective Impact Addresses Complexity,' Stanford Social Innovation Review, Jan. 21. Retrieved from http://www.ssireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity.

Call to Action – Key Recommendations

The case for transformative community partnerships to improve individual and community health—as well as the health of the bottom line—is increasingly compelling. Respected national medical and quality organizations, public health at all levels, the academic community, and foundations know this. Health systems are learning it, and many are sharing successes with demonstrated, replicable outcomes based on the population health model.

Health systems today face pressing needs to increase access to prevention and primary care, and develop person-centered, place-based care models to lessen the load on emergency departments and reduce readmissions. Each high-leverage clinical priority opens new doors for transformative community partnerships that return the health systems' investment of time and money many times over—and result in sustainable health improvement empowered by the common good. With these challenges and opportunities at hand, we're making a shared commitment to the following actions:

- To **approach our community health work collaboratively**, as one steward among many others with a responsibility to improve the health of our communities.
- To **proactively invest a percentage of what we currently spend on charity care, with a focus in neighborhoods** where there is clear opportunity to achieve substantial measurable improvements.
- To monitor our proactive investments, our finance departments will work together to **develop new, standard financial metrics and accountability processes**, and to share them broadly within the health care community.
- To extend the interval between readmissions beyond 30 days. To do this we will **develop, benchmark, and validate new practices in population health management**. In the process, we will jointly seek to share in the financial gains produced which would otherwise only flow to the payers.
- To develop shared-outcome metrics and accountability measures to **capture the impact of collaboration** among government, private payers and community partners. We will invite vendors to **create IT products that build capacity and connectivity** in the complex partnerships at the heart of our new opportunities.
- To **engage and collaborate with governmental partners, foundations and non-traditional partners**, to leverage their mission with ours to favorably impact our communities and become economic engines within our settings. When possible, we will work even with our competitors to achieve the common good—healthier people in healthier communities.
- To better **understand our diverse communities through the lens of race/ethnicity, linguistics/literacy and socioeconomics** to ensure we are equipped to meet their needs in culturally appropriate ways.

To move these recommendations into action, here are some key next steps:

- Establish a governance infrastructure that designates a senior executive leader for community health who reports directly to the CEO
- Develop, monitor and report community health metrics that support and leverage health system strategic goals at the highest level of the organization
- Secure a broadly subscribed automated software system to collect, track and report Community Benefit information that is quantifiable, standardized, and fully compliant with IRS reporting requirements
- Agree to set a system-wide Community Benefit goal that not only meets, but annually transcends IRS requirements to serve the community

We will continue to learn together as providers motivated by our common mission and, as we hone our ability to implement the ensemble of practices, we will **share our learning transparently** with others.

Reverend Dr. Gary Gunderson and Dr. Kimberlydawn Wisdom, on behalf of the Health Systems Learning Group, April 2013

Chapter 3

Transformative Ensembles and Social Return on Investment

The HSLG partners are jointly committed to the optimal fulfillment of our charitable mission, particularly in focusing our efforts on communities where health inequities are concentrated. We also have a responsibility to ensure the enduring economic viability of our organizations. This requires good stewardship in the allocation of charitable resources, and the right balance of services and reimbursement mechanisms for a stable funding base.

These combined challenges push us to think of our mission in terms of the ensemble of ideas, people, and practices that will enable us to transform population health in our communities and to aim at what some have termed a ‘collective impact’ in our particular areas of activity. The challenges also push us to rethink our organizational responsibilities in terms of return on investment, in ways that go beyond only financial and economic parameters to include a consideration of the ‘social return on investment.’ Collective impact helps us re-imagine our part in enhancing the health status of our communities as a whole, while social return on investment—a modified form of the economic concept of ‘return on investment’—helps us think about how we use our resources.

The HSLG embraces both. It also recognizes that good concepts and tools are vital but not enough: a sense of what makes an ensemble of ideas, people, and practices ‘transformational’ is fundamental, especially for ‘mission-driven’ faith-based health systems. Indeed, it can be argued that *all* health systems are ‘faith-based,’ if one means by that not a religious affiliation, but a conviction that their mission goes beyond their own institutional imperatives to be accountable, as far as possible, for something greater than themselves—the health of all in the society within which they are located. Analogous to the public health notion of the social determinants of health, one could even speak here, in ‘non-religious’ terms, of the spiritual determinants of health—the recognition that every human being, every human person, irrespective of differences between us, has intrinsic worth.¹ This implies a commitment to decisions and actions that take seriously that no person ought to be treated as a means towards an end, but always as an end in themselves, that every person is worthy of our best.

Engaging ‘Collective Impact’

In this regard, the importance of community partnerships and collaboration has come up repeatedly throughout the HSLG’s learning process and discussions, and throughout this report, with good reason. Growing evidence confirms what experienced community health practitioners have surmised: improving community health requires expertise and engagement, not only beyond the hospital campus, but beyond the health sector. A community or population health lens requires us to think more inclusively, including addressing health disparities and the place-based social and physical conditions that underlie them. It also leads us to look for, and recognize, other actors and stakeholders in communities that have major roles to play in addressing these social determinants of health and enhancing the health of all.

Root cause analysis helps identify intervention points where comprehensive strategies can be designed by a stakeholder collective, while an assessment of tangible and intangible community assets for health enables us to understand what we, collectively, have to work with and can build upon. Yet partnership or collaboration requires more. We must bring the same rigor and focus to our approach to collaboration as to other aspects of our work for the transformation the HSLG believes possible. Not all collaboratives achieve meaningful or sustained results.

John Kania and Mark Kramer have identified the features of collaboratives that will enable them reliably to achieve what they call ‘collective impact.’ Their approach is comprehensive, aiming at a full spectrum of stakeholders in pursuit of a shared set of outcomes. They stress that a singular yet comprehensive focus by aligned organizations from many sectors is more likely to produce measurable and sustainable impacts, in our case, for community health.

¹ For some of these insights, we are indebted to Fred Smith, a member of the HSLG team.

The five conditions of collective impact identified by Kania and Kramer are: a common agenda; shared measurement; mutually reinforcing activities; continuous communication; and an independent ‘backbone support’ project management organization with the appropriate set of skills.² To meet these conditions, we need to:

1. Take responsibility for assembling the elements of a solution;
2. Create a movement for change;
3. Include solutions from outside the non-profit sector; and
4. Use actionable knowledge to influence behavior and improve performance.

In an operating environment where outcomes will be tied to value-based payment programs, financial viability may depend on meaningful engagement of stakeholders from sectors identified in the April Signature Leadership Series report referenced previously. Hospitals are anchor assets in many communities. In metropolitan areas, they may have existing partnerships with public health departments and higher education through health professions training programs. In smaller communities, hospitals may be leading employers and a care site through arrangements with the local health agency or community clinic. Aside from their brick and mortar presence, hospitals *can* be trusted and respected entities (though, critically, trust can never be assumed, but must be won and sustained over time),³ able to give voice to evidence showing the important contribution non-health sectors with economically sustainable assets can make to creating healthier communities.



Lutheran Healthcare Project Safe

Hospitals, public health departments, schools, and law enforcement also have valuable data that can be mapped in order to visually pinpoint the location and extent of contributing factors to poor health. Higher education brings not only access to the latest analytical techniques, research, and emerging practices but also a student workforce that can be deployed across various stakeholder organizations. Community and faith-based organizations are incubators for emerging and informal local leaders who are skilled negotiators and gatekeepers with access to the groups and individuals who know the unspoken history and culture of neighborhoods down to the block level. Data, interpreted by those who live the experience, can depict, identify problems, causes, and validate the improvement effort to a community. This participatory action research and analysis approach is key to the collective impact of the work undertaken by the HSLG: honoring and integrating the ‘blended intelligence’ of often under-represented and/or marginalized community stakeholders.⁴

The business community is also increasingly recognized as a critically important stakeholder in comprehensive community health improvement and, thus, collective impact. The persistence of health and social problems in local communities is inextricably linked to poverty and poor physical infrastructure, and the interaction of these factors impedes potential economic development and associated location decisions by corporate interests. Economic firms recognize that continued rising costs in health care are negatively impacting their profitability, and a key factor in rising costs is the continued growth in the burden of chronic diseases in these communities. Targeted investment in small business development, youth leadership development and career mentoring, and neighborhood revitalization are important complements to investments by the health and educational sectors.

² Kania, J., & Kramer, M, Winter 2011, ‘Collective Impact,’ Stanford Social Innovation Review, Vol. 43. Retrieved from http://www.ssireview.org/articles/entry/collective_impact; also Spring 2013, ‘Embracing Emergence: How Collective Impact Addresses Complexity,’ Stanford Social Innovation Review, Jan. 21. Retrieved from http://www.ssireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity.

³ *Time* magazine’s headline focus of March 4, 2013, Vol. 181, No. 8, by Steven Brill on ‘Why Medical Bills Are Killing Us,’ outlines just how significant—and compromised—the question of trust is.

⁴ Gunderson, G., and Cochrane, J., 2012, *Religion and the Health of the Public: Shifting the Paradigm*, Palgrave MacMillan.

The Role of Financial Institutions

There is growing interest in strategic investment in community development linked to community health improvement as an important way for financial institutions to fulfill their Community Reinvestment Act responsibilities. The Robert Wood Johnson Foundation has partnered with the Federal Reserve Bank of San Francisco to facilitate dialogue between health and financial stakeholders across the country in pursuit of these investment strategies.

There is also increased interest among private philanthropy in *impact investing* as a complement and to leverage traditional grant making.⁵ Impact investments, like conventional investments, are made with the expectation of a financial return; but unlike conventional investing, they do so with the added intention of generating a social or environmental return as well. Impact investments enable foundations to expand their support and ability to help shape and drive social change, helping to bring innovations to scale and contribute to sustainability of achieved results. Also referred to as social investing or program-related investing, the approach enables foundations to recover the principal or earn a financial return, hence expanding their outlay within a particular year and recovering the funds for subsequent years. A small number of large health systems across the country have initiated impact investment strategies, as well, as a means of supplementing traditional charitable resource allocations. Examples of health system investments to date range from creating revolving loan funds for community health centers to micro-lending for small business development in inner city communities.

Integration and expansion of the ROI model to capture and quantify both monetary and social returns on investment is an elemental part of fostering shared accountability for health in our communities. In the process, we have the opportunity to more effectively and creatively leverage our resources and arrive at substantive returns that are relevant and important for the full spectrum of stakeholders. The Collective Impact approach, when combined with effective tracking of SROI, grounds returns on interventions in stakeholder agreements and accords, rendering traditional unilateral actions inefficient and obsolete in a health care environment that is committed to fundamental transformation.

Return on Investment: The Standard Model

Return on investment (ROI) is a set of measures that describe the financial performance of an investment. In business finance, ROI measures include return on assets, return on capital, and return on invested capital. Each measure captures the value of a gain or loss attributed to an investment decision.

ROI was first used by DuPont in 1912 to compare returns across several lines of business the company had acquired after first making its name with explosives.⁶ Applying the skills of economists and statisticians, the new form of accounting enabled DuPont to compare its investments in automobiles, lacquer, nylon, and other innovations. Applying ROI analysis made it possible to compare vastly different lines of business using a common measure. Today, more complex ROI analysis is applied in the development and management of mutual funds, where computer models predict the best combination of individual stocks with varying ROIs that minimize risk for fund clients.

As a decision making exercise, ROI analysis can be conducted prospectively or retrospectively. The prospective approach entails making assumptions about resources and outcomes, both tangible and intangible. The retrospective approach uses data collected after making an investment or during the implementation of a project. Then ROI analysis is no longer based on assumptions but on empirical performance—actual returns generated or reported results of implementation.

In the inexorable movement towards global budgeting in health care financing, integrated health care systems will be reimbursed per patient rather than per service. They will thus directly experience the costs of overutilization, poor disease management, or excessive diagnostics. Health systems such as Kaiser Permanente already operate in a global budget

⁵ Richter, L., Guide to Impact Investing, May 2011, Grantmakers in Health, Retrieved from <http://www.gih.org>

⁶ DuPont Corporation. 1919 DuPont, GM & Cars. Retrieved from http://www2.dupont.com/Phoenix_Heritage/en_US/1918_detail.html



Inova Health Systems, Promotores de Salud

environment, and ROI is directly tied to their ability to keep populations healthy. Increasingly, however, the expansion in enrollment through the Affordable Care Act (ACA) will move into communities where environmental conditions may impede the ability of residents to adopt healthy behaviors. In this context, and given the limits to what can be accomplished in the delivery of clinical services, it will become increasingly important for hospitals to build partnerships with diverse community stakeholders who are better positioned to address and improve some of the conditions in community environments. Understanding ROI in this context has the potential to contribute to the long term economic viability of hospitals, the health status of populations, and the social, economic, physical and psychological vitality of communities.

Expanding the Model

The use of traditional ROI models by hospitals to evaluate the impact of focused clinical interventions may be appropriate. But they are not readily applicable to evaluating investments in comprehensive approaches to community health improvement. Still, dozens of innovative health systems are already engaged in these more complex activities. As the regulatory and financial context of care provision changes, it is thus imperative to provide new language and analytic tools to better evaluate, guide, and build upon activities already underway or newly envisaged. The tools are needed to gain the sustained support within our organizations of others less familiar with community health improvement practice the target of such investments. They are also needed to identify, calculate, and demonstrate the *non-financial* returns on community health efforts.

How do we expand the ROI model? ROI in financial circles is about profit, or at least margin. We need a positive corollary relevant to hospital investment in community health improvement. For maximum effect we need the tools and mechanisms to track community and social returns. A model that addresses both the monetary dimension of ROI and broader returns at the community (societal) level, will enable mission-based organizations to validate current investments and feel the ache of missed opportunities. This includes the pain of lazy charity that currently focuses on the emergency room, absorbing millions of dollars that could be better spent with far greater returns to both the hospital and the broader community. Failing prospectively and proactively to invest resources to reduce preventable (costly) utilization of our emergency rooms and inpatient facilities, and to calculate monetary *and* broader returns on the investment, perpetuates waste and profound suffering in our populations.

Consider some of the challenges in adapting ROI methodologies for community health improvement. Traditional ROI analysis requires detailing cash flows from several payer sources, which makes it difficult accurately to quantify the timing of those cash flows. Second, reaching agreement on cost allocation across several functions and rates over time is also challenging. Third, a highly dynamic and competitive operating environment complicates scenario development and testing of variables and constraints.

Nonetheless, health care practitioners have applied the ROI approach. Groundbreaking work by the Institute for Healthcare Improvement (IHI) and the passage of the Patient Protection and ACA are driving interest in various models to measure progress in quality improvement across the continuum of care. While the Joint Commission on the Accreditation of Healthcare Organization recognized the Deming cycle, root cause analysis, and other tools in the early 1990s, the IHI was one of the first to see the importance of incorporating W. Edward Deming's philosophy of 'continuous improvement' into patient care delivery processes. Now a recognized leader in disseminating quality improvement practices to health care organizations, by systematizing measurement and assessment of practices the IHI laid the groundwork for introducing calculations of return on investment.

The Commonwealth Fund and the Robert Wood Johnson Foundation (RWJF) have been instrumental in taking the next step: using ROI analysis to make the business case for quality. A project funded by Commonwealth documented four case studies involving the use of ROI models, including a lipid clinic, a diabetes management program, a smoking cessation program in three separate integrated health systems, and a worksite wellness program for General Motors employees.⁷ In 2008 RWJF's Diabetes Initiative delineated ten steps in the development of the business case for self-management support.⁸

In 2008, the Center for Health Care Strategies developed the ROI Calculator with funding from RWJF to aid health sector stakeholders' efforts to assess the financial impact of quality improvement activities. The ROI Calculator is an online tool that allows users to enter target patient population data, costs, and anticipated changes in utilization based on data from published studies incorporated in the ROI Calculator's database. In addition to weighing proposed quality improvement initiatives, the tool has been used by a state agency in its negotiations with potential contractors for a chronic care management program.⁹

While movement towards improving the health of populations in the community context is an emerging and important part of health reform, the primary focus at present is on quality improvement in the delivery of clinical services. Payment reform is expected to push health care organizations to deliver higher quality care by bearing more risk and receiving a financial reward for hitting their marks. Health systems that can calculate ROI on their quality improvement efforts will have crucial information that will enable them to be more successful in the transition to the new payment mechanisms.

Current models that penalize hospitals for failure to meet benchmarks are inadequate, primarily because they do not effectively integrate external factors that may significantly impact clinical outcomes. As documented extensively by McGinnis and colleagues,¹⁰ the interaction between behavior, environmental conditions, and social circumstances represents approximately 60% of factors contributing to early death. Genetic predisposition contributes 30%, and shortfalls in medical care contribute only 10%. So while accountability for quality in clinical settings is vitally important, our models for evaluation of investments and interventions must improve if they are to reflect the complex interaction of factors that contribute to changes in utilization patterns and improved health outcomes.

An example of the inadequacy of many current models is the prescribed 30-day window for readmission penalties for hospitals. It does offer the potential to encourage more robust implementation of care management strategies, but the most significant factors in early readmission may be poor living conditions, a lack of local support systems, and established maladaptive behavioral patterns. Readmission penalties may be particularly problematic for chronic diseases with negative prognostic trajectories, like congestive heart failure (CHF). The model neglects the reality that such patients will be returning to the hospital as the disease progresses, regardless of their external circumstances. Also, patients grappling with such diseases may return more frequently for reasons that lie outside the domain of a hospital's ability to control. This is particularly true in caring for patients from lower socioeconomic circumstances and/or racial and ethnic backgrounds, who are more likely to experience health disparities driven primarily by factors external to access and quality of care.

Hospitals should be rewarded when they lengthen time in between readmissions for patients with CHF, especially when the patients are stage 3 or 4 in their disease process, manifest high levels of multiple chronic co-morbidities, and/or are from communities with substantial health inequities. Similar adjustments to readmissions penalties will need to be made to reflect the specific disease trajectories of other illnesses, and the additional challenges faced by some patient populations with each illness. Currently, ROI approaches applied in health system settings show a fair amount of variation, due quite possibly to exactly these sorts of complexities. While the complexities will persist, methodology may become more standardized in specific intervention categories.

⁷ Leatherman, S., Berwick, D., Illes, D., Lewin, L.S., Davidoff, F., Nolan, T., & Bisognano, M., 2003, The Case for Quality: Case Studies and an Analysis. *Health Affairs*, 22, 17-30. doi: 10.1377/hlthaff.22.2.17

⁸ Kilpatrick, K.E. & Brownson, C.A., 2008, Building the Business Case for Diabetes Self Management: A Handbook for Program Managers. (Accessed 2012, May 24). Retrieved from www.diabetesinitiative.org/documents/BusinessCasePrimerFINAL.pdf

⁹ Hamblin, A., April 2008, Using ROI Forecasting to Maximize the Value of Medicaid Investments. (Accessed 2012, May 22). Retrieved from <http://www.rwjf.org/files/research/roicalculatorbriefapril2008.pdf>

¹⁰ McGinnis, M.J., Williams-Russo, and Knickman, J.R., The Case for More Policy Attention to Health Promotion, *Health Affairs*, 2002, Vol. 21, No. 2, 78-93

Another ongoing challenge in calculating ROI within the health care sector is accounting for the passage of time in a complex and rapidly changing financial and regulatory environment. Currently RWJF sets the standard for ROI calculation of quality improvement initiatives using a discount rate. As the ROI calculator is refined and used more widely, and retrospective ROI analyses are conducted, evidence regarding its predictive ability will increase. However, even if a calculator's predictive value is verified over a three-year period, the operating environment will be undergoing rapid change, weakening the accuracy and usefulness of another prospective ROI calculation at end of year three.

Community Prevention and Social Return on Investment

Besides driving quality improvement in the delivery of clinical services, ACA helps create an environment where prevention is understood to be central to successful health care system transformation. This includes strategies that improve community conditions. The Signature Leadership Series report, *Managing Population Health: The Role of the Hospital*, notes that the ACA identifies 'creating healthier communities' as a population health management strategy, and identifies several relevant issues, such as housing conditions, open space and the availability of parks for physical activity, and health literacy (a proxy for level of education).¹¹ A Joint Commission-recognized *root cause analysis* would identify these factors. For example, the proximate cause for a diabetic patient's hyperglycemia may be failure to take medication as directed and/or poor self-management skills; a root cause may be lack of safe and convenient locations for a daily walk.

Despite the challenges of applying ROI analysis to these complex sets of variables, leaders in the public health community have begun to make the case that a healthy nation is good for business. In 2006, Georges C. Benjamin, Executive Director of the American Public Health Association, wrote: 'The real ROI for a country is not just the dollars it invests and the direct financial return it achieves but, rather, the total economic return to communities, which includes economic attainment, reduced crime, improved financial status, and greater business productivity.' The term has now migrated from rhetoric to practice: ROI analysis is being applied to childhood obesity and tobacco control interventions, and its utility has been explored as a metric for interventions targeting health disparities.^{12 13}

Changing the nation's health outcomes requires a mindset and manner of execution that reflects recognition of the complex interactions between physical, psychological, social, economic, and political factors that contribute to poor health, particularly in low income and disadvantaged communities. Clearly, health care systems must work in collaboration with a broad spectrum of stakeholders to achieve measurable and sustainable improvements in such communities.

Social return on investment (SROI) methodology was introduced in 2000 by the San Francisco-based Roberts Enterprise Development Fund. SROI practice has since been adopted in the United Kingdom's charity and social service sector. The methodology was refined over time, first with funding from the William and Flora Hewlett Foundation, later the Scottish government. SROI offers a way to think about and assess health systems' community health improvement efforts by taking into account financial investments and returns, while also accounting for benefits to population health and community well-being. It holds promise as a robust tool for guiding health system and collaborative action.

¹¹ Health Research & Educational Trust, April 2012, *Managing Population Health: The Role of the Hospital*. (Accessed 12, May 23). From http://www.hpoe.org/resources-and-tools/resources/Population_Health.pdf

¹² Dilley, J.A., Harris, J.R., Boysun, M.J., & Reid, T.R., 2012, Program, Policy, and Price Interventions in Tobacco Control: Quantifying the Return on Investment of a State Tobacco Control Program. *American Journal of Public Health*, 102, e22-e28.

¹³ Lurie, N., Somers, S.A., Fremont, A., Angeles, J., Murphy, E.K., & Hamblin, A., 2008, Challenges to the Business Case for Addressing Health Disparities. *Health Affairs*, 27, 334-338. doi: 10.1377/hlthaff.27.2.334

An examination of SROI leads us to ask: **what** are the benefits to be accrued, and **to whom**? The benefits of neighborhood revitalization, for example, are more difficult to monetize in the near term and/or to translate into health outcomes, but they lay the groundwork for complementary health improvement interventions. Multiple sets of linked investments thus have the potential to build the critical mass needed to translate individual improvements into aggregate-level health outcomes. In the process, benefits can be accrued by a broad spectrum of stakeholders. Expenditures by law enforcement agencies and the courts can be reduced by successful strategies to reduce juvenile delinquency, K-12 revenues increased by reduced absenteeism, and local businesses uplifted through increased consumption of goods and services associated with youth job development strategies.



*Florida Hospital/Adventist Health System's
Bithlo Transformation*

In short, a social return on investment (SROI) lens keeps the demand to assess the value of investments and interventions *and* integrates the spectrum of social, environmental, economic, and health impacts. Involving the community in determining what is measured and how it is measured is one of the seven principles associated with SROI. Intended and unintended changes are identified, particularly in a retrospective analysis. Assigning financial value to measures and erring on the side of conservatism are additional principles, as is transparency that allows all stakeholders to validate the calculated SROI. Valuation in SROI is difficult. It requires assigning a monetary figure to non-monetary dimensions and outcomes. For example, assigning monetary value to increased use of a new neighborhood park may require factoring in the potential increase in housing values over time, and the reduction in law enforcement expenditures due to elimination of criminal activity.¹⁴

In sum, by adapting the concept of return on investment and developing appropriate tools to calculate ROI, health systems can vastly strengthen their decision-making in the current environment and as the forthcoming health reform changes take effect. But some of these changes, alongside the longstanding missions of non-profit hospital systems, push us to extend our thinking beyond ROI to *social* returns on investment. This fits an expanded understanding of health. Increasingly, as we work to improve quality and improve community health while caring for patients from underserved communities, we recognize that factors far beyond our clinical care influence patient health, in ways that also impact our clinical measures. As we work collaboratively within communities to address these external factors, we are also likely to see changes in the community—returns on our and others' investments—that go beyond the financial. Developing the tools to identify, assess, and measure these social returns, along with more conventional ROI, enables us as mission-driven organizations that are also committed to financial stability to make the best application of both our charitable and non-charitable investments.

¹⁴ The SROI Network, January 2012, A Guide to Social Return on Investment. Retrieved from http://www.thesroinetwork.org/publications/doc_details/241-a-guide-to-social-return-on-investment-2012

Chapter 4

Charity Care • Quadruple Aim

Overview

Among the key changes in national health reform are a significant expansion in health care coverage for many people who are currently uninsured or underinsured and an increasing emphasis on prevention. These in some ways build upon what was accomplished with the introduction of Medicaid and Medicare and the establishment of a ‘community benefit’ requirement. Yet they go further. Changes to financing mechanisms will require us to do business differently. As the American Hospital Association notes, ‘Although the financial incentives are not yet fully aligned, specific efforts to improve care delivery in the current volume-based market also will be essential for care delivery in the future value-based market.’¹⁵

In this context, the Health Systems Learning Group (HSLG) came together as a group of mission-driven hospitals to collectively rethink the mission and vision of our individual hospitals and health systems. In the process, we have re-evaluated the narrow focus of our ‘acute care’ role, recognizing that it limits our effectiveness and impact in achieving optimal health outcomes. We have thus committed to reclaim our original purpose: that of being trusted partners in improving the health of the communities we serve. This means validating community engagement as a vital part of the hospital’s mission and vision. What does this mean?

From Charity Care to Community Benefit: Population Health Management

To retain tax-exempt status as non-profit hospitals, we operate under Internal Revenue Service requirements to allocate a specified proportion of revenues to charitable activities. Prior to 1965, the overwhelming weight of this requirement was fulfilled through the provision of charity care—care provided, unreimbursed, to uninsured patients without the means to pay. Still, a hospital or health care system’s focus remained squarely in the clinical realm. Both its primary business of patient care and its charitable obligations were met through provision of care *within* the walls of the hospital.

The first shift that led health care systems to begin to broaden their perspective was set in motion in 1965 with the passage of Medicare and Medicaid legislation. As coverage rapidly expanded the demand for hospital treatment of uninsured patients decreased. A growing impetus arose to broaden the scope of services that tax-exempt hospitals could provide to meet their charitable obligations. In 1969, the IRS issued Revenue Ruling 69-545, which defined community benefit as ‘services and activities that benefit the community as a whole.’¹⁶ This Ruling was further codified by IRS Ruling 83-157 (1983), which called upon non-profit hospitals to ‘promote the health of a class of persons broad enough to benefit the community as a whole, even though not benefiting all persons directly.’ The reference to a defined community suggests a population health orientation. Moreover, the emphasis on determining a ‘class of persons broad enough’, i.e. a minimum size for the class of beneficiaries needed in order to produce a benefit for the larger defined community, suggests accountability to achieve a measurable impact.¹⁷

This definition encourages hospitals and health systems to expand their focus *beyond* the clinical setting to meet their charitable requirements. Just as we would conduct a risk assessment of a defined membership in a managed care arrangement, so community health professionals consider the health risks to community residents based on at least three things: a community health needs assessment; the socio-economic barriers of a given neighborhood; and the demand for care as evidenced by utilization. They then focus resources where there is the greatest risk, and correlatively the greatest need.

This lens shows the importance not only of addressing the urgent health care needs of a high risk population, but also of mitigating socio-environmental risks that negatively impact health. In addition to treating community members’ immediate presenting illnesses, the root causes of a community’s health problems—including the socio-economic barriers of poverty, unemployment, lack of education, cultural and linguistic isolation and housing—also need to be addressed.

¹⁵ American Hospital Association, Association for Community Health Improvement, ‘Managing Population Health: The Role of the Hospital’ p.6, April 2012.

¹⁶ The Hilltop Institute, ‘Hospital Community Benefits after the ACA: The Emerging Federal Framework,’ January 2011 Issue Brief.

¹⁷ IRS Ruling 69-545 (1969) and IRS Ruling 83-157 (1983)

Goals of Health Reform: The National Strategies for Prevention and Quality

The Affordable Care Act (ACA) draws on the concept of population health as articulated in earlier IRS rulings, and takes it to scale as an emerging core function for hospitals and health systems. It includes among its provisions the development of a National Quality Strategy. The National Quality Strategy includes three broad aims:

- **Better Care** — Improve overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities** — Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care** — Reduce the cost of quality health care for individuals, families, employers, and government.¹⁸

The ACA also called for the creation of the National Prevention Council and the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. In the words of the Council, ‘... the National Prevention Strategy is critical to the prevention focus of the ACA and builds on the law’s efforts to lower health care costs, improve the quality of care, and provide coverage options for the uninsured.’¹⁹ Complementing the goals of the National Quality Strategy, the overarching goals of the National Prevention Strategy are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities. These are goals that mirror our own (though we might add a fourth, now considered part of access to health care and relevant to our basic mission namely, the ‘acceptability’ to target populations of an intervention, a concept that pushes us to consider how those for whom services are intended view and receive such services).

Under the ACA, non-profit hospitals have a responsibility to advance the aims of the National Prevention Strategy Act. This responsibility is reinforced and supported by the new requirement in Section 9700 of ACA, and associated reporting requirements in IRS 990 Schedule H, for non-profit hospitals to conduct a community health needs assessment (CHNA) every three years, and to document in an implementation plan how the hospital will address identified unmet needs. The CHNA is considered conducted when it is made public, and the implementation plan is considered completed when the governing board of the hospital has approved it. Both must then be attached to the Schedule H of the IRS 990 report, beginning in 2013. To ensure that the health of the populations served by not-for-profit is improved, the ACA recommends that measures of accountability for governance, management, and operations be established and codified by governance bylaws, policy, and clearly articulated job responsibilities. In addition, the HSLG believes that accountability for community engagement is important and feasible, as we outline in Chapter 6 on ‘Transformative Partnerships.’



Indiana University Health's Garden on the Go

¹⁸ U.S. Dept. of Health and Human Services, ‘National Quality Strategy will promote better health, quality care for Americans,’ March 21, 2011.

¹⁹ National Prevention Council, ‘National Prevention Strategy, 2010.

Operating in Two Worlds

The passage of the ACA has driven home the need to think and act more broadly. Yet, we still labor under the perverse incentives in the current system of fee-for-service financing. In this light, the HSLG proposes to identify what we can do now, and to map what we should plan for in the near future. One important challenge will be to keep the attention of leadership on these issues in the context of growing complexity, changes in functionality, a requirement to build competencies in new areas, new constraints on reimbursements, and the need to keep bond ratings strong.

To ensure steady movement towards the transformational goals of the Health Systems Learning Group given these challenges, we recommend the following:

- Establish *local forums* as active partners—a representative body of individuals, groups, and organizations that: a) have an interest in health outcomes, b) can act to improve community health, and c) have access to resources (funding, expertise, community groups, etc.) to engage other health partners in the community.
- Seek opportunities to better *understand key social determinants* of health by improving hospital, physician, and community relationships, and supporting the engagement of stakeholders from other sectors in community health improvement.
- Including community health *needs assessments* as a key foundation for understanding communities and as a key instrument in health system strategic planning, while adding community health *assets assessments* wherever possible.
- Work with collaborative partners to identify issues that will yield the highest *social return on investment* (SROI), using existing data reports, program experience, and dialogue.
- Build on the considerable accomplishments to date in *participatory action research* to engage community members as full partners in achieving measurable improvements in health status.
- *Align community health metrics* across stakeholders and sectors to reflect shared ownership for collective impact.

Proceeding proactively, non-for-profit hospitals have the opportunity to take action now to improve the health of communities, and to lay the groundwork for new approaches to the 'global care' context.



Loma Linda University Health's Healthy Communities Initiative

From Triple to Quadruple Aim

The ‘Triple Aim’ concept has been developed by the Institute of Healthcare Improvement (IHI) to improve the experience of care, improve the health of populations, and reduce per capita costs of health care. The HSLG agrees that these three aims are critical to transforming our health delivery system, but contends that it is not possible to achieve these aims without adding a fourth. This is identified in the National Prevention Strategy, and is essential to true population health: the reduction and ultimate elimination of profound health disparities in many of our urban and rural communities.

We therefore refer to a simultaneous pursuit of the ‘Quadruple Aim’:

1. Improve the experience of care
2. Improve the health of populations
3. Reduce per capita costs of health care
4. Reduce health disparities

Although financial incentives are not yet truly aligned, health care organizations can take efforts to improve care delivery in the current volume-based market that will be even more essential in the future value-based reimbursement system. Charity care and public pay shortfalls have historically been the largest portion of community benefit expense reported. This is not an effective strategy for achieving the transformation necessary for our health systems, and even reinforces irresponsible health care delivery.

In collaboration with community partners, the health systems represented by the HSLG are already moving forward with deliberate strategies that will help bring about the realization of health reform goals. We anticipate, through focused community benefit programming, and joint planning wherever possible, that we will be poised to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

Common community health initiatives, such as health promotion and disease management education, immunizations and screenings, mobile health vans, healthy community initiatives, and diabetes management programs are sometimes delivered apart from an overall strategy or impact analysis. To achieve maximum impact (e.g. maximizing SROI), such efforts must simultaneously: be evidence-based and data-driven; identify areas of highest need; provide interventions that address the relevant social determinants of health; partner with other community organizations and individuals well positioned to address the real needs; and assess the results of these collective efforts. A shift in delivery models is necessary, and a new population and community health infrastructure required. These would include:

- A. Population and community health management competencies within our health systems.
- B. Partnerships with individuals, families, and community agencies.
- C. Redesign of our primary care network.
- D. Financial management.
- E. A new digital data infrastructure.

We, based on a collective body of learning from 36 hospitals, are thus proposing in our systems that we accept responsibility for the ‘quadruple aim’, and for the development of the necessary framework and infrastructure to accomplish this lofty but increasingly vital goal.

Building a Population and Community Health Infrastructure

Creating the health infrastructure we need in order to achieve 'quadruple aim' goals will require both institutional alignment within health systems, and external alignment across the WHOLE system, including health systems and all community assets. Health system elements to be addressed include:

- Operational links between finance and community benefit
- Integration of community benefit and organizational strategic planning
- Inter-department accountability to address disparities
- Population health competencies among member(s) of senior leadership
- Metrics and rewards tied to performance

It will also require that we:

- Align our governance, management and operations in the development of a comprehensive community health strategy.
- Identify appropriate partners from among the assets of the community to address prevention, basic needs, primary care, and mental health access in a way that is consistent with the lifestyles and life circumstances of the community's residents.
- Ensure the competencies of staff charged with community benefit at the facility (including knowledge/experience of populations and communities in the primary service area, demonstrated skill in partnership development, expertise in review and interpretation of population health data and information, knowledge of public health concepts, expertise in the design and implementation of project monitoring strategies, and demonstrated knowledge of clinical service delivery).
- Align departments in health systems to reflect the coordination of community benefit, public affairs, community outreach, and communication, in a way that aligns with reporting or connecting to the operational strategies of the health system.
- Compose a board that is reflective of community makeup. Establish a role of the board or board committee with responsibility and accountability for community benefit.
- Establish the business case for community benefit by demonstrating how utilization of unreimbursed services impacts the bottom line.
- Establish the mission imperative to address unmet needs within the resource limitations and capacity of the hospital.
- Focus efforts to address identified health disparities.

With the passage of the Affordable Care Act one thing is quite clear: it will be through broad collaboration that the goals of health reform will ultimately be realized. In creating a framework for a comprehensive approach to the delivery of healthcare, including health promotion and disease prevention and improved access to care and services along a continuum, collaborative arrangements are necessary to enhance the opportunities we have to make a greater impact in the communities we serve.

What this means we will discuss in much more detail in coming chapters. Here we note steps or actions (with one example: see sidebar) that might enable deeper and more effective partnership for collective community health goals:

- Design and capture elements of a patient's record based upon integrated care—holistic, spiritual, social determinants and medical care.
- Ensure that there is integration of health information systems of all health systems so patients have a seamless health record.
- Create formal data agreements with health departments, mental health agencies, and various post-acute providers (e.g. skilled nursing facilities, home health) to create consistent patient health records across the continuum.
- Engage the Hospital Association and American Medical Association to advocate for Community Health
- Redefine geography of where health services are provided—out of the hospital and into the community, with a primary focus on specific areas with disproportionate unmet health needs.
- Create formal relationships with faith-based institutions/congregations and align with clinical and social needs like care transitions, access to care, chronic disease self-management, readmissions, etc.
- Look not just at the needs of patients grappling with disparities, but also at the strengths they bring, creating non-clinical roles where their experiences can assist others (e.g. as chronic disease self-management mentors) as well as promoting education, training and career advancement into clinical roles serving within the community.

In what follows, we expand on three key elements that will be involved in pursuing the 'quadruple aim': the primary care network, financial management, and a digital and data infrastructure.

Engaging Community Partners to Transform a Forgotten Community

Adventist Health System/Florida Hospital's work in the Bithlo Transformation Effort shows a collaborative, multi-sectoral approach to a community where many factors have fostered generational poverty for nearly 80 years.

For most of Bithlo's 8,200 people, a semi-rural community in Orlando (FL), poverty is the norm—and it is generational. Residents struggle daily with basic survival needs: food, clothing and shelter. Jobs are scarce, and the major industry is junk yards. No grocer, barber shop, library, gym, swimming pool, or place to earn a GED exists, with housing consisting largely of dilapidated trailers. The nearest bus stop is miles away. An estimated 60% of adults are functionally illiterate, and teen pregnancy rates are high in girls 13-15. Substance abuse is rampant. With no public water or sewer, well water is contaminated with elements from an old gas station and illegal landfill.

In August 2009, a small 501c3, United Global Outreach, conducted a door-knocking campaign; it sparked the 'Bithlo Transformation Effort,' focusing on Education, Environment, Transportation, Health Care, Housing, Basic Needs and Building Community. After discussion with UGO leaders, Florida Hospital adopted Bithlo as a local mission effort/footprint project in 2011. It supports UGO's mission of 'transforming forgotten communities into places in which we'd all want to live.' Critically, the hospital committed to support UGO—not take over or insist on 'the hospital way.'

The partner list then grew to over 65 entities. Florida Hospital has provided some funding but, more importantly, has leveraged its business, community and political partners to help with the Transformation Effort. Since 2011:

- The first permanent medical clinic (a Federally Qualified Health Center or FHQC) opened.
- County Government committed to 7 miles of sidewalks.
- The FL Dept of Transportation committed to widening a dangerous bridge in 2014 (instead of 2022).
- Bus service is being restored to Bithlo.
- Florida Hospital is advocating to bring in clean water.
- Florida Hospital leveraged its relationships with its construction, fire system and other vendors to donate services to the community.
- Hospital departments, including the College of Health Sciences, provide hundreds of hours of volunteer time.
- The hospital serves as the fiscal agent for several grants, including one for much-needed dental services.
- UGO operates a 40-student private school in Bithlo, and Florida Hospital contributed seed money toward the purchase of the adjacent property.

Very soon, the three-acre 'Transformation Village' will anchor a sense of place for Bithlo, with the school, a coffee shop, a hydroponic community garden, larger community events, a library and computer lab, adult education, social services and Medicaid enrollment, and more.

While in the ER one morning, Tim McKinney, the UGO Executive Vice President who is leading the Bithlo Transformation Effort, encountered five patients from Bithlo. One was a man who had cut his hand. The others were a mother and her three children. The 8-year-old boy had had a respiratory infection for several days; the 5-year-old boy had conjunctivitis; and the 13-year-old girl was in pain from a urinary tract infection. When the conjunctivitis worsened, the mother called an ambulance to bring them all to the ER.

ER data from Florida Hospital/Adventist Health System for Bithlo's two census tracts show that Bithlo's 8,200 residents accounted for over 4,000 ER visits during the previous year. As with the family Tim saw, many of these visits as well as EMS usage are for non-urgent care that would be better addressed through primary care.

The Bithlo Transformation Effort is working to address not only this, but many other issues, improving educational level, employment, access to primary care, and access to transportation. Florida Hospital/Adventist Health System's ER records will be one of the ways that the partnership can assess the impact of the effort.

Having been an isolated, forgotten community for nearly 80 years, Bithlo's health and social issues loom large. But baseline measures are in place, and there is a broad commitment to transformation. Bithlo residents and partners are confident that the root causes of poor health—the physical, built, economic and social conditions—will be positively impacted by the Bithlo Transformation Effort.

A Redesign the Primary Care Network

With an increasing focus on a more planned, proactive approach to charity care aimed at reducing preventable emergency room and inpatient care for the uninsured, the basic issue has been good stewardship—making optimal use of limited charitable funds. A more proactive and strategic allocation of resources enables hospitals to help low income populations avoid preventable pain and suffering; this, in turn, allows the reallocation of funds to serve an increasing number of people experiencing health disparities.

To this end, a growing number of hospitals across the country are engaged in efforts to address ambulatory care sensitive conditions (ACSC) as framed by John Billings,²⁰ or more recently, as described by the Agency for Healthcare Research and Quality (AHRQ) via Prevention Quality Indicators. ACSCs are diagnoses resulting in hospitalizations that are judged to have been preventable had there been timely and appropriate access. In a study published in 2007, the AHRQ estimated the costs for preventable hospitalizations at \$29 billion, or 10% of total hospital expenditures.²¹ Numerous studies have documented higher concentrations of these conditions among uninsured, underinsured, and/or underserved racial and ethnic populations.^{22,23}

Many studies have demonstrated substantial reductions in ACSC admissions associated with the implementation of care management strategies in clinical and community based settings.^{24,25,26} A growing number of facilities across the country are implementing these strategies in practical efforts to reduce costs and redirect charitable resources to more effective and far-reaching endeavors.

In the process, community health managers often become sensitized to social and environmental determinants that impede efforts to change health behaviors and improve population health. Hospitals generally lack the expertise and resources to address these complex conditions, and they should not be expected to on their own. Moreover, in ROI terms, it would be difficult to justify such investments. But, collaboration with diverse stakeholders does offer the potential to design and implement more comprehensive strategies that expand the concept of ROI beyond economic returns for an individual institution. Movement in this direction opens the door to a broader model of SROI as well as better patient and population health outcomes.

Improving the primary care network for population and community health might then include:

- Health homes for patients in the community, including Federally Qualified Health Centers (FQHCs), and enrollment assistance to help patients know how and when to use primary care.
- Community health workers—who play an important role on an expanded primary care team and serve as the essential link between clinical care management and place-based, population health improvement—can support care transition, enrollment, navigation of health services, adherence and disease self-management, and help patients access community resources related to other needs such as food, housing, and employment.
- Using a more aggressive ‘pipeline’ recruitment plan, to build a more diverse health care workforce—doctors, nurses, allied health professionals etc.—from persons who live in targeted, vulnerable communities, both to help a shift in culture that could durably impact on health literacy and overall knowledge of healthy behaviors and lifestyles, and to gain the intelligence needed for a sensitive and trustworthy engagement with such communities.
- Collaboration with school systems to encourage children to enter the health field, and actively foster their potential as health care providers who can be expected to ‘give back’ to their community, especially in populations considered to be ‘charity or quadruple eligible.’

²⁰ Billings, J., Teicholz, N., 1990, Uninsured patients in District of Columbia hospitals, *Health Affairs*, (Millwood), 9(4); 158-65.

²¹ Russo, Allison, et al, 2007, Trends in Potentially Preventable Hospitalizations Among Adults and Children, 1997-2004, Statistical Brief #36, Healthcare Cost and Utilization Project, Agency for Healthcare Research & Quality.

²² Oster, A., and Bindman, A., 2003, Emergency department visits for ambulatory care sensitive conditions: Insights into preventable hospitalizations, *Medical Care*, Vol. 41, Issue 2, 198-207.

²³ Ladiha JN and Ladiha SB, 2006, Race, Ethnicity, and Hospitalization for Six Chronic Ambulatory Care Sensitive Conditions in the USA, *Ethnicity and Health*, Vol. 11, Issue 3

²⁴ Bindman, A., et al, 2005, The impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions, *Health Services Research*, Vol. 40, Issue 1, 19-38.

²⁵ Fedder, DO, et al, 2003, The Effectiveness of a Community Health Worker Outreach Program on Health Care Utilization of West Baltimore City Medicaid Patients with Diabetes, With or Without Hypertension, *Ethnicity and Disease*, Vol. 13, 22-27

²⁶ Carrillo, J.E., Shekhani, N.S., Deland, E.L., Fleck, E.M., Mucaria, J., Buimento, R., Kaplan, S., Polf, W.A., Carrillo, V.A., Paredes, H., Corwin, S., 2011, A Regional Health Collaborative Formed by New York-Presbyterian Aims to Improve the Health of a Largely Hispanic Community. *Health Affairs*, Vol. 30

- A more direct involvement of electronic medical systems (EMS) in designing the framework for these populations, given that EMS systems greatly vary in resources and protocols.
- Discouraging advertisements that promote utilization of the emergency department (ED), e.g. '30 minute wait,' and instead, promoting primary care access in the community.
- In an integrated Accountable Care Organization (ACO) type of environment (risk reduction, keeping patients out of hospital), develop metrics around programs that support patients' self-care; connect it with Primary Care Provider (PCP) post-discharge and measures of potential savings to quantify the cost/benefit for programs like transitional care management, community based disease self-management programs, etc.
- Provide metrics on chronic care focused on diagnosis readmissions and associated penalties. These avoidable costs could be compared to the cost of developing infrastructure to prevent readmission. Though the penalties may not presently be financially significant, there is a cost to being on the public list of institutions that do poorly in controlling readmissions. Further, significant 'community' costs outside of the hospital walls may be important to understand in establishing metrics that reflect the true costs to the broader system as a whole.

Dignity Health

At Dignity Health the integration of community benefit in strategic planning and operations most recently involved an initiative to reduce readmissions for ambulatory care sensitive conditions and has been successfully completed. Costs for treating these conditions across a network of 40 hospitals were more than \$261 million in FY2010, representing more than 29,000 hospitalizations and more than 120,000 inpatient days. From 2008-2010, its hospitals invested \$5.7 million in preventive and disease management programs for patients deemed at risk for hospitalization for asthma, diabetes, or congestive heart failure. This resulted in 8,917 individuals participating in disease self-management programs, and 86% were not seen in the emergency department or hospital within the six months post intervention.

Moving into full implementation of the Patient Protection and Affordable Care Act, the goal of Dignity Health hospitals is to institutionalize evidence-based chronic disease self-management programs as an essential component of a broader disease management strategy. With a focus on disproportionate unmet health-related need populations, these programs will help Dignity Health confront the challenges of continuing to care for the uninsured/ underinsured populations in an era of health care reform.

STRATEGY: Offer evidence-based chronic disease self-management (CDM) programs to help avoid hospital admissions for two of the most prevalent ambulatory care sensitive conditions, as identified by community needs assessments and hospital utilization data. We expect at least 50% of participants to avoid admission to a hospital or emergency department for six months following their participation.

1. Each facility/service area will:
 - a. Identify and engage a clinical champion, e.g. physician, pharmacist, clinical nurse educator.
 - b. Engage clinical health professionals in the development and implementation of the program, e.g. hospital case managers.
2. The intervention strategy may include home health, outpatient case management and/or evidence-based education programs.
3. The primary, but not exclusive, focus will be on the uninsured and populations covered by Medicaid, Medicare/Medicaid, or other means-tested government programs.
4. Where appropriate, strategies should seek to place patients in the community clinic/ FQHC system or other community health care providers, including medical home models, so that long-term coordination of care can be managed in a primary care setting.

CHALLENGES: Besides identifying the most appropriate staff member to lead an evidence-based program, and to commit to non-productive time to plan, implement and evaluate the program, thoughtful planning and budgeting is required to ensure allocation of adequate resources. Here the key is the understanding that such a program is needed, and that there will be a return on the investment. This has meant ongoing education of leadership and the sharing of hospital-specific data to establish a business case in support of the strategy. One of the many lessons learned is the importance of including physicians in the planning of this kind of intervention strategy, their support being vital to ongoing referrals of participants for the program.

PERFORMANCE: In FY2011, more than 5,400 persons were served by our disease management programs with an average admission rate of only 7% among those participants.

In 2008 Dignity Health financially supported ten hospitals to implement a Stanford model, evidence-based Chronic Disease Self Management Program (CDSMP) with monies raised through a corporate golf tournament. The CDSMP is now offered in 24 Dignity Health facilities with modest support from funds collected through the Dignity Health employee giving campaign. The expansion of this program is a great success and participants in it continue to enjoy improved health outcomes and report improved quality of life.

B Financial Management

Financial management to fulfill the ‘quadruple aim’ will need to change substantially. The previous chapter discussed some tools and techniques to calculate return on investment, and extended this notion to social return on investment. Health systems and the institutions that support them will need to adapt these models and tools, continuing to evolve them as health reform changes take effect.

Some key considerations for health systems are that they need to:

- Be able to calculate bundled costs and construct equitable ways of sharing ever-shrinking reimbursement, in the light of global financing.
- With the extension of coverage through health reform, to adjust models for calculating readmission rates and other key indicators to account for the differing disease trajectories faced by populations grappling with disparities.
- Identify and be transparent about true ED costs, and costs associated with other potential stakeholders in the community (ambulatory, post-acute, primary care, mental health, support programs)—this could evoke innovative models for providing the ‘right care at the right time.’
- Identify and understand direct and indirect costs of poor health outcomes (e.g. readmissions, cognitive, functional, activities of daily living skills, IADLS, quality of life, medical-particular disease, employer, Medicaid, Medicare, private insurance) outside of the hospital, to understand and develop ‘community metrics’ that could lead to more sustainable partnerships and expectations of those partnerships.

Using Hospital DSH Dollars to Fund an Integrated System of Care for the Uninsured

Two Disproportionate Share Hospital (DSH) facilities in Orlando, FL donate \$15 million in annual DSH dollars to help fund the Primary Care Access Network (PCAN) of Orange County (FL). This cost-avoidance strategy has created an affordable, integrated system of medical care built on a foundation of Federally Qualified Health Center (FQHC) medical homes. Non-urgent, self-pay ED vs ER visits are down 25%.

In 1999 in Orange County, FL, two hospital EDs and a Health Department primary care clinic closed within weeks of each other—unleashing a flood of non-urgent, self-pay visits to the remaining hospital EDs. The county’s three hospital CEOs—including Florida Hospital/Adventist Health System—and the Health Department approached the Orange County Government’s Health Services Department for assistance. This group and a small Federally Qualified Health Center (FQHC) formed a Work Group.

They found that Orange County had the state’s highest rate of uninsured people, but the lowest rate of Medicaid enrollment, and that many uninsured people could or would pay something for their health care—which resonated with the county’s Mayor and County Commission.

The Work Group convened all of the county’s safety net providers to form the Primary Care Access Network (PCAN) in 2001. Its goal: developing an affordable, integrated system of care for the county’s 200,000 uninsured residents. Built on existing assets to avoid service duplication, and leveraging disproportionate share (DSH) dollars to reduce non-urgent ED vs. ER use, PCAN now includes 22 safety net providers: three hospital systems, FQHC entities, a Secondary Care clinic, free volunteer clinics, respite care, the Health Department, EMS, and others.

- The backbone of PCAN is a network of 12 FQHC medical homes who take all comers including undocumented residents.
 - The County now puts \$12.9 million per year into the state’s Inter-Governmental Transfer (IGT) program, drawing down additional Medicaid match dollars and securing buyback rates for the two DSH hospitals.
 - The DSH hospitals donate back all IGT dollars to supplement the FQHCs, partially fund non-volunteer secondary care, and support the free clinics.
 - All three hospitals donate PCAN-referred surgeries and diagnostics as charity care
- Fifty-year-old “John, 50-years-old, fell and broke his jaw and did not have the money to get it set properly.” Nearly a year later, his jaw had fused shut and he had lost the ability to swallow. He was down to 85 pounds—literally starving to death. He could not work and became homeless.

In desperation, John came to a PCAN faith-based, volunteer urgent care center. They immediately referred him to the secondary care clinic. A surgeon donated his time, and the hospital donated the surgery. After his successful surgery, John had occupational therapy (donated by a hospital) and was enrolled in a primary care medical home. Case managers along the way helped him find sustainable housing, and he is now employed.

Without access to PCAN and its network of services, John would likely be dead. Yet PCAN must still improve its reach within the communities it serves—had John’s jaw been properly set initially, he would not have suffered for 10 months and his medical costs would have been less than \$5,000, rather than in excess of \$70,000.

In 2001, PCAN had two small primary care clinics serving 5,000 people. Today, 10 faith-based volunteer clinics serve as urgent care centers. Over 92,000 people are enrolled in 12 medical homes and 10,000 patients are enrolled in the secondary care system. There is a faith-based respite care/transition living facility for hospital-discharged patients who live in substandard housing or are homeless.

Since 2001:

- Hospital ERs have seen a sustained 25% drop in non-urgent, self-pay visits through their strategic support of the Primary Care Access Network (PCAN).
- Nearly half of Orange County’s 200,000 uninsured are enrolled in affordable medical homes.
- PCAN safety net partners donated \$62 million in care (excluding hospital charity care) in 2012.
- Ongoing evaluation of the PCAN’s FQHC medical homes shows a 68% decrease in blood pressure, an 83.3% decrease in cholesterol, and a 95% patient report of personal health improvement.
- Informal ‘parking lot meetings’ among partners have generated millions of additional grant dollars.



St. Joseph Health, Sonoma County – Community-led Clean Up

- Support, create, or advocate for funding sources and funding mechanisms to ensure that community stakeholders and partners have the resources they need to provide community-based care and support, which will be essential to sustaining these partner groups and therefore the partnerships.
- Consider whether related social safety net organizations could be included in the bundled payment structure (this could be approached by thinking about the patient journey, perhaps sharing funds with hospitals and safety net organizations upon which that person depends, as in Dignity Health's model).
- Address how to accommodate significant variations in the payer mix, population dynamics, and social and environmental conditions that play a central role in health behaviors, health status, and quality of life.
- Calculate social returns on investment in partnership contexts, which will require developing agreed upon measures of social benefit and agreed upon monetization of those benefits.

The role of the community hospital as a community health manager must include a full continuum of services. This necessary infrastructure will provide the expertise necessary to manage distinct populations and accept the responsibility of the 'quadruple aim' in their communities. Many health systems, in collaboration with community assets, are aggressively pursuing these competencies. The HSLG is composed of health systems that collectively have many of the necessary components and are committed to learning the missing pieces together and at an accelerated pace.

C Digital and Data Infrastructure

Monitoring what is actually happening within the community at large, and linking it to clinical care that is actually being delivered, is a major analytical activity. It requires a vastly different view of how we use information technology to inform and support our activities. Administrative information systems, (ADT, discharge abstracts, decision support), until now, have largely been used as historical data repositories tapped for episodic community and institutional analysis (e.g. strategic planning, retroactive QC). The business imperatives of the ACA require something much more timely, and they require analysis that is more finely grained in its geographic specificity.

To create new sustainable models of care will require real-time capacity to monitor and understand the health needs of communities, including understanding how our interventions are making improvements in the lives of families and in neighborhoods we serve. New tools, and a different lens to look at community health, are essential in developing the missing analytical capacity that health systems need, such as examining geographic variability, location analytics, or predictive modeling.

Some steps health systems executives will need to take include:

- Higher quality patient addresses in their patient registration systems and clinical data repositories (e.g. point-of-service address verification), for higher confidence in analysis and interventions using sound best practices,
- Adding new types of highly localized information to manage the new healthcare environment, such as more accurate physician supply information, neighborhood characteristics (e.g. socio/demographic), lifestyles characteristics, environmental hazards and exposures, and estimated demand for healthcare services.

Most health systems have never incorporated this type of information into their automated systems. For example, most hospitals do not have Geographic Information Systems (GIS) capacity and electronic medical records with address validation as a standard feature. Such new technologies would give us the ability to invest strategically in prevention with a focus on areas of greatest need in our communities. They would also allow us to facilitate data and intelligence from other community partners (emergency workers/paramedics, etc.).

Critical needs going forward therefore will include:

- Common community metrics to connect community prevention to clinical prevention (e.g. Prevention Quality Indicators),
- Shared information systems or ‘common versions of the truth’ within communities,
- GIS technology relevant to health systems,
- Predictive modeling,
- Address validation features as a standard feature for electronic medical records,
- The use of hot-spotting tools along with the intelligence of emergency workers/paramedics, etc. (what Methodist Le Bonheur Healthcare calls ‘participatory hot-spotting’).

Another way to think of this is to ask, ‘Can we tease out what might have been done that could have prevented many of our readmissions?’ This data would give us the opportunity to take action. While it is in hospital interests to do all that is necessary once a patient is at our doors, we must recognize, and act upon the recognition, that the hospital is one among many stewards who care for this person. By the time a person enters the hospital, the admission is of course no longer preventable. But data and intelligence about the communities in which our patients live using appropriate technologies can help us prevent readmissions, and identify preventable emergency department utilization. We will require four major sources of data in order to incorporate community based analytical capabilities:

1. **Demographic**—exact knowledge about changes within the make up of the community and their likely impact on the future demand for health services.
2. **Health service needs**—knowledge about the exact nature of the resources that were consumed (physician and hospital) to meet patient’s needs.
3. **Unmet need or gaps** in hospital services, physician capacities, and social services within the various communities that we serve.
4. **Locally held community health assets**—knowledge about who is doing what and how that contributes to communal and population scale health, with which the health system can partner.

‘I like to tell the story of a small rural town that became the site of a huge new hospital complex because of the many severe car accidents that occurred at a dangerous mountain curve on its outskirts. The town prospered from the bounty the many injuries brought it. Then a child asked, ‘Why don’t you just put up a guardrail?’ My point is similar: Why don’t we save a lot of misery and money by embracing prevention?’

– Walter Bortz. *Next Medicine: The Science of Civics and Healing*. New York, New York: Oxford University Press, 2011, page 19.

A new data lens will help us to identify variations in health status, payer mix, population dynamics, social and environmental conditions, and local assets (tangible and intangible) that play a central role in health behaviors, health status, and quality of life.

The health system of the future will depend upon reliable and useful information—with information systems that can deliver just-in-time analytics that reflect changing conditions, similar to the situational analysis operation centers that have grown out of the need for managing disasters. This includes, critically, information that can be trusted not only because of technological or modeling prowess and advances, but also because it can be verified experientially by those for whom the health system exists—the communities and populations it serves, those ‘who actually live on the map’ that is being drawn, to put it another way.

Health systems will need to change the way they view their investments in information technology, from valuing only systems that improve clinical efficiencies and patient care to investing in systems that deliver a continuous flow of clinically and community relevant information to caregivers to support desirable lifetime outcomes.

From Clinical Care Management to Community-Based Prevention

The challenges are big, yet the HSLG believes that health systems can bring these components together to effect a real and meaningful transformation in the health of communities. To achieve the ‘quadruple aim,’ and thereby accomplish both financial sustainability for our organizations, and to fulfill our missions by doing our utmost to improve the health of the communities we serve, we must address health disparities. This is not unimaginable for a health system. Addressing health disparities becomes a tractable challenge when we recognize that disparities are place-based, rooted in the differential neighborhood contexts and conditions in which our patients live.

Place gives us a point of entry. It makes visible the concrete and specific social and physical contexts of our patients’ lives, pinpoints social work needs and interventions, and helps us begin to identify, assess, and measure the social determinants of their health. Understanding patients as place-based gives us a toehold into understanding many factors and circumstances that complicate their medical conditions. Perhaps more importantly, place helps us begin to identify assets, stakeholders, and potential partners that we can engage, and join with, to help address those issues that lie beyond the scope and expertise contained within our walls or professional arenas. By expanding our view, we begin to grasp the social complexity that is a crucial factor in differential health outcomes.

From Clinical Care Management to Community-Based Prevention

Methodist Le Bonheur’s Congregational Health Network demonstrates the impact of shared ownership for community health investment and the data collection/metrics to support the investment.

Memphis has disproportionate numbers of under-served African Americans suffering from cardiovascular disease (twice as high as for European Americans), diabetes (amputee capital of the Southeast), and other conditions that lead to frequent hospitalizations and readmissions. Social determinants, such as poverty, can limit access to stabilizing medications or transport for follow-up to primary care offices after discharge.

In seeking to strengthen the health status of the city of Memphis, Methodist Le Bonheur turned to the region’s greatest health ‘assets’—its over 2,000 faith communities. It created the **Congregational Health Network (CHN)**—a community partnership program based on a formal **covenant relationship** (in which trust is more central than legal agreements) with Methodist Healthcare. This now includes 500 congregations.

One of the more successful models of its kind, Methodist hired 10 congregational navigators, who work both inside and out of the hospital, connecting with volunteer liaisons in each of the congregations. The navigators work as community care coordinators with several hundred church-based liaisons to arrange post-discharge services and facilitate the transition to home and community medical services. A hospital-employed navigator visits the patient to determine his or her needs, and then works with a church-based liaison to arrange post discharge services and facilitate the transition to a medical home and their community.

Community health literacy has been raised via training over 2,000 CHN members, with up to 12 specialized programs such as Care for the Dying, Mental Health First Aid, and Navigating the Healthcare System. This greatly builds the capacity of community caregivers to help prevent and manage chronic disease and identify acute events. Enrolled congregants (now over 13,000) are flagged by the health system’s electronic medical record system (EMR) whenever one is admitted to the hospital, so that one can track and compare hospital utilization of those in CHN network to those outside of it.

‘George’ is a man in his eighties, who was hospitalized over 8 times annually for his CHF after his wife died, because he was eating salty foods out of cans, had difficulty getting his medications and making it to his follow-up PCP appointment post-discharge. After activation of the CHN, upon news of his release the navigator called the liaison, who helped George obtain his medications, watched any quick weight gains that could signal he is going into failure and limited the salt in his diet. In the first year of CHN community caregiving, George’s admits decreased in half to only 4 times and in this past year, George has only been to the hospital one time.

Preliminary aggregate results from our MLH EMR show that, for CHN members in the network versus an out-of-network control population (matched on age, ethnicity, gender and DRGs), readmissions have declined by 20%, mortality is less than half, and total charges on average were \$8,705 per capita less.



Summa Health System’s Community Youth Partners

Chapter 5

Integrated Care for Socially Complex People in Socially Complex Neighborhoods

What do we mean by social complexity?

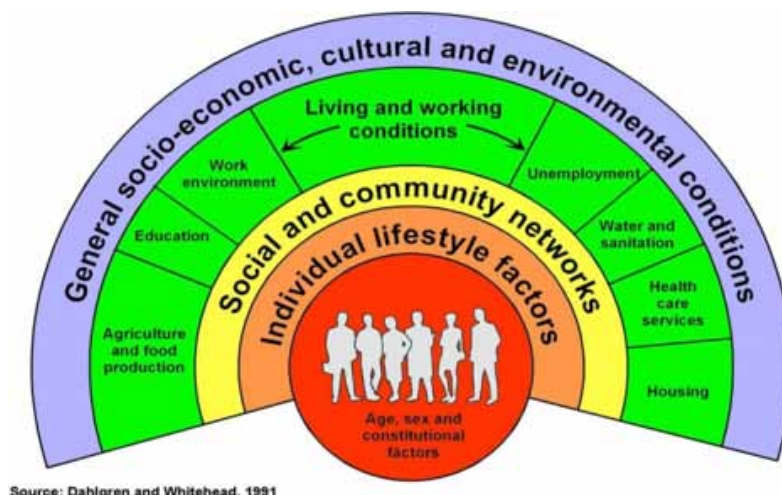
All people and all neighborhoods are socially complex. Complexity is the rich and desirable context in which all life flourishes, from single celled entities to human beings. Life could not exist outside of the interconnected web of systems and relationships that shapes the social and physical environments in which we live. As complex beings living in complex social environments, we should expect that our context will profoundly influence our well-being.

Researchers have consistently concluded that the factors that have greatest impact on health arise from the environments in which we live, work, and play. We know that our provision of medical care only accounts for 10-15% of what produces health and reduces the risk of premature death. Genetic pre-determination also plays an important role (25-30%); but environmental factors (e.g. food consumption, toxin exposure, chronic stress) also produce an epigenetic effect, affecting whether some genes and associated proteins are activated or not. The most significant factors in determining health (60%) come from human interactions and behavior, and the social and physical environment. The specific mechanisms and relative contributions of different factors are not well understood, but they are highly significant for research and action in the field of community health.

The Social Ecological Model

'Place' (as related to health) refers to the environment in which people live, the context that so powerfully predicts health outcomes. More than just the natural environment, the notion of place incorporates aspects of the lived experience of the physical, built, economic, and social context around us. We create our environment, and in turn, our environments create us. Place matters. Many aspects of the places where people live have been shaped by policies from the past with powerful implications for how current residents live. Examples include access to fresh and healthy foods, quality housing, access to great schools, and exposure to shared community characteristics that impact on stress, such as crime rates, wealth or poverty levels, and the presence or absence of safe clean parks as places to play and relax.

In the Social Ecological Model of health, the individual is not an isolated being, but must be viewed and understood in relation to their family, their social and physical environment within which they live and work, and the larger socio-economic, political, cultural and environmental context.

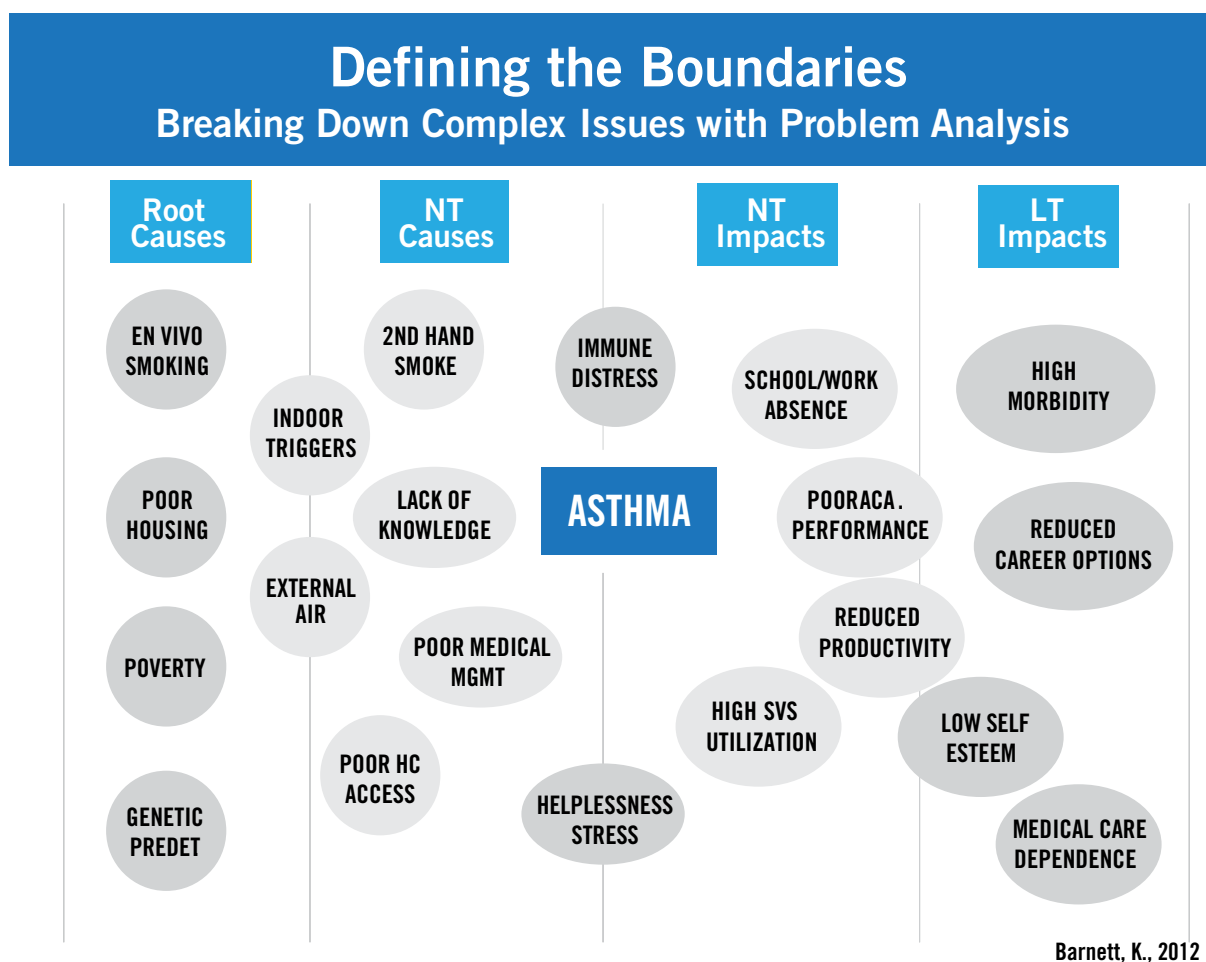


Social Determinants and Health Disparities

The impact of “place” or social context on our health is called the “social determinants of health” by public health practitioners.

Of particular concern for faith- and mission-based institutions is the question of health equity that accompanies the social determinants of health. We know that people who have more access to resources, services and power live longer and have better health outcomes—both mental and physical. Also, those with less access to health care services do not fare as well, as noted in the Agency for Healthcare Research and Quality.²⁷

Context matters. To give just one typical example, the following diagram tracks the linkages between the root causes of asthma disparities and the near-term and long-term cyclical impact it can have on a child’s life.



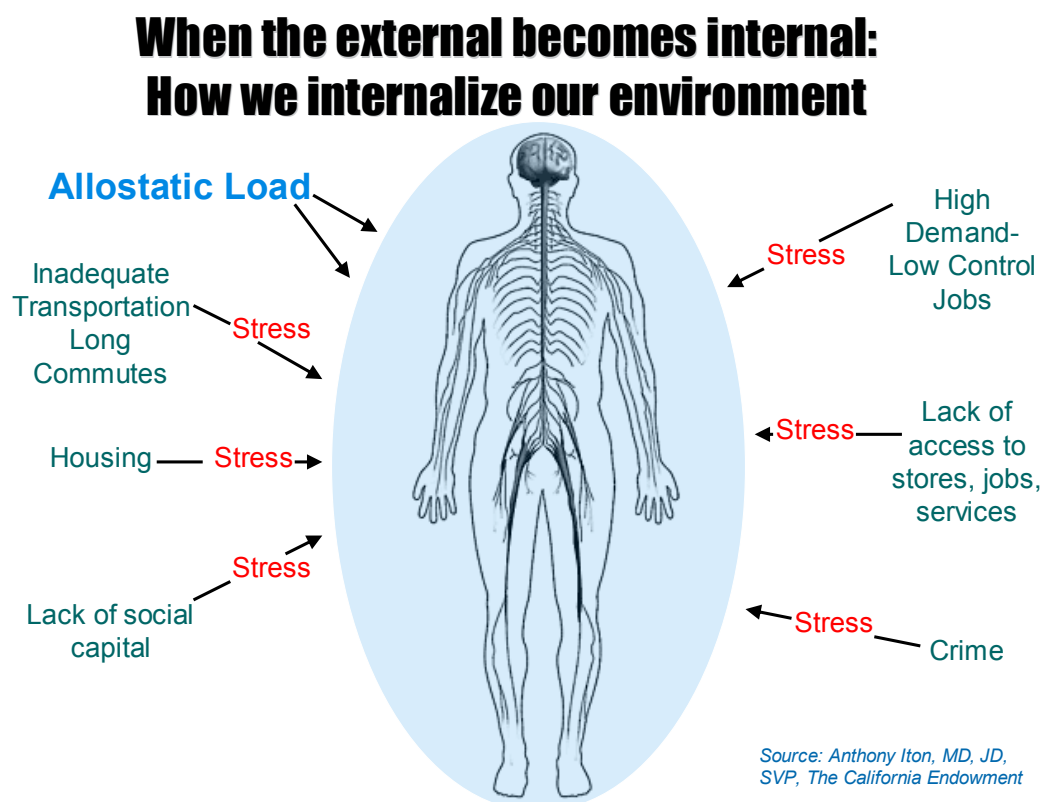
²⁷ (AHRQ) National healthcare disparities report 2008. Chapter 3, Access to healthcare. Washington: AHRQ; 2008. Available from: <http://www.ahrq.gov/qual/nhdr08/Chap3.htm>. Context matters.

Patients come to our hospitals to receive treatment for their physical or mental health issues, yet we know they come with a much more socially complex history. For example, we commonly see patients with the following social challenges:

- Limited financial means to balance health care, housing, and other living necessities
- Social isolation and weak systems of social support
- Limited education
- Homelessness or inadequate housing
- New immigrants, some with limited English proficiency and/or lack of documentation
- Re-entry into the communities after incarceration
- Hunger or lack of access to fresh, quality foods in their neighborhoods
- Community or family violence
- Emotional or behavioral health issues that are aggravated by social environments
- Substance abuse and addictions

None of this escapes its impact on the psyche or the body. The public health literature identifies embodiment as the processes in which social determinants 'get under the skin' and become translated into health outcomes. This might involve exposure to environmental toxins or a violent event. It might involve less obvious pathways, such as the lack of healthy resources or chronic stress in daily life.

Stress and the Embodiment of Social Determinants





*UMass Memorial Health Care:
H.O.P.E. Coalition, YouthNet
and Building Brighter Futures*

Many of our patients who live in pervasive neighborhood poverty and with systemic racism face such chronic stress challenges. Their poor health is created and sustained within unjust social environments, so simply treating the body or mind does not improve health outcomes. Moreover, these patients repeatedly return to our health care systems—an unnecessary, and preventable, drain on resources. Medical professionals and institutions have significant opportunities in this regard to play a far greater role in advancing the health of the populations they serve through community prevention efforts.

Understanding how social conditions become ‘embodied’ has led to new thinking about interventions and policies to protect and promote health. As faith- and mission-driven organizations, we strive to provide quality medical care that is integrated, holistic, innovative, and effective. As we expand our understanding of the social determinants of health and the health care regulatory landscape changes, we have the opportunity to become stronger leaders and partners in supporting our patients’ health by promoting the well-being of the communities in which they live and addressing the root causes of these social challenges.

Culture Shift — From the Individual to the Community

Disparities in health status are preventable, but this requires responses that incorporate a rigorous social analysis, and a commitment to finding, supporting and jointly building upon the strengths and capacities—the ‘assets’—that exist in complex communities. Health and well-being—long before illness—begin in our homes, schools, jobs, and communities. Community-based prevention, particularly interventions that look upstream to address the root causes of disease, can reduce the burden of preventable illnesses both on the population and the health care system overall.

Paying attention to the determinants of health opens up the public debate regarding individual versus social responsibility in the broad spectrum of our life together. The tendency is to advocate for one or the other rather than **acknowledge that both are legitimate, related, and interacting constructs**. In health care, we tend to focus on getting individual patients to adopt healthy behaviors; their failure to do so is often viewed as non-compliance, or a lack of individual responsibility.

This is driven in part by an inclination to focus on issues that lie within provider control. Physical and social environments are beyond the direct control of medicine, and so may be discounted. Clinicians are typically trained and incentivized to manage the diseases and symptoms of individuals. We have also created a system of care that is highly successful in attending to a person’s physical parts. Specialties and sub-specialties allow for deep understanding and skill in addressing disease as it manifests itself physically or externally. Technology affords us the ability to isolate and treat very specific aspects of our bodies and their functioning. Care that connects the person’s body, mind, and spirit may be a goal that all of our health care systems strive for, but communication and integration across and beyond specific specialties and disciplines is incredibly difficult to do well.

The new paradigm that health care providers are being asked to embrace asserts that our patients will be best served by not only attending to their individual bodies, but also to the communal assets (including relationships) they might hold, and to the social determinants of their health—to the health of the community as a whole. For example, the Affordable Care Act (ACA) not only requires tax-exempt hospitals to conduct Community Health Needs Assessments and Implementation Strategies to address identified needs, but asks the hospitals to track the five-year impact on broader community health trends. We are being asked, not only to identify community health issues, but also to be accountable for improving the health of our communities. Affecting health trends across a community requires a deeper understanding of the communities in which our patients and families live and intervention strategies that are grassroots-based, collaborative, and focused on root causes.

Actualizing the treatment plans will depend not only on individual medication and behavioral recommendations but also on making neighborhood improvements that facilitate access to healthy foods and safe places for physical activity. It will also call into play the resources or ‘assets’ (tangible and intangible) that are available within their own context to the person on treatment. These environmental and relational changes are important for preventing disease, for delaying and reducing its onset and extent, for minimizing its impact for those who are affected, and for enhancing their quality of life.

This paradigm shift is a challenge for our health systems; but the readiness is there. In a recent survey of chief executives, 98% of respondents agreed that, at least some level, hospitals should investigate and implement population health strategies.²⁸ Michael Rowan, executive vice president and chief operating officer of Catholic Health Initiatives in Englewood, Colorado, noted that in an environment where ‘collaboration, preventive health, value-based purchasing and accountable care are the watch-words ... we’re no longer focused predominantly on acute care services: instead we are managing the wellness of entire populations, which simply underscores the historic mission of Catholic health care.’²⁹

There is no doubt that staff in our health systems are already experiencing and working with patients and families whose illnesses are exacerbated by social conditions. A brief, unscientific survey of staff in six health systems that are members of the HSLG identified Access to Care, Mental Health issues, Substance Use, and Diet and Exercise as the top social issues affecting the patients they serve. Barriers that they experience in attending to patients with these social issues included adequate resources, costs, reimbursement structures, and knowledge of effective intervention and best practices.

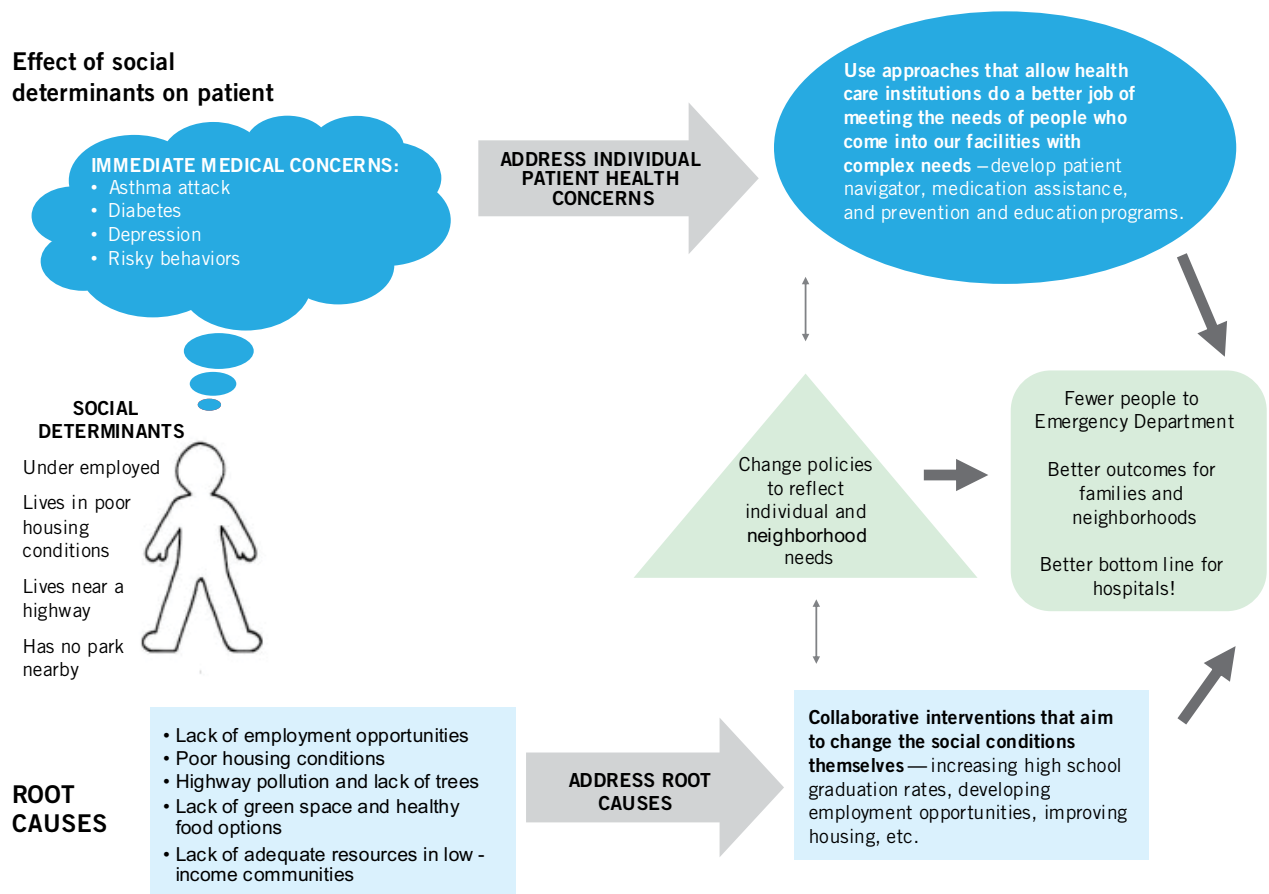
²⁸ AHA and ACHI, *Managing Population Health: The Role of the Hospital* (April, 2012): 7

²⁹ Michael Rowan, ‘Radical Changes Demand New Skills,’ *Health Progress* (July-Aug 2012): 18.

Of course, addressing the social conditions from which our patients come can seem a distraction from our core clinical commitments. However, there are now significant incentives (as well as ACA requirements) for health care systems to integrate the social environment as one of the key factors impacting both our patient health and financial outcomes. And indeed, across the country, chronic disease management and other low-cost interventions are showing dramatic reductions in preventable readmissions, non-urgent emergency department (ED) vs ER visits, and length of stay. There are several examples in this paper, some of which use community 'hot-spotting' as the basis for effective interventions that improve population health and reduce health care costs for very ill patients.

This diagram illustrates how a health system can impact the social determinants of health in both individual care and community health initiatives. The top pathway points to a new way of viewing a patient's treatment, acknowledging the importance of additional support. Most commonly, this comes in the form of education opportunities or 'patient navigators.' The bottom pathway addresses root causes, given that presenting symptoms may be caused by non-medical factors. It suggests that health systems can incorporate cross-sector partnerships to impact community-based challenges. In addition, there is a need for changes to public policy to appropriately incentivize this type of intervention and care for our patients and communities. In the long-term, this will help reduce inappropriate utilization of the emergency department, limit unnecessary readmissions, reduce the bottom line for hospitals, and create better outcomes overall for families and their communities.

HOW TO IMPACT SOCIAL DETERMINANTS OF HEALTH



For example, medical costs associated with treating preventable obesity-related diseases are on an upward trend and are expected to increase by up to \$66 billion per year nationally. But with a modest reduction in average BMI, it is predicted that nearly every state could save between 6.5% and 7.9% in health care costs. By 2030, this could equate to cumulative savings ranging from \$81.7 billion in California to \$1.1 billion in Wyoming.

A study by Trust for America's Health, the Urban Institute, and The New York Academy of Medicine found that an investment of \$10 per person per year in proven community-based disease prevention programs (such as walking programs, anti-smoking campaigns and home evaluations to address asthma triggers) could within one to two years yield net savings of more than \$2.8 billion annually in healthcare costs, more than \$16 billion annually within five years, and nearly \$18 billion annually in 10 to 20 years (in 2004 dollars).³⁰

Acting Strategically: Target Areas

Health inequity is costly for health care providers and increases morbidity and mortality among those who are affected. Health issues, such as chronic disease, maternal health and infant mortality, mental health, frailty and isolation among older adults, and childhood obesity are good examples where disparities are often significant. The following case studies highlight a few of these issues and make the connections between the individual and their social environment and the impact this has both on the individual and the health care system

³⁰ Jeffery Levi et al., *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (February, 2009): 65.

Mental Health Issues—Stress, Depression, Anxiety, and Risky Drinking/Drugging

The vast majority of patients with mental health issues are not those with true psychiatric disorders, but rather, life issues. They are people who struggle with the anxiety and depression that can accompany the challenges of navigating through life's stresses. Early exposure to violence, educational challenges, low wages in unstable work environments, exposure to the criminal justice system, or the 'thousand cuts' of chronic racism and economic difficulties magnify stress and represent the social determinants of mental health disparities. For example, a 2011 Princeton University study (Currie & Tekin) found that for every 100 foreclosed properties in a community, anxiety-related ED vs ER visits and inpatient admissions increased 12%.

The stigma of mental health issues creates a high barrier to early detection and to seeking treatment. It can lead to non-compliance, instability in family relationships, and lack of self-care resulting in obesity, substance abuse, and other self-defeating behaviors. The evidence is clear that behavioral issues such as depression and problem drinking or drugging not only coexist quite often with chronic medical problems such as asthma, diabetes, and congestive heart failure, but that they also make these medical conditions more complicated and much more expensive. Mental health issues and risky substance abuse, even short of addiction, greatly increase the costs of chronic medical conditions. Mental health issues cause repetitive, escalating presenting problems, complicate treatment, and are likely to foster bounce-back for other care as well.

The costs to the overall community are also significant. The social welfare, education, and criminal justice systems are just some of the places where these increased costs are incurred. The situation is greatly complicated by the fact that resources for the recognition and treatment of mental health and risky substance use are dwindling. Many states faced with severe budget problems and deficits are scaling back their commitment to addressing these issues. And the implementation of the ACA, which recognized the importance of these issues by making mental health and substance abuse prevention and treatment services 1 of the 10 categories of essential health benefits, has been complicated by both the actions of Department of Health and Human Services and the ruling of the US Supreme Court to leave to individual states the decision to expand Medicaid to the safety net population.

Homeless Person with Mental Health Conditions

This middle-aged homeless individual lives on the streets and is frequently brought to the ED by police for psychiatric and physical conditions, or to get food and be warm. The patient is unemployed with no ability to pay for medical treatment. He is overweight, a smoker and has poor oral health. He has several serious medical and mental health conditions but is frequently brought to the ED primarily for social requirements, e.g. food, shelter.

SOCIAL DETERMINANTS	
INDIVIDUAL RISK FACTORS	'PLACE' FACTORS
Does not have a primary care doctor or access to health and specialty behavioral care	Lack of shelter and stable address/housing and therefore unable to enroll in services
Does not have a stable address and therefore unable to enroll in SSI and other benefits	Poor integration of primary care and behavioral health services
Does not have health insurance and can't pay for provider visits or medication	Lack of access to nutritious food
Patient experiences food insecurity and poor nutrition	Lack of connection to medical and oral health care
Patient has poor oral health and overweight	Inability to pay for doctor visits and medication
Patient lacks transportation	Inconsistent or no treatment for mental health conditions
Patient lacks family or access to community and social support	Limited access to community-based specialty mental health/addiction care e.g. Assertive Community Treatment (ACT) Team
Patient lacks access to community-based mental health services	
Patient has mental health issues but is frequently brought to ED for social conditions	

IMPACT ON HEALTH	
INDIVIDUAL	HEALTH CARE SYSTEM
Chaotic access to care leads to episodic symptom reduction, does not resolve underlying health concerns	Unnecessary overuse of ambulance services and ED for social issues
Poor care coordination delays needed services, increasing severity of illness and complications	Unnecessary use of ED congests ED flow and bed availability
Lack of ability to pay for care and medications produces added financial stress	Unnecessary administrative burden to the health care system, law enforcement and EMS
Lack of medication adherence	Impact on hospital's bottom line and available Charity Care dollars
Mental and medical condition can worsen	

INTERVENTION EXAMPLES	
INDIVIDUAL	HEALTH CARE SYSTEM
Social support coordination interfaces with the patient in the ED	Promote close integration of primary care and behavioral health providers
Patient has access to community-based mental health services	Advocate for ACT teams having access to primary care doctors
Patient has access to supportive housing conditions resulting in stable address	Advocate for stabilization housing program to allow patient to secure disability income, health insurance and other benefits
Patient has linkage to insurance enrollment and connectivity to a primary care provider	Advocate for community-based behavioral health organizations
Patient is enrolled in public benefits (e.g. food stamps, home heating assistance) and medication assistance programs	Advocate for establishment of automatic reenrollment in disability insurance for mental health patients who are arrested (currently they lose their benefits then) and released
Patient has connectivity to long-term employment and other life/skill-building options	Advocate for a diversion structure to process frequent ED mental health patients (so full processing doesn't have to occur for each visit)

POTENTIAL OUTCOMES	
INDIVIDUAL	HEALTH CARE SYSTEM
Patient has established relationship with a comprehensive core care team—both specialty and primary care	Reduction in unnecessary ED visits and administrative costs
Patient has a stable address/housing	Reduction in ED clinical costs
Patient has disability income or employment services/employment training	Reduction in ED disruption due to improved coordination with law enforcement, EMS and ACT team
Patient has access to health insurance, medications, Food Stamps/pantries and oral health care	Improved fiscal bottom line to hospital
Patient has improved medical adherence	Improved health outcomes for patient
Patient is enrolled in smoking cessation and exercise programs	Full integration of services and enrollment in benefits
Patient has a more stable and productive life and improved health outcomes	

PARTNERS
Local mental health organizations
The local judicial system including police
Local social service organizations
EMS
Community Health Centers
State Department of Housing & Urban Development
State Department of Health and Human Services
U.S. Department of Health and Human Services—Bureau of Primary Care, Health Resources and Services Administration
U.S. Department of Housing & Urban Development
Faith-based organizations
Third-party payers

Frail and Disconnected Elderly

Studies have consistently found that older adults constitute a large proportion of the patient base of our national health systems, consuming approximately 50% of hospital care.³¹ According to the National Coalition for Dually Eligible People, an estimated six million people with both Medicare and Medicaid benefits consume one-third of all Medicare and Medicaid expenditures at a cost greater than \$120 billion each year. With an estimated 77 million baby-boomers heading into retirement, in the coming years there will be a huge burden on the health system to provide necessary care for individuals in their 7th through 10th decades of life decades of life.

While frail older adults represent a minority within their own age group, they are disproportionately represented as users of health care, and they are at high risk for negative health outcomes. This is due in large part to the risk factors and barriers to care that are a common part of the aging process, including physical and cognitive impairments and disconnection or social isolation. The ability of a frail elder to withstand and rebound from physiological or psychosocial challenges is limited. Functional decline, readmission to hospitals, and exacerbation of chronic illnesses are easily triggered. It has been well documented that frailty increases the risk for falls, disability, hospitalization, iatrogenic complications, and mortality.³² The disparities experienced by frail elders are magnified among those with chronic co-morbid diseases and older adult populations that face cultural, social, and financial barriers.

Frail older adults potentially require a coordinated network of health services addressing both acute and long-term needs. With acute and chronic complex health conditions affecting multiple body systems, a fragmented system of specialty care fails to address the interdependence of physical, psychosocial, and functional health. While it is well recognized that a team approach led by geriatricians or gerontological nurse practitioners (GNPs) can make a difference, competing models and funding structures continue to affect care delivery negatively. There is an inefficient disconnection between episodic and chronic care management, and between community-based services and hospitals.³³



Indiana University Health's Garden on the Go

³¹ Mezey & Fulmer, 1998

³² Fried et al., 2001; Hart, Birkas, Lachmann, & Saunders, 2002; Mick & Ackerman, 2002

³³ Clarfield, Bergman, & Kane, 2001; Merlis, 2000

Frail and Disconnected Elderly Patient

This low-income patient lives in public housing and does not have a vehicle. She has several chronic conditions, depression, and no family support system. She lives alone and has limited outside contact. When a health issue arises, she calls an ambulance and is brought to the ED.

SOCIAL DETERMINANTS	
INDIVIDUAL RISK FACTORS	'PLACE' FACTORS
Does not have a primary care doctor	Limited primary care resources available in community
Lives on a fixed income and is unable to afford additional co-pays or cost of medications	High costs of medication
Poor nutrition	Food instability and lack of nutritious food near public housing
Difficulty getting to doctor's appointments or picking up medication	Healthcare system is difficult to navigate
Difficulty navigating healthcare system	Lack of public transportation options, specifically those with handicap accessibility
Lacks family or social support	

IMPACT ON HEALTH	
INDIVIDUAL	HEALTH CARE SYSTEM
Episodic care enables symptom reduction, but does not resolve underlying health concern	Unnecessary overuse of ambulance services
Poor medication adherence	Unnecessary use of ED congests ED flow and bed availability
Added financial stress	Unnecessary medical testing and invasive procedures
Poor care coordination delays needed services	Impact on hospital's bottom line and available charity care dollars
Medical condition can worsen	

INTERVENTION EXAMPLES	
INDIVIDUAL	HEALTH CARE SYSTEM
Service coordination collocated with housing complex for early identification of problems	Advocacy for increase in nutrition programs (e.g. senior center, meals-on-wheels)
CHW facilitates understanding of access and optimal utilization	Reduce 'food deserts' through establishment of green markets
CHW coordinates communication between all involved parties: e.g. ED staff, EMS and housing personnel	Establish partnership with para-transit organizations
Linkage to insurance enrollment and ensure connectivity to a primary care provider	Implement wellness activities in community settings
Enroll in public benefits (e.g. food stamps, home heating assistance)	Collocate health care and public housing
Enrollment in medical assistance programs and secure home pharmacy or mail delivery	Advocacy with health insurance and pharmaceutical companies to reduce disruptions to formulary
Connect to senior center or adult day program	Establish primary care centers linked to ED and other acute care centers
	Partnership with or establishment of home visiting program

POTENTIAL OUTCOMES	
INDIVIDUAL	HEALTH CARE SYSTEM
Patient has a primary care provider who oversees care	Reduction in unnecessary ED visits and ambulance use
Transportation is coordinated	Reduction in ED costs
Patient has health insurance	Reduction in unnecessary testing and invasive procedures
Patient has access to affordable medications	Reduction in the number of 30-day penalties for readmissions
Patient understands how to navigate the health care system or has appropriate navigation assistance	Improvement in quality-related clinical indicators
Patient has food	Improved fiscal bottom line to hospital
Patient is no longer socially isolated	
Patient has improved medical adherence, improved health outcomes, and better quality of life	

PARTNERS
County Department of Aging
Local Social Service organizations
Volunteer Organizations (e.g. AmeriCorps)
U.S. Department of Health and Human Services—Bureau of Primary Care, Health Resources and Services Administration
U.S. Department of Housing and Urban Development
Para-transit companies
Faith-based organizations
Pharmaceutical companies and local pharmacies
Health insurance organizations

Childhood Obesity

Among these case studies, childhood obesity represents perhaps the most significant challenge to reducing health care costs in the coming years. Rates of obesity have more than doubled among children (from 7% to 18%) and tripled among adolescents (from 5% to 18%) in the last 30 years.^{34,35}

While rates have increased for all groups, they have grown more rapidly among lower income populations and in households where parents have less education. For example, recent rates are as high as 25.3% among Mexican American boys between the ages of 2-19, and 25.1% among African American girls in the same age group.³⁶

These youth are at significant risk from a wide array of chronic diseases, including type II diabetes. Diabetes is the seventh leading cause of death in the U.S., a major cause of heart disease and stroke, and the leading cause of kidney failure, non-traumatic injury amputations, and blindness among adults. A recent study based upon fasting glucose or hemoglobin A1c levels found that 35% of adults 20 years or older had pre-diabetes.³⁷

Consortium to Lower Obesity in Chicago Children (CLOCC)

CLOCC, a broad collaborative of organizations and individuals across sectors and neighborhoods, uses an ecological frame to understand childhood obesity and design interventions. Its guiding principles are Social Ecology, Evidence-Based Decision Making, Community Engagement, and Health Equity.

CLOCC was founded in 2002 by Dr Katherine Kaufer Christoffel, a pediatrician at the Ann and Robert H. Lurie Children's Hospital of Chicago (formerly Children's Memorial Hospital). Her vision for the consortium grew out of her daily clinical experience: seeing increasing numbers of obese patients in the nutrition clinic. She was well-versed in the clinical significance of this epidemic.

CLOCC conducted the first citywide prevalence data for Chicago children (aged 3-7) entering school for the first time. The data showed that 24% of Chicago children were entering school already obese—two-and-a-half times the national average then. Politicians took note, introducing more than 40 related pieces of legislation. CLOCC officially sponsored the passage of the 2004 Illinois state bill that called for schools to collect data relating to obesity when performing annual student health examinations.

Early on, CLOCC's efforts focused on short-term, specific programs and interventions to start or keep individual children on a path to a healthy lifestyle. CLOCC's attention to individually-focused approaches, and the recognition that children and families needed sound information to make good decisions on nutrition and physical activity, led them to develop the **5-4-3-2-1 Go!**[®] healthy lifestyle message. Over time, CLOCC began to recognize the importance of making health easier by changing the environments within which children and families live, work, learn, and play. Known as Policy, Systems, and Environmental change (PSE) strategies, these approaches support communities with the goal of making healthy options the default options.

Today CLOCC comprises more than 3,000 individuals representing over 1,200 organizations working on childhood obesity prevention in Chicago, across Illinois, throughout the nation, and beyond. Working together, CLOCC staff and partners have sought to increase individual and family knowledge about healthy lifestyles; strengthen organizational and institutional practices to support healthy eating and physical activity; and improve environments so that healthy food and physical activity are widely available where people, and especially children, live, work, learn, and play.

Dr. Christofel, commenting on her own journey in obesity prevention, says, "When I entered medical school I dedicated myself specifically to health and health promotion.

"To be of help, I had to learn how families work, hour by hour, week by week, year by year. People trusted me to pry and spend time with them to learn about them. To cross the ocean that divided us. My attention gradually turned to problems related to primary calorie imbalance, both malnutrition and obesity, and this became my clinical focus for decades.

"When evidence of the obesity epidemic showed up in my examining room, I saw that protecting kids from this scourge required approaches well beyond what can be offered in the clinic. This was clearly a very big mountain indeed, spanning many areas of life and unjustly affecting those most in need. I took its measure and concluded that what was needed was a very comprehensive approach, with a focus on primary prevention and so an emphasis on young children...

"Some of the ideas that I've learned along the way that informed the design of CLOCC include:

- Partner with others who have complementary work preferences and skills.
- Understand your limited perspective.
- Remember that many things can't be controlled.
- Work in teams, which achieve the most and provide perspective."

As a result of CLOCC's work over five years from 2002-2007, Chicago achieved a statistically significant decrease in obesity among children entering school, from 24% to 22%.

³⁴ Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of obesity and trends in body mass index among US children and adolescents, 1999-2010. *Journal of the American Medical Association* 2012;307(5):483-490.

³⁵ National Center for Health Statistics. *Health, United States, 2011: With Special Features on Socioeconomic Status and Health*. Hyattsville, MD; U.S. Department of Health and Human Services; 2012.

³⁶ Ogden CL, Lamb MM, Carroll MD, Flegal, KM. Obesity and socioeconomic status in children: United States 1988-1994 and 2005-2008. NCHS data brief no 51. Hyattsville, MD: National Center for Health Statistics. 2010.

³⁷ Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.



Consortium to Lower Obesity in Chicago's Children, or CLOCC

If applied to the general population, this suggests an estimated 78 million or more adults with pre-diabetes. These trends suggest that the dramatic increases in obesity rates among youth represents a potential tsunami of increased health costs in the coming years. Average medical care expenditures for persons with diabetes are estimated to be approximately 2.3 times higher than people without diabetes.³⁸

Most of what we can do to address this immense societal challenge must occur outside of clinical settings. Children and adolescents must be provided with both education on the importance of healthy food choices and feasible options in school, neighborhood, and home settings. Schools play a critically important role, not only in providing more healthy food choices, but in creating a safe and supportive environment for physical activity. A more coordinated effort is needed at the neighborhood, community, and city and county levels and by stakeholders across sectors to educate, develop supportive policies, and address physical conditions that can impede or enhance efforts to improve nutrition and increase physical activity among our youth. Of course, healthy eating behaviors are not only a matter of personal choice, but are also deeply affected by social determinants, including available income and affordable good foods.

More definitive efforts are needed at the local and regional level to build on initiatives such as the Obama Administration's \$400 million Healthy Food Financing Initiative, which supports local investment in bringing grocery stores and other healthy food retailers to underserved urban and rural communities across America. The initiative is a partnership between the Departments of Treasury, Agriculture, and Health and Human Services. First Lady Michelle Obama's *Let's Move!* campaign offers a similar platform for strategic investment by hospitals, public health, and other major local stakeholders such as financial institutions to create local environments that support healthy behaviors.

³⁸ Ibid

Obese Adolescent

This 12-year-old weighs in excess of 200 pounds, has been diagnosed with pre-diabetes, and lives in an inner-city neighborhood. His two female siblings are also obese. They are cared for by a single parent (mother) who works two part-time jobs. The family is above the current threshold to qualify for Medicaid coverage.

SOCIAL DETERMINANTS	
INDIVIDUAL RISK FACTORS	'PLACE' FACTORS
Does not have a primary care doctor	Few primary care physicians who accept Medicaid patients
Goes to a school that has scaled back its physical education program	Lack of public sector funding for schools
Relies on fast food outlets for lunch and dinner	High concentration of fast food outlets and liquor stores, but no grocery store within walking distance
Does not participate in any organized sports	Intermural sports and after-school programs terminated
Spends most afternoons playing video games	No parent home between 3 and 11 p.m.
Has low self-esteem and limited social life	Lack of street lighting, parks, and sports facilities

IMPACT ON HEALTH	
INDIVIDUAL	HEALTH CARE SYSTEM
Diagnosis with blood glucose level above 110 and high blood pressure	Frequent preventable use of ED for heart palpitations and shortness of breath
Anxiety about difficulty in complying with nutrition and physical activity recommended by physician	Preventable use of ED congests ED and bed availability
Lack of understanding of creative options given health education that is not culturally competent	Current negative impact on hospital's bottom line and available charity care dollars
Gradual deterioration of condition	Future challenge in managing evolution to full-scale diabetes in capitated Medicaid contract

INTERVENTION EXAMPLES	
INDIVIDUAL	POPULATION HEALTH/PLACE-BASED
Develop health education tailored to socio-economic circumstances and cultural practices	Engage pre-diabetic youth in training programs to <ul style="list-style-type: none"> • Develop maps of food sources and alcohol outlets • Lead neighborhood organizing on relevant issues • Provide support for adults with diabetes and disabilities
Identify and facilitate increased knowledge and access to feasible options for better nutrition and physical exercise	Lead /support public advocacy campaigns to <ul style="list-style-type: none"> • Remove soda machines and fast food from schools • Strengthen school physical education programs • Secure public funding for after-school programs • Increase and/or renovate public park space • Establish safe routes to school and bike lanes
Engage and deploy community health workers/promoters that work with youth to reinforce adoption of health behaviors	Engage financial institutions and philanthropy to expand quality food access in inner-city communities

POTENTIAL OUTCOMES	
INDIVIDUAL	HEALTH CARE SYSTEM
Regular primary care provider supported by CHWs	Reduction in <ul style="list-style-type: none"> • Unnecessary ED visits and ambulance use • Excess costs beyond reimbursement rates
Youth begins to lose weight and blood glucose drops to within normal range	Improvement in quality-related clinical indicators
Improved self-esteem through weight loss, increased exercise, and engagement in community campaigns	

PARTNERS
Other hospitals
Local public health agencies
Health insurance companies
Community health centers
Financial institutions/CDFIs
Faith-based organizations
YM/WCA
Local advocacy groups and neighborhood watch groups
Local schools
Local Chamber of Commerce
Parks and Recreation Departments
United Way
Grocery store chains and local food outlets
Farmers

The case studies we have discussed have long-term etiologies with increasingly expensive and complex management issues for the provider system. All require a smooth and trusted referral pathway from the earliest levels of detection and care to the highest level interventions and back again.

Partnership

Socially complex realities reinforce the commitment to solutions that are intersectoral and collaborative. Health care providers cannot and should not work on addressing them on their own. It is not our role to become economic development organizations or housing specialists.

Still, in general, the linkage between clinical services and the community has been approached in terms of how health services can be provided in the community (e.g. vaccinations in schools), and how to engage needed community services to advance patient treatment (e.g. transit to get someone to the health center). Health care systems have relied on other organizations—public health, community-based organizations, advocacy groups—to address the complexities of the social environment.

One of the great opportunities in this new landscape is to begin to identify partners who are already working to improve community well-being. Addressing the social determinants of health puts us into conversation with partners in housing, transportation, education, agriculture, public health, economic development, etc. Health care providers do not need to carry the freight of solving complex social issues on their own, but they can strategically align their resources and efforts with those of others who specialize in these areas. In fact, partnership with communities and across health systems is one of the standards under Community Health Needs Assessment regulations, so it is now an expected and rewarded stance for healthy system community engagement efforts.

Just what kind of partnerships are likely to be most helpful, however, is an important question. A full discussion of Partnership can be found in Chapter 6.



Wake Forest Baptist Medical Center's FaithHealthNC Covenant Signing

Thoughts on Measurement

The notion of *‘doing good and doing well’* needs to guide strategic investments in the development of systems of integrated care for socially complex people and communities. That means using focused, measurable approaches to meet the challenges, in the process of furthering the mission and well-being of our hospital systems. This is our ACA and business stewardship mandate. Our faith-based missions drive us to serve socially complex and underserved communities, but also before us lies a responsibility to ensure that our efforts effectively ‘move the needle’ in community and population health and are sustainable over time.

The Institute for Healthcare Improvement (IHI) reminds us that ‘measurement is a critical part of testing and implementing changes; measures tell a team whether the changes they are making actually lead to improvement.’ Measurement tools are readily available, and there is no lack of benchmarks for the case examples above: the mental health burden, frail and disconnected elderly, and childhood obesity. Sources include Healthy People 2020, measures from the Agency for Healthcare Research and Quality (AHRQ), the Health Department MAPP (Mobilizing for Action through Planning and Partnerships) tool, our own hospitals’ Community Health Needs Assessments (CHNAs), and many others. Our own hospital utilization data clearly points us to the needs of our communities, challenging us to develop interventions that can be tracked over time.

The development of such strategic interventions should follow a clear process:

- Clearly defining the audience
- Understanding the real (vs. assumed) preliminary data from internal and external sources
- Defining the external forces of change and the social complexity that impact on the issue
- Involving the community or target audience in defining the issues to be addressed
- Appropriately sharing the responsibility for addressing the need with other community partners
- Determining baseline numbers for each planned intervention
- Setting outcome goals with short- and long-term measures
- Providing continuous feedback to all stakeholders

Some Existing Approaches to Integrated Care in a ‘Social Complexity Framework’

The HSLG acknowledges that such complexity makes it difficult to attribute impacts (or proportions thereof) to individual interventions. Nonetheless, we understand the importance of comprehensive strategies that involve multiple, mutually reinforcing interventions. This offers major potential to build a critical mass of services, action, and investment that will produce measurable and sustainable outcomes. This follows the same process that clinicians already utilize and with which health care is very comfortable: collecting data, diagnosing the problem, and undertaking a treatment and care plan.

Taking Two Steps to Prevention Framework

(From the Prevention Institute, 2003; <http://www.preventioninstitute.org/component/jlibrary/article/id-96/127.html>)

The traditional health system trajectory in the United States starts with the medical condition, such as a heart attack, and immediately moves to medical interventions and the drugs needed to treat the illness. ‘Taking two steps to prevention’ is a way to trace the pathway from illness and injury to community conditions, norms, and root factors that in the first place lead to poor health and inequality. It focuses efforts on a comprehensive, systemic view rather than a narrow individual one.

Step 1: Identify risk factors, such as poor diet, sedentary behavior, and stress.

Step 2: Reveal the environment that shapes the factors leading to the heart attack—an environment that lacks available opportunities for safe physical activity—and promotes cheap fast food on the run.

Taking two steps to prevention—focusing on the community environment—is an important element of quality prevention, because tangible solutions lie within the local arena. In fact, that also suggests that, accompanying the first step of identifying risk factors, preventive factors and locally available ‘assets’ also need to be identified. By applying these solutions, advocates, practitioners and researchers can improve community conditions, increase resiliency, and challenge root factors like poverty, oppression, racism, and discrimination.

THRIVE

THRIVE (TOOLKIT FOR HEALTH & RESILIENCE IN VULNERABLE POPULATIONS) is an evidence-based tool created by the Prevention Institute that builds on the Taking Two Steps to Prevention concept by helping people understand and prioritize the factors within their own communities that promote health and resiliency at that second level of prevention. The tool identifies key factors and allows a user to rate how important that factor might be in the community. It also provides information about how each factor is related to health outcomes and some direction about what to do to address the factor and where to go for more information.

THRIVE identifies 13 factors that can guide thinking within a clinical context and with partners about the second step of prevention. The 13 community health factors either directly influence health and safety outcomes (e.g., air and water quality) or directly influence behaviors that in turn affect health and safety outcomes (e.g., the availability of healthy food affects nutrition). The factors are organized into three interrelated clusters:

RACIAL JUSTICE:

- Jobs and local ownership
- Education

THE PLACE:

- What’s sold and how it’s promoted
- Look, feel and safety
- Parks and open space
- Getting around
- Housing
- Air, water and soil
- Arts and culture

THE PEOPLE:

- Social networks and trust test
- Participation and willingness to act for the common good
- Acceptable behaviors and attitudes

By using this tool, health care organizations can better see the connections between the individual manifestations of disease in their hospitals and the external, social determinants of these conditions so that the organization can play a more proactive role in convening partners to address the root causes.



Inova Promotores Graduation

‘Hot Spotting’

Some health care systems are achieving dramatic health improvement outcomes by identifying ‘high-utilizers’ and providing targeted, coordinated care to them.

For example, Advocate Health Care’s ‘Advocate Care’ program identifies patients who are frequent users of health care or who are seeing a specialist for a chronic disease, initially targeting those with Blue Cross/Blue Shield coverage, now also Medicaid and Medicare. It then provides a team of care managers who follow them to coordinate care and link them to support services. Advocate’s ACO is tracking performance using five new measures: emergency department visits, admissions, readmissions, length of stay, and network care coordination. The system expects to continue to reduce utilization—visits to the emergency room and time spent in the hospital—and improve care coordination, resulting in improved patient outcomes and financial results.

Dignity Health Care uses a Community Need Index to identify community areas that have a high volume of readmissions. Using this information, Dignity works in partnership with the community to identify root causes and provide targeted services.

Community Health Workers

One approach that warrants a more developed description is the Community Health Worker model. Community health workers (CHWs) have been a vital part of our workforce for decades. Yet only recently has their contribution received full attention and scrutiny, with HHS defining their work as key to eliminating disparity, and the ACA recognizing them as part of the workforce. Various definitions for CHWs exist along with many models (paid, unpaid, stipended, working with a team, or solo).

The American Public Health Association defines the CHW role as a frontline public health worker who serves as a liaison between health/social services and the community, while building individual and community capacity within a broader community-based health system. Core competencies for CHWs include communication, interpersonal skills, knowledge base, service and care coordination, capacity-building, advocacy, teaching, organization, cultural competency and outreach, and enrollment. It is estimated that there were about 121,000 CHWs in 2005, a 41% increase from 2000. While older models placed CHWs in community as somewhat isolated ‘outreach’ workers, more recently the trend is for CHWs to be integrated into the more traditional ‘clinical’ healthcare team.

Optimally, however, CHW activity should be much more than that, so that it increasingly reflects a partnership with community agents. One thought-provoking example of how this might be reimagined comes from Wake Forest Baptist Medical Center (WFBMC). Following the decision to outsource its environmental services, WFBMC conducted an analysis of the down-sized workforce and where they lived.

Pausing the decision long enough to overlay the map of where the Environmental Service or EVS workers lived with the map of the hospital's \$42 million of charity care, it found a near perfect alignment: 48% of the workers lived where 49% of that care was concentrated, most of it ER-based diagnostics. Leaders thought, "Surely we could do better if we partnered with our own employees who live on those streets?" The Faith Health Division, already seeking to hire liaisons to develop community partnerships, offered to redirect those funds, form a partnership with the EVS department, and train their own workers. The Care Transitions Department joined the partnership, providing a project manager to ensure full access to the crucial clinical intelligence on the most common causes of problems in post-treatment home care and inappropriate ED utilization. The Forsyth Department of Public Health also joined in; its greatest challenges focus in those same neighborhoods. Wake Forest Medical School Department of Public Health Sciences came to the table too, with an embedded evaluator to keep track of expectations and results. The Human Resources Department added training experience. The first meeting of the design committee blended the intelligence of a long time EVS manager and four housekeepers. The team will develop criteria for training and equipping the 'Agents of Health' with what they need to make the path back to home more effective and the path to appropriate services more successful. Helping the hospital learn how to be part their home team, one of the women said, 'Healing takes the whole team and we're part of it.'

As we reimagine the CHW role in broader systems, a brief review of current certification is useful. There are no national standards for certification, training requirements, or defined scope of practice for CHWs. Three states require CHW certification (Alaska, Ohio, Texas), while North Carolina and Nevada have mandated state level training requirements. Kash³⁹ cites three models for training: 1) schooling at community college level; 2) on-the-job training that improves standards of care, CHW income, and retention; and 3) certification at the state level that acknowledges guild standing and facilitates reimbursement. Some states (e.g. Michigan's Community Health Worker Association or MiCHWA) have taken the lead in advocacy and the setting of such standards⁴⁰.

Early evaluation of CHW programs showed limited pre-post health improvement outcomes to justify program sustainability.⁴¹ But traditional metrics (e.g. Relative Value Units) are inadequate to show the full spectrum of skills and unique work done by CHWs, especially as their work links to interventions at the social determinant level.⁴² Now, however, the push for innovative bundled care financing structures and use of targeted staff to prevent readmissions and improve care transitions creates a more favorable environment for CHWs. Freudenberg & Tsui⁴³ argue persuasively that CHWs (along with two other entry-level workers, environmental protection and food service) have long-term potential to reduce government spending, shift the focus from treatment to prevention, directly address social determinants of health (e.g. unemployment), and contribute to the improved prevention and control of chronic diseases. The Wake Forest Baptist Medical Center environmental service workers initiative described above is a superb example of how these front line employees' efforts can be realigned to address economic and chronic care problems faced by our nation.

³⁹ Kash Bitu Arbab, May, Marlynn & Tai-Seale, M. (January 2007). 'Community health worker training and certification programs in the United States: Findings from a national survey,' *Health Policy*, 80, 1: 32, available at www.sciencedirect.com/science/article/pii/S0168851006000364.

⁴⁰ Duthrie P., Phillipi E. & Mitchell, K. (2012). Supporting CHWs as part of the health care team through policy change and successful supervision. Ppt presented at Michigan Community Health Worker Alliance Spectrum Health Healthier Communities meeting, Big Rapids, Michigan, October 3.

⁴¹ Sprague, L. (2012). Community Health Workers: A Front Line for Primary Care? National Health Policy Forum Issue Brief No. 846, September 17.

⁴² Rush, CH. (2012). Return on Investment from Employment of Community Health Workers. *J of Ambulatory Care Management*, 35 (2); 133-137.

⁴³ Freudenberg N. & Tsui, E. (2011). Analysis & Commentary: Training New Community Health, Food Service and Environmental Protection Workers Could Boost Health, Jobs and Growth. *Health Affairs* 30(11), 2098-2106.

More recent studies have shown cost-savings and positive return on investment (ROI) of various CHW models. For example, the Men's Health Initiative in Denver, Colorado, which helped patients establish a medical home and primary care provider with system navigation and case management, reduced inpatient hospital visits and demonstrated an ROI of 2:28:1:00.⁴⁴ In Baltimore, Maryland, for a cohort of 117 African-American Medicaid diabetic patients, Fedder et al. showed a 40% decrease in emergency room visits and average cost-saving per patient of \$2,245.⁴⁵ Patients working with CHWs, in a randomized study of 309 African-American men with hypertension, reported twice the level of satisfaction in their treatment than those treated with more traditional education and referral from a nurse practitioner.⁴⁶



*Sew Up the Safety Net for Women & Children
(Detroit Regional Infant Mortality Reduction Task
Force - Henry Ford Health System)*

CORE Health, as part of Spectrum Health's Michigan's Healthier Communities Programs, works with maternal and child health, hypertension, diabetes, nutrition and healthy lifestyles in schools, hospitals and communities; it demonstrated an ROI of \$1.68 dollars saving per dollar spent in a 3 year analysis.⁴⁷ New Mexico Medicaid managed care showed an ROI of \$4.00 savings for every dollar spent by intervening with high utilizers to decrease high emergency room usage and low treatment adherence.⁴⁸ The volunteer-based program of the Congregational Health Network in Memphis, Tennessee, relies on over 600 unpaid trained CHWs (called 'liaisons') in over 512 churches, to work with 10 hospital-based, paid employee 'navigators' or community triagers, to help patients in and out of the hospital system, with early savings of over \$8,000 per capita on total hospital charges compared to controls for those not in the network.⁴⁹ Lastly, Detroit's HFHS and other partners (including competing health systems) have begun an ambitious initiative, Sew Up the Safety Net for Women & Children (SUSN), to address the social determinants of health that impact on infant mortality. SUSN is working with 1,500 at-risk women and relying on CHW staffing, along with provider education on health equity and 'high tech/high touch' social marketing to decrease infant mortality.⁵⁰

Funding models for CHW initiatives include: 1) charitable foundation or governmental agency grants or contracts, which are usually short-term; 2) general governmental funding via grants or programs that have CHWs as a line item in a public health department budget; 3) private sector funding like hospital or health plans; and 4) Medicaid (in Alaska and Minnesota), often reimbursed through waiver programs or capitated rates.⁵¹ Some funding mechanisms are hybrids of these models. For example, Methodist Le Bonheur Healthcare's CHN program relies on stable hospital funding to cover its navigators, director, evaluator and administrative support, with evaluation, supplies, stipends to congregational partners, and training costs are covered through philanthropy and foundation grant funding.⁵²

⁴⁴ Whitley EM, Everhart RM. & Wright RA. (2006). Measuring return on investment of outreach by community health workers. *Journal of Health Care for the Poor and Underserved*, 17(1), 6–15.

⁴⁵ Fedder DO, Chang R J, Curry S, & Nichols G. (2003). The effectiveness of a community health worker outreach program on healthcare utilization of west Baltimore City Medicaid patients with diabetes, with or without hypertension. *Ethnicity and Disease*, 13(1), 22–27.

⁴⁶ Felix-Aaron K., Hill MN, Rubin HR. Randomized trial of nurse practitioner-community health worker intervention: Impact on young black men's satisfaction with high blood pressure care. *Abstr Acad Health Serv Res Health Policy Meet.* 2000.

⁴⁷ IBID, 40

⁴⁸ Johnson D, Saavedra P, Sun E, et al. (2012). Community health workers and Medicaid Managed Care in New Mexico. *Journal of Community Health*, 37:563-571.

⁴⁹ Cutts, T. (2011). The Memphis Congregational Health Network Model: Grounding ARHAP Theory 'In *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*, edited by James R. Cochrane, Barbara Schmid, and Teresa Cutts, Pietermaritzburg, South Africa: Cluster Press, 193-209.

⁵⁰ Wisdom K., Clement J. & Combs N. "A Game-Changing Collaboration to Reduce Infant Mortality" Panel presented at the Health Systems Learning Group (HSLG), Detroit, Michigan, October 10-11, 2012.

⁵¹ IBID 41

⁵² IBID 49

Approaching Social Determinants at the Population Scale by “Sewing Up the Safety Net”- Collaborating with Competitors to Save Infant Lives

The CEOs of four major health systems serving Detroit (Henry Ford Health System, Detroit Medical Center, Oakwood Healthcare System, and St. John Providence Health System) committed their organizations to find enduring, collaborative solutions to reduce the city's infant mortality – among the highest in the nation. In 2008, they commissioned the Detroit Regional Infant Mortality Reduction Task Force, under the leadership of Henry Ford's Kimberlydawn Wisdom, MD, to develop an action plan.

A true public-private partnership, the Task Force represents a range of expertise and perspectives, from clinical to community, and from programmatic to policy, environment and behavior change. The health systems bring the strength and size of their provider networks, and their ability to reach women and families at multiple points across the clinical spectrum. Public health leaders from state and local health departments provide population-based perspectives and a focus on the social determinants of health – racism and its relentless cascade of socioeconomic factors influencing the life course. Agency members provide further policy expertise and links to organizations conducting synergistic work. An equally important cadre of community partners – neighborhood organizations and stakeholder groups – joined the Task Force in designing an innovative grassroots approach.

THE RESULT – the \$2.6-million grant-funded Sew Up the Safety Net for Women & Children – demonstrates place-based population health management; innovative, sustainable service delivery models; high-tech/high touch social marketing; provider education on the health equity framework; and institutional alignment – even amongst competing health systems.

Sew Up the Safety Net is funded by the Robert Wood Johnson Foundation, The Kresge Foundation, W. K. Kellogg Foundation, PNC Foundation, University of Michigan School of Public Health, and the four health systems.

Infant mortality is known as a “sentinel” health indicator – the infant mortality rate correlates with the health status of the community. In Detroit, infant mortality hovered around 14.4/1000 for the past three years, or about 200 babies each year who do not survive their first birthday. Higher than some developing countries and over twice the U.S. rate, these statistics are even more painful when the racial health disparity of 15.9/1000 for black babies is compared to 5.6/1000 for white infants for the same period.

According to a 2009 survey conducted by the Detroit Regional Infant Mortality Reduction Task Force, many local programs and services to support women at risk for infant mortality were significantly underused. It was then that the Task Force conceived Sew Up the Safety Net, to tighten this loose web of disconnected medical, social, and community organizations into an accountable network of care.

The project works in three neighborhoods to connect women at risk for infant mortality with community health workers, known as Community & Neighborhood Navigators (“CNNs”), framed by three key objectives:

- The first objective centers on the CNN-participant relationship. Trained as community health workers by a specialist from the Detroit Department of Health & Wellness Promotion (Institute for Population Health) with additional education in maternal-child health, the CNNs mentor participants by helping them learn to navigate an array of socially and economically appropriate healthcare services, tailored neighborhood resources, and phone and Web-based information. Moreover, the CNNs provide the vital validation that says “I believe in you” amidst the oft-discouraging, lonely life journeys that many young women in poverty describe facing. In turn, participants become empowered to link their own social networks to similar resources for long-term success and improved health and well-being of women, families (including men), neighborhoods and communities. Over three years, 1,500 women – 375 pregnant and 1,125 nonpregnant women of childbearing age – will participate.
- The second objective is providing education on the health equity framework to 500 physicians and other healthcare professionals. Built on a tested, successful Henry Ford healthcare equity CME course, the interactive, challenging workshops are designed to improve awareness of health equity and racial disparities, resulting in increased understanding of how life's difficult circumstances impact health. Resources such as MIBridges and United Way 2-1-1 are shared in a case study approach. A train-the-trainer course also is being offered to expand provider education reach.
- The third objective is to establish technologically relevant products to engage the broader community in promoting good health status prior to and during pregnancy. Social media, a program website and text messaging are being used to connect women to the program, link to related services, and provide a virtual “living room” for sharing and learning. Project planners learned in early focus groups that the name “Sew Up the Safety Net” was not as relatable for the target population as for health professionals. A CNN proposed the new name, *Women-Inspired Neighborhood Network Detroit (WIN Network Detroit)* to very positive reception from program members, and it is now used.

At a neighborhood health fair, a CNN recruited “Sonya,” 27, a single mom pregnant with her second child. The CNN learned that Sonya and her 5-year-old son “Derek” are “couch-homeless” – living with various relatives for short periods. Sonya opened up to the CNN about the hardships and disappointments of moving her life from house to house whenever a family member was “tired of having them.” The CNN immediately referred Sonya and Derek to a shelter program that is assisting them with permanent housing. Sonya told her CNN that before her involvement with *Sew Up the Safety Net*, she felt lost and unsupported. Thanks to her CNN, she said she now “feels hope” and is making plans to become a registered nurse after her second child is born. Meanwhile, the CNN continues to mentor Sonya, connecting her with other needed resources including food, clothing, and a referral to a college counselor. In a sign of her growing sense of optimism and self-efficacy, Sonya has already enrolled in college classes.

While too early for reportable outcomes, as of February 2013, the project had enrolled more than 135 pregnant women and engaged hundreds of women who are pre-pregnancy or between pregnancies. *Sew Up the Safety Net* is measuring impact around three distinct yet interdependent metrics: 1) no preventable infant deaths among participants – with measures including the effectiveness of community-based referrals, increased social support, and behavior change; 2) knowledge and behavior change on equity-promoting strategies among the 500 healthcare professionals participating in health equity education; and 3) knowledge and behavior change on prenatal care, preconception health, interconception health, and access to community services via the social media campaign.

Conclusion

Many of our communities face enduring, persistent, and systemic health challenges. Getting to the place where health systems are active partners with community members, public health, government, local businesses, community-based organizations, faith communities, schools, institutions of higher education and other sectors that impact the health of the community as a whole is long-term and sometimes difficult work. That this work is long-term is not a weakness or a hindrance but is a realistic response to the complexity of our patients and the communities in which they live.

Some of the basic elements that lay the groundwork for the shift in practice include:

CREATE THE CULTURE

Making the shift to providing care through the Social Ecological Model may require many of our health care systems to begin to shift from a culture of the individual to a culture that sees our patients as socially complex individuals living in socially complex communities. A culture supportive of this way of seeing is:

- willing to listen in new ways
- attentive to interconnections
- transparent about limits and agendas
- able to manage difficult conversations about issues like poverty and racism
- open to partnership and collaboration

This is not insignificant change, yet many of our health care systems already have the cultural framework readily available in the theological and ethical perspectives of their faith sponsors. Creating a culture to support health care that is decent, efficient, and proactive and that encompasses the health of all in the communities and populations we serve can connect us more deeply and meaningfully with our faith-based partners and core missions.

BUILD THE RELATIONSHIPS AND PARTNERSHIPS

We cannot achieve this without working collaboratively. Collaborative work is based on trusting relationships, that take time to build and that often do not produce immediate results. Partnership relationships are an investment over time, especially in the people that live in the communities that we serve.

INCREASE SKILLS AND KNOWLEDGE

Creating the right culture and building the fitting relationships and partnerships will not ‘come naturally,’ but require an investment in appropriate skills and knowledge. Some of it may reside in our institutions but not be optimally utilized, some of it may need to be developed, and some of it may need to be acquired from elsewhere.

MEASURE THE RESULTS

Being able to demonstrate results from interventions and activities is critically important for accountability, learning, innovation and sharing best practices. Public health and academic partners are ready allies in designing outcomes measurement tools and processes and have access to many tools and resources for measuring results. Practices such as collective impact and social return on investment are examples of forward-leaning frameworks for organizing and guiding program design and evaluating outcomes.

DEVELOP THE INFRASTRUCTURE

All of the above requires that we rethink our institutional infrastructure in ways that proactively support the culture, the relationships and partnerships, the skills and knowledge, and the measurable accountability we seek.

Throughout this document, we have spoken of collaborative relationships and vital partnerships, but without fully discussing just what kind of relationships and partnerships are ideal or necessary, if we are to achieve the aims represented by the elements of our ‘transformational ensemble.’ That is the subject of the next chapter, on ‘Transformative Partnerships.’

Chapter 6

Transformative Partnerships

‘Health is a journey, not a list of medical events. The hospital is, and can only be, one part of it, especially for chronic illnesses.’

– *Gunderson and Cochrane*

As hospitals and health systems struggle under the weight of uncompensated care, emergency department overuse, and readmissions—the greater portion directly attributable to spiraling chronic disease—the case for transformative community partnerships becomes increasingly clear.

- In **Memphis, TN, Methodist Le Bonheur Healthcare** has reached out to over 500 faith communities, created roles for community navigators, and by working with community assets as well as needs in a person-centered approach, reduced readmissions by 20% and showed total sum charges of ~ \$4,000,000 less than matched controls over 26 months.⁵³
- In **Alaska, Southcentral Foundation's** Customer Owner model of integrated healthcare delivery has resulted in a 50% drop in urgent care and emergency room utilization, a 53% drop in hospital admissions, and a 91% increase in customer satisfaction.⁵⁴
- **New Jersey's Camden Coalition** created the ‘hotspotting’ model for tracking high utilizers and meeting their needs more locally, pulling together local hospitals, social service agencies, and other stakeholders to provide comprehensive care and decrease avoidable emergency room visits.⁵⁵

Venerable institutions are taking note. The Institute of Medicine (IOM), the American Medical Association, the American Hospital Association, the Institute for Healthcare Improvement (IHI), and major funders such as the Robert Wood Johnson Foundation and The Kresge Foundation, are among those organizations who have weighed in strongly on the evidence basis for health systems to work in new, vibrant partnerships with public health, neighborhoods, and communities.

Why are we seeing this movement? IOM states in its landmark 2012 publication, *Primary Care and Public Health—Exploring Integration to Improve Population Health*:

- The dramatic rise in health care costs has led many stakeholders to embrace innovative ideas
- Health research continues to clarify the importance of social and environmental determinants of health and the impact of primary prevention
- An unprecedented wealth of health data is providing new opportunities to understand and address community level health concerns
- The Affordable Care Act presents an overarching opportunity to change the way health is approached in the United States⁵⁶

In fact, just two days after the Presidential election, on Nov. 8, 2012, the IHI drew more than 100 health care leaders from across the nation to Washington, DC, for its ‘Out of the Blocks’ conference. The follow-up Action Brief is excerpted below:

Speakers also emphasized that community organizations were frequently an essential link in improved care delivery, though today they are often isolated from formal health care organizations. (IHI CEO Maureen) Bisognano said that as new and diverse patients enter the system under expanding insurance coverage, providers will have to respond with new models of care that meet the patient’s deepest needs, be they in a hospital or in a community setting. **‘We need to move from ‘what’s the matter? medicine to ‘what matters to you?’** she said. Chas Roades highlighted the work of Chicago’s Rush University Medical Center, which is treating diabetes in part through a block-by-block community campaign. Community members go door-to-door bearing tablet computers with predictive modeling software, doing risk assessments, administering questionnaires, and giving dietary counseling. **‘What they realize is, we can’t simply sit inside the academic medical center and apply our traditional strategies and make that problem get better,’** Roades said, **‘We actually have to engage at a community grassroots level.’**⁵⁷ (emphases our own)

⁵³ Teresa Cutts, ‘The Memphis Congregational Health Network Model: Grounding ARHAP Theory ‘In *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*, edited by James R. Cochrane, Barbara Schmid, and Teresa Cutts, Pietermaritzburg, South Africa: Cluster Press, 2011.

⁵⁴ <http://www.methodisthealth.org/about-us/faith-and-health/research/learning-collaborative/september-20-2011-meeting/Southcentral>

⁵⁵ http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande

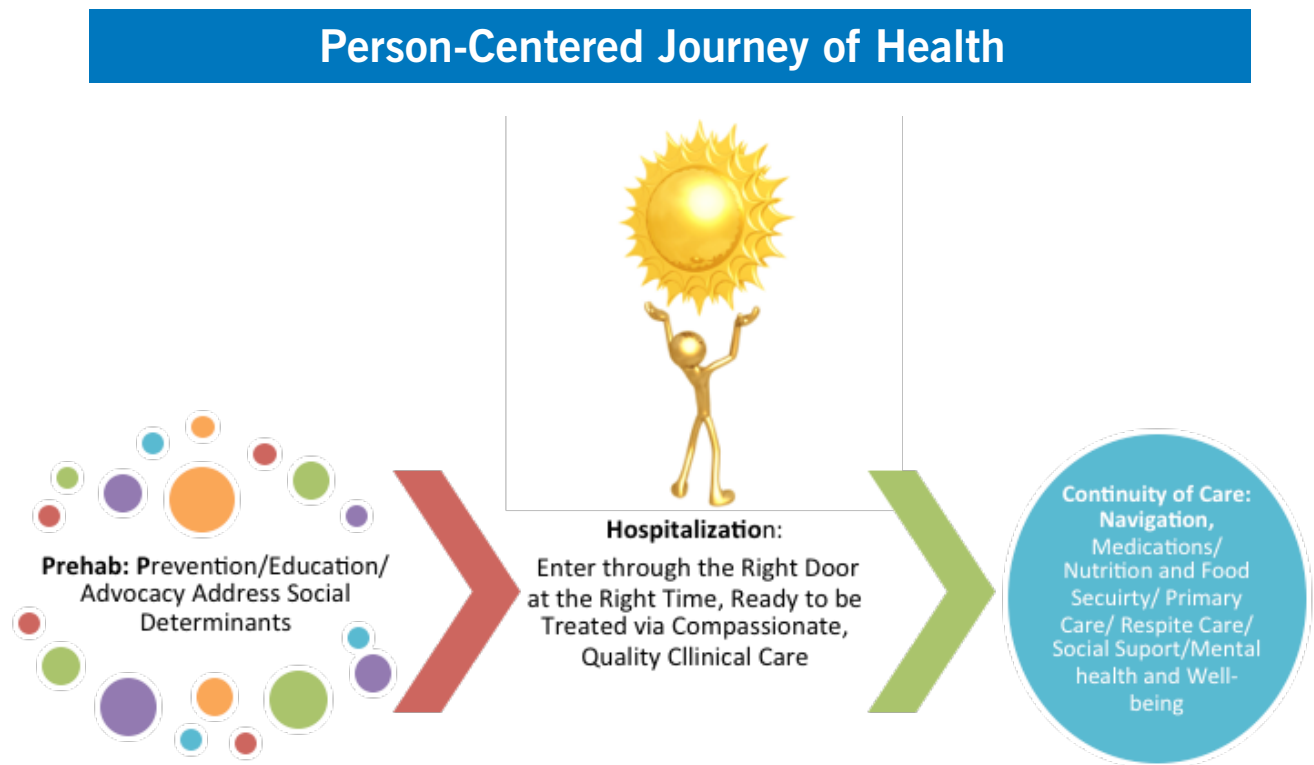
⁵⁶ Board on Population Health and Public Health Practice, Institute of Medicine. *Primary Care and Public Health: Exploring Integration to Improve Population Health* (March 2012): <http://www.iom.edu/Reports/2012/Primary-Care-and-Public-Health.aspx>

⁵⁷ Institute for Healthcare Improvement. *Out of the Blocks: An Action Brief for Healthcare Leaders in the Post-Election Era* (December 2012), 10:

In 2011, The Kresge Foundation studied the population health approach of four early adopters—Genesys Health System in Grand Blanc, Michigan; Memorial Healthcare System in Hollywood, Florida; Southcentral Foundation in Anchorage, Alaska; and the Central Michigan Regional Triple Aim initiative representing 14 counties in Central Michigan. They report that:

... looking at the evidence, the health care delivery system does little to improve population health. While it is important to provide access to quality health care delivery, only 10% of the improvement in population health can be attributed to this sector. Looking back over the last century, 25 years of the 30-year increase in life expectancy can be attributed to public health efforts, social policy, community action, changes in lifestyle, smaller family size, and socioeconomic factors, such as increased education levels. Those with less education and who live in poverty are sicker and die at a younger age than those with higher incomes and better education. To improve health we must address upstream determinants of health.⁵⁸

The 2014 Medicaid expansion as part of the Affordable Care Act—pending states' adoption—provides still more compelling reasons to engage in transformative partnerships. Health systems will need new and trusted paths to work in collaboration with faith communities, neighborhood organizations, and other settings where people live their lives and make their health choices—which for many will include new health coverage choices. We advocate a broadening of the concept of 'care transitions' or other hospital system language, to craft these ideal health journeys from the person-centered view versus a hospital-centric one.



⁵⁸ Ann Batdorf-Barnes, D.O., M.P.H., The Kresge Foundation Population Health Project Final Report (November 2011): 9

Improving Health through Ownership and Relationships

Southcentral Foundation's Nuka System of Care is built around the understanding that personal, long-term, accountable relationships with customer-owners, their families, and their communities are the key to making a difference in the ongoing choices and habits that drive health and wellness.

For 50 years, Alaska Native people in Southcentral Alaska received their health care as “patients” of the Indian Health Service’s Native hospital. Patients had to wait weeks to get an appointment, and saw different providers each time. Treatment was inconsistent, care was impersonal, and there was a disconnect between care for the mind and care for the body. Departments and programs acted independently. Patients weren’t happy, employees weren’t happy. Health statistics were bleak. Many patients left the Alaska Native system altogether to find better care. Then, Congress passed a federal law in favor of self-determination. This gave Alaska Native people a voice in the planning and implementation of programs to respond to the true needs of their communities. It also opened the door for tribes to eventually own the entities that deliver the services. The Alaska Native leadership of Southcentral Foundation (SCF) saw this new law as an opportunity for innovation – to completely redesign the tribal health care system in Southcentral Alaska with a primary focus on relationships.

By 1999, Alaska Native people were no longer “patients” of a government-run system, but, rather, chose to become “customers” and “owners” of their tribally managed health care. What followed was a customer-driven overhaul of health care delivery, philosophy and values. As a result, SCF has today what is known as its “Nuka System of Care.” It addresses the challenges that health care systems around the world face – how to improve health care outcomes and customer satisfaction without skyrocketing costs. It works because SCF redesigned the entire health care system based on the wants and wishes of its customer-owners (who asked for the emphasis on relationships), and, in doing so, empowered those receiving the services to share responsibility.

Finding the correct diagnosis and creating the best treatments are secondary to the real work of partnering, encouraging and supporting in personal relationships over time.

Once under Alaska Native customer ownership, SCF recognized the need to introduce Alaska Native managers into the system. Not only did this build highly capable Alaska Native leadership for the future, but it also allowed the doctors and nurses who had previously been serving as the department managers to return to predominantly clinical work. Today, over 60% of the organization’s managers are also customer-owners. In their management roles, again, the emphasis is on relationships – both with co-workers and fellow customer-owners. Grace Hamner is a good example. She has served as the Optometry Clinic’s manager for over 10 years. She’s been a part of customers’ lives from adolescence through adulthood. She also gets to know her employees and the areas they want to grow into, so that she can match them with related learning opportunities. Her strong relationships with the other managers make it easy to ask questions, learn what works well in their settings, and then modify it for her setting. She says, “As Alaska Native people providing services for our own families, we know the importance of looking at the needs, forecasting, and determining what direction we need to go next.”

The Nuka System of Care is a departure from “patients” serving as mere recipients of tests, diagnoses, and pills. Instead, customer-owners actively share responsibility for the success of the health care system and for their family’s health and wellness.

SHARED RESPONSIBILITY

Providers:	Customer-owners:
Listen	Communicate goals
Provide choices	Engage in decision making
Keep commitments	Keep commitments

Before the Nuka System of Care, far too many Alaska Native people believed that they had no control or opportunity for input. This belief was conditioned over many decades of well-intended with government-run health care that promoted the message “we will take care of you.” While the system is far from perfect, there have been measurable improvements. For example, a recent yearlong survey asking customer-owners about their experiences in SCF’s clinics showed that 98.5% of the respondents agreed with the following statement: “I was given the chance to provide input into decisions about my health care.”

OTHER RESULTS:

- In 1996, only 35% of the local Alaska Native population had a designated primary care provider. Of those, 43% did not know who that provider was. Now, over 95% are empanelled to an integrated primary care team. Providers know their customers’ names, as well as their histories, preferences, and family dynamics.
- Before Nuka, the average delay to schedule a routine appointment was four weeks. Now, Southcentral Foundation offers same-day access, in person or by phone or email (customer’s choice).
- Phone wait times, before Nuka, were in excess of two minutes, and are now limited to less than 30 seconds.
- A 36% reduction in hospital days, 42% reduction in ER and urgent care usage, and 58% reduction in specialty clinic visits have been sustained for 10+ years.
- Staff turnover is one-fourth of the level it was five years earlier.
- Customer satisfaction with respect for their cultures and traditions is at 94%.

SCF’s customer-owners recognize that their families will own, manage and benefit from these services for generations to come. With this ownership, comes a sense of shared responsibility for the health care system’s success. The people of the region are working to continuously improve the services and ensure that the decisions made are in alignment with a set of relationship-based operational principles. By being involved, Alaska Native people are now more aware of health promotion and disease prevention options and are more interested and willing to make changes.

The value put on relationships in this Alaska Native-owned system of care provides a dramatically different care experience than what was encountered when the health system was under government control. Better relationships have meant not only healthier customer-owners, but also healthier employees and a healthier organization.

What Do We Mean by a ‘Transformative Partnership?’

Transformative community partnerships embrace—yet move beyond—public relations, outreach, community development, and the traditional collection of community benefit activities for the IRS. A transformative partnership:

- Provides a level playing field where all participants are open to learning from one another, recognizing the strengths and assets each partner brings to the table. The hospital may not always take the lead. As Henry Ford Health System CEO Nancy Schlichting has told the health system’s Community Pillar Team, ‘We can lead well, but we can also be a great partner.’
- Is replicable, with demonstrated outcomes that can be taken to scale, and metrics agreed upon from the start by all partners.
- May often leverage the sophisticated tools of marketing, planning, research, health promotion, and care management that health systems already have, but shift the focus to populations that may not have been the target of previous efforts.
- Is culturally competent in the broadest sense, using the tenets and tools of equity, cultural humility, and health literacy.
- Is a **relationship**, not an outcome, which exists along a continuum of engagement.

Continuum of Partnership Engagement⁵⁹

NETWORKING

Exchanging information for mutual benefit.

COORDINATION

- Exchanging information, altering activities for mutual benefit for a common purpose.
- Requires more organizational involvement than networking. A crucial change strategy, coordinated services are “user-friendly” and reduce barriers for those seeking access. Involves more time, higher levels of trust yet limited access to each other’s turf.

COOPERATION

- Requires greater organizational commitments and may involve legal agreements. Can encompass a variety of human, financial, and technical contributions. Can require substantial time, high levels of trust, and significant access to each other’s turf.

COLLABORATION

- Exchanging information, altering activities, sharing resources, and enhancing the capacity of one another for mutual benefit to achieve a common purpose.
- Each organization wants to help partners become the best that they can be at what they do. It assumes that organizations share risks, responsibilities, and rewards, each of which contributes to enhancing each other’s capacity to achieve a common purpose.



Methodist Le Bonheur Healthcare’s Riverview Kansas Initiative

⁵⁹ Arthur T. Himmelman. Collaboration for a Change: Definition, Decision-making Models, Roles and Collaboration Process Guide, Himmelman Consulting, January 2002, found at http://depts.washington.edu/ccph/ped_files/4achange.pdf

Why Build and Engage in Transformative Partnerships?

Transformative community partnerships are a necessary sustaining component to reduce uncompensated care, inappropriate ED use, readmissions and more—helping solve big problems health systems have. As opposed to episodic, event-oriented outreach, ongoing community engagement—working in concert with clinical frameworks such as disease management and patient-focused medical home—builds the critical mass needed to bring about meaningful, measurable health improvement for individuals, communities, **and** the health system's bottom line.

Community Partners Can Include

KEY LEADERS/INSTITUTIONS

- Regional federal officials
- Community foundations
- Local elected officials (elected, appointed and career staff)
- State and local conversion foundations
- Regional federal officials
- National foundations
- Regional planning agencies
- Health commissions

BUSINESS/ECONOMIC DEVELOPMENT SECTOR

- Local small businesses
- Banking and financial investment institutions
- Developers and architects
- Corporations with local presence
- Community development corporations
- Housing and economic development agencies
- Chambers of commerce
- Media partners

COMMUNITY EDUCATION AND ACTION SECTOR

- Service-oriented community-based organizations (e.g., youth development, senior centers, community centers)
- Resident-led action-advocacy oriented community-based organizations
- Faith-based organizations
- Community residents with special skills/knowledge
- Educational institutions (K-12 and higher education)
- Associations (e.g., neighborhood watch, business, health, sports)
- Law enforcement

HEALTH AND SOCIAL SERVICES SECTOR

- Other hospitals and health systems, even competitors
- Provider groups
- FQHCs, free clinics and other community health providers
- Health plans
- Governmental, public health and social service agencies
- Health professions' educational institutions

How Do We Engage Great Partners?

The short answer: *be* a great partner!

Health systems that are starting to see results in addressing complex, persistent health problems are those that are moving beyond focus groups and town halls to participate in more formal, ongoing forums—mapping community assets as well as needs, and exchanging wisdom with diverse stakeholders.

In doing so, health systems are sharing responsibility (better said, they are acknowledging that the shared responsibility has been there all along) for planning and action at all stages of the community health improvement process.

Each transformative partnership will clearly have a unique life and structure of its own. In what follows, we offer a checklist of basic practices that health system leaders can deploy to help ensure enduring success.

Leaders will note that many of these activities they are already doing and have been for years, perhaps using other terminology and—at least ostensibly—framed in terms of different objectives: PR and marketing, strategic planning, professional practice development, customer relations management, quality management, and disease management.

The skills and even many of the tools are well-practiced and in place. It's a matter of opening up the lens to include target populations that previously may not have shown up in the business plan. That widened lens will include these strategies, detailed in the following pages.

A Case Report

Loma Linda University Health (LLUH) shows the impact of shared ownership for community health investment.

CONTEXT

Inland Empire residents have among the worst health outcomes of all Californians. In 2011 San Bernadino County and Riverside were among the worst for clinical care, and second worst for physical environment among Californian counties. The overall health factors rank of SBC was 50th, with Riverside 42nd out of 56 ranked counties. A highly diverse population is seriously and disproportionately afflicted by diseases related to obesity that prove extremely challenging to mitigate. Language and cultural barriers abound, especially among recent immigrant Latinos, a major population group. Resources are limited and many gaps in services exist.

The living environment obviously affects residents of the Inland Empire, including their quality of life, years of healthy life lived, and health disparities. To change the built environment, address social determinants, and improve health status is difficult; it takes an entire community. With a sense of urgency about growing chronic diseases it must include an ongoing commitment from the health sector.

OUR STORY

LLUH engaged communities in a vision for a healthier future through the Healthy Communities Movement. Going well beyond merely improving programs, behaviors, or attitudes, it is a paradigm shift that involves a common passion for creating community 'where we all have a purpose and a sense of belonging.' With coalitions of community partners, it seeks to address social determinants of health, improved access to health services, increased health system readiness, and an enhanced built environment. Municipal governments are primary partners, but universities, school districts, health care providers, non-profit organizations, and the business sector all play critical roles. Beginning with 3 communities in 2006, in 2012 it included 22 of 24 county communities and moved into two contiguous counties.

IMPACT

Since 2010, many San Bernardino County health indicators have improved, perhaps influenced by the comprehensive multi-sectoral initiative. Social and economic factors are still unchanged but a full county has galvanized around common metrics for improving health behaviors and outcomes.

	2010	2012
Health Factors	45	41
Health Behaviors	48	45
Clinical Care	54	50
Physical & Social Factors	37	39
Physical Environment	54	55

Assess Community Health Needs and Assets

A critically important first step in the community health improvement process is to build shared knowledge through an assessment of health needs and assets. Traditional health needs assessments tend to view communities, particularly those with serious health disparities, as bleak, dysfunctional, oppressive places with little positive potential.

Yet trusted community agents have long known that the social conditions of their neighborhoods are affecting the health of their community. They have great intimacy with issues and community wisdom that can inform prevention and care strategies, as well address social determinants affecting health disparities. Health systems that engage community representatives can tap community assets—neighborhood-based knowledge, strengths, and skills—moving beyond needs assessment to harnessing other vital tools to improve community health.

Moreover, rather than paying outside experts to perform traditional CHNA, health systems can leverage publically available data sets (CDC, state and local public health department data, their own utilization data) and a community asset-mapping process, thus saving dollars that can be redirected to proven community health approaches.

Even more reason to map assets as well as needs: Documenting and mapping community assets can itself be an important way to build trusted and enduring relationships with diverse stakeholders.

Memphis Participatory Mapping and Hotspotting Methodology

Methodist Le Bonheur's (MLH) Participatory Mapping and Hotspotting Methodology demonstrates the impact of place-based population health management, shared ownership for community health investment and the data collection/metrics to support the investment.

Memphis' poorest zip code is 38109. Its 98% African-American residents experience a greater share of cardiovascular and renal disease, diabetes, and other conditions that lead to frequent hospitalizations and readmissions than any other in the city. Poor housing, unremitting stress and violence add to this chronic co-morbidity cocktail. MLH rates of readmissions, inappropriate emergency department use and charity care write-offs are concentrated in this zip code, with \$6.3 million spent there alone in 2010. Using technical hotspotting, MLH tracked these patients to the Memphis neighborhood called 'Riverview Kansas.'

To improve community health and decrease inappropriate hospital utilization, MLH turned to one of the region's greatest health 'assets'— the Congregational Health Network (CHN)—a community partnership program based on a covenant relationship with over 500 congregations.

One CHN partner in 38109 is Rev. James Kendrick, whose fledgling nonprofit Health Watch Urban Ministries renovates blighted housing, offers life and job skills training, and transports residents of these tough neighborhoods. Their aim is 'building people,' not infrastructure.

Since April 2012, MLH leaders and Kendrick have hosted active listening sessions with residents and clergy in 38109 to 'co-create' a plan to improve community health and hospital use. MLH combines this 'high-touch' relationship and capacity building—they call it 'participatory hotspotting'—with its internal GIS research. A recent CIGNA community grant award allows them to micro-grant funds to clergy and Health Watch to further these efforts.

'Ms. Mamie,' an uninsured 61-year-old, two years post cerebrovascular accident (CVA), lives in a burned-out apartment complex in 38109. MLH provided stroke care, but she remains dysarthric from her stroke and is vulnerable to crime in her area. Health Watch is helping renovate her complex, while Pastor Kendrick and CHN developed a relationship with Mamie, working to help her better self-manage her hypertension and, in case of another CVA, to get her to hospital sooner. Grateful to MLH's care for her without insurance, she wants a better life for herself, her niece and grandson.

Annualized data comparing CHN members from 2011 to 2012 (when work began in 38109) shows a drop in Hospital Readmission Rate for any reason from 24.24% to 18.18%, and a drop in DRG Readmission Rate for heart failure from 18.18% to an astounding 2.27% (>90% reduction).

Community Asset Mapping Strategies

- Survey employees and existing community partners to identify community-based organizations addressing different content areas
- Engage community members in participatory research to document and map existing assets, as well as negative factors (e.g. vacant lots, liquor outlets, fast food outlets) that can be turned to positive purposes
- Work with public sector agencies to identify community-based offices and local resources (e.g. parks, recreation areas)
- Engage business associations to identify neighborhood-level business configurations, zoning restrictions, current priorities, and emerging opportunities
- Engage religious leaders to identify current social roles and interests, and to explore areas for potential collaboration
- Engage the funding community so that writing a grant becomes the logical extension of an ongoing conversation
- Engage policymakers to build relationships for dynamic information exchange, and policy change
- Interview patients to map their individual health journeys, and community-based resources they found useful
- Geographic information systems (GIS) can be used by health systems to map or track high utilizing patients from certain areas and develop more strategic interventions, drilling down to the social determinant level, to decrease inappropriate utilization of healthcare resources
- Other mapping strategies, like the Memphis Community Health Assets Mapping Partnership (CHAMP) and their “Participatory Mapping and Hotspotting” methodology, have been developed to engage in place-based population health management.



Memphis' Community Health Assets Mapping Partnership (CHAMP)

Identify Stakeholder Roles and Contributions

A balanced approach to the identification of needs and assets positions diverse community stakeholders to play an active role in priority-setting, intervention design, action planning, implementation, and monitoring progress. Community members and organizations offer special knowledge of resident perspectives and emerging priorities, the ability to reach and engage other community members, and in-kind activities such as meeting setup, advocacy, and information/data collection, among other valuable contributions.

Health systems and other key institutions can serve as catalysts, conduits for funding, advocates for activities, investments and policy/system change, and technical assistance providers—helping with data retrieval, research design, planning expertise, legal opinions, and providers of in-kind services such as helping prepare funding proposals.

Neighborhood Care Staff/Agents of Change Training in our Neighborhoods (ACTION)

St. Joseph Health-Sonoma County's community programs, NCS/ACTION, are place-based population health management and 'shared ownership for community health' investments

For many people in Sonoma County, the basic conditions that support health and well-being seem out of reach. Families struggle financially and many youth do not graduate from high school. Sedentary lifestyles and unhealthy eating contribute to increasing levels of obesity and overweight, yet access to affordable healthy foods and opportunities for physical activity is often lacking. Tobacco use and substance abuse, unhealthy community conditions, and lack of access to health and support services also contribute to preventable illness and inhibit a healthy community.

St. Joseph Health-Sonoma County continues a 400-year community action legacy of the Sisters of St. Joseph through its Community Benefit Department, healthy communities programs, Neighborhood Care Staff (NCS), and grassroots leadership development programs—Agents of Change Training in our Neighborhoods (ACTION). Through NCS, the hospital transcends its walls to help people help themselves. Every major achievement of NCS has started small: handshake by handshake, door by door, NCS organizers are building relationships across the county.

An NCS organizer, once having attracted a core group of willing community leaders or activists, facilitates their dialogue, helps them define and focus their values, issues, and actions—not NCS values or agenda. Deeply rooted in the principles and practices of social justice and healthy communities, ACTION leadership training then helps the group build its capacity for collective action and develop local Agents of Change.

ACTION graduates have addressed violence and adversarial relationships between law enforcement and Latino residents by creating an annual, violence-free Cinco de Mayo celebration, led and supervised by residents, that attracts up to 10,000 people each year. Others have successfully petitioned the blocking of new liquor stores in a neighborhood, partnered with the Redwood Empire Food Bank to expand its summer lunch program; organized multiple community gardens, created a farm cooperative through a partnership with day laborers and a local church; and initiated bilingual community radio shows led by children, adolescents, and adults.

Sandy and Lizbeth, with support from NCS and ACTION training, decided to help form Nuestra Voz (Our Voice). It seeks to engage and educate the local Latino community to improve and protect the health of their neighborhood. Visiting the library weekly, they selected stories to read on the air, birthing the new radio show, 'Nuestras Voces' ('Our Little Voices'). It engaged children and youth in discussions about the stories, and brought guests to address issues important to them. The children also received ACTION training, becoming recognized leaders within their organization, Nuestra Voz. In creating a new vision for themselves and their communities, Sandy and Lizbeth, grew in confidence. Supported by scholarships, Sandy is now completing her degree in psychology and Lizbeth studies medicine to become a pediatrician.

ACTION-trained leaders of Nuestra Voz have had many environmental, policy, and social impacts. In 2011 the Sonoma County Board of Supervisors partnered with the Larsen Park Garden Coalition to create the first-ever community food garden located in a Sonoma County regional park, in a community-driven effort to increase access to healthy foods and take public spaces from local gangs. The county contracted with Nuestra Voz to build, operate and maintain the garden.

Local Spanish-speaking women, concerned about poor food being served to their children in schools, felt powerless. With support from Nuestra Voz, they entered into dialogue with the Sonoma Valley Unified School District's Food Services Director. Within months, the District was offering healthier choices and establishing a new relationship with the local Latino community.

Ask: ‘What’s Valuable to this Community?’ What Measures will Ring True with those Values?’ Then, Collaboratively Set Measures of Success.



Advocate Health Care's CEASEFIRE Violence Interrupter meets with Patient

In its 2012 report, *An Integrated Framework for Assessing the Value of Community-Based Prevention*, the IOM discusses three domains of community-based prevention: health, community well-being, and community process. It also posits all three as outcomes, including the community process itself:

The value of an intervention depends on the community's perspectives, beliefs, and priorities. The value of an intervention also hinges on how, where, and how effectively it is carried out ... Decision makers should consult with the community and other stakeholders to ensure that the value of community-based prevention policies and wellness strategies reflect their preferences. Even if the appropriate decision makers are involved, they must be sure to make decisions in the right way in order to gain legitimacy. The committee's framework emphasizes the importance of transparency. Open and transparent assessments of the value of a given intervention can enhance its legitimacy among community members.⁶⁰

Community-Based Participatory Research (CBPR) is one acknowledged approach to dealing with communities in this way. It provides a reliable set of guidelines for setting program metrics that are academically rigorous yet understandable and acceptable to community participants. The University of Michigan's Barbara Israel and University of California, San Francisco's Lawrence Green have identified key principles of CBPR as a continuum that includes: building on community strengths and resources; facilitating a collaborative, equitable partnership in all phases of the research; taking an ecological perspective that attends to social inequities and the social determinants of health; disseminating results to all partners and involving them in that process; and having a commitment to sustainability. While traditional research might create knowledge to advance a field, or for knowledge sake, CBPR is described as 'an iterative process, incorporating research, reflection, and action in a cyclical process.'⁶¹

Another recent approach developed within the context of public health is that of Community Health Assets Mapping Partnership (CHAMP), based on an earlier framework for mapping and assessing 'religious health assets' and since applied in Methodist Le Bonheur Healthcare's Congregational Health Network model in Memphis (as well as elsewhere in the world, for palliative care). It also produces a range of community defined measures that assist in building and sustaining durable partnerships.

⁶⁰ Committee on Valuing Community-Based, Non-Clinical Prevention Programs, Institute of Medicine, Report Brief, *An Integrated Framework for Assessing the Value of Community-Based Prevention* (November 2012): 3.

⁶¹ Green et al. 2003; Israel et al. 2003)

Link Key Measures to Important Health System Priorities in a Way That All Leaders Can Understand and Embrace.

What do faith community nursing and community health workers have to do with a healthier bottom line? Community health metrics need to be relatable and culturally competent—not only on the ‘outside,’ but within the health system as well. Do they speak the language of finance?

Clinical quality and safety? Strategic planning? If the faith community nurses or community health workers are making home visits to post-discharge patients and reducing likely readmissions, then the metrics need to plainly make that connection. Broadly speaking, community health programs and partnerships need clear institutional alignment with the health system’s strategic direction, and the metrics that govern it.

Henry Ford’s Community Pillar is ‘Weight-Bearing and Accountable’

In conferring upon Henry Ford Health System the coveted Malcolm Baldrige National Quality Award for 2011, Baldrige examiners noted the health system’s highly aligned focus on community as a strong distinguishing factor. Henry Ford’s Community Pillar is the epicenter of all community engagement and health improvement strategies for the system – the forum where Community Health Needs Assessment and Community Benefits interact, with robust targets and measurable outcomes. Pillar metrics are board-reportable and institutionally aligned—as weight-bearing and accountable as any finance target. Quarterly, the Community Pillar Team convenes high-ranking leaders from the health system’s seven business units to review metrics on strategic objectives in key areas of infrastructure and community benefit, wellness, access, equity, and new and emerging programs/partnerships. Working groups in each of these areas meet regularly for greater alignment.

The ‘Henry Ford Experience’ is built on seven pillars representing its strategic priorities: People, Service, Quality & Safety, Growth, Research & Education, Finance, and Community. The Community Pillar has equal standing with every other pillar, and its goals are aligned synergistically with other pillar goals. For example, the Equity initiatives of the Community Pillar link strongly to related initiatives in Quality & Safety, in keeping with the Institute of Medicine’s designation of Equity as one of the six aims of Quality.

As part of the Community Pillar, the Healthcare Equity Campaign has gained national recognition for its comprehensive goal to increase knowledge, awareness, and opportunities to ensure that healthcare equity is understood and practiced by system providers and other staff, the research community, and the community-at-large, and to link healthcare equity as a key measurable aspect of clinical quality. Administered through the system’s Institute on Multicultural Health, the Campaign touched all seven performance pillars over its three years (2009-2012). Among other strategies, the campaign, with others: developed a strong communications platform to raise awareness on equity and disparities as measured by the AMA-originated instrument, the AREA Scale; created and implemented original continuing education credit programs around equity, uprooting racism, and cultural competency, including an online course; brought in nationally known speakers; collaborated with researchers and registration teams to modify patient registration tables to include race-ethnicity and language fields; worked closely with system quality leaders to designate an ever-increasing number of quality measures stratified by race-ethnicity; and collaborated with diversity leaders to plan and sponsor numerous community events including MLK Day and diversity celebrations attended by more than 400 guests annually.

A direct result of the Community Pillar’s Equity focus: more than 300 Healthcare Equity Ambassadors have been trained; over 7,500 employee and continuing education contact hours logged; more than 360,000 patient self-reported race-ethnicity/language forms entered into the point-of-service registration system; and focus groups conducted within five diverse racial-ethnic communities to better understand how healthcare equity programs can contribute to Southeast Michigan’s richly diverse multicultural population (recognizing and, wherever possible, working with existing health beliefs and cultural preferences). A national partnership has been established with the Johns Hopkins’ Center for Health Disparities Solutions (Culture-Quality-Collaborative), five pilot patient-care projects have been funded through the Gail and Lois Warden Endowed Chair in Multicultural Health, 14 system boards and leadership academies have undergone equity education, residency programs now include equity and cultural competency coursework, and a tailored version of the CME/CEU program is being rolled out to an additional 500 community providers as one of three objectives of the \$2.6-million grant-funded Sew Up the Safety Net for Women and Children project of the Detroit Regional Infant Mortality Reduction Task Force.

Find and Leverage the Natural, Strategic Synergies Between Community Needs and Assets, and Health System Goals and Competencies.

From the community, these natural points of synergy could include Medicaid outreach locations, faith-based organizations as sites for healthy cooking classes, and an urban farming network for neighborhood farmers' markets. From the health system perspective, such core competencies could include prevention or disease management programs that can be opened up to community members, and employee volunteerism focused on organizations whose missions contribute to healthier communities.

Comprehensive approaches to health improvement involve the coordination and alignment of multiple actions, in which some focus on the delivery of professional services, while others focus on areas such as physical development or policy advocacy. Each activity is informed and advanced by different forms and levels of engagement among community stakeholders.

Advocate Christ Medical Center & CeaseFire Partnership: Hospital-Based Violence Reduction Program

Advocate Health Care provides a quarter of trauma care for Illinois, mostly unreimbursed. At Advocate Christ Medical Center, a Level 1 Trauma Center, physicians and staff began to recognize patients who were being admitted multiple times and partnered with Chicago-based CeaseFire, which has been effective in reducing community violence rates. The partnership offers services to trauma patients, their families, and communities, within an hour of a violent incident. Conversations happen when patients are willing and able to reflect on the import of retaliation and the cycle of violence they are caught up in.

In Chicago, violence is a leading cause of death for people between 15-34 years. The majority are male, low income, young and minorities. This deadly violence is concentrated in communities with high unemployment rates, few business opportunities and limited social service resources. Repeat violent injury patterns are common. According to one study, after being victimized once, a person's risk of being violently re-injured is 1.5 to 2.4 times greater than an individual who has never been victimized. In communities where violence is an accepted method of resolving conflict, victims and their families are also highly susceptible to retaliation.

In 2005, Advocate Christ Medical Center, a Level 1 Trauma Center, partnered with CeaseFire to develop the region's first hospital-based gun violence prevention project. CeaseFire, which works in five 'hotspot' communities that overlap with Christ Medical Center's service area, employs trained 'violence interrupters' and 'community-based outreach workers.' The violence interrupters—individuals who may previously have been in street gangs—use cognitive-behavioral methods to mediate conflict between gangs, and intervene to stop the cycle of retaliatory violence that threatens after a shooting. Professionally trained and credible, they are able to work effectively with highest-risk individuals to change thinking around violent behavior. The community-based outreach workers provide counseling and services to high risk individuals in communities with high violence rates.

The program builds on the strong role of chaplains already working in the Emergency Department as part of the trauma care team. When a gunshot victim is admitted, an Advocate chaplain alerts the hospital response coordinator, who is available 24/7, to their pending arrival. Hospital responders immediately work one-on-one with the victim, and family and friends, to diffuse tension and reduce the risk of retaliation. Responders are street-savvy individuals (many are ex-offenders) with strong community ties to the high-risk population. They leverage their network of contacts with CeaseFire 'violence interrupters' to mediate conflicts and squash retaliations.

Dante, previously in a gang, forged a strong bond with the hospital case manager, whose own 'street history' allowed Dante to confide about serious family and social issues he faces in his transition away from the street activity. In the course of these conversations, the hospital case manager supported Dante, encouraging him to seek clinical care from a licensed therapist. Due to the stigma associated with mental health issues and treatment within his community, it would have been very difficult for another intervener to successfully connect Dante with the services needed.

In 2011, the Christ CeaseFire Violence Prevention Project responded to a total of 580 incidents of violent injury and connected 298 patients to community-based violence interrupters. While unable yet to assess actual impact on costs, Advocate Christ Medical Center invested \$120,000 in 2013 to support the case manager role. The program's success has led to its replication at two other Chicago trauma centers.

A Systems Approach to Health Literacy and Strategic Communications is Key.

Health literacy goes beyond assessing the reading level of a document. It spans all opportunities to help patients/persons engage fully in taking care of their health, and easing navigation of seemingly convoluted, oft-siloed systems of care. A ‘systems approach’ to health literacy, as described in *Health Affairs* (February 2013), will increase opportunities for individuals within target populations not only to understand their options, but to participate as full partners in understanding them, take advantage of community supports, and make informed decisions—all of which support improved outcomes. Such an approach features a hand-in-glove alignment with care processes, every step of the way.⁶²

In June 2012, the Institute of Medicine released the discussion paper, ‘Ten Attributes of Health Literate Health Care Organizations.’ Prepared by the IOM Roundtable on Health Literacy, the paper notes that at least 77 million Americans have limited health literacy, and many more have difficulty understanding and using available health information and services.⁶³

Authors describe a ‘health-literate health care organization’ as one that: makes health literacy a priority at all levels, integrating it into planning, evaluation measures, patient safety, and quality improvement; includes populations served in the design, implementation, and evaluation of health information and services; meets the needs of populations with a range of health literacy skills while avoiding stigma; uses health literacy strategies in interpersonal communications and confirms understanding at all points; provides easy access to health information and services and navigation assistance; designs and distributes content that is easy to understand and act on; and addresses health literacy in high-risk situations, including care transitions and communications about medicines.⁶⁴

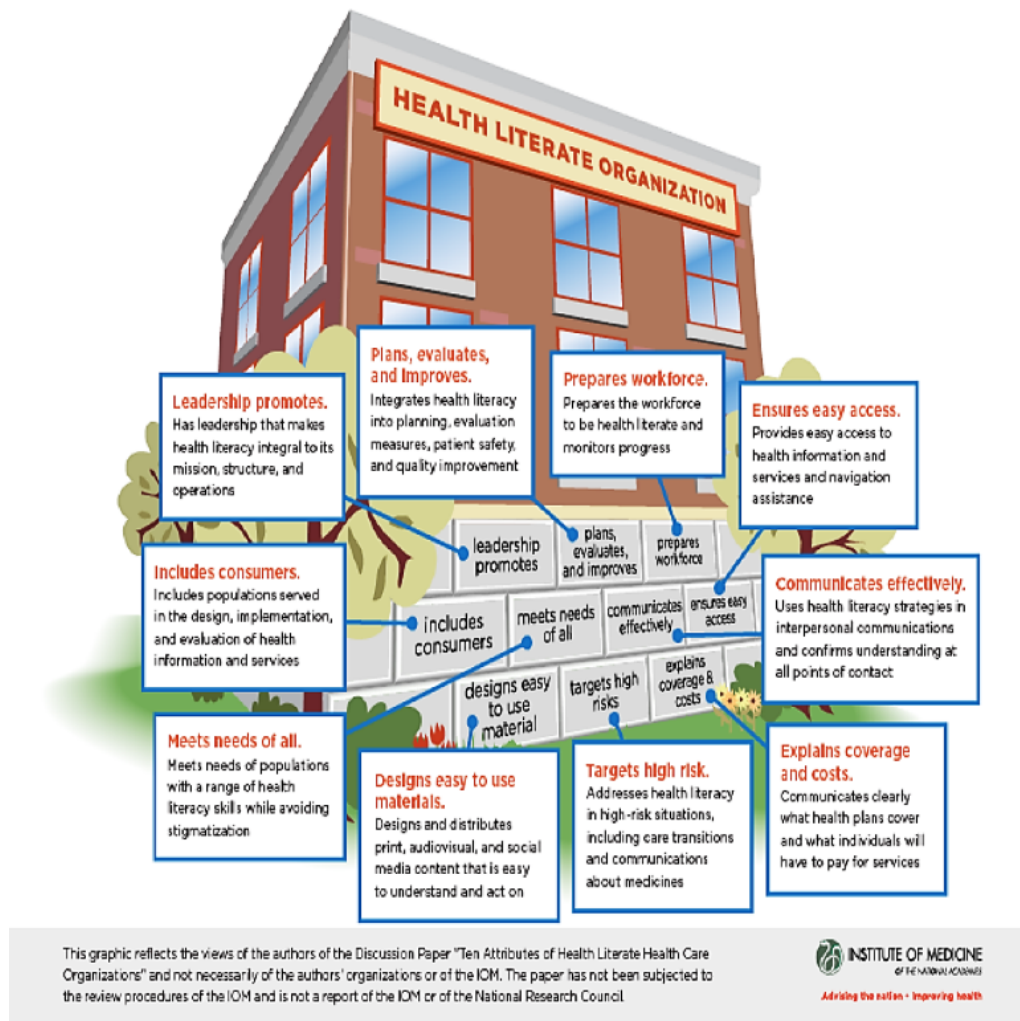
The IOM workgroup aims its paper primarily to clinical audiences, but without exception the attributes proposed are also highly applicable in community settings. In fact, to be effective, the clinical attributes must resonate outside the clinical environment. It is within communities that clinically originated communications can be vetted, enriched, and empowered to make a difference in patients’ day-to-day lives, the lives they live outside the doctor’s office.⁶⁵

⁶² Howard K. Koh, Cindy Brach, Linda M. Harris and Michael L. Parchman, A Proposed ‘Health Literate Care Model’ Would Constitute A Systems Approach To Improving Patients’ Engagement In Care, *Health Affairs*, 32, no.2 (2013):357-367

⁶³ Cindy Brach, Debra Keller, Lyla M. Hernandez, Cynthia Baur, Ruth Parker, Benard Dreyer, Paul Schyve, Andrew J. Lemerise, and Dean Schillinger, National Academy of Sciences Institute of Medicine Roundtable on Health Literacy, Ten Attributes of Health Literate Health Care Organizations (June 2012):1 http://iom.edu/~media/Files/Perspectives-Files/2012/Discussion-Papers/BPH_Ten_HLit_Attributes.pdf

⁶⁴ Brach et al: 3

⁶⁵ Brach et al: 5



To build awareness and engage stakeholders, program leaders often will find win-win's with health system communications, marketing, and fund development staff, as well as community benefit departments looking for great stories to tell or important issues to illustrate. Teams will want to inventory and leverage all available communications vehicles, including social media, to inform stakeholders of progress toward goals, engage new stakeholders, and support specific program objectives. Promotional, educational, and informational resources should be culturally competent and powerful in their venues—drawing participants, internal and external stakeholders, and funders alike.

Leaders can harness the power of stories and testimonials to bring the data to life. Champions inside and outside the health system—clinicians, pastors, participants, trusted community members, and sometimes even celebrities—can be recruited, cultivated, and equipped with key messages. Milestones can be celebrated.

Last, program communications themselves need to be measurable. Metrics can include but are not limited to focus groups, pre- and post-surveys, client interviews, web hits and responses, enrollment, and trended shifts in attitude and behavior. The evaluation should include both lead and lag measures, so that mid-course corrections can be made as needed.

Summary

The case for transformative community partnership to improve individual and community health—as well as the health of the bottom line—is increasingly compelling. Respected national medical and quality organizations, public health at all levels, the academic community, and foundations know this. Health systems are learning it, and many are sharing successes with demonstrated, replicable outcomes based on the population health model.

Embracing yet transcending traditional categories of community benefit, transformative community partnership is assets- as well as needs-based. It leverages the new possibilities inherent in the Affordable Care Act—including the hoped-for Medicaid expansion. In addition to calling forth new skills, transformative partnership also leverages core competencies that health systems and community organizations already have in place.

Health systems today face pressing needs to increase access to prevention and primary care, and develop person-centered, place-based care models to lessen the load on emergency departments and reduce readmissions. Each high-leverage clinical priority opens new doors for transformative community partnerships that return the health systems' investment of time and money many times over—and result in sustainable health improvement empowered by the common good.



HSLG Meeting, Henry Ford Health System, Detroit, October 2012

Chapter 7

Creating the Beloved Community of Health

“Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

– *Dr. Martin Luther King, Jr.*

On the anniversary of Dr. King’s assassination, executives from some of our nation’s leading faith-based and values-inspired health care organizations gathered in Washington, D.C. to discuss their shared mission in creating a more just and humane health care system. The White House-sponsored gathering of the Health Systems Learning Group was an historic opportunity to reconsider the distinctive role of charitable health care institutions in shaping the future of American health care. The group was reminded of Dr. King’s prophetic words that “...the arc of the moral universe is long but it bends toward justice.” How can health systems, rooted in faith and shared human values, help to lead the nation toward the prophetic goal of equitable health care for every citizen? How can a vision of a more just health care system inspire action that will lead to what Dr. King called the “beloved community?” The work of the Health Systems Learning Group is energized by the conviction that we can collaborate in offering some of the most creative responses to these vital questions.

A careful look at the heritage of the participating organizations in the Health Systems Learning Group provides an inspiring reminder of the foundational principles we cherish and hold in common. While not all of the participating organizations are historically faith-based, all share the core commitment to building the health of our communities above other motivations. The goal of equitable health care for all members of our communities is paramount. We accept our responsibility to be prophetic voices in society, calling for and demonstrating distributive justice and more effective commitment to the common good.

In this final chapter, we express fully and directly the shared convictions that move us toward a more visionary future for health care that is free of preventable disparities. We celebrate the fact that we are called to lead institutions that have thrived in mission effectiveness, integration, and accomplishment — even during difficult financial times and the vicissitudes of seemingly incoherent reimbursement schemes. We understand that clarity about our fundamental beliefs and their accompanying values is essential if the work we do is to be sustained through the dramatic changes now needed in American health care. Here, then, in summary form, are some of the most important of these shared convictions.

We believe that we are created as whole persons — each one a unity of body, mind, and spirit. **Health is wholeness**, not simply the absence of disease. **Healing is restoration of that wholeness** and should always attend to the physical, emotional, mental, spiritual and communal dimensions of personhood. Abundant life for all requires accessible, affordable, and accountable institutions that address the needs and possibilities of the whole person.

Health care is first and foremost a matter of love and service, grounded in mission, purpose, and values. Some of our institutions make their religious identity and spirituality explicit, while others do so implicitly. But all provide significant opportunities for their employees and physicians to live lives of meaning, good work, respectful community, and recognition of the transcendent.

Health care should never be reduced to a commodity. Healthcare disparities are the clearest expression of the need for these missions to continue.

We believe that every person is deserving of compassionate health care that attends to the needs and the resources of the whole person. No one is left out; everyone counts. And our communities cannot experience their full potential when glaring health disparities continue to be inadequately addressed. These glaring disparities within the United States become even more challenging when the needs of persons in the developing world are considered. For them healthcare begins with core needs for sanitation, clean water, and vaccinations.

We believe that the distinctive needs of those who are most vulnerable, whose conditions are most difficult and complex, and whose resources are most limited, should receive strategic priority. Faith-based healthcare institutions universally began their missions by attending to the needs of the poor, vulnerable, and dying. We will never abandon our commitment to respond to their pleas for mercy, no matter how challenging or inconvenient.

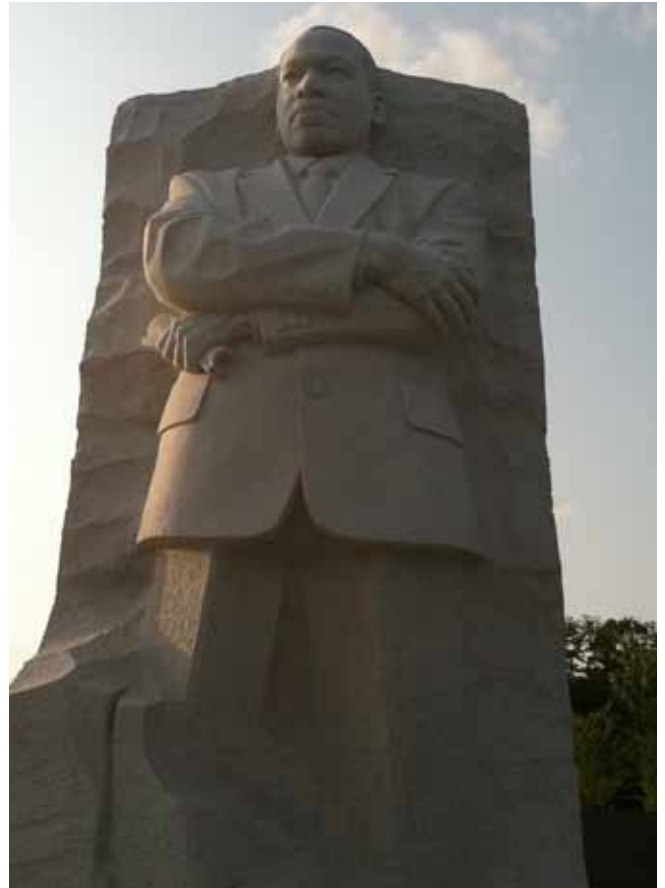
We believe that primacy should be given to addressing the social determinants of health, as well as prevention of disease, accidents, and violence. Healthy living requires a community of health. While we will always strive to provide the highest quality, safest, and most affordable health care, we will also constantly seek to give priority to the promotion of healthful living for entire communities.

We believe that we are called to create new forms of collaboration for health in our communities. We intend to foster cooperative efforts among organizations that share our commitment to human health and equitable access to care. We are committed to transformative partnerships. And, we welcome accountability to our communities for this cooperation.

We are committed to the highest levels of integrity and transparency in the operations of our health systems. We believe we should establish exemplary business practices that bear full scrutiny by the communities we serve. It is essential that we offer the most effective services to meet people's needs in the most efficient manner possible.

We celebrate the richness of human diversity among those we serve and those we employ for that service. We commit ourselves to ensuring respect for the dignity of every person. One of the surest signs that the beloved community of compassion and fairness is emerging is this commitment to fully embrace diversity and inclusivity.

As we continue to build on these foundational commitments, we accept our responsibility to lead organizations that will pioneer new ways of achieving truly healthy communities. We know we have a significant role in helping to create and sustain communities that invite the engagement of all members – communities that sense both their shared heritage and their shared future. We intend to lead, without fear, from a clear vision of that future. Because we believe that love for humanity is the strongest moral force on the earth, and because we believe that love overcomes fear, we have the audacity to believe in a future in which a healthy, beloved community is an achievable reality. We commit all our HSLG organizations to achieving this hope-filled goal.



Dr. Martin Luther King, Jr. Monument, Washington, D.C.

Chapter 8

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Chapter 9

Appendices

APPENDIX 1

Basic Principles

We recommend approaches that:

- Are multi-sectoral
- Are positive and asset-based
- Are collaborative
- Assume the community is a mutual partner in the work
- Build on our existing strengths—what are we already doing that's working?
Learn more about our own approaches, share and learn with others
- Keep the focus on the root cause—not on managing disease
- Advocate for policies that support just and equitable resources and conditions for communities to function well
(As Sir Michael Marmot has said, "All policy is health policy.")
- Strive for collective impact
- Connect hospital leadership and staff more directly with people in the community. When people talk and connect, it becomes more clear what needs to be done
- Are innovative. ("If we wait to act until we have evidence-based practices, we will be 10 years behind." - Steve Tierney, MD)
- Are accountable through measured outcomes and rigorous evaluation. Metrics may include:
 - Readmissions rates
 - ED use
 - Community relations scores
 - Costs per patient
- Use techniques such as geo-mapping to identify 'hot spot' areas for strategic intervention
- Connect and integrate with public health partners and strategies
- Use an approach based on the Studer Group 'Flywheel' for achieving results
 - Be rooted in the mission—the 'why'
 - Connect people with the 'why' and their own sense of calling
 - Use key principles to carry out prescribed actions (these principles would not be the same ones identified by Studer which were developed for performance improvement among hospital staff. Part of the learning task ahead is to figure out what the key principles are for achieving results in addressing social determinants)
 - Measure results



Acacia Salatti of HHS and Gary Shorb of Methodist, April 4th Leadership Summit

APPENDIX 2

Archetypical Patients: Examples of Costly and Socially-Complex Patients

1. FREQUENT ED USERS

These include patients that present frequently to the Emergency Department with legitimate health concerns overlying a foundation of major social issues which generally precipitate their ED visits. An ED utilization range of 20-30 times per year is not uncommon by this group of individuals. The individual's tenuous grasp on health stability is easily shattered by what may be considered a minor inconvenience for individuals in middle class categories. The ER then becomes the main home base or security net for the patient's multiple social needs, focused primarily on their health issue. The unstable housing may be the result of homelessness due to unemployment or underemployment, behavioral health issues that may require supervised housing, or unhealthy home environmental factors such as mold, lack of heat or unsanitary conditions (such as roach, rat or bed-bug infestation, for example) among many others. Common examples include:

a. The Medically Complex Homeless Patient

A 53-year-old homeless patient is frequently escorted to the ED by the police following their repeated encounters. The individual is brought in for a variety of reasons over time—including the individual's evident medical conditions (diabetes, foot ulcers and, on occasion, chest pain) or simply a lack of adequate social supports in a particular situation (e.g. cold winter nights). In addition, these patients often have one or more psychiatric mental health issue (e.g. psychotic, manic depression, etc.), or a history of alcoholism or substance abuse.

b. The Chronically Sick Child

This young child with asthma lives in a sub-standard housing/low income neighborhood, with mold and roach infestation in their apartment. These asthma triggers repeatedly force the child's parents to bring the child to the ED. Parents may also smoke without an understanding of the harm second- and third-hand smoke imposes on their asthmatic child. Such parents are often low income with limited English-speaking skills. These parents are often lacking the knowledge of their rights as tenants. As a result they do not pursue avenues for living condition improvements. They also do not understand the treatment plan, correct use of the nebulizer and potentially have difficulty accessing the medication. These factors impact their medication adherence resulting in frequent ED visits that require treatment as well as a significant impact on the frequency of absences from work by the parent, if they are indeed employed. Commonly, the high degree of school absenteeism of the student due to asthmatic episodes impacts the educational status of the child, and can ultimately lead to life-long educational and employment failures.

2. EXAMPLES OF THE USE OF THE ED AS THE MEDICAL HOME OPTION

Insured Patient: Lack of access to a community provider. This patient has insurance, is working but unable to get access to a primary care physician. The waiting period to get an appointment is three months but he/she needs to get in ASAP. The patient is a heavy smoker. The patient wants to start smoking cessation but it is impossible to get an appointment. By going to the ED, the patient thinks they might be able to get what is needed. The lack of primary care access leads to misuse of the ED because the patient has no other available.

Uninsured/undocumented patient: This patient shows up at the ED in need of care and with limited English-speaking skills and is not connected to a primary care physician. The patient has not been feeling well for a while and is here illegally. He/she tried to get care at a federally qualified community health center but the staff there started to ask general information questions, so the patient turned around and went out the door. She has no choice but to go to the ED.

3. INAPPROPRIATE USE OF AMBULANCE:

This school-aged student lives in a low-income neighborhood. The school nurse is aware the student is taking medications but it is difficult to keep track of medication changes. This child has been prescribed new meds by her doctor but the school nurse has not been informed of the medications and cannot provide them to the child. In other cases, the child stopped taking her meds on her own and is now showing serious behavioral issues. The principal at the school where she attends has to call an ambulance for this child again in the middle of the morning. Calling the ambulance is not unusual at this school for this reason. Every time the ambulance is called it not only adds to health care costs but causes a significant disruption of the normal routine of the students.

Other Reasons for misuse of EMS and ED

(compiled from a focus group with UMass Memorial ED and EMS staff for the Community Health Needs Assessment)

- Lack of primary care doctors leads to misuse of EMS/ED—they have no other resources
- There is also a misperception that if you arrive to the ED in an ambulance that you will be given priority in terms of when seen—which is not the case; it is based on seriousness and urgency.
- Some perceive EMS/ambulance/ED as an opportunity for free care.

Substance Abuse:

- EMS services & the ED are the 'dumping ground' for those who are intoxicated/ under the influence of drugs
- Chronic alcoholics seen in the ED tend to be in the 30-60-year-old range
- Chronic alcoholism/substance abuse/ homelessness and mental illness all go hand in hand and as referenced in (2.), above, these often result in multiple repeat visits for the same patients for these issues
- Elderly and frail (due to falls, dementia, etc). These patients end up in acute care but need intermediate care.

APPENDIX 3

QUALITIES OF MEANINGFUL COMMUNITY PARTNERSHIP

- Relationships characterized by mutual trust, respect, and commitment to the partnership itself, as well as its shared vision
- Aligned with principles of Collective Impact
- Diversity with both depth and breadth, representing all communities of interest and stakeholder groups and levels of engagement (e.g. individuals to government).
- Shared learning in the open, including successes and challenges
- Specific purpose mutually defined to drive shared risks, responsibilities, accountability, mission, values, goals, measurable outcomes and resources
- Continually works towards an equitably shared and democratic balance of power
- Clear and open communication that creates a safe environment
- Respects self-interests, and strives to be curious versus defensive
- Plans and processes are established with input and agreement of all, especially those regarding decision-making and conflict resolution, with established mechanisms for feedback
- Self-sustaining; building on its own strengths and assets, identifying opportunities to build capacity
- All members are stewards of the partnership's integrity
- Culturally competent, in the broadest sense, within the healthcare system and organizations



Fred Smith of Wesley Seminary and Thomas Strauss of Summa Health System at the April 4, 2013 Leadership Summit