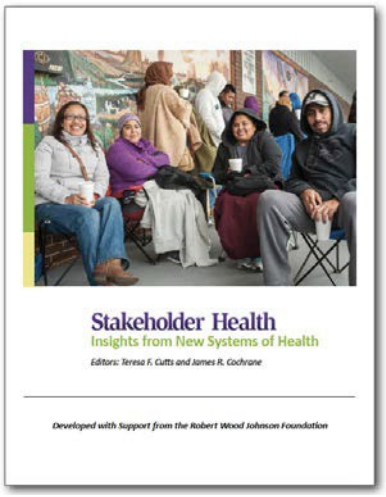
Stakeholder Health

Chapter 8

Financial Accounting that Produces Health



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CHAPTER 8

Financial Accounting that Produces Health

Kevin Barnett with Teresa Cutts and Jeremy Moseley

Overview

In 1948, the United Nations approved the Universal Declaration of Human Rights, Article 25 that states "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, medical care, and necessary social services" (United Nations, 1948). The establishment of health as a basic human right would appear to position it beyond economic considerations, but the practical reality is that governments and others make daily decisions about systems of taxation, economic incentives, and allocation of resources that directly impact the health and well-being of individuals, families, and populations.

As the wealthiest nation on the planet, one committed to the idea of minimally regulated capitalism, we are engaged in a perpetual struggle between two versions of reality. On one hand, we see ourselves through a lens of what some would refer to as a delusion of rugged individualism, where we are the masters of our own destiny, and all who work hard and play by the rules will succeed. A more sober analysis leads us to recognize that there are winners and losers in our capitalist enterprise, and there is a need for investment of resources to provide support and/or create opportunities for those who may be less fortunate or capable of providing for themselves. While providing this support may be viewed as essential in an advanced society, determining what forms, how much, and when to provide it calls for an assessment of costs and the associated returns on these investments.

What we are learning, and will discuss in this chapter, is the fact that inadequate investment in addressing the social determinants of health often results in more costly negative outcomes. This is so whether we are talking about a lack of investment in disease prevention that then yields high acuity and costly inpatient care for preventable chronic conditions, or about a lack of investment in early childhood education which contributes to higher costs for special education in the medium term and higher rates of incarceration over the long term. In this context, the driving motivation may be a commitment to make better business investments at the societal level.

At present, the U.S. ranks last among 11 peer countries on dimensions of access, efficiency, and health care equity (David, Stremikis & Shoen, 2014). Whereas Organization for Economic Cooperation and Development countries (OECD) spend an average of $2 on social services for every $1 spent on health care, the United States spends 60 cents (Bradley & Taylor, 2013). Table I highlights the disparity, which is driven at least in part by higher per capita costs for health care. For example, while the U.S. has shorter lengths of stay in hospitals and fewer discharges per 1000 people, spending per discharge in 2009 was $18,142, compared to $11,112 in Denmark, $5,204 in France, and $5,072 in Germany. In addition, prices for drugs in the U.S. are one third higher than in Canada and Germany, and double what is spent in Australia, France, and the U.K. (Squires, 2012).

There are multiple factors driving the disparity in health care and social service expenditures between the U.S. and other developed nations. In some cases, we have chosen to charge more on a per capita basis for the same goods and services than other countries; in others, we have decided that regardless of our assets, we do not focus on providing affordable childcare, education, housing, and transportation

at the level that matches other economically advanced countries. It is unavoidable that these decisions made in the public and private sector impact health and well-being at the family, community, and societal level.

In this chapter, we'll first summarize current dynamics and emerging trends in the context of health reform with a focus on implications in the shift from fee-for-service to value-based reimbursement. Next we'll discuss how the history and legacy of discrimination has created pockets of extreme poverty, social dysfunction, and persistent health problems in communities across the country. These geographic concentrations of economic, social, and health inequities highlight the need for focused attention and investment not just by health care organizations but by a broad spectrum of stakeholders across sectors in order to produce meaningful and sustainable improvement. This may be one of the most significant challenges we face in building a healthy society in the coming years.

We will then review the emerging focus on comprehensive approaches to health improvement that leverage the resources of the health and community development sectors. We'll also explore the emerging roles of employers as potential partners in health production, touching on some of the most innovative practices and outcomes to date. Finally, we close the chapter by sharing sample innovative practices of Stakeholder Health members that build systems to support and reinforce an ethic of shared ownership for health with the broader community.

From Bradley et al, 2011

Health Care Financing in Context: Considering the Challenges

Fee-for-service (FFS) reimbursement has been the predominant form of payment for health care in the 20th and the 21st Centuries. This form of payment rewards the producers of increasingly costly procedures, equipment, pharmaceuticals, and facilities for treatment of illnesses (many of which are preventable). Not only has the capital necessary to finance this medical care juggernaut been allocated at the expense of investments in the leading causes of life, but it has also contributed to an erosion in the profitability of other economic sectors.

In the face of the continued escalation of costs in recent decades, health care leaders increasingly recognize that the FFS model is unsustainable. The passage of the Affordable Care Act (ACA) has put into play an incremental series of changes that are gradually but inexorably moving us towards what is currently referred to as "pay for value," a generalized term that is intended to communicate a shift in financial incentives away from conducting procedures and filling beds and towards keeping people healthy and out of clinical care settings. We used to call this form of payment capitation, until that term became associated with the practices of some insurers in the 1990s when care "gatekeepers" focused more on limiting access to specialty services than proactively managing care (i.e., with an emphasis on prevention).

Examples of incremental steps in the evolution to a "pay for value" system have included, but are not limited to, "bundling" payments for sets of procedures for a particular diagnosis, establishing shared savings for achievement of established quality metrics and associated utilization patterns for population groups, and limiting reimbursement for readmissions for particular procedures, as CMS has done in recent years. A growing number of providers and payers have made a more complete shift to full-risk capitation, or what is most often referred to as global budgeting.

The ACA has significantly expanded coverage, despite the fact that only 30 of 50 states have participated in the Medicaid expansion to date. Medicaid coverage has increased by 14 million since October 2013, and reports indicate that this expansion has not resulted in a reduction in employer-based coverage (Lyons, 2015). Most new enrollees are low-to-moderate income individuals that receive some form of subsidies. While there were concerns about the risk pool of new enrollees, approximately half are under 35, and it appears that the newly insured are in better health than those who remain uninsured.

Uninsured rates were 10.5% in the second quarter of 2015, down from 16.6% in 2013. States that participated in the Medicaid expansion experienced reductions in the percentage of uninsured from 14.9% in 2013 to 8.5% in 2015 (Kaiser Family Foundation, 2015). Gaps in coverage still exist for approximately 3 million adults who are low-wage workers who don't meet income thresholds, live in states that are not expanding Medicaid, or are undocumented immigrants. Most of those individuals live in states like Texas, Florida, Georgia, and North Carolina.

The combined impact of an expansion in coverage to low-to-moderate income individuals (who live in communities where social determinants serve as obstacles to desired health behaviors) and the assumption of financial risk presents an immense challenge to providers in the years ahead. A current CMS program that ties Medicare reimbursement to improved performance will reduce payments by 1% for the lowest performing quartile of hospitals in 2016, with a net estimated reduction of $364 million in spending for those 700-800 hospitals (Evans, 2015).

Some have made the case that it will be difficult for low performers to improve because the CMS risk adjustment measure fails to adequately reflect that poor and sicker patients with more complex conditions will continue to experience disproportionate adverse events. CMS recently acknowledged that Medicare underpays for dual eligible patients (i.e., those who are both poor and either elderly or disabled), and has launched a retrospective analysis of 2014 data. Preliminary indications are that CMS

overpays for beneficiaries with low medical costs, and underpays for those with high costs. CMS plans to publish final changes in February 2016 (Dickson, 2015).

On the positive side, states that have implemented the Medicaid expansion have reported savings in behavioral health, criminal justice, and uncompensated care as well as increased revenue (Cunningham et al., 2015). Federal officials have calculated that charity care has dropped by $3.9 billion in states that expanded Medicaid. At the same time, Medicaid shortfalls have expanded. Medicaid shortfalls accounted for 48% of what hospitals reported as community benefit in 2013, a figure that is approximately twice as large as was reported for charity care (24%). As part of a strategy to better target resources, health systems like Dignity Health have indicated that they are directing an increasing share of their community benefit dollars to increase access to primary care for Medicaid patients (Evans, 2015).

The imperative for a more comprehensive approach to improving health and reversing the prevalence in diabetes, heart disease, and other chronic diseases is becoming clearer with each passing day. Non-communicable Diseases (NCDs) account for 7 of the top 10 causes of death in the U.S., and heart disease and cancer account for 48% of all deaths (Heron, 2013). NCDs account for more than 80% of U.S. health care costs, estimated at $2.9 trillion, or 17.4% of the GDP in 2013 (CMS, 2015). While deaths due to lung cancer and heart disease have declined over the last two decades due to decrease in tobacco use and improved care management, deaths from diabetes and mental illness are continuing to trend upward (Lancet, 2015). Between 1990 and 2013, the prevalence of obesity in the U.S. increased 153%, from 11.6 to 29.4% of U.S. adults (UnitedHealth Foundation, 2014).

Likewise, the growth in the proportion of seniors in the population also presents our health care system with significant challenges in the coming years. Americans aged 65 years or older are expected to represent approximately 19% of the total population by 2030, nearly one in five people (U.S. Department of Health and Human Services, Administration for Community Living, Administration on Aging, Aging Statistics, 2015). Among the challenges of managing the care for a growing senior population with higher rates of NCDs is coming to grips with the limits of doing so in traditional long term care institutions, and the increasing demand for supportive services in community-based settings.

The challenges faced in the transformation of health care in the U.S. are myriad, but they are centered on moving from a fragmented and reactive system of resource allocations for treatment for often preventable conditions in acute care settings to the financing of a health producing enterprise at the institutional, community, and societal level. In this new world, acute medical care services are essential elements of a larger system of primary care, preventive services, and strategic investments in social and physical infrastructure that together comprise the leading causes of life. The accounting for this system will view health systems as “nestled” enterprises that thrive when services, activities and investments are optimally aligned to foster life, liberty, and the pursuit of happiness.

We must seek an alternative to the historical frame that looks at health care expenditures in isolation, with only the providers, payers, equipment manufacturers, and pharmaceutical companies setting the terms of transactions. The net result has been a steady upward spiral of costs, driven in part by economic mechanisms (e.g., barriers to market entry, imperfect information, high complexity, societal view of medical care as essential services) that contribute to the unfettered escalation of costs. It is time for a dialogue that looks beyond who should pay for goods and services that are unhinged from basic market mediators, and considers the relative value of medical care delivery in the context of a broader set of societal investment options.

Health Inequities and Community: How Did We Get Here?

THE SOCIAL DETERMINANTS OF HEALTH

A search for improved health outcomes naturally leads us to a complex array of social, economic, and environmental factors that play a fundamental role in influencing our ability to meet our basic needs and feel a sense of stability, hope, purpose, and connectedness to the world around us. As reviewed in Chapter Two of this volume, these social determinants of health impact health in ways that far outweigh traditional medical care.

A central consideration in an examination of the social determinants of health (SDH) is the degree to which investment in primary prevention produces impacts on health status, costs, and other outcomes of interest to diverse stakeholders. Woolf and Braveman (2011) describe four elements of complexity, including:

- Different determinants, or ***factors that influence*** health
- Different ***dimensions impacted*** by determinants, including morbidity, mortality, function, and well-being
- Different ***causal pathways*** in which SDH exert their influence, depending on differential configurations, intensity, temporality, etc.
- Different ***levels of influence,*** at the individual, cultural group, neighborhood, societal.

All four elements play out differentially in complex ways in which individuals respond according to different times in their lives, the unique circumstances of the moment, what kinds of support systems may be in place, and reasons they may be more or less receptive, responsive, or resistant to particular factors in place.

Social and physical environmental factors include income and wealth, family and household structure, social support, education, occupation, neighborhood, social institutions, and it is important to consider how their influence is exerted and what is reinforced or ameliorated in the life course and across generations. All this makes it very difficult to parse out and attribute relative contributions to individual factors. Appropriate attention is being given to the impact of SDH at the earliest ages, including a more substantial impact on cognitive and non-cognitive development (e.g., executive function), which in turn affect behavioral tendencies (e.g., deferred gratification) and, hence, increases in risk behaviors. Growing attention to epigenetics points to the ways in which exposures to traumatic experiences in vivo and in the earliest years of life can also serve as genetic triggers that contribute to the development of chronic diseases later in life (see Chapter 7).

In consideration of the substantial contributions of the social determinants to health or illness, we would naturally want to know the relative cost of ensuring access to things such as quality education, and compare those costs to the downstream costs for failing to ensure quality. In the educational arena, one study reported that interventions that increase high school graduation rates produce an average of $166,000 in savings of government expenditures associated with higher tax revenues, reduced crime, and lower public health costs (Levin, Belfield, Meunnig & Rouse, 2007).

The growing focus on walkability is supported by findings that increased walking and decreased driving contribute to reduced stress, increased social capital, improved public safety, and reduced rates of traffic fatalities and violent crime (Furie & Desai, 2010; Litman, 2010).

INEQUITIES AND HISTORICAL FACTORS

Historical factors that have contributed greatly to the persistent and profound health inequities are concentrated in specific communities across the country. As noted in the introduction to this chapter, these "facts on the ground" are driven in part by a series of decisions made in the public and private sectors that have contributed to the flight of capital and the concentration of poverty and poor health in particular neighborhoods across the country.

While the pattern of discriminatory public policies can be traced back much further in our history as a nation, we'll start with efforts to reduce poverty and create opportunities during the Great Depression. One element of Franklin D. Roosevelt's New Deal involved the establishment of the Home Owner's Loan Corporation in 1933. One of the early actions of this federal agency was to draft maps of communities to determine which were worthy of mortgage lending. Neighborhoods were ranked and color-coded, and the D-rated ones—with "inharmonious" racial groups—were outlined in red. This strategy was quickly adopted by private banks, and "redlined" communities were effectively cut off from essential capital.

This policy was implemented during a time when millions of African Americans were fleeing oppression during the Jim Crow era in the South in search for job opportunities and stability for their families. The expansion of industrial production during and in the wake of World War II provided substantial impetus and hope for these families. In their search for housing, African Americans and other ethnic minorities quickly discovered that their options were often limited to these "redlined" communities. Given the high demand and limited availability, landlords were able to charge exorbitant prices for often dilapidated housing, with "contract mortgages" (Satter, 2010) that enabled them to evict families without equity payouts after years of making payments.

One of the numerous actions taken by the federal government that impeded the accumulation of capital among low-income communities was the passage of the Housing Act of 1949 with the stated purpose to provide "a decent home and a suitable living environment for every American family." In order to secure the votes for this law, low income housing advocates had to agree to the parallel clearing of "blighted" areas from the urban core. The Housing Act provided a subsidy to municipalities covering two thirds of the costs of clearing, and language covering the use of the land indicated that development would be "predominantly residential" (50% of construction had to be residential) allowing for inclusion of commercial properties as part of renewal initiatives (Biles, 2000). The net effect, in many cities, was the displacement of large numbers of residents of color.

In 1956, the Federal Aid Highway Act shifted control over highway development, so decisions were made to route highways directly through what had been economically vibrant urban neighborhoods in the interest of expediting traffic in and out of the city core. The resulting deterioration of commercial activity in turn degraded the tax base of cities, and the only housing options for many people of color who were displaced were highly concentrated public housing projects.

Further amendments to the Housing Act in 1954 and 1959 included the addition of Section 112, which made universities eligible for funds without requirements for links to residential housing. This was extended to hospitals in 1961 at the request of the American Hospital Association. In addition, Section 112 permitted cities to claim expenditures by universities or hospitals as part of their 2:1 Federal- local match. If the expenditures surpassed the match, cities were given credits towards further urban renewal projects, which created an incentive for cities to expand their urban renewal efforts. By 1964, 154 projects involving 120 universities and 75 hospitals had taken advantage of Section 112. Examples include Detroit Medical Center, which is currently a for-profit facility, and Johns Hopkins University Medical Center.

Redlining was technically outlawed by the passage of the Fair Housing Act of 1968, but more subtle forms of discrimination continue to this day (see sidebar on Banks Assessed Penalties for Redlining).

These longstanding patterns of discrimination have had a profound intergenerational impact upon the ability of African American and Latino populations to accumulate capital. Harmful public policies, lending practices, and capital flight have all conspired to limit the wealth that parents in each successive generation can pass on to their children.

Given this history, it is not surprising that the residents of urban inner city neighborhoods continue to struggle with limited capital, poor housing quality, dysfunctional schools, and a lack of access to healthy food, banking services, retail goods, transportation, and employment opportunities. While there have been an array of initiatives launched by private foundations, going back as far as the Gray Areas program led by the Ford Foundation in the 1940s and by the federal government (the War on Poverty in the 1960s, Model Cities in the 1970s, and the Empowerment Zones initiative in the 1990s), none of these efforts have brought a sufficient concentration of resources and support services to overcome the deeply established structural inequities that were put in place in the early to mid-20th century.

Setting aside for a moment the geographic concentrations of inequities, a 2009 study found that the average wealth of white heads of households in the U.S. was 20 times higher than black heads of households (Taylor et al., 2011). A recent report cited an estimate that the U.S. economy loses approximately $309 billion per year due to the direct and indirect impact of disparities (Norris & Howard, 2015).

As noted in the beginning, the scope and scale of these challenges is daunting, yet there are emerging signs of understanding and commitment in both the public and private sector that offer hope for the future. The next section will provide an overview of recent actions being taken by public sector agencies to implement financial innovations that encourage work across sectors, with a central focus in communities and with populations where health inequities are concentrated.

BANKS ASSESSED PENALTIES FOR REDLINING

At least six banks have been assessed penalties in the last five years for discriminatory lending practices, including:

- **Hudson City Savings Bank** (CT, NJ, NY)
  Paid a $33 million fine to the Consumer Financial Protection Bureau and the Justice Department after review of data indicated that only 25 of 1,886 approved mortgages in 2014 (.013%) went to black borrowers. Of 54 branches opened between 2004 and 2010, only 3 were in predominantly Black or Latino neighborhoods. While these neighborhoods accounted for more than a third of the market in NY and NJ, Hudson deployed only 12 of their 162 brokers in those communities (Swarns, 2015).
- **Associated Bank** (WI)
  Agreement to pay $10 million in mortgage assistance and finance $200 million in loans in selected census tracts in response to documented patterns of discriminatory lending.
- **Evans Bancorp** (NY)
  Agreed to pay a $1M fine and $200k in advertising in low income African American neighborhoods after investigators discovered a map that defined trade areas that excluded Buffalo's east side.
- **Santander Bank** (RI - Providence)
  In a settlement with the City of Providence, Santander agreed to give $350,000 to the Providence Community Library for programs on financial literacy and homeownership; $450,000 to a nonprofit community arts center to support a mixed-use project; and $500,000 to the Rhode Island Local Initiatives Support Corp to help pay mortgage down payments and closing costs for low- and moderate-income Providence residents. (Providence Journal, 2014).
- **Five Star Bank** (NY - Rochester)
  Investigators discovered a map that excluded downtown and suburban census tracts with majority minority populations. In the settlement, Five Star will drop their mortgage minimum (75,000) and will open branches and offer $750,000 in discounts and loan subsidies in minority neighborhoods. (Daneman, 2015).

Financial Innovations: A Review of Emerging Models

FEDERAL SUPPORT OF STATE INNOVATIONS

Since the passage of the ACA, the Center for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, and other federal agencies are working with states, providers, and payers to launch initiatives that encourage work across sectors—with a central goal to "bend the cost curve." The following is a sampling of state level strategies documented in a recent report (Spencer et al, 2015):

- **OREGON**
  Has established Coordinated Care Organizations (CCOs) under the 1115 waiver, with a global budget and a fixed trend rate, with incentive payments to meet performance objectives. CCOs develop payment methodologies for providers that tailor services to meet specific community needs. Parameters used in determining the scope of services include that they a) are "health-related," b) lack billing codes, and c) have the potential to be cost-effective alternatives to covered benefits and produce cost savings. Examples of services include but are not limited to transportation, gyms, cooking classes, athletic shoes, farmers markets, referrals to job training, and housing repairs.
  Early reports indicate that the integration of these kinds of non-traditional services has been a gradual process which, because the scope of services ranges beyond billable codes, has required considerable deliberation in the development of clear policies to provide guidance. A key factor in the expansion of the scope of services was diversity in the competencies and experience of CCO board members.
- **UTAH**
  Engaged four managed care organizations (MCOs) to develop full-risk capitated ACOs as part of their 1115 waiver. The ACOs are charged by the state legislature with "delivering the most appropriate services at the lowest costs" (Lundquist, 2014). No specific scope of services is defined, and ACOs can pay for self-help activities, housing supports, and living improvements.
- **VERMONT**
  The Blueprint for Health Initiative is a multi-payer, patient-centered medical home program delivered by diverse Community Health Teams (CHTs). The Blueprint includes elements such as the Support and Services at Home (SASH) initiative, which links seniors and persons with disabilities with support services and affordable housing. In this initiative, regional housing authorities link with home health, mental health agencies, and agencies on aging to establish care teams that provide a broad array of services. In addition to State funding, SASH now also receives funding through Medicare's Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration program. The configuration of team members is based upon identified community needs.
  Providers that have established Primary Care Medical Homes (PCMHs) receive a per-member-per-month (PMPM) payment (referred to as a capacity payment) tied to their performance against NQCA ratings, and payers share in the cost at $1.50 a month per beneficiary. Integration of data systems was identified as one of the most significant near term challenges. For the next phase of systems redesign, Vermont is negotiating the establishment of an all payer, full risk capitated system for all providers to be launched in early 2017.
- **NEW YORK**
  A Medicaid Redesign Team (MRT) was established in 2011, and includes supportive housing, with a focus on dual eligible beneficiaries. An affordable housing work group was established with over 40 stakeholders, with a charge to identify barriers to housing and to propose solutions. The outcome was the launch of the two-year, $10 million MRT Supportive Housing Olmstead Housing Subsidy Program in October 2015. The program will establish supportive housing for Medicaid recipients who need nursing home level care, and will use non-Medicaid state funds to provide rental subsidies and coordination with community support services. Health care providers are required to coordinate with non-health service providers, including supportive housing organizations.
  MRT is linked with the DSRIP (Delivery System Reform Incentive Payment) program, which has allocated $9 million over two years for rental subsidies. Since Medicaid does not pay for rental subsidies or capital funding, it is paid for by NY's state-share Medicaid dollars. In 2015, NY allocated $47 million in state-share Medicaid funding to expand supportive housing units for high cost Medicaid patients, another $38 million in rental subsidies and related supportive services, $24 million in supportive housing pilot programs, and $2.5 million for monitoring and evaluation.
- **MASSACHUSETTS**
  The state has established a program that focuses on supportive services for treatment of high-risk pediatric asthma patients to cover things such as bed covers, filters, and housing remediation for pests. It is a single bundled payment arrangement for a defined period for an episode of care. This, the Children's High Risk Asthma Bundled Payment (CHABP) program, was initially authorized by the state legislature in 2010. CMS provided an 1115 waiver in 2011 for a pilot, and approved a protocol for formal implementation in 2014. The first phase of the program included a $50 per patient per month (PMPM) payment for high risk patients 2-18 years of age.
  Providers are required to use community health workers (CHWs), do monthly monitoring of patients, and could use funding for home assessments and provision of filters, bed covers, and pest management supplies. CHWs were also authorized to support advocacy for landlord improvements. Unfortunately, the program did not proceed beyond the first phase, given other dynamics around health care financing. CMS provided guidance on June 26, 2015, with the release of an Informational Bulletin that outlined the kinds of services and activities that could be integrated into reimbursement strategies.

FINANCING INNOVATIONS AND HOUSING-RELATED SERVICES

In recent years, CMS launched two programs that give particular attention to Medicaid coverage of housing-related activities and services, with a "goal of promoting community integration for individuals with disabilities, older adults needing long term care services and supports (LTSS), and those experiencing chronic homelessness" (DHHS, 2015). These services do not include funding for room and board, but a variety of other essential housing-related services and activities.

Two programs in particular, the Money Follows the Person (MFP) rebalancing demonstration program and the Real Choice Systems Change (RCSC) grants, provide excellent models for health care organizations and partners that seek support from Medicaid to cover housing-related activities and services. Participants in MFP have shown that engaging housing specialists, assisting with searches, and paying for moving expenses have reduced health care costs by transitioning individuals out of high cost nursing homes and into community living (Lipson et al, 2011). There are three categories of housing related activities and services, including:

INDIVIDUAL HOUSING TRANSITION SERVICES

Services include:

- Tenant screening and housing assessment
- Individualized housing support plan
- Assistance with housing application process
- ID resources to cover security deposit, moving costs
- Ensure safety in living environment
- Arrange and manage move
- Develop housing support crisis plan.

INDIVIDUAL HOUSING & TENANCY SUSTAINING SERVICES

Services include:

- Early ID and intervention for behaviors that may jeopardize tenancy
- ED and training on tenant responsibilities
- Coaching on relationships with landlords
- Assistance in resolving disputes
- Advocacy and links with community resources
- Assistance with housing recertification
- Review and update of plan.

STATE LEVEL HOUSING RELATED COLLABORATIVE ACTIVITIES

Services include:

- Develop agreements and working relationships with state and local housing and Community Development Corporations (CDCs)
- Participating in state and local housing and CDCs
- Create and ID opportunities for additional housing options.

There are also a number of federal waivers that states can use to cover many of these kinds of expenditures. The 1915(c) HCBS (Housing and Community Based Services) Waivers can be used by states to cover some housing transition, tenancy sustaining activities and environmental modifications. The 1915 (i) HCBS State Plan Optional Benefit helps those transitioning out of Medicaid-funded institutions to a private residence, and Medicaid can provide reimbursements for security deposits, set up fees for utilities and phone, essential household furnishings, moving expenses, and cleaning prior to occupancy. The 1915 (k) Community First Choice (CFC) State Plan Optional Benefit permits reimbursement for person-centered home and community-based attendant services and supports.

The 1915 (b) Waivers permit states to use savings from services covered through 1915 (b) waiver to provide additional services. Examples include a behavioral health waiver in Iowa, specialty inpatient health plans for children with serious emotional disturbances in Michigan, a family care waiver in Wisconsin, and an integrated care delivery system waiver in Ohio. Finally, there are Section 1115 Research and Demonstration Programs, which are approved for a five-year period and can be renewed, typically for three years. The core condition is that they have to be budget neutral for the federal government. Examples include the Road to Community Living Program in Washington State, which uses funds to support housing-related transition and sustaining services, and to support collaboration across agencies, while Texas uses administrative funding to support collaboration between state housing and local agencies.

The most recent national initiative launched by the Center for Medicare and Medicaid Innovation (CMMI) is Accountable Health Communities (AHC). Successful applicants for this initiative will receive between $1-4.5 million in funding to support the establishment of an “integrator” function that facilitates the alignment of population health management strategies with a broad array of non-health care services and activities in communities, ranging from food to housing support.

HEALTH AND SCHOOL FUNDING

Regarding areas for targeted investment to improve health, it is important to consider public expenditures associated with K-12 schools, and financial losses associated with absenteeism, truancy, suspensions, and dropouts. Since schools are paid through a formula based upon daily attendance, each of these problems directly impacts their bottom line. In 2013, California schools lost over $1 billion in funding due to truancy alone (Office of the CA Attorney General, 2014).

Absenteeism is highest in the earliest years of elementary school, when the foundation for learning is being established with a focus on reading skills. In California, over 250,000 students were absent 18 or more days per year. Forty thousand (40,000) of those missed more than 36 days per year (Office of the CA Attorney General, 2014).

The figures on dropouts are even more alarming. Each year, approximately 120,000 California residents reach the age of 20 without a high school diploma. A 2007 study estimated the annual cost to the state of California at $46 billion per year in lost tax revenues, medical costs, welfare, and criminal justice expenditures. Conversely, the economic benefit of each additional graduate would be $392,000 (Rumberger, 2007).

Strategies that focus on creating the conditions that support increased attendance and improved performance, particularly at the early years, offer considerable potential to contribute to increases in funding for local schools, improved health, increased life expectancy, and increased economic vitality.

PAY FOR SUCCESS

One of the most exciting financial innovations in recent years is the pay for success (PFS) model. At the most basic level, the PFS model looks to investors to make financial bets that an intervention will yield financial returns beyond the initial investment. Most of the PFS models tested to date focus in areas such as early childhood education to reduce the demand for special education, and life and job skills training and placement for incarcerated youth to reduce recidivism. Successful implementation of these models offers the promise to both improve health and well-being and reduce financial burden in the public sector. For health care providers and payers, PFS investments offer the potential to prospectively finance strategies to reduce the demand for treatment of preventable health problems, ranging from chronic diseases such as asthma and diabetes to behavioral health issues. Examples of PFS models include:

- **Early childhood intervention (Chicago)**—A $16.9 million social impact bond (SIB) deal was secured in 2013 in Chicago to provide early childhood educational services (pre-K) to up to 2,620 children over four years. The intervention is a half-day Child-Parent Center (CPC) model, funded by the Goldman Sachs' Social Impact Fund and Northern Trust and the J.B. and M.K. Pritzker Family Foundation. The intervention goals are to increase kindergarten readiness, improve third-grade literacy, and reduce the need for special education. The program is intended to serve 4 year old children who qualify for the federal free and reduced lunch program, but do not attend at least a half-day of pre-kindergarten. If successful, Chicago public schools will receive approximately one third of the savings generated, with the rest going to pay back investors. The loans and repayments will be managed by IFF, a nonprofit community development financial institution (CDFI). The program covered 374 children in the first year, up to 782 in the next two years and at least 680 in the fourth year. This covers more than half of the roughly 1,500 eligible low-income children who currently do not receive pre-K services. The remaining half will start getting pre-K education in the 2015-16 school year through $9.4 million in additional funding from the city and Chicago Public Schools, plus a $4.5 million state grant.
- **Reducing asthma (Fresno, CA)**—In 2012 a pilot program was launched in Fresno, California, with a goal to reduce asthma acuity and incidence. Approximately 20% of the population in Fresno has asthma, compared to an 8% rate at the national level (Badawy, 2012). This is the first PFS model to be implemented in the health care arena, and is being coordinated by Collective Health and Social Finance. Payers hoping to reduce costs include Anthem Blue Cross and Health Net, and care is being coordinated by Clinica Sierra Vista, a federally qualified health center serving low-income residents in the region. The development of the PFS and piloting phase is being supported through a grant from The California Endowment. The average baseline costs of care for targeted patients is approximately $15,000 per year. A total of 200 patients are being served during the pilot phase, with a plan to expand to 3,500 patients with investments from banks, individuals and foundations. In addition to care coordination services, the intervention includes home cleaning services, weatherizing, bed covers, and pest extermination.
- **Reducing recidivism (New York City)**—In 2012, New York launched the first social impact bond in the country. Program funding was provided through a $9.6 million loan from the Urban Investment Group of Goldman Sachs, and Bloomberg Philanthropies covered most of that investment with a $7.4 million loan guarantee. If the program intervention produced a reduction in recidivism beyond a target of 10%, Goldman Sachs would secure a substantial profit. MDRC served as an intermediary, working with partners to negotiate the financial elements, and oversaw the implementation of the intervention at New York City's

Rikers Island. The Adolescent Behavioral Learning Experience (ABLE) program, a cognitive behavioral therapy program for 16- to 18-year-olds was carried out by the Osborne Association and Friends of Island Academy. The program focused on personal responsibility education, training, and counseling. An independent evaluation of the program was conducted by the Vera Institute of Justice. In August of 2015, shortly after the release of a preliminary report (Vera Institute of Justice, 2015), the decision was made to terminate the program based upon findings that the program did not meet the target established in order for the City of New York to repay investors.

Each of these three early experiments offers invaluable insights in consideration of similar strategies going forward. The use of social impact bonds (SIBs) to fund these types of interventions is a new concept, with the earliest testing in Great Britain in 2010. As such, assessing the relative effectiveness of specific programs and understanding the implications for similar efforts is still in its infancy. On one hand, New York taxpayers avoided paying the costs for the failure to meet the objectives of the Riker's Island program. Some would posit that while narrowly focused programs provide the basis for clear-cut evaluation of relative effectiveness, a failure to produce a measurable impact reflects the reality that producing measurable outcomes will require more comprehensive strategies. A related concern is that these PFS models are limited by a demand for near term results, leading to a bias towards approaches that contribute to overly simplistic public discourse about solving complex problems. Complexity also works against the design of mechanisms for financial returns. In Fresno, considerable time and effort has been devoted to sorting through how savings from reduced preventable utilization will be secured by providers and repaid to investors, given the complexity of financial mechanisms in health care financing.

Some concern exists that SIBs are not viable for the long-term, but are simply the latest "fad" for philanthropy. On the positive side, program-related investments (PRIs) or below-market rate investments that are primarily made to achieve programmatic rather than financial objectives by foundations, have served as a mechanism to move beyond annual grant financial targets. The potential downside is that increased expectations for foundations to "smooth the path" for investors may divert attention and program support for other innovative programs.

INTERMEDIARIES AS THE "GLUE" FOR COLLABORATION

At the same time that many are looking to philanthropy to direct funds towards social impact bonds (SIBs), there is a parallel (and somewhat related) emphasis on support for local/regional intermediaries, or "backbone" entities which can serve as objective brokers of diverse stakeholders for "collective impact" approaches to solving complex social, economic, and health-related problems. These terms have been popularized by FSG, a consulting firm based in Boston and San Francisco, through a series of articles published in the Stanford Innovation Review over the last five years. The initial article (Kania & Kramer, 2011) profiled the Strive initiative in Cincinnati, an effort to align the broader educational community on an organized set of strategies to improve academic performance among youth.

The Collective Impact model identifies five conditions for success: 1) a common agenda, 2) shared measurement systems, 3) mutually reinforcing activities, 4) continuous communication, and 5) a backbone organization. The backbone organization is intended to be an independent organization (separate from organizations charged with roles in interventions) with standing among diverse stakeholders which can serve as a convener, facilitator, manager, administrator, and monitor of progress.

There is growing recognition among philanthropic organizations that demands for communities to "collaborate" without an infrastructure to facilitate the kind of deeper engagement and mutual accountability envisioned in the collective impact model has been unrealistic at best. With this in mind, there are calls not only for national foundations, but particularly for local and regional foundations to

step definitively into this role. In many communities (particularly in urban settings), there are a plethora of public and private sector organizations delivering an array of most often individually-focused services in an inefficient, and often duplicative manner. Achievement of the Collective Impact objective of mutually reinforcing activities will often require a substantial re-design process. Options can include, but are not limited to co-location of activities, consolidation of program elements and administration, and co-investments in new program areas of focus. While larger organizations such as hospitals and local public health agencies may view themselves as appropriate entities to serve as "backbones," the need for an independent organization viewed as an objective broker may lead local stakeholders in different directions (see Chapter 3 on leading complex health structures).

There is much to learn about these new areas of partnership, investment, and alignment of programs, services, and activities across sectors. In such an environment, philanthropy can play a key role, and it is important to preserve a focus on relatively untested innovations that help to solve complex problems. Chapter 9 offers more details on how philanthropy can be leveraged to best impact broader community health.

THE LEADERSHIP ROLE OF MISSION-DRIVEN HEALTH SYSTEMS: HOW DO WE FINANCE SHARED OWNERSHIP?

Giving more focus to the social determinants of health and to geographic areas where health inequities are concentrated represents a shift for health care organizations from the question "**Who** is at greater risk for disease?" to the question "**Why** are some people at greater risk of preventable illness, injury and death than others?" The next, even more critical question, however, is "**What** are we going to do about it?" This section outlines the unique responsibility of mission-driven health systems to provide leadership in bringing health care costs under control and into the broader context of a "leading causes of life" investment strategy.

In consideration of what forms of leadership to provide in mission-driven health systems, it is essential to consider how best to establish and reinforce an ethic of shared ownership for health. As noted in Chapter 3, this approach requires hospitals and health systems to reconsider a more traditional "command and control" approach to engagement and explore a more generative model that seeks to optimize participation and encouragement of distributed leadership among diverse stakeholders. Key framing here is how best to align a spectrum of internal and external "assets" that offer the greatest potential to leverage the important, but limited resources of health care organizations.

Within the broader responsibility to provide leadership, this work will continue to evolve in different demographic, regional, and regulatory environments (e.g., states where the Medicaid expansion is not occurring, different payer mixes and reimbursement rates, federal, state, and local resource allocations for essential services and infrastructure, etc.).

INVESTMENTS IN DATA INFRASTRUCTURE

In order to effectively monitor progress in comprehensive approaches to health improvement, it is essential for hospitals to build the data capacity that will allow for a more in depth analysis of utilization patterns, and identification of pathways to health and illness in the geographic community context.

This is not only essential for individual organizations; systems are needed that support interoperability across provider organizations as an essential path to timely assessment of costs, quality, and outcomes. The configuration of stakeholders, their relative capacity, local/regional demographics, and the larger regulatory environment differs widely across the country—as such, there is no single rule of thumb, beyond a commitment to shared ownership for health.

In the development of these more comprehensive data systems, there is growing recognition (Morrissey, 2015) that electronic health records (EHRs) that are designed for a FFS system are not sufficient for fee-for-value systems. As noted in Chapter Four, a more evolved system requires accommodation of a more complex array of care settings, providers, and so on who are assuming risk and can contribute to improved outcomes through different modalities of treatments, procedures, input, and health improvement strategies.

As coverage continues to expand, hospitals and health systems will see a drop in the demand for charity care, and while some of those resources will be directed towards a growing population of Medicaid patients, hospitals are beginning to increase their allocation of charitable resources towards more proactive community health improvement strategies. Stakeholder Health partner Ascension Health System reported a 9.3% drop in traditional charity care in FY15. Some of these funds were shifted to Medicaid shortfalls, but they also increased their allocations for community health initiatives by 6.2%, or $37 million. In states that have not implemented the Medicaid expansion, bad debt reporting in hospitals in Medicaid expansion states increased 8.9%, compared to only 2.5% in states that expanded Medicaid coverage (Kutscher, 2015).

Scrutiny of tax-exempt hospitals can be expected to increase in the coming years, with growing pressure by advocacy groups to eliminate the group exemption that allows health systems to provide only aggregate totals in their 990H, and begin to require facility-specific reporting of community benefit contributions. Challenges such as the most recent tax settlement by Morristown Medical Center (NJ) to pay $26 million in property taxes are expected to continue. A growing number of hospitals are coming to the conclusion that access to care is not the most important public health issue in their community. In communities like the Tenderloin District of San Francisco, Saint Francis Memorial Hospital, part of the Dignity Health System, is giving focus to issues such as crime reduction, toxic stress, and substance abuse, and homelessness. In order to monitor progress in addressing these complex issues, and to partner effectively with diverse stakeholders, data systems are needed that connect these dots.

HEALTH AND COMMUNITY DEVELOPMENT: ROLES FOR HOSPITALS AND HEALTH SYSTEMS

Approximately four years ago, with support from the Robert Wood Johnson Foundation, the Federal Reserve Bank of San Francisco began to convene a series of regional meetings across the country that brought together financial institutions and the public health community. These meetings focused on the fact that many of the kinds of investments made by financial institutions in fulfillment of their Community Reinvestment Act (CRA) responsibilities had important health implications. The focus of these investments ranged from affordable housing and childcare centers to job training programs, grocery stores, charter schools, and federally qualified health centers. Much of the early dialogue focused on how to move towards more of a health frame in the selection of investments, and on developing metrics that better capture health impacts and reinforce a more integrated approach across the health and community development sectors.

In consideration of this important new development, it was suggested (Barnett, 2012) that these conversations would benefit from bringing a key stakeholder to the table with a shared interest in a more comprehensive approach to community health improvement, i.e., hospitals. Like financial institutions, tax-exempt hospitals have a legal obligation—and increasingly a strategic imperative—to target their resources in communities where health inequities are concentrated, and to leverage those resources through alignment with those of diverse community stakeholders. With this in mind, there is growing attention among hospitals and health systems across the country in the formation of partnerships with CDFIs, community development corporations, and other stakeholders in the community development arena. Many of these partnerships focus on real estate investments linked explicitly to better

management of chronic diseases such as diabetes, cardiovascular disease, asthma, as well as mental and behavioral health issues.

As part of these health-community development partnerships, a number of Stakeholder Health systems are directing a portion of their investment portfolios to support linked development strategies. Dignity Health, Trinity Health, Bon Secours, and Henry Ford Health System all have well established track records, often making strategic investments at the pre-development phase that provide a critically important bridge and stability as local developers and CDFIs seek loans for construction. Other health systems are beginning to step into this arena as well, in recognition of the need for alignment across sectors.

Engagement of hospitals and health systems in these targeted investment strategies address a critical need among CDFIs and other community development stakeholders to secure early capital that creates a glide path for CRA-related investments by financial institutions. At the same time, these strategic-minded health systems are optimally leveraging their resource allocations in health improvement activities by linking them to the kinds of physical infrastructure investments that are critically needed to reverse the negative health impacts associated with decades of redlining and disinvestment.

This expanding arena of strategic investment and alignment of the health and community development sectors is reinforced by the recent framing of hospitals, academic institutions, and other large employers with a mission focus as “anchor institutions” (Kelly & McKinley, 2015). This framing strengthens a focus on “place” in local economic development. It also emphasizes the need to bring a “third player” beyond cities and businesses, where historical dynamics have led to a process where a city’s ability to deliver value to its residents is undermined by a bidding war in which revenues are sacrificed in the form of tax abatements to influence corporate location decisions. The “third player” is the combined force of anchor institutions, community groups, community-based organizations, philanthropy, and local small businesses.

Whereas a recent focus has been on pressuring larger businesses, there is a growing movement towards a more proactive form of systems level planning and economic development. A key dimension is developing, expanding, and building the capacity of under-utilized local assets. Examples include social networks, physical infrastructure, arts and cultural communities, and so on. In one recent example, spending resources at locally owned firms created a feedback loop where wealth recirculated at least three times as much in the local economy (Chevas, 2013).

The framing of tax-exempt hospitals and universities as potential anchor institutions involves over $1 trillion in economic activity, representing approximately 7% of GDP (Institute of Education Sciences, 2013; CMS, 2014). Hospitals and health systems alone account for more than $780 billion in total annual expenditures, $340 billion in purchasing of goods and services, and more than $500 billion in investment portfolios (Norris & Howard, 2015). Examples of an anchor institution approach is reflected in the following examples:

- A plan to spend $1.2 billion for facility development between 2005 and 2010 by University Hospitals (UHS) in Cleveland. UHS partnered with the Mayor’s office and local building trade unions to establish the Vision 2010 program with a goal of procuring 80% of the $1.2 billion from local and regional firms. Over the next five years, they created over 5,000 jobs, and procured 92% from local and regional firms. More recently, UHS developed a Step Up to UH program that includes training and wrap around support services in a pipeline to hire residents of proximal low-income African American communities (Serang, Thompson, & Howard, 2013). In another example, the Mayo Clinic in Rochester, MN helped to finance a community land trust to ensure long term affordable housing for employees and the larger community (Zuckerman, 2013).

- The Fifth Season Cooperative, a multi-stakeholder food hub established in 2010 in La Crosse, WI, was launched with the support of the Gunderson Lutheran Health system, the University of Wisconsin-La Crosse, and three local public school systems. The cooperative provides ongoing technical assistance to members to support the scaling of the operation. Early support came from the Vernon County Economic Development Association through a local state grant, as well as from fundraising through the sale of stocks to local residents.
- New Orleans Works (NOW) is a workforce initiative with support from the National Fund for Workforce Solutions, and is a partnership with local health care sector stakeholders, including the Ochsner Health System, the Southeast Louisiana Veterans Healthcare System, and Delgado Community College. A current focus is on the training and deployment of Medical Assistants (Greater New Orleans Foundation, 2014).

The anchor institution perspective involves a more global consideration of potential contributions of hospitals, moving beyond the compliance-constrained idea of community benefit to "be accountable for all of their impacts on community health, and leveraging all of their assets to ensure the well-being of the community in which they are based" (Norris & Howard, 2015; Page 5).

Moving in this direction also calls for colleagues in the community development arena to expand their thinking beyond building physical structures (and on a single transaction) without consideration of the neighborhood context. This historical, decontextualized approach to development closely parallels a similar focus on individuals or groups of patients in the health care sector—both must be remedied if we are to address the persistent and profound social, economic, and health inequities that are prevalent in the most affluent society on the planet. Super Church (2013) cites as an example one of the first Whole Foods stores (located in Dedham, MA) to achieve Green Globe certification, but it is located in a strip mall area that is "virtually unreachable on foot from nearby neighborhoods."

A more contextual approach to community development brings attention to a broader array of factors in planning and decision-making. For example, a recent study in Washington, DC observed that more walkable neighborhoods with proximity to transit have higher rents, retail revenues, and housing values than less walkable neighborhoods. Whereas the cause and effect dynamic suggests that investments in walkability are hand-in-glove with the gentrification process that often displaces low income residents, it is appropriate to consider walkability as an important part of neighborhood revitalization that contributes substantially to improvements in health status and quality of life (Leinberger & Alfonso, 2012). Housing prices in walkable neighborhoods fell substantially less than the national average between 2006 and 2011, and the U.S. Conference Board estimated that they will rise much faster than the national average between 2014 and 2017 (Urban Land Institute, 2011).

Super Church (2013) notes that new financial tools are needed to support more comprehensive approaches to community development, pointing to substantial financing gaps for both moderate-income housing and retail/commercial and industrial development: "The available subsidies are very limited and highly competitive, and most developers do not have sufficient equity to self-fund projects of this scale." An additional complicating factor is the impact of the Supreme Court ruling in June 2015 on the Fair Housing Act, which has resulted in the lack of Low Income Housing Tax Credits in neighborhoods where there is a concentration of poverty.

Many project underwriters have been unwilling to finance larger scale efforts, since project costs are high, rents are limited, and there is insufficient evidence that rents would increase at a level that would overcome near term concerns. Increased investments are needed by private equity funds established through contributions from philanthropy (program-related investments) and impact investors, including hospitals and health systems.

A recent Health Affairs blog (Somers & McGinnis, 2014) expanded on the concept of the ACO model to reflect a trend towards the assumption of responsibility under global budgeting for a broader array of services beyond medical care delivery (e.g., mental health, substance abuse treatment, housing support services). These entities are referred to as "totally accountable care organizations," or TACOs. While such an integrated role is largely an aspiration at this juncture in the national health reform process, a growing number of organizations have taken important steps in this direction.

The development of a Medicaid ACO at Hennepin County Medical Center (HCMC) represents an early model worth examining. HCMC works with homeless shelters, supportive housing providers, the criminal justice system, and the public health department. Because HCMC already operates under a global budget system, incentives have driven investments in areas such as a sobering center, a far more humanistic and cost-effective option than care in ED settings and county incarceration facilities. As a county facility (but with operation as a 501c3 nonprofit), HCMC is in a good position to explore opportunities with local public sector agencies for a more cost-effective allocation of resources. State agencies across the country are in an optimal position to signal to localities that similar approaches may be rewarded.

A CATALYZING ROLE FOR EMPLOYERS

U.S. employers have a major stake in the achievement of the goals of national reform given the fact that they provide coverage for approximately 54% of the population (Smith & Medalia, 2014). In 2012, they spent $578 billion on group health coverage, a 72% increase over the $336 billion spent in 2000 (CMS, 2014).

Steady increases in obesity in the U.S. have taken their toll on employers, with some industries more impacted by others. One study found, for example, that obese women with a BMI of 40 or greater miss 8.2 days/year, 141% or nearly 1 week more than normal weight women (Finkelstein et al, 2005). Overall, it is estimated that obesity produces an additional $1,152 in medical expenditures per year for males and $3,613 for females in the U.S. Lost productivity is estimated at $3,792 for males, and $3,037 for females (The Week, 2012). Over a decade ago, productivity losses due to absenteeism were estimated to cost employers approximately $226 billion per year (Stewart et al, 2003). Trends suggest that current costs are likely to be significantly higher.

Nearly 80% of U.S. employers offer workplace wellness programs, given considerable evidence of substantial returns on their investment. A review of 36 peer reviewed studies of workplace wellness programs found an average reduction in medical care costs of $3.27 for every dollar invested (Baicker, 2010).

The next frontier for employers in efforts to supporting wellness and reducing health care costs involves expanding their engagement beyond employees to their families and surrounding communities. Approximately 90% of larger firms offer some form of wellness programs for employees, but only 63% offer them to spouses or dependents, and only a fraction of those to surrounding communities (Kaiser Family Foundation, 2013).

A growing number of larger firms are moving beyond the more narrow interpretation of corporate responsibility articulated by Milton Friedman (1970), and thinking about their roles in fostering health in the communities in which their employees and families reside. For example, Friedman's narrow view is frequently illustrated by this quote: "There is one and only one responsibility of business—to use its resources and engage in activities designed to increase its profits, so long as it stays within the rules of the game, which is to say, engages in open and free competition without deception or fraud." (Friedman, 1962). The concept of corporate social responsibility emerged in the 1970s, and led a

number of companies to begin to direct resources towards investing in local economic development and in some cases, social policy development (Carroll, 1999). Consideration of the roles of firms in this regard has continued to evolve towards a more integrated approach framed as "Shared Value," where competitiveness in the marketplace is directly tied to advancing the economic and social vitality of communities in which they operate (Porter et al, 2011). A recent report (Oziransky et al, 2015) commissioned by the Robert Wood Johnson Foundation offers a number of excellent examples, including:

- A $10 million, 10 year corporate investment by Campbell's Soup in a Collective Impact approach to reducing obesity and hunger by 50% in Camden, NJ.
- A partnership between General Dynamics Bath Iron Works and L.L. Bean to fund diabetes prevention programs for their workforce, their dependents, and the local community near both corporate headquarters.
- A multi-stakeholder health system initiative in Cincinnati, Ohio, supported by General Electric to improve quality of care, reduce costs, and improve health outcomes for its employees and the larger community.

In short, the corporate community increasingly recognizes the practical reality that their long term vitality is inextricably tied to the health and well-being of their employees, which in turn is inextricably tied to the communities in which they reside. This placed-based, integrated view of the health enhancement process is essential if we are to begin to address the profound and persistent economic, social, and health inequities that are concentrated in urban and rural communities across the country.

We'll close this chapter with sidebar profiles of internal and external systems development by two Stakeholder Health member organizations to build a framework for shared ownership for health with local community stakeholders.

Summary

In summary, health systems must begin to explore new means of financial accounting that expands beyond their walls and incorporates partnerships with other entities, as well as allowing them to be better positioned and resourced to help address the social determinants of health. While these efforts are at a rudimentary stage, promising practices from many SH partners offer hope for a new way of doing business that can result in improved health and healthcare outcomes for all.

BUILDING SYSTEMS FOR SHARED OWNERSHIP: PROFILES OF METHODIST LE BONHEUR AND WAKE FOREST BAPTIST HEALTH

To date, few health systems have actually created financial metrics to show ROI, much less SROI. Basic financial accounting finds both the scope and the ability to assign "causation" in a broad model that includes numerous internal health systems, as well as community partners to be a difficult task. However, in our work with faith-based and community partners and networks in both Memphis, TN (with the Congregational Health Network or CHN) and Wake Forest (with Supporters of Health—hybrid community health workers), we have created very granular accounting and data dashboard strategies for outlining system costs and share these beginning models here.

CONGREGATIONAL HEALTH NETWORK OF METHODIST LE BONHEUR HEALTHCARE, MEMPHIS, TN

The work of the Memphis Model or Congregational Health Network (CHN) was highlighted extensively in the first HSLG monograph. Now over 600 congregations, with mostly African-American members, the CHN members showed decreased healthcare utilization for Methodist Le Bonheur Healthcare (MLH). For example, using predictive modeling, we showed that CHN members vs. non-members (matched on 8 variables) had significantly longer times (69 days) to readmissions (Barnes et al., 2014). Place-based efforts in zip code 38109 and the smaller neighborhood of Riverview Kansas began in 2010, anticipating the ACA and readmission non-payment. Focus groups with clergy, community coalitions and lay persons in this violent and decimated neighborhood revealed a need for increased access to health care. CEO Gary Shorb took a community tour with Rev. Drs. Chris Bounds and Bobby Baker (Director of Faith and Community Partnerships) and then brought his leadership team to Rev. James Kendrick's church, Oak Grove, since Rev. Kendrick had been working with the disenfranchised young men of color on the streets in his Health Watch ministry for many years. The CHN's first place-based navigator, Joy Crawford Sharp, was hired in 2011 and hit the ground running. The Wellness without Walls initiative began with bi-monthly events at the local community center and careful follow up of every need by Joy. By 2012, aggregate charity care charges had dropped overall for MLH, particularly in the target zip code of 38109. See table 1 below.

	Year	Visits	Full Costs	Variable Costs	Average per Capita Charity Costs	Net (Percent) Charity Care Change from Prior Year
38109	2010	5,566	$6,269,769	$4,737,311	$1126.44	NA
	2011	6,772	$9,055,808	$6,732,605	$1337.24	$2,786,039 increase (↑30.8 %)
	2012	6,568	$8,249,922	$6,404,569	$1256.08	$-805,866 decrease (↓8.9 %)

The Chief Financial Officer then suggested that a cost to charge ratio be calculated, versus looking only at encounters, so we began tracking cost associated with the write-off amount, based on transaction, not discharge date, which increased the numbers evaluated. Those data are presented below, but still represented a decrease in charity care costs.

CHARITY CARE 38109 - NEW METHODOLOGY		
Year	Write-Off Cost*	Volume
2010	$6,505,332.19	6,905
2011	$6,826,729.90	7,104
2012	$6,676,539.42	7,595
July YTD 2013	$3,012,650.18	4,930
*Cost of Write-off = cost to charge ratio applied to transaction amount		
Cost to charge ratio 2010 = 25%		
Cost to charge ratio 2011 =23.5%		
Cost to charge ratio 2012 =23.15%		
Cost to charge ratio 2013 = 23.15%		

WAKE FOREST BAPTIST MEDICAL CENTER (WFBMC):
SUPPORTERS OF HEALTH COHORT AND AGGREGATE SELF-PAY DATA

As reported in the HSLG monograph (2013, p. 60) and related in a blog by IHI's Kathy Luther (http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=111), in 2012, soon after starting work, VP Gary Gunderson stepped up to save the jobs of 267 environmental service workers who were under threat of outsourcing. He managed this by promising to cross-train some of these workers as community health workers, as part of the FaithHealth divisional work. The Supporters of Health model of hybrid community health workers/community care triagers was born and now WFBMC has 5 FTE Supporters, or what we term the "Fab Five." Supporters of Health efforts, along with our full FaithHealth division, Transitional Care staff, Patient Financial Services and more, are responsible for the aggregate and cohort data seen below.

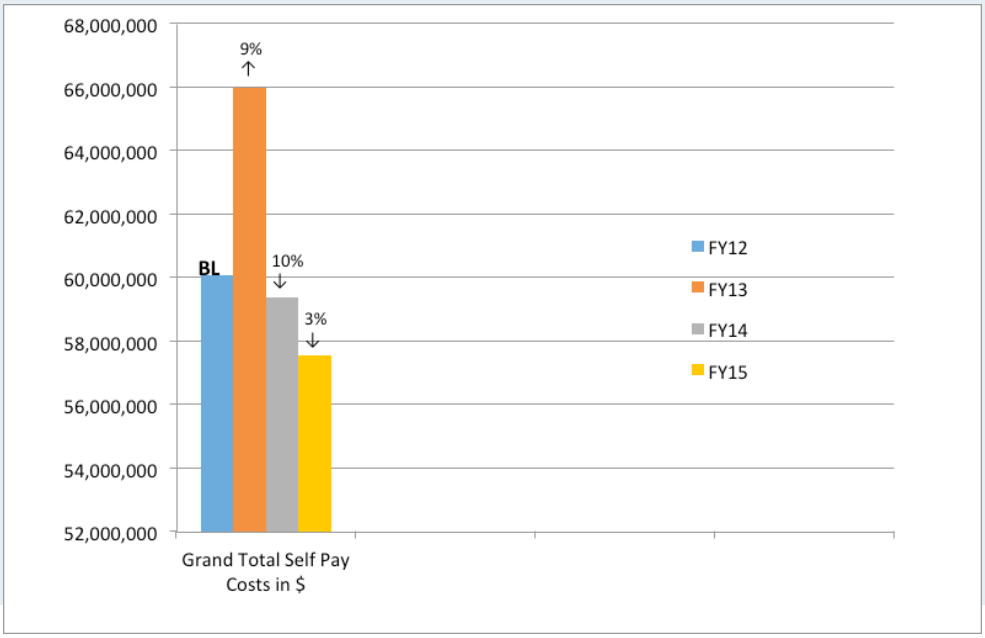
Supporters of Health Cohort: Financial Data: Six Months Prior and After Enrollment

	6 MONTHS PRIOR TO ENROLLMENT	6 MONTHS AFTER ENROLLMENT
Total Encounters	875	877
Patients	132	130
Average Encounters Per Patient	6.6	6.7
Average Cost Per Encounter	$2,208	$1,846 (16%↓)
Average Cost Per Patient	$14,634	$12,451 (15%↓)
Charges	$5,514,374	$4,624,047 (16%↓)
Charges Per Inpatient Encounter	$19,293	$18,794 (3%↓)
Charges Per Outpatient Encounter	$1,927	$1,741 (10%↓)

Early Supporters of Health cohort data have been very promising. See above financial data from the first six months of work of the Supporters (1.2 FTEs, as the program was started) with 132 patients. The average cost per patient decreased by 16% from pre- and post-enrollment and there was a significant move toward ambulatory vs. inpatient treatment.

One of Gary's promises to the WFBMC Board when he started employment at Wake Forest in 2012 was that FaithHealth efforts would show a decrease in charity care costs overall and in five target zip codes by Year Three efforts. In order to show that FaithHealth was impacting charity care, a very granular aggregate self-pay data dashboard was developed in conjunction with Financial Services staff. Inpatient and outpatient ratios were calculated, along with direct variable costs per encounter, which we believe are key parts of costs to the health system that can be decreased (versus indirects).

Gary's predictions for WFBMC have been realized since 2012. In aggregate, overall total self-pay costs to the system have dropped by 4% from FY12 to FY15, resulting in decreased costs to the system of $2,508,460.



Additionally, charity care costs in our 5 target under-served zip codes have decreased by $1,040,459, with a decrease in direct variable cost per encounter from $202 to $200.

FISCAL YEAR	UNIQUE PATIENTS (N)	TOTAL COST ($)*	TOTAL COST PER ENCOUNTER ($)	DIRECT VARIABLE COST PER ENCOUNTER ($)	MEDIAN INCOME ($)
FY12	11,661	18,552,721	490	**202**	36,386
FY13	13,500	19,899,214	488	**200**	36,011
FY14	12,316	18,622,795	483	**201**	35,636
FY15	12,218	17,512,262	489	**200**	35,636

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