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.

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 U.S. Department of Health and Human Services **Center for Faith-Based and Neighborhood Partnerships**. The Department’s initial interest in programs that seek to create different models of health care—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 gravely 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 that follows.
Introduction and Acknowledgements

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

*Heidi Christensen of HHS and John O’Brien of UMass at April 4, 2013 Leadership Summit*
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.


Huge thanks go to the Working Group Chairs listed below, without whose many hours of work (amidst their real day jobs!) on sub-tasks, conference calls and early compilations, we would lack the substantial content of this piece. We also deeply appreciate the core Writing Team, who struggled to bring all these diverse threads together in a coherent fashion, particularly Dora Barilla, Nancy Combs and Kirsten Peachey, who demonstrated impressive weaving of sometimes divergent streams of learning. Thanks are also due to Jim Cochrane for his magnificent editing of what was a rather ‘wild and wooly’ narrative at times. Lastly, Methodist Le Bonheur Healthcare’s Center of Excellence staff (Niels French, Liz Dover, Teresa Cutts), as Secretariat, have provided an administrative backbone to keep the meetings, Working Groups, and various Teams moving, writing and growing.

**Writing Team**

Dora Barilla, Kevin Barnett, Heidi Christensen, Jim Cochrane, Nancy Combs, Teresa Cutts, Gary Gunderson, Kirsten Peachey, Tom Peterson, Fred Smith, Jerry Winslow and Kimberlydawn Wisdom

**Working Groups** *(Key writing Contributors are highlighted)*

**CHARITY CARE: QUADRUPLE AIM FOR TRIPLE ELIGIBLES**

*Chairs: Dora Barilla, Eileen Barsi, Jeremy Moseley, Anne Rieger*

*Members:* Marti Baum, Mike Bekheet, Kathie Bender Schwich, Lori Cooper, Harry Durbin, Illana Hearshen, Maureen Kersmarki, Debora Murray, Billi Copeland King, Paul Szilagyi

**SOCIALLY COMPLEX PEOPLE LIVING IN SOCIALLY COMPLEX NEIGHBORHOODS**

*Chairs: Kirsten Peachey, John Bartlett, Steve Tierney*

*Members:* Kevin Barnett, Marti Baum, Heidi Christensen, Stephanie Cihon, Teresa Cutts, Alyse Erman, Joshua Franks, Niels French, Jim Galloway, Gary Gunderson, Kathleen Hopkins, Maureen Kersmarki, Cynthia Lang, Monica Lowell, Fred Smith, Fahad Tahir

**ARTS OF ALIGNMENT: TRANSFORMATIVE PARTNERSHIPS**

*Chairs: Amelia Brown, Nancy Combs, Teresa Cutts, Dory Escobar*

*Members:* Kevin Barnett, Barbara Blum-Alexander, Bonnie Condon, Shawna Davis, Sue Heitmiller, Kirsten Langstraat, Shirley Perry, E. Demond Scott, Jill Yore

**THEOLOGICAL ADVISORY TEAM (TAT)**

*Chairs: Steve Ivy and Fred Smith*

*Members:* Kathie Bender Schwich, Gwendolyn Hill Brown-Felder, Heidi Christensen, Jim Cochrane, Teresa Cutts, John Englehard, Gary Gunderson, Michael Knecht, Melissa Rogers, Don Stiger, Sue Thistlewaite, Jerry Winslow, Keith Vesper
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, 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 Affordable Care Act 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.

The Affordable Care Act (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). A 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 non-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.

---


Charity Care

The ‘Triple Aim’ concept has been developed by the Institute for Healthcare Improvement (IHI) to improve the experience of care, improve the health of populations, and reduce per capita for 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 Billings, 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. Numerous studies have documented higher concentrations of these conditions among uninsured, underinsured, and/or underserved racial and ethnic populations.

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.
6 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 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.

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 Affordable Care Act 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 of 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 Affordable Care Act 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 nonprofit 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.

Transformative community partnerships move beyond public relations, outreach, and a short term programmatic approach where 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. 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. 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.

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*
Executive Summary

HSLG Meeting, Henry Ford Health System, Detroit, October 2012
For more information, go to website links:
or www.wakehealth.edu/faithhealthnc/