Embargoed Draft prepared for consideration at the
Strategic Investment in Shared Outcomes:
Transformative Partnerships between Health Systems and Communities.

Washington, DC, April 4, 2013
April 4, 2013

Dear Colleagues,

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

• Our communities, home to people with ponderous health challenges – chronic disease, infant mortality, health disparities and more. Our communities, home to environmental drivers that can profoundly shape health issues – lack of access to care, jobs, education, fresh food and other factors we know to be social determinants of health.

• But also, our communities, home to rich, largely untapped assets. People who are natural leaders mobilizing neighbors to improve quality of life … practitioners of time-honored cultural practices that positively impact health behavior … school and faith-based initiatives that are changing lives … the list of potential health partners goes on. Not to mention the treasure troves of knowledge and wisdom that can inform sustainable community partnerships fueled by shared responsibility, where everyone wins.

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

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

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

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

Sincerely,

Katherine Gottlieb
Katherine Gottlieb, President and CEO
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### On Our Cover:

A pregnant mom discusses infant car seat safety with an exhibitor at a community kick-off event for Sew Up the Safety Net for Women & Children (SUSN), a $2.6-million project of the Detroit Regional Infant Mortality Reduction Task Force. The project has engaged and trained community health workers in three Detroit neighborhoods to improve opportunities for mothers and families to succeed – and babies not only to survive, but to thrive. SUSN is demonstrating place-based population health management; innovative, sustainable service delivery models; high-tech/high touch social marketing; provider education on the health equity framework; and institutional alignment – even amongst competing health systems.
Chapter 1

Introduction and Acknowledgements
Introduction

The Health Systems Learning Group (HSLG) brings together 40 health systems to take advantage of the opportunities presented by national health reform to re-examine health system practices. The HSLG:

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

Acknowledgements

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

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

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

The support, leadership and seed funding from key health systems that make up the Provisional Integration Team have been critical to our movement—they are highlighted in the full health system partnership listing below:
| Adventist Health Central Valley Network, CA |
| 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** |
| **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** |
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| People Improving Community by Organizing Network (PICO) |
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| **Robert Wood Johnson Foundation** |
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| 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** |
| The California Endowment |
| Trinity Health System, Livonia, MI |
| UMASS Memorial Health System, Worcester |
| University of Illinois Health and Hospital System, Chicago, IL |
| **Wake Forest Baptist Health, Winston-Salem, NC** |
| Wesley Theological Seminary, Washington DC |
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-PI, 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.

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Chapter 2

Executive Summary
Executive Summary

**Situation**

Nearly 40 non-profit and faith-based health systems have been engaged in an 18-month learning collaborative. The group has studied how these health systems and hospitals—driven by their common mission of community benefit—can fulfill their promise by integrating the community as a critical partner and place of health and healing. The expectation is not only that health outcomes will improve, and the overall health and economic viability of our communities as a result, but so will the bottom line.

The group meets again on April 4, 2013 at a forum co-hosted with The White House and the HHS Center for Faith-based and Neighborhood Partnerships, along with health system CEOs, to consider a call to action, captured in the recommendations below.

**Background**

Health care in the United States is fragmented and torn by many conflicting forces, resulting in substantial inequities in access to care and poorer health outcomes among populations and communities across the country. The irrationalities produce many direct and indirect costs that are proving very difficult to control, much less reduce. As a collective, we fail to fulfill the promise of 21st century science while also falling short of our own long-held mission that predates governmental mandates. The Affordable Care Act creates a policy context that continues to promote inpatient care delivery models to shift significantly—by linking clinical services to population health management and community health improvement activities outside the walls of our inpatient institutions. While far from perfect in practice, this policy environment 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. To do this calls for operational changes that align with the profound changes occurring in all aspects of health care provision. The last 18 months of focused learning by our own health care leadership confirms that we are strategically prepared to guide organizations through those changes.

**Assessment**

Our health systems have already completed, or are in the process of conducting the first generation of federally mandated Community Health Needs Assessments (CHNAs) to identify and address the significant opportunities to advance the health of the communities we serve. These generally confirm significant and persistent health problems among vulnerable populations (low-income, people of color, others in disadvantaged communities) that are beyond the ability of any single provider-institution to comprehensively address. The assessments have called for a new kind of community leadership that drives us to go beyond our usual hospital and health systems thinking, traditionally more comfortable with programs directed at individual health issues. Some of our systems have demonstrated significant community health impact by working with a broad coalition of local entities, including other acute health care providers. The CHNA process has hastened what our mission already encouraged, but it only begins to move the needle of the paradigm shift in health care delivery that will enhance the health of a community.

The HSLG identifies **three points of high leverage** that can accelerate and sustain the changes needed. Not interventions as hospitals usually think of discrete programs, they are three components of an ensemble of practices. If skillfully adapted to the particular needs and opportunities of our local realities, the promised convergence of 21st century science and art of medicine, linked to age-old compassion, can be realized. The ensemble of transformative practices builds on many other quality and cost improvements efforts common to our health systems, including extensive investments in IT, clinical quality and safety. But it dissolves the walls between health care and health, hospital, and community, individual and population; and it finds true cost savings—both financially and related to human suffering—in the process. Seeing things differently, we see promise where others may see only problems: the social complexity of our patients is an asset, not just a confounder; the community is where we find relevant partners, not just needs and service recipients; and the money needed is money we are already spending—on less effective charity care. The ensemble of practices thus points us to:

1. Capture greater value from funds already going to charity care,
2. Engage the social complexity of our patients, and
3. Work with large scale community partnerships.

This report unpacks measurable processes to get us there. It also suggests that we will be more effective if we learn together, rather than separately, through a continued commitment to shared knowledge and understanding.
The next right steps—a commitment

- We, the participating health systems, will approach our community health work collaboratively, knowing that we are one steward—albeit a major one—among others for the health of the community, including other providers, faith- and community-based organizations, businesses, and public health bodies.

- We expect these large-scale partnerships to achieve four shared benefits that are represented in part in the Triple Aim:
  1. Lowered health care costs,
  2. Improved access to appropriate health care,
  3. Improved health status of the communities served, and
  4. Reduced health disparities.

- Our partners can expect us proactively to invest a percentage of what we currently spend on charity care in the neighborhoods where there is clear opportunity to make health care more accessible, appropriate to the needs, as well as efficient, patient-centered, safe and equitable.

- To monitor that proactive investment, our finance departments will work with each other to develop new, standard financial metrics and accountability processes. As these tools are validated we will share them broadly within the health care community.

- We will aim 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.

- We will collaboratively implement and monitor the enrollment of eligible uninsured individuals, and connect newly insured individuals, to medical homes, age- and condition-appropriate screening services and care management.

- We will ask our health informatics departments to develop shared-outcome metrics and accountability measures to capture the impact of collaboration among government, private payers and community partners.

- We will invite IT vendors we have in common to create even more effective IT products to support the capacity and connectivity of the complex partnerships at the heart of our new opportunities.

- We will also engage and collaborate with governmental partners, to leverage their mission with ours to favorably impact our communities and become economic engines within our settings.

- We will engage foundations and non-traditional partners to further our mutual goals around capacity-building and restoration of our neighborhoods. When possible, we will work even with our competitors to achieve the common good—healthier people in healthier communities.

- We will 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.

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

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

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

Engaging ‘Collective Impact’

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

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

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

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

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

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

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

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

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

The Role of Financial Institutions

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

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

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

Return on Investment: The Standard Model

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

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

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

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

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

Expanding the Model

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

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

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

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


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

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

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

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

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

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

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

### Community Prevention and Social Return on Investment

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

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

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

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

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

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

In sum, by adapting the concept of return on investment and developing appropriate tools to calculate ROI, health systems can vastly strengthen their decision-making in the current environment and as the forthcoming health reform changes take effect. But some of these changes, alongside the longstanding missions of not-for-profit hospital systems, push us to extend our thinking beyond ROI to social returns on investment. This fits an expanded understanding of health. Increasingly, as we work to improve quality and improve community health while caring for patients from underserved communities, we recognize that factors far beyond our clinical care influence patient health, in ways that also impact our clinical measures. As we work collaboratively within communities to address these external factors, we are also likely to see changes in the community—returns on our and others’ investments—that go beyond the financial. Developing the tools to identify, assess, and measure these social returns, along with more conventional ROI, enables us as mission-driven organizations that are also committed to financial stability to make the best application of both our charitable and non-charitable investments.

Chapter 4
Charity Care ➔ Quadruple Aim
Overview

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

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

From Charity Care to Community Benefit:
Population Health Management

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

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

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

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

15 American Hospital Association, Association for Community Health Improvement, ‘Managing Population Health: The Role of the Hospital’ p.6, April 2012.
16 The Hilltop Institute, ‘Hospital Community Benefits after the ACA: The Emerging Federal Framework,’ January 2011 Issue Brief.
17 IRS Ruling 69-545 (1969) and IRS Ruling 83-157 (1983)
Goals of Health Reform: The National Strategies for Prevention and Quality

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

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

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

Under the Affordable Care Act, not-for-profit hospitals have a responsibility to advance the aims of the National Prevention Strategy Act. This responsibility is reinforced and supported by the new requirement in Section 9700 of ACA, and associated reporting requirements in IRS 990 Schedule H, for not-for-profit hospitals to conduct a community health needs assessment (CHNA) every three years, and to document in an implementation plan how the hospital will address identified unmet needs. The CHNA is considered conducted when it is made public, and the implementation plan is considered completed when the governing board of the hospital has approved it. Both must then be attached to the Schedule H of the IRS 990 report, beginning in 2013. To ensure that the health of the populations served by not-for-profit is improved, the Affordable Care Act recommends that measures of accountability for governance, management, and operations be established and codified by governance bylaws, policy, and clearly articulated job responsibilities. In addition, the HSLG believes that accountability for community engagement is important and feasible, as we outline in Chapter 7 on ‘Transformative Partnerships.’

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19 National Prevention Council, ‘National Prevention Strategy, 2010.'
Operating in Two Worlds

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

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

• Establish local forums as active partners—a representative body of individuals, groups, and organizations that: a) have an interest in health outcomes, b) can act to improve community health, and c) have access to resources (funding, expertise, community groups, etc.) to engage other health partners in the community.

• Seek opportunities to better understand key social determinants of health by improving hospital, physician, and community relationships, and supporting the engagement of stakeholders from other sectors in community health improvement.

• Including community health needs assessments as a key foundation for understanding communities and as a key instrument in health system strategic planning, while adding community health assets assessments wherever possible.

• Work with collaborative partners to identify issues that will yield the highest social return on investment (SROI), using existing data reports, program experience, and dialogue.

• Build on the considerable accomplishments to date in participatory action research to engage community members as full partners in achieving measurable improvements in health status.

• Align community health metrics across stakeholders and sectors to reflect shared ownership for collective impact.

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

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

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

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

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

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

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

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

We, based on a collective body of learning from over 35 hospitals, are thus proposing in our systems that that we accept responsibility for the Quadruple Aim, and for the development of the necessary framework and infrastructure to accomplish this lofty but increasingly vital goal.
Building a Population and Community Health Infrastructure

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

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

It will also require that we:

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

With the passage of the Affordable Care Act one thing is quite clear: it will be through broad collaboration that the goals of health reform will ultimately be realized. In creating a framework for a comprehensive approach to the delivery of healthcare, including health promotion and disease prevention and improved access to care and services along a continuum, collaborative arrangements are necessary to enhance the opportunities we have to make a greater impact in the communities we serve.
What this means we will discuss in much more detail in coming chapters. Here we note steps or actions (with one example: see sidebar) that might enable deeper and more effective partnership for collective community health goals:

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

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

Engaging Community Partners to Transform a Forgotten Community

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

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

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

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

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

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

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

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

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

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

With an increasing focus on a more planned, proactive approach to charity care aimed at reducing preventable emergency room and inpatient care for the uninsured, the basic issue has been good stewardship—making optimal use of limited charitable funds. A more proactive and strategic allocation of resources enables hospitals to help low income populations avoid preventable pain and suffering; this, in turn, allows the re-allocation 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 Billings20 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 percent of total hospital expenditures21. Numerous studies have documented higher concentrations of these conditions among uninsured, underinsured, and/or underserved racial and ethnic populations22,23.

Many studies have demonstrated substantial reductions in ACSC admissions associated with the implementation of care management strategies in clinical and community based settings24-26. A growing number of facilities across the country are implementing these strategies in practical efforts to reduce costs and redirect charitable resources to more effective and far-reaching endeavors.

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

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

• Health homes for patients in the community, including Federally Qualified Health Clinics, and enrollment assistance to help patients know how and when to use primary care.

• Community health workers—who play an important role on an expanded primary care team and serve as the essential link between clinical care management and place-based, population health improvement—can support care transition, enrollment, navigation of health services, adherence and disease self-management, and help patients access community resources related to other needs such as food, housing, and employment.

• Using a more aggressive ‘pipeline’ recruitment plan, to build a more diverse health care workforce—doctors, nurses, allied health professionals etc.—from persons who live in targeted, vulnerable communities, both to help a shift in culture that could durably impact on health literacy and overall knowledge of healthy behaviors and lifestyles, and to gain the intelligence needed for a sensitive and trustworthy engagement with such communities.

• Collaboration with school systems to encourage children to enter the health field, and actively foster their potential as health care providers who can be expected to ‘give back’ to their community, especially in populations considered to be ‘charity or quadruple eligible’.

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20 Billings, J., Teicholz, N., 1990, Uninsured patients in District of Columbia hospitals, Health Affairs, (Millwood), 9(4); 158-65.
23 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
25 Fedder, DO, et al, 2003, The Effectiveness of a Community Health Worker Outreach Program on Health Care Utilization of West Baltimore City Medicaid Patients with Diabetes, With or Without Hypertension, Ethnicity and Disease, Vol. 13, 22-27
• A more direct involvement of electronic medical systems (EMS) in designing the framework for these populations, given that EMS systems greatly vary in resources and protocols.

• Discouraging advertisements that promote utilization of the emergency department, e.g. ‘30 minute wait,’ and instead, promoting primary care access in the community.

• In an integrated ACO type of environment (risk reduction, keeping patients out of hospital), develop metrics around programs that support patients’ self-care; connect it with PCP post-discharge and measures of potential savings to quantify the cost/benefit for programs like Transitional Care Management, community based disease self-management programs, etc.

• Provide metrics on chronic care focused on diagnosis readmissions and associated penalties. These avoidable costs could be compared to the cost of developing infrastructure to prevent readmission. Though the penalties may not presently be financially significant, there is a cost to being on the public list of institutions that do poorly in controlling readmissions. Further, significant ‘community’ costs outside of the hospital walls may be important to understand in establishing metrics that reflect the true costs to the broader system as a whole.

Dignity Health

At Dignity Health the integration of community benefit in strategic planning and operations most recently involved an initiative to reduce readmissions for ambulatory care sensitive conditions has been successfully completed. Costs for treating these conditions across a network of 40 hospitals were more than $261 million in FY2010, representing more than 29,000 hospitalizations and more than 120,000 inpatient days. From 2008-2010, its hospitals invested $5.7 million in preventive and disease management programs for patients deemed at risk for hospitalization for asthma, diabetes, or congestive heart failure. This resulted in 8,917 individuals participating in disease self-management programs, and a 86% reduction in or avoidance of admissions for its participants.

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

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

1. Each facility/service area will:
   a. Identify and engage a clinical champion, e.g. physician, pharmacist, clinical nurse educator.
   b. Engage clinical health professionals in the development and implementation of the program, e.g. hospital case managers.

2. The intervention strategy may include home health, outpatient case management and/or evidence-based education programs.

3. The primary, but not exclusive, focus will be on the uninsured and populations covered by Medicaid, Medicare/Medicaid, or other means-tested government programs.

4. Where appropriate, strategies should seek to place patients in the community clinic/​FQHC system or other community health care providers, including medical home models, so that long-term coordination of care can be managed in a primary care setting.

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

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

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

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

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

- Be able to calculate bundled costs and construct equitable ways of sharing ever-shrinking reimbursement, in the light of global financing.
- With the extension of coverage through health reform, to adjust models for calculating readmission rates and other key indicators to account for the differing disease trajectories faced by populations grappling with disparities.
- Identify and be transparent about true ED costs, and costs associated with other potential stakeholders in the community (ambulatory, post-acute, primary care, mental health, support programs)—this could evoke innovative models for providing the ‘right care at the right time.’

In 1999 in Orange County, FL, two hospital ERs and a Health Department primary care clinic closed within weeks of each other—unleashing a flood of non-urgent, self-pay visits to the remaining hospital ERs. The county’s three hospital CEOs—including Florida Hospital/Adventist Health System—and the Health Department approached the Orange County Government’s Health Services Department for assistance. This group and a small Federally Qualified Health Center (FQHC) formed a Work Group. They found that Orange County had the state’s highest rate of uninsured people, but the lowest rate of Medicaid enrollment, and that many uninsured people could or would pay something for their health care—which resonated with the county’s Mayor and County Commission.

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

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

In desperation, John came to a PCAN faith-based, volunteer urgent care center. They immediately referred him to the secondary care clinic. A surgeon donated his time, and the hospital donated the surgery. After his successful surgery, John had occupational therapy (donated by a hospital) and was enrolled in a primary care medical home. Case managers along the way helped him find sustainable housing, and he is now employed. Without access to PCAN and its network of services, John would likely be dead. Yet PCAN must still improve its reach within the communities it serves—had John’s jaw been properly set initially, he would not have suffered for 10 months and his medical costs would have been less than $5,000, rather than in excess of $70,000.

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

Since 2001:

- Hospital ERs have seen a sustained 25% drop in non-urgent, self-pay visits through their strategic support of the Primary Care Access Network (PCAN).
- Nearly half of Orange County’s 200,000 uninsured are enrolled in affordable medical homes.
- PCAN safety net partners donated $62 million in care (excluding hospital charity care) in 2012.
- Ongoing evaluation of the PCAN’s FQHC medical homes shows a 68% decrease in blood pressure, an 83.3% decrease in cholesterol, and a 95% patient report of personal health improvement.
- Informal ‘parking lot meetings’ among partners have generated millions of additional grant dollars.
• Identify and understand direct and indirect costs of poor health outcomes (e.g. readmissions, cognitive, functional, ADLS, IADLS, quality of life, medical-particular disease, employer, Medicaid, Medicare, private insurance) outside of the hospital, to understand and develop ‘community metrics’ that could lead to more sustainable partnerships and expectations of those partnerships.

• Support, create, or advocate for funding sources and funding mechanisms to ensure that community stakeholders and partners have the resources they need to provide community-based care and support, which will be essential to sustaining these partner groups and therefore the partnerships.

• Consider whether related social safety net organizations could be included in the bundled payment structure (this could be approached by thinking about the patient journey, perhaps sharing funds with hospitals and safety net organizations upon which that person depends, as in Dignity Health’s model).

• Address how to accommodate significant variations in the payer mix, population dynamics, and social and environmental conditions that play a central role in health behaviors, health status, and quality of life.

• Calculate social returns on investment in partnership contexts, which will require developing agreed upon measures of social benefit and agreed upon monetization of those benefits.
Digital and Data Infrastructure

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

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

Some steps health systems executives will need to take include:

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

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

Critical needs going forward therefore will include:

- Common community metrics to connect community prevention to clinical prevention (e.g. Prevention Quality Indicators),
- Shared information systems or ‘common versions of the truth’ within communities,
- GIS technology relevant to health systems,
- Predictive modeling,
- Address validation features as a standard feature for electronic medical records,
- The use of hot-spotting tools along with the intelligence of emergency workers/paramedics, etc. (what MLH calls ‘participatory hot-spotting’).
Another way to think of this is to ask, ‘Can we tease out what might have been done that could have prevented many of our readmissions?’ This data would give us the opportunity to take action. While it is in hospital interests to do all that is necessary once a patient is at our doors, we must recognize, and act upon the recognition, that the hospital is one among many stewards who care for this person. By the time a person enters the hospital, the admission is of course no longer preventable. But data and intelligence about the communities in which our patients live using appropriate technologies can help us prevent readmissions, and identify preventable emergency department utilization. We will require four major sources of data in order to incorporate community based analytical capabilities:

1. **Demographic**— exact knowledge about changes within the make-up of the community and their likely impact on the future demand for health services.

2. **Health service needs**—knowledge about the exact nature of the resources that were consumed (physician and hospital) to meet patient’s needs.

3. **Unmet need or gaps** in hospital services, physician capacities, and social services within the various communities that we serve.

4. **Locally held community health assets**—knowledge about who is doing what and how that contributes to communal and population scale health, with which the health system can partner.

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


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

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

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

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

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

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

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

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

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

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

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

Preliminary aggregate results from our MLH EMR show that, for CHN members in the network versus an out-of-network control population (matched on age, ethnicity, gender and DRGs), readmissions have declined by 20%, mortality is less than half, and total charges on average were $8,705 per capita less.
Chapter 5

Integrated Care for Socially Complex People in Socially Complex Neighborhoods
What do we mean by social complexity?

All people and all neighborhoods are socially complex. Complexity is the rich and desirable nature of human life and of the social and physical environments within which we interact with and shape each other. Appreciating complexity helps people and communities adapt to change, be resilient in times of challenge, and grow and flourish in unexpected ways.

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

The Social Ecological Model

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

In the Social Ecological Model of health, the individual is grasped and understood in relation to their family, their social and community networks, the social and physical environment within which they live and work, and the larger socio-economic, political, cultural and environmental context.
Social Determinants and Health Disparities

No matter who we are, what our income, opportunities, physical environment, status, or treatment by society, our health is impacted by our social context or, as public health practitioners name it, by the ‘social determinants of health.’ Medical professionals and institutions, as primary health points of contact and authority, have significant opportunities in this regard to play a far greater role in advancing the health of the populations they serve through community prevention efforts.

Of particular concern for faith- and mission-based institutions is the question of health equity that accompanies the social determinants of health. We know that people who have more access to resources, services and power live longer and have better health outcomes—both mental and physical. Those with less access do not fare as well. Pervasive neighborhood poverty and systemic racism, in particular, create entrenched and intergenerational social dynamics that exacerbate poor health by taking a physical and emotional toll on residents. For example, harsh working conditions or chronic unemployment affect behavioral health and make it difficult to access needed medications or adhere to proper nutrition regimen. If ‘Place’ is the water in which we swim, it follows that where there is healthy water, there is a higher probability of healthy fish—and vice-versa. Context matters.

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

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

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

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

When the external becomes internal: How we internalize our environment

Allostatic Load

Stress

High Demand-Low Control Jobs

Stress

Lack of access to stores, jobs, services

Stress

Crime

Source: Anthony Iton, MD, JD, SVP, The California Endowment
Stress is widely accepted to be a critical aspect of health and wellness. The stress response, a natural response designed to help evolving animals survive life-threatening situations, is all too often triggered in the lives of people living in difficulty. The space and time to decompress from stress is rare for people struggling to make ends meet. Constant stress over time contributes to an overall allostatic load that impedes immune response and healing, increases susceptibility to pathogens and disease processes, escalates unhealthy coping behaviors such as overeating, smoking, or substance abuse, and affects learning, memory, social interactions and relationships.

Many of our patients who live in pervasive neighborhood poverty and with systemic racism face such chronic stress challenges. Their poor health is created and sustained within unjust social environments, so simply treating the body or mind does not improve health outcomes. Moreover, these patients repeatedly return to our health care systems—an unnecessary, and preventable, drain on resources.

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

**Culture Shift — From the Individual to the Community**

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

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

This is driven in part by an inclination to focus on issues that lie within provider control. Physical and social environments are beyond the direct control of medicine, and so may be discounted. Clinicians are typically trained and incentivized to manage the diseases and symptoms of individuals. We have also created a system of care that is highly successful in attending to a person’s physical parts. Specialties and sub-specialties allow for deep understanding and skill in addressing disease as it manifests itself physically or externally. Technology affords us the ability to isolate and treat very specific aspects of our bodies and their functioning. Often we do a good job of seeing how a person’s organs and body parts operate as part of a physical system, but we still struggle even with this level of complexity! To go further appears too big a stretch. Care that connects the person’s body, mind, and spirit may be a goal that all of our health care systems strive for, but communication and integration across and beyond specific specialties and disciplines is incredibly difficult to do well.
Compartmentalizing is (very) useful at times, but it all too easily prevents us from seeing that a person's health status is dynamic, contextually shaped, and constantly responding to the interplay between treatment and a wider environment. A better approach categorizes people, when that is helpful, for triage or delivering medical services, but better still is to consider the entire population in order to focus environmental improvements that benefit all. For example, understanding the community conditions that produce and exacerbate Type II diabetes helps inform an effective treatment plan. Actualizing the treatment plan will depend not only on individual medication and behavioral recommendations but also on making neighborhood improvements that facilitate access to healthy foods and safe places for physical activity. It will also call into play the resources or ‘assets’ (tangible and intangible) that are available within their own context to the person on treatment. These environmental and relational changes are important for preventing diabetes, for delaying and reducing its onset and extent, for minimizing its impact for those who are severely affected, and for enhancing their lives.

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

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

There is no doubt that staff in our health systems are already experiencing and working with patients and families whose illnesses are exacerbated by social conditions. A brief, unscientific survey of staff in six health systems that are members of the HSLG identified the following as the top social issues affecting the patients they serve:

- access to care
- mental health issues,
- substance use, and
- diet and exercise.

Barriers that they experience in attending to patients with these social issues included adequate resources, costs, reimbursement structures, and knowledge of effective intervention and best practices.

27 AHA and ACHI, Managing Population Health: The Role of the Hospital (April, 2012): 7
This diagram illustrates some ways of impacting on the social determinants of health in both individual care and community health initiatives. The top pathway points to a new way of viewing a patient's treatment, acknowledging the importance of additional support. Most commonly, this comes in the form of education opportunities or ‘patient navigators.’ The bottom pathway further points to the need to address root causes, given that presenting symptoms may be caused by non-medical factors. It suggests that health systems can incorporate cross-sector partnerships to impact community-based challenges. Further, we need changed public policy to appropriately incentivize this type of treatment and care for our patients and communities. In the end, this will help reduce inappropriate utilization of the emergency department, limit unnecessary readmissions, reduce the bottom line for hospitals, and create better outcomes overall for families and their communities.

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

**HOW TO IMPACT SOCIAL DETERMINANTS OF HEALTH**

**Effect of social determinants on patient**

**IMMEDIATE MEDICAL CONCERNS:**
- Asthma attack
- Diabetes
- Depression
- Risky behaviors

**SOCIAL DETERMINANTS**
- Under employed
- Lives in poor housing conditions
- Lives near a highway
- Has no park nearby

**ROOT CAUSES**
- Lack of employment opportunities
- Poor housing conditions
- Highway pollution and lack of trees
- Lack of green space and healthy food options
- Lack of adequate resources in low-income communities

**ADDRESS INDIVIDUAL PATIENT HEALTH CONCERNS**

Use approaches that allow health care institutions to do a better job of meeting the needs of people who come into our facilities with complex needs—develop patient navigator, medication assistance, and prevention and education programs.

**ADDRESS ROOT CAUSES**

Change policies to reflect individual and neighborhood needs

Collaborative interventions that aim to change the social conditions themselves—increasing high school graduation rates, developing employment opportunities, improving housing, etc.

Fewer people to Emergency Department

Better outcomes for families and neighborhoods

Better bottom line for hospitals!
This diagram illustrates some ways of impacting on the social determinants of health in both individual care and community health initiatives. The top pathway points to a new way of viewing a patient’s treatment, acknowledging the importance of additional support. Most commonly, this comes in the form of education opportunities or ‘patient navigators.’ The bottom pathway further points to the need to address root causes, given that presenting symptoms may be caused by non-medical factors. It suggests that health systems can incorporate cross-sector partnerships to impact community-based challenges. Further, we need changed public policy to appropriately incentivize this type of treatment and care for our patients and communities. In the end, this will help reduce inappropriate utilization of the emergency department, limit unnecessary readmissions, reduce the bottom line for hospitals, and create better outcomes overall for families and their communities.

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

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

Acting Strategically: Target Areas

There are five areas of health inequity that have been particularly costly for health care providers—both financially and in terms of patient outcomes.

- Low birth weight babies and sick mothers
- Mental health burdens of stress, depression and anxiety
- Patients with chronic disease
- Frail and disconnected elderly
- Childhood obesity

If we address the social environments that perpetuate poor health outcomes in these five areas, we will make great progress in reducing health disparities. In what follows, we consider the how and the why for each of these strategic target areas.

Low Birth Weight Babies and Sick Mothers

Pregnant women who struggle with their health and babies born too early result in significant costs to health care providers. Mothers and babies may require long Length of Stays. Preterm babies are likely to need NICU care and longer-term health care treatments, including therapies that may last a lifetime. Mothers and babies in the hospital are vulnerable to hospital acquired infections and complications. Hospitals feel these costs both in financial terms and patient outcomes—through NICU costs, Length of Stays, infant mortality rates, and other costs of care. Because up to half of the babies born in many states are covered by Medicaid, the costs for premature and low birth weight babies are major contributors to the skyrocketing health care cost curve.

Social conditions that appear to impact a woman’s ability to carry her baby to term include prenatal care, education, and adequate nutrition. But stress, poverty, educational achievement, housing quality, and social connectedness may be even more critical. In 2005, the Health Policy Institute of the Joint Center for Political and Economic Studies convened a National Commission on Infant Mortality. The Commission argued that disparities in low birth weight and infant mortality have less to do with prenatal care and access to services, and more to do with the physical consequences of the stress that occurs when social relationships are not healthy. They called for interventions that ‘focus on the repair and support of interpersonal relationships at all levels—interpersonal, systemic and structural.’

Some practices that have been shown to be effective include home visits by nurses, doulas, or community health workers; WIC to ensure good nutrition; and Centering Pregnancy, which integrates social support and mentoring into prenatal care. The Life Course Approach to maternal and child health has emerged as a leading framework for developing effective services to pregnant women and their babies. Life Course theory makes the case that the ability of a woman to deliver a healthy full-term baby is related to the experience of the mother from the time that she was herself in the womb. In this scenario, reducing the number of low birth weight babies and infant deaths means not just providing good prenatal care, but also making sure that young girls have a good diet, that teens (girls and boys) know how to manage stress, that girls are not victims of physical and sexual violence, that they get a good education, and that they are raised in an economically stable environment.

A hospital or health care system could partner with local community-based organizations, faith communities, schools, business, etc. to tackle any of these issues and make a considerable contribution to improving maternal and child health in their community.
Mental Health Issues—Stress, Depression, Anxiety, and Risky Drinking/Drugging

The vast majority of patients with mental health issues are not those with true psychiatric disorders. They are people who struggle with the anxiety and depression that can accompany the challenges of navigating through poverty, racism and other social stresses; or people who end up seeking relief from these pressures through the misuse of alcohol and/or drugs. These stresses may include early exposure to violence, educational challenges, low wages in unstable work environments, exposure to the criminal justice system, or the ‘thousand cuts’ of chronic racism and economic difficulties. For example, a 2011 Princeton University study (Currie & Tekin) found that for every 100 foreclosed properties in a community, anxiety-related ER visits and inpatient admissions increased 12 percent.

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

The costs to the overall community are also significant. The social welfare, education, and criminal justice systems are just some of the places where these increased costs are incurred. The situation is greatly complicated by the fact that resources for the recognition and treatment of mental health and risky substance use are dwindling. Many states faced with severe budget problems and deficits are scaling back their commitment to addressing these issues. And the implementation of the Affordable Care Act of 2010, which recognized the importance of these issues by making mental health and substance abuse prevention and treatment services one of the ten categories of essential health benefits, has been complicated by both the actions of HHS and the decision of the US Supreme Court to leave to individual states the decision to expand Medicaid to the safety net population.
Homeless Person with Mental Health Conditions

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

### SOCIAL DETERMINANTS

<table>
<thead>
<tr>
<th>INDIVIDUAL RISK FACTORS</th>
<th>‘PLACE’ FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not have a primary care doctor or access to health and</td>
<td>Lack of shelter and stable address/housing and therefore unable to enroll</td>
</tr>
<tr>
<td>specialty behavioral care</td>
<td></td>
</tr>
<tr>
<td>Does not have a stable address and therefore unable to enroll</td>
<td>Poor integration of primary care and behavioral health services</td>
</tr>
<tr>
<td>in SSI and other benefits</td>
<td></td>
</tr>
<tr>
<td>Does not have health insurance and can’t pay for provider</td>
<td>Lack of access to nutritious food</td>
</tr>
<tr>
<td>visits or medication</td>
<td></td>
</tr>
<tr>
<td>Patient experiences food insecurity &amp; poor nutrition</td>
<td>Lack of connection to medical and oral health care</td>
</tr>
<tr>
<td>Patient has poor oral health and overweight</td>
<td>Inability to pay for doctor visits and medication</td>
</tr>
<tr>
<td>Patient lacks transportation</td>
<td>Inconsistent or no treatment for mental health conditions</td>
</tr>
<tr>
<td>Patient lacks family or access to community and social support</td>
<td>Limited access to community-based specialty mental health/addiction care e.g. ACT Team</td>
</tr>
<tr>
<td>Patient lacks access to community-based mental health services</td>
<td></td>
</tr>
<tr>
<td>Patient has mental health issues but is frequently brought to</td>
<td></td>
</tr>
<tr>
<td>ED for social conditions</td>
<td></td>
</tr>
<tr>
<td>Patient has difficulty navigating the healthcare system</td>
<td></td>
</tr>
</tbody>
</table>

### IMPACT ON HEALTH

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

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

### POTENTIAL OUTCOMES

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

### PARTNERS

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

Preventable chronic diseases, like heart disease, stroke and cancer, are the leading causes of death and disability—and expense—in the United States. Indeed, almost 1 out of every 2 adults in our country has at least one chronic illness, with one out of four being limited in their daily activities. Often contributing heavily to chronic diseases are limited access to a healthy environment, and community-based behaviors. For instance, the leading underlying causes of the majority of these chronic diseases are poor nutrition, lack of physical activity, tobacco use, and excessive alcohol consumption. CDC reports that 23% of adults have no leisure-time physical activity at all in the preceding month; only 22% of high school students and 24% of adults have appropriate daily fruit and vegetable intake; one in five adults—and a similar number of high school students—smoke tobacco. Yet, studies like the Trust for America’s Health report noted earlier have repeatedly shown significant health and fiscal benefits in undertaking evidence-based community prevention interventions, for example, such as access to and affordability of healthy food, the availability of safe recreational facilities, and the walkability of the neighborhood.

Faith- and mission-driven hospitals have the opportunity to provide leadership in implementing care management strategies that will prepare us for the ‘cradle to grave’ responsibility we will have under federal health reform. We are already building Integrated Care Systems and Accountable Care Organizations (however the latter are defined) in order to meet the Triple Aim of lower-cost, quality care that improves population health, adding to this the fourth aim of reducing health disparities.

The extension of team-based patient-centered care into the community and the home, to reach marginalized and lower income communities and link them to support systems, medical and non-medical, has been shown to be a powerful intervention for those with chronic disease. Utilizing community health workers, pharmacists, home health and faith-based nursing, among others, has been repeatedly shown to have significant benefits for the improvement of the health of the residents as well as ‘the bottom line.’ For instance, an intervention in children with asthma utilizing Community Health Workers in Chicago, consisting of 3 to 6 home visits over 6 to 12 months for one-on-one individualized asthma education to the child and caregivers, resulted in a 62% reduction in asthma related ED visits and a 67% decrease in asthma related hospitalizations and a 7 to 1 ROI (Margellos-Anast et al). Similarly dramatic improvements have been recognized in diabetes, HIV, and overall medication adherence, to name a few.

The opportunity of our healthcare systems to engage and appreciably impact the health of those we serve with chronic disease while simultaneously improving the organization’s bottom line through community prevention and outreach are just emerging as powerful drivers of our organizations and the health of our nation.
Frail and Disconnected Elderly

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

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

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

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30 Mezey & Fulmer, 1998
31 Fried et al., 2001; Hart, Birkas, Lachmann, & Saunders, 2002; Mick & Ackerman, 2002
32 Clarfield, Bergman, & Kane, 2001; Merlis, 2000
Frail and Disconnected Elderly Patient

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

### SOCIAL DETERMINANTS

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

### IMPACT ON HEALTH

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>HEALTH CARE SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episodic care enables symptom reduction, but does not resolve underlying health concern</td>
<td>Unnecessary overuse of ambulance services</td>
</tr>
<tr>
<td>Poor medication adherence</td>
<td>Unnecessary use of ED congests ED flow and bed availability</td>
</tr>
<tr>
<td>Added financial stress</td>
<td>Unnecessary medical testing and invasive procedures</td>
</tr>
<tr>
<td>Poor care coordination delays needed services</td>
<td>Impact on hospital’s bottom line and available Charity Care dollars</td>
</tr>
<tr>
<td>Medical condition can worsen</td>
<td></td>
</tr>
</tbody>
</table>

### INTERVENTION EXAMPLES

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

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

## PARTNERS

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

Among the five target areas, childhood obesity represents perhaps the most significant challenge to reducing health care costs in the coming years. Rates of obesity have more than doubled among children (from 7% to 18%) and tripled among adolescents (from 5% to 18%) in the last 30 years.\textsuperscript{33,34}

While rates have increased for all groups, they have grown more rapidly among lower income populations and in households where parents have less education. For example, recent rates are as high as 25.3% among Mexican American boys between the ages of 2-19, and 25.1% among African American girls in the same age group.\textsuperscript{35}

These youth are at significant risk from a wide array of chronic diseases, including type II diabetes. Diabetes is the seventh leading cause of death in the U.S., a major cause of heart disease and stroke, and the leading cause of kidney failure, non-traumatic injury amputations, and blindness among adults. A recent study based upon fasting glucose or hemoglobin A1c levels found that 35% of adults 20 years or older had pre-diabetes.\textsuperscript{36}

As a result of CLOCC’s work over five years from 2002-2007, Chicago achieved a statistically significant decrease in obesity among children entering school for the first time. The data showed that 24% of Chicago children were entering school already obese—two-and-a-half times the national average then. Politicians took note, introducing more than 40 related pieces of legislation. CLOCC officially sponsored the passage of the 2004 Illinois state bill that called for schools to collect data relating to obesity when performing annual student health examinations.

Early on, CLOCC’s efforts focused on short-term, specific programs and interventions to start or keep individual children on a path to a healthy lifestyle. CLOCC’s attention to individually-focused approaches, and the recognition that children and families needed sound information to make good decisions on nutrition and physical activity, led them to develop the 5-4-3-2-1 Go!® healthy lifestyle message. It was intended to be a roadmap for children and families. Over time, CLOCC began to recognize the importance of making health easier by changing the environments within which children and families live, work, learn, and play. Known as Policy, Systems, and Environmental change (PSE) strategies, these approaches support communities with the goal of making healthy options the default options. 5-4-3-2-1 Go!® public education remains a foundation of CLOCC’s work, but it is now squarely supported by environmental change solutions that help families achieve the recommendations more easily.

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

Dr. Christophel, on her own journey in obesity prevention—crossing oceans and moving mountains: ‘When I entered medical school I dedicated myself specifically to health and health promotion. I chose pediatrics because I was sure that caring for children would always remain compelling and optimistic. It has been a pleasure and privilege working with children and families. I am humbled by the welcome granted to me to enter the private space children share with their adults. To be of help, I had to learn how families work, hour by hour, week by week, year by year. People trusted me to pry and spend time with them to learn about them. To cross the ocean that divided us. My attention gradually turned to problems related to primary calorie imbalance, both malnutrition and obesity, and this became my clinical focus for decades. When evidence of the obesity epidemic showed up in my examining room, I saw that protecting kids from this scourge required approaches well beyond what can be offered in the clinic. This was clearly a very big mountain indeed; spanning many areas of life and unjustly affecting the most those most in need. I took its measure and concluded that what was needed was a very comprehensive approach, with a focus on primary prevention and an emphasis on young children...’

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

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

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

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\textsuperscript{34} National Center for Health Statistics. Health, United States, 2011: With Special Features on Socioeconomic Status and Health. Hyattsville, MD; U.S. Department of Health and Human Services; 2012.


If applied to the general population, this suggests an estimated 78 million or more adults with pre-diabetes. Given these trends, it is not too much of an exaggeration to suggest that the dramatic increases in obesity rates among youth represents a potential tsunami of increased health care costs in the coming years. Average medical care expenditures for persons with diabetes are estimated to be approximately 2.3 times higher than people without diabetes.\(^{37}\)

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

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

\(^{37}\) Ibid
Obese Adolescent

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

<table>
<thead>
<tr>
<th>SOCIAL DETERMINANTS</th>
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</tr>
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<tbody>
<tr>
<td><strong>INDIVIDUAL RISK FACTORS</strong></td>
<td><strong>‘PLACE’ FACTORS</strong></td>
</tr>
<tr>
<td>Does not have a primary care doctor</td>
<td>Few primary care docs who accept Medicaid patients</td>
</tr>
<tr>
<td>Goes to a school that has scaled back its physical education program</td>
<td>Lack of public sector funding for schools</td>
</tr>
<tr>
<td>Relies on fast food outlets for lunch and dinner</td>
<td>High concentration of fast food outlets and liquor stores, but no grocery store within walking distance</td>
</tr>
<tr>
<td>Does not participate in any organized sports</td>
<td>Intermural sports and after school programs terminated</td>
</tr>
<tr>
<td>Spends most afternoons playing video games</td>
<td>No parent home between 3 and 11 p.m.</td>
</tr>
<tr>
<td>Has low self-esteem and limited social life</td>
<td>Lack of street lighting, parks, and sports facilities</td>
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<table>
<thead>
<tr>
<th>IMPACT ON HEALTH</th>
<th>HEALTH CARE SYSTEM</th>
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</thead>
<tbody>
<tr>
<td><strong>INDIVIDUAL</strong></td>
<td><strong>HEALTH CARE SYSTEM</strong></td>
</tr>
<tr>
<td>Diagnosis with blood glucose level above 110 and high blood pressure</td>
<td>Frequent preventable use of ED for heart palpitations and shortness of breath</td>
</tr>
<tr>
<td>Anxiety about difficulty in complying with nutrition and physical activity recommended by physician</td>
<td>Preventable use of ED congests ED and bed availability</td>
</tr>
<tr>
<td>Lack of understanding of creative options given health education that is not culturally competent</td>
<td>Current negative impact on hospital’s bottom line and available Charity Care dollars</td>
</tr>
<tr>
<td>Gradual deterioration of condition</td>
<td>Future challenge in managing evolution to full scale diabetes in capitated Medicaid contract</td>
</tr>
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<thead>
<tr>
<th>INTERVENTION EXAMPLES</th>
<th>POPULATION HEALTH/PLACE-BASED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INDIVIDUAL</strong></td>
<td><strong>POPULATION HEALTH/PLACE-BASED</strong></td>
</tr>
<tr>
<td>Develop health education tailored to socio-economic circumstances and cultural practices</td>
<td>Engage pre-diabetic youth in training programs to • Develop maps of food sources and alcohol outlets • Lead neighborhood organizing on relevant issues • Provide support for adults with diabetes and disabilities</td>
</tr>
<tr>
<td>Identify and facilitate increased knowledge and access to feasible options for better nutrition and physical exercise</td>
<td>Lead/support public advocacy campaigns to • Remove soda machines and fast food from schools • Strengthen school physical education programs • Secure public funding for after school programs • Increase and/or renovate public park space • Establish safe routes to school and bike lanes</td>
</tr>
<tr>
<td>Engage and deploy community health workers/promoters that work with youth to reinforce adoption of health behaviors</td>
<td>Engage financial institutions and philanthropy to expand quality food access in inner city communities</td>
</tr>
</tbody>
</table>
### POTENTIAL OUTCOMES

<table>
<thead>
<tr>
<th>INDIVIDUAL</th>
<th>HEALTH CARE SYSTEM</th>
</tr>
</thead>
</table>
| Regular primary care provider supported by CHWs | Reduction in  
  • Unnecessary ED visits and ambulance use  
  • Excess costs beyond reimbursement rates |
| Youth begins to lose weight and blood glucose drops to within normal range | Improvement in quality-related clinical indicators |
| Improved self-esteem through weight loss, increased exercise, and engagement in community campaigns | Improvement in quality-related clinical indicators |

### PARTNERS

- Other hospitals
- Local public health agencies
- Health insurance companies
- Community health centers
- Financial institutions/CDFIs
- Faith-based organizations
- YM/WCA
- Local advocacy groups and neighborhood watch groups
- Local schools
- Local Chamber of Commerce
- Parks and Recreation Departments
- United Way
- Grocery store chains and local food outlets
- Farmers
All five of the conditions we have discussed have long-term etiologies with increasingly expensive and complex management issues for the provider system. All require a smooth and trusted referral pathway from the earliest levels of detection and care to the highest level interventions and back again.

**Partnership**

Partnership is explored in more depth in another chapter in this document, so we do not cover it here. Clearly, however, these socially complex realities reinforce the commitment to solutions that are intersectoral and collaborative. Health care providers cannot and should not work on addressing them on their own. It is not our role to become economic development organizations or housing specialists.

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

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

Just what kind of partnerships are likely to be most helpful, however, is an important question, for they come in many forms, and they are not always productive or effective in changing health patterns at population scale, at community level, or durably—hence a separate chapter on this.

**The Role of Data Driven Decision Making**

In shifting from a perspective that focuses on individual patients to one that takes a more macro-level approach, it is important to move forward in a well-thought out, informed and effective way. Data on many different levels provides a lens by which we can view social determinants and guide the design of effective interventions for positive and sustained impact on health status. In its most basic form, data-driven decision making is about:

- Collecting appropriate demographic, risk factor, protective factor, and utilization data
- Analyzing that data in a meaningful fashion
- Getting the data into the hands of the people who need it
- Using the data to increase efficiencies and improve health status and outcomes
- Communicating data-driven decisions to key stakeholders

Data helps health systems and administrators see things they might not otherwise see. When data is examined from all angles, it may highlight a program that, although efficient in its use of resources and well utilized by patients, does not improve patients’ health status. Data can help drill down to the root causes of a problem, allowing health care systems to solve the whole problem and not just the symptoms. This gives health professionals greater insight into interventions, helping them promote effective programs and modify or discontinue programs that are not working.

Data can provide useful information within and across health organization in formats that staff at all levels can quickly use to determine best practices or collective impact. These examples of performance excellence or collaborative value can then be shared with other systems, providing the opportunity for the field to learn from each other.

Data can arm administrators with facts and figures that tell a more complete story and help key audiences understand the root causes of the health challenges faced by their community, and the better ways of going about responding to them.
Thoughts on Measurement

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

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

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

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

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

Taking Two Steps to Prevention Framework

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

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

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

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

THRIVE

THRIVE is an evidence-based tool for understanding health and resilience in vulnerable environments. It is a framework that connects health outcomes to community conditions. THRIVE identifies 13 factors that can guide thinking within a clinical context and with partners about the second step of prevention: getting specific about what in the community environment is shaping health, safety and equity.

‘Hot Spotting’

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

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

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

Adventist Health Care in Florida convened community partners to create the Bithlo Community Transformation Effort (place-based) to address these root causes. While planning is still underway, this initiative is an exemplar for a faith-based health care organization embracing the connection between clinical outcomes, utilization of services, and health care costs and the social environment which shape them as part of their mission.
One approach that warrants a more developed description is the Community Health Worker model. Community health workers (CHWs) have been a vital part of our workforce for decades. Yet only recently has their contribution received full attention and scrutiny, with HHS defining their work as key to eliminating disparity, and PPACA recognizing them as part of the workforce. Various definitions for CHWs exist along with many models (paid, unpaid, stipended, working with a team, or solo).

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

Optimally, however, CHW activity should be much more than that even, so that it increasingly reflects a partnership with community agents. One thought provoking example of how this might be reimagined comes from Wake Forest Baptist Medical Center. To reduce overall hospital costs, WFBMC considered a recommendation to save a million dollars by 'outsourcing' the cleaning of our hospital. This meant replacing 267 environmental service (EVS) workers, many with a long tenure. The Committee, probing how the savings would actually be achieved, realized it was mostly from a simple fact: the outside firm would pay less, with less benefits. They were overlooking the full contribution those long term employees have, not only in the lives of patients, but also in the lives of their neighborhood.

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

As we reimagine the CHW role in broader systems, a brief review of current certification is useful. Three states require CHW certification (Alaska, Ohio, Texas), while North Carolina and Nevada have mandated state level training requirements. Kash (2007) cites 3 models for training: 1) schooling at community college level; 2) on-the-job training that improves standards of care, CHW income, and retention; and 3) certification at the state level that acknowledges guild standing and facilitates reimbursement. There are no national standards for certification, training requirements, or defined scope of practice for CHWs. Some states (e.g. Michigan’s Community Health Worker Association or MiCHWA) have taken the lead in advocacy and the setting of such standards (Duthrie, 2012).
Early evaluation of CHW programs showed limited pre-post health improvement outcomes to justify program sustainability (Sprague, 2012). But traditional metrics (e.g., Relative Value Units) are inadequate to show the full spectrum of skills and unique work done by CHWs, especially as their work links to interventions at the social determinant level (Rush, 2012). Now, however, the push for innovative bundled care financing structures and use of targeted staff to prevent readmissions and improve care transitions creates a more favorable environment for CHWs. Freudenberg & Tsui (2011) argue persuasively that CHWs (along with two other entry level workers, environmental protection and food service) have long-term potential to reduce government spending, shift the focus from treatment to prevention, directly address social determinants of health (e.g., unemployment), and contribute to the improved prevention and control of chronic diseases. The Wake Forest Baptist Medical Center environmental service workers initiative described above is a superb example of how these front line employees’ efforts can be realigned to address economic and chronic care problems faced by our nation.

More recent studies have shown cost-savings and positive return on investment (ROI) of various CHW models. For example, the Men’s Health Initiative in Denver, Colorado, which helped patients establish a medical home and primary care provider with system navigation and case management, reduced inpatient hospital visits and demonstrated an ROI of 2:28:1:00 (Whitley et al, 2006). In Baltimore, Maryland, for a cohort of 117 African-American Medicaid diabetic patients, Fedder et al (2003) showed a 40% decrease in emergency room visits and average cost-saving per patient of $2,245. Patients working with CHWs, in a randomized study of 309 African-American men with hypertension, reported twice the level of satisfaction in their treatment than those treated with more traditional education and referral from a nurse practitioner (Felix-Aaron, Hill & Rubin, 2000). CORE Health, as part of Spectrum Health’s Michigan’s Healthier Communities Programs, works with maternal and child health, hypertension, diabetes, nutrition and healthy lifestyles in schools, hospitals and communities; it demonstrated an ROI of $1.68 dollars saving per dollar spent in a 3 year analysis (Duthrie, 2012). New Mexico Medicaid managed care showed an ROI of $4.00 savings for every dollar spent by intervening with high utilizers to decrease high emergency room usage and low treatment adherence (Johnson, et al, 2011). The volunteer based program of the Congregational Health Network in Memphis, Tennessee, relies on over 550 unpaid trained CHWs (called ‘liaisons’) in over 512 churches, to work with 10 hospital-based, paid employee ‘navigators’ or community triagers, to help patients in and out of the hospital system, with early savings of over $8,000 per capita on total hospital charges compared to controls for those not in the network (Cutts, 2011). Lastly, Detroit’s HFHS and other partners (including competing health systems) have begun an ambitious initiative, Sew Up the Safety Net for Women & Children (SUSN), to address the social determinants of health that impact on infant mortality. SUSN is working with 1,500 at risk women and relying on CHW staffing, along with provider education on health equity and “high tech/high touch” social marketing decrease infant mortality (Wisdom & Combs, 2012).

Funding models for CHW initiatives include: 1) charitable foundation or governmental agency grants or contracts, which are usually short-term; 2) general governmental funding via grants or programs that have CHWs as a line item in a public health department budget; 3) private sector funding like hospital or health plans; and 4) Medicaid (in Alaska and Minnesota), often reimbursed through waiver programs or capitated rates (Sprague, 2012). Some funding mechanisms are hybrids of these models. For example, Methodist Le Bonheur Healthcare’s CHN program relies on stable hospital funding to cover its navigators, director, evaluator and administrative support, with evaluation, supplies, stipends to congregational partners, and training costs covered through philanthropy and Foundation grant funding.
Conclusion

We have seen health care systems around the country working in partnerships at various stages of development, ranging from solo program implementation to engaging other sector leaders in durable and sustainable efforts for collective impact. We understand that this is long-term and sometimes difficult work.

That this work is long-term is not a weakness or a hindrance; precisely the need to counteract short-term responses to enduring, persistent, and systematic health challenges is what drives the HSLG to seek to learn together about the transformational ensembles of purpose, partnership and practice that will ensure a positive, measurable, durable and accountable shift in population health and community well-being. We will not make the shift immediately. But we can lay the groundwork.

In sum, what we have arrived at is a recognition of certain basic elements that will define the required transformational ensemble—reminding ourselves that rather than any selective appropriation of these elements, it is the ensemble that matters: the coherent, congruent application of all the elements. In this respect we are talking about a way of seeing before it is a way of doing.

CREATE THE CULTURE
The HSLG in its process and its thinking seeks to represent the kind of culture that we believe must be nurtured if we are to achieve the lofty but profound aims that bring us together, health care that is decent, efficient, and proactive, encompassing the health of all in the communities and populations we serve.

BUILD THE RELATIONSHIPS AND PARTNERSHIPS
We cannot achieve this without working collaboratively. This is as true of the learning process we are engaged in, as it is of the practices we need to invent or enhance. For this reason, building appropriate and productive relationships with each other, and with others in the communities and populations we serve, is a sine qua non.

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

MEASURE THE RESULTS
We are aware of the importance of showing demonstrated results from the interventions and activities we engage in—of being transparently accountable for what we claim to be doing. Equally, we know of several ways in which this may be measured, including collective impact, social return on investment, and standard return on investment tools.

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

Throughout this document, we have spoken of collaborative relationships and vital partnerships, but without fully discussing just what kind of relationships and partnerships are ideal or, better, necessary, if we are to achieve the aims represented by the five elements of our ‘transformational ensemble.’ That is the subject of the next chapter, on ‘Transformative Partnerships.’
Chapter 6
Transformative Partnerships
‘Health is a journey, not a list of medical events. The hospital is, and can only be, one part of it, especially for chronic illnesses.’

– Gunderson and Cochrane

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

• In Memphis, TN, Methodist Le Bonheur Healthcare has reached out to over 500 faith communities, created roles for community navigators, and by working with community assets as well as needs in a person-centered approach, reduced readmissions by 20% and showed total sum charges of ~ $4,000,000 less than matched controls over 26 months.38

• In Alaska, Southcentral Foundation’s Customer Owner model of integrated healthcare delivery has resulted in a 50% drop in urgent care and emergency room utilization, a 53% drop in hospital admissions, and a 91% increase in customer satisfaction.39

• New Jersey’s Camden Coalition created the ‘hotspotting’ model for tracking high utilizers and meeting their needs more locally, pulling together local hospitals, social service agencies, and other stakeholders to provide comprehensive care and decrease avoidable emergency room visits.40

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

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

• The dramatic rise in health care costs has led many stakeholders to embrace innovative ideas

• Health research continues to clarify the importance of social and environmental determinants of health and the impact of primary prevention

• An unprecedented wealth of health data is providing new opportunities to understand and address community level health concerns

• The Affordable Care Act presents an overarching opportunity to change the way health is approached in the United States41

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

Speakers also emphasized that community organizations were frequently an essential link in improved care delivery, though today they are often isolated from formal health care organizations. (IHI CEO Maureen) Bisognano said that as new and diverse patients enter the system under expanding insurance coverage, providers will have to respond with new models of care that meet the patient’s deepest needs, be they in a hospital or in a community setting. ‘We need to move from ‘what’s the matter? medicine to ‘what matters to you?’’ she said. Chas Roades highlighted the work of Chicago’s Rush University Medical Center, which is treating diabetes in part through a block-by-block community campaign.

Community members go door-to-door bearing tablet computers with predictive modeling software, doing risk assessments, administering questionnaires, and giving dietary counseling. ‘What they realize is, we can’t simply sit inside the academic medical center and apply our traditional strategies and make that problem get better,’ Roades said, ‘We actually have to engage at a community grassroots level.’42 (emphases our own)

40 http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande
42 Institute for Healthcare Improvement. Out of the Blocks: An Action Brief for Healthcare Leaders in the Post-Election Era (December 2012), 10:
In 2011, The Kresge Foundation studied the population health approach of four early adopters—Genesys Health System in Grand Blanc, Michigan; Memorial Healthcare System in Hollywood, Florida; Southcentral Foundation in Anchorage, Alaska; and the Central Michigan Regional Triple Aim initiative representing 14 counties in Central Michigan. They report that:

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

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

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Person-Centered Journey of Health

**Prehab:** Prevention/Education, Advocacy Address Social Determinants

**Hospitalization:** Enter through the Right Door at the Right Time, Ready to be Treated via Compassionate, Quality Clinical Care

**Continuity of Care:** Navigation, Mediations, Nutrition and Food Security, Primary Care, Respite Care, Social Support, Mental Health and Well-being
What do We Mean by a ‘Transformative Partnership’?

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

• Provides a level playing field where all participants are open to learning from one another, recognizing the strengths and assets each partner brings to the table. The hospital may not always take the lead. As Henry Ford Health System CEO Nancy Schlichting has told the health system’s Community Pillar Team, ‘We can lead well, but we can also be a great partner.’

• Is replicable, with demonstrated outcomes that can be taken to scale, and metrics agreed upon from the start by all partners.

• May often leverage the sophisticated tools of marketing, planning, research, health promotion, and care management that health systems already have, but shift the focus to populations that may not have been the target of previous efforts.

• Is culturally competent in the broadest sense, using the tenets and tools of equity, cultural humility, and health literacy.

• Is a relationship, not an outcome, which exists along a continuum of engagement.

Continuum of Partnership Engagement

NETWORKING
Exchanging information for mutual benefit.

COORDINATION
• Exchanging information, altering activities for mutual benefit for a common purpose.

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

COORDINATION

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

COOPERATION

COLLABORATION

• Exchanging information, altering activities, sharing resources, and enhancing the capacity of one another for mutual benefit to achieve a common purpose.

• Each organization wants to help partners become the best that they can be at what they do. It assumes that organizations share risks, responsibilities, and rewards, each of which contributes to enhancing each other’s capacity to achieve a common purpose.

COLLABORATION

Why Build and Engage in Transformative Partnerships?

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

### Community Partners Can Include

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<thead>
<tr>
<th>KEY LEADERS/INSTITUTIONS</th>
<th>BUSINESS/ECONOMIC DEVELOPMENT SECTOR</th>
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<tr>
<td>• Regional federal officials</td>
<td>• Local small businesses</td>
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<td>• Community foundations</td>
<td>• Banking and financial investment institutions</td>
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<td>• Local elected officials (elected, appointed and career staff)</td>
<td>• Developers and architects</td>
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<td>• State and local conversion foundations</td>
<td>• Corporations with local presence</td>
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<tr>
<td>• Regional federal officials</td>
<td>• Community development corporations</td>
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<tr>
<td>• National foundations</td>
<td>• Housing and economic development agencies</td>
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<td>• Regional planning agencies</td>
<td>• Chambers of Commerce</td>
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<td>• Health commissions</td>
<td>• Media partners</td>
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<tr>
<th>COMMUNITY EDUCATION AND ACTION SECTOR</th>
<th>HEALTH AND SOCIAL SERVICES SECTOR</th>
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<tr>
<td>• Service-oriented community-based organizations (e.g., youth development, senior centers, community centers)</td>
<td>• Other hospitals and health systems, even competitors</td>
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<td>• Action-advocacy oriented community-based organizations</td>
<td>• Provider Groups</td>
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<td>• Faith-based organizations</td>
<td>• FQHCs, free clinics and other community health providers</td>
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<td>• Community residents with special skills/knowledge</td>
<td>• Health Plans</td>
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<td>• Educational institutions (K-12 and higher education)</td>
<td>• Governmental, public health and social service agencies</td>
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<td>• Associations (e.g., neighborhood watch, business, health, sports)</td>
<td>• Health Professions’ educational institutions</td>
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<td>• Law enforcement</td>
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How Do We Engage Great Partners?

The short answer: be a great partner!

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

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

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

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

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

A Case Report

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

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

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

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

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

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<thead>
<tr>
<th>Metric</th>
<th>2010</th>
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<td>Health Factors</td>
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<tr>
<td>Health Behaviors</td>
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<td>Clinical Care</td>
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<td>Physical &amp; Social Factors</td>
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<td>39</td>
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<tr>
<td>Physical Environment</td>
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Assess Community Health Needs and Assets

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

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

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

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

Memphis Participatory Mapping and Hotspotting Methodology

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Neighborhood Care Staff/Agents of Change Training in our Neighborhoods (ACTION)</th>
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<tr>
<td><strong>St. Joseph Health-Sonoma County</strong>'s community programs, NCS/ACTION, are place-based population health management and 'shared ownership for community health' investments</td>
</tr>
<tr>
<td>For many people in Sonoma County, the basic conditions that support health and well-being seem out of reach. Families struggle financially and many youth do not graduate from high school. Sedentary lifestyles and unhealthy eating contribute to increasing levels of obesity and overweight, yet access to affordable healthy foods and opportunities for physical activity is often lacking. Tobacco use and substance abuse, unhealthy community conditions, and lack of access to health and support services also contribute to preventable illness and inhibit a healthy community. St. Joseph Health-Sonoma County continues a 400 year community action legacy of the Sisters of St. Joseph through its Community Benefit Department, healthy communities programs, Neighborhood Care Staff (NCS), and grassroots leadership development programs—Agents of Change Training in our Neighborhoods (ACTION). Through NCS, the hospital transcends its walls to help people help themselves. Every major achievement of NCS has started small: handshake by handshake, door by door, NCS organizers are building relationships across the county. An NCS organizer, once having attracted a core group of willing community leaders or activists, facilitates their dialogue, helps them define and focus their values, issues, and actions—not NCS values or agenda. Deeply rooted in the principles and practices of social justice and healthy communities, ACTION leadership training then helps the group build its capacity for collective action and develop local Agents of Change. ACTION graduates have addressed violence and adversarial relationships between law enforcement and Latino residents by creating an annual, violence-free Cinco de Mayo celebration, led and supervised by residents, that attracts up to 10,000 people each year. Others have successfully petitioned the blocking of new liquor stores in a neighborhood, partnered with the Redwood Empire Food Bank to expand its summer lunch program; organized multiple community gardens, created a farm cooperative through a partnership with day laborers and a local church; and initiated bi-lingual community radio shows led by children, adolescents, and adults. Sandy and Lizbeth, with support from NCS and ACTION training, decided to help form Nuestra Voz (Our Voice). It seeks to engage and educate the local Latino community to improve and protect the health of their neighborhood. Visiting the library weekly, they selected stories to read on the air, birthing the new radio show, ‘Nuestras Voces’ (‘Our Little Voices’). It engaged children and youth in discussions about the stories, and brought guests to address issues important to them. The children also received ACTION training, becoming recognized leaders within their organization, Nuestra Voz. In creating a new vision for themselves and their communities, Sandy and Lizbeth, grew in confidence. Supported by scholarships, Sandy is now completing her degree in psychology and Lizbeth studies medicine to become a pediatrician. ACTION-trained leaders of Nuestra Voz have had many environmental, policy, and social impacts. In 2011 the Sonoma County Board of Supervisors partnered with the Larsen Park Garden Coalition to create the first ever community food garden located in a Sonoma County regional park, in a community-driven effort to increase access to healthy foods and take public spaces from local gangs. The county contracted with Nuestra Voz to build, operate and maintain the garden. Local Spanish-speaking women, concerned about poor food being served to their children in schools, felt powerless. With support from Nuestra Voz, they entered into dialogue with the Sonoma Valley Unified School District’s Food Services Director. Within months, the District was offering healthier choices and establishing a new relationship with the local Latino community.</td>
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</table>
Ask: What’s Valuable to this Community?
What Measures will Ring True with those Values?
Then, Collaboratively Set Measures of Success.

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

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

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

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

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

Green et al. 2003; Israel et al. 2003)
Link Key Measures to Important Health System Priorities in a Way That All Leaders Can Understand and Embrace.

What do faith community nursing or community health workers have to do with a healthier bottom line? Community health metrics need to be relatable and culturally competent—not only on the ‘outside,’ but within the health system as well. Do they speak the language of finance? Clinical quality and safety? Strategic planning? If the faith community nurses or community health workers are making home visits to post-discharge patients and reducing likely readmissions, then the metrics need to plainly make that connection. Broadly speaking, community health programs and partnerships need clear institutional alignment with the health system’s strategic direction, and the metrics that govern it.

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

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

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

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

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

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

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

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

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

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

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

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

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

In 2011, the Christ CeaseFire Violence Prevention Project responded to a total of 580 incidents of violent injury and connected 296 patients to community-based violence interrupters. While unable yet to assess actual impact on costs, Advocate Christ Medical Center invested $120,000 in 2013 to support the case manager role. The program’s success has led to its replication at two other Chicago trauma centers.
A Systems Approach to Health Literacy and Strategic Communications is Key.

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

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

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

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

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

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

\textsuperscript{c} Brach et al: 3

\textsuperscript{d} Brach et al: 5
To build awareness and engage stakeholders, program leaders often will find win-win’s with health system communications, marketing, and fund development staff, as well as community benefit departments looking for great stories to tell or important issues to illustrate. Teams will want to inventory and leverage all available communications vehicles, including social media, to inform stakeholders of progress toward goals, engage new stakeholders, and support specific program objectives. Promotional, educational, and informational resources should be culturally competent and powerful in their venues—drawing participants, internal and external stakeholders, and funders alike.

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

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

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

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

Health systems today face pressing needs to increase access to prevention and primary care, and develop person-centered, place-based care models to lessen the load on emergency departments and reduce readmissions. Each high-leverage clinical priority opens new doors for transformative community partnerships that return the health systems’ investment of time and money many times over—and result in sustainable health improvement empowered by the common good.
Chapter 7

Bibliography


APPENDIX 1

Basic Principles
We recommend approaches that:

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

Appendices
APPENDIX 2

Archetypical Patients: Examples of Costly and Socially-Complex Patients

1. FREQUENT ED USERS

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

a. The Medically Complex Homeless Patient

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

b. The Chronically Sick Child

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

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

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

Uninsured/undocumented patient: This patient shows up at the ER in need of care and with limited English speaking skills and is not connected to a primary care physician. The patient has not been feeling well for a while and is here illegally. He/she tried to get care at a federally qualified community health center but the staff there started to ask general information questions, so the patient did a 180-degree turn and went out the door. She has no choice but to go to the ER.

3. INAPPROPRIATE USE OF AMBULANCE:

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

Other Reasons for misuse of EMS and ED

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

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

Substance Abuse:

- EMS services & the ER are the ‘dumping ground’ for those who are intoxicated/ under the influence of drugs
- Chronic alcoholics seen in the ER tend to be in the 30-60 year old range
- Chronic alcoholism/substance abuse/ homelessness and mental health all go hand in hand and (as referenced in point 2 above) these often result in multiple repeat visits for the same patients for these issues
- Elderly and frail (due to falls, dementia, etc). These patients end up in acute care but need intermediate care.
APPENDIX 3

QUALITIES OF MEANINGFUL COMMUNITY PARTNERSHIPS

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