

National Forum on Hospitals, Health Systems and Population Health:

PARTNERSHIPS TO BUILD A CULTURE OF HEALTH

OVERVIEW AND HIGHLIGHTS



Acknowledgements

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For more than 40 years the **Robert Wood Johnson Foundation** has worked to improve health and health care. We are striving to build a national Culture of Health that will enable all to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

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National Forum on Hospitals, Health Systems and Population Health:

PARTNERSHIPS TO BUILD A CULTURE OF HEALTH



Robert Wood Johnson Foundation

Office of the President and CEO

In October 2014, the Robert Wood Johnson Foundation (RWJF) sponsored the National Forum on Hospitals, Health Systems and Population Health bringing together people and organizations with the capacity and creativity to improve the health of everyone in our diverse society. The goal of the Forum was to inform and galvanize key community partners across sectors through discussions about how best to transform the current health care system to one that connects treatment with care, while also considering the life needs of, patients, families, caregivers, and the community beyond the four walls of a clinic. This document summarizes the major themes, programmatic highlights, and key takeaways from the National Forum. It also includes brief descriptions of the population health initiatives featured at the event.

The National Forum demonstrated the many bright spots across the country where hospitals and health systems are increasingly engaged in strategic conversations on advancing population health. Leaders nationwide are excited and energized about their work to connect what happens in the clinical setting with what happens in the community. Cross-sector collaborations are necessary to build the ongoing partnerships needed to create fundamental change and remove the barriers to poor health. Federal policy is shifting to support population health, including consideration of necessary health care delivery and financing reforms. At RWJF, we believe that a cultural shift is underway to make health the bedrock of all we do.

The challenge now is to accelerate the movement to build a Culture of Health in the United States by firmly incorporating its principles within health system reforms, spreading and scaling what works, and continuing to build a constituency. We are dedicated to this journey and we look forward to working with many committed partners to achieve this vision. We hope this document, which reflects the many important lessons learned at the National Forum, will be shared in the spirit of fostering the leadership, partnerships, and critical thinking needed to transform the nation's health for the better.

Sincerely,

Risa Lavizzo-Mourey, MD, MBA
President and CEO

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National Forum on Hospitals, Health Systems and Population Health:

PARTNERSHIPS TO BUILD A CULTURE OF HEALTH

Overview and Highlights

Introduction

The National Forum on Hospitals, Health Systems and Population Health, sponsored by the Robert Wood Johnson Foundation in October 2014, brought together more than 300 national leaders committed to improving the health of all Americans. The Forum highlighted innovative and effective health care delivery system-based approaches to advance population health and, ultimately, help to build a Culture of Health that will enable all Americans to live longer, healthier, and more productive lives.

Chief executives of hospitals, health systems, health plans, and community-based organizations, along with public health and state and federal officials, shared strategies for improving the health of their communities, including:

- Partnerships that build bridges between public health and health care;
- Innovations to address the drivers of health, including income, housing, access to affordable and nutritious food, and education;
- New ways to use and share data, analytics, and information technology;
- Best practices for augmenting the traditional health care workforce with nontraditional workers and connecting patients to the social and community-based services they need; and,

“Building a culture of health means shifting our values so health becomes part of everything we do”

Risa Lavizzo-Mourey, MD, MBA
Keynote Address

- Emerging payment models to incentivize and sustain initiatives.

By sharing highlights of transformative work and bringing together stakeholders from around the country, the Forum capitalized on the significant momentum already under way that is designed to improve the health of communities.

National Forum
on Hospitals,
Health Systems
and Population
Health:

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BUILD A CULTURE
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Themes and Highlights

The Forum was organized as a series of panel discussions encouraging open dialogue and movement beyond a simple description of “what” is happening to better illuminate “how” and “why” strategies are being implemented. The key take-aways from the plenary and breakout sessions are summarized in the following section.

Risa Lavizzo-Mourey, MD, MBA, president and CEO of the Robert Wood Johnson Foundation opened the Forum with a keynote address laying out the Foundation’s vision of building a Culture of Health. She added that efforts are under way across the

country to achieve this vision, including cross-sector partnerships addressing obesity, chronic disease, health equity, and less traditional health issues such as investments in early childhood education and safe housing.



Making the Case

Hearing from Federal Leaders on Prevention and Population Health

Remarks from Acting Surgeon General Boris Lushniak, MD, MPH:

Acting Surgeon General Lushniak gave a keynote address about federal strategy and leadership on prevention and population health. He explained that the National Prevention Council models the multisector approach to improving population health, underscoring the need to refocus emphasis from treating to preventing disease. He added that the Council has been working for the past four years to leverage each agency's role in improving population health and developed the National Prevention Strategy with four goals, including healthy and safe community environments, and integrated clinical and community preventive services. In closing, he also emphasized that engaged, empowered communities are key to addressing health disparities.

Remarks from Centers for Medicare & Medicaid Services (CMS) Acting Principal Deputy Administrator, Patrick Conway, MD, MSc; Centers for Disease Control and Prevention (CDC) Associate Director for Policy John Auerbach, MBA; U.S. Department of Health and Human Services Deputy Assistant Secretary for Health, Anand Parek, MD, MPH; and Health Resources and Services Administration (HRSA) Acting Administrator, James Macrae, MA, MPP:

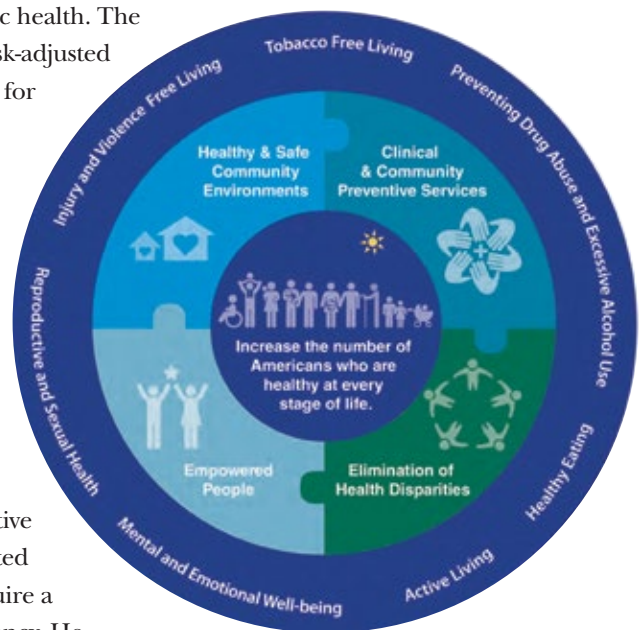
Recognizing that improving population health requires the participation of public health, health care, and non-health sectors, Macrae said that the federal government is making new investments in proven and innovative programs that promote such partnerships. He added that HRSA provides services to special populations and works to promote better coordination between primary care,

The major natural resource of this country is the health of its people. We need to refocus on the importance of health in society.

Acting Surgeon General Lushniak, MD, MPH

behavioral health, and public health. The agency currently provides risk-adjusted payments to incentivize care for those most in need. Finally, he noted the importance of workforce training and emphasized that a social determinants framework should be a component of workforce education so the future workforce can support efforts that build bridges across silos.

CMS is likewise very supportive of population health, reported Conway, though it does require a cultural transition at the agency. He predicted the move to population-based payments will facilitate this transition and that the Center for Medicare and Medicaid Innovation (CMMI) is developing a new model called Accountable Health Communities to invest in population health. CDC is increasingly "looking upstream" and promoting the importance of working with partners in other sectors on both primary and secondary prevention, said Auerbach. Parek noted they are encouraging local health departments and nonprofit hospitals to collaborate on community health needs assessments, and working to coordinate and support community health workers.



Hearing from Health Care Leaders:

WHY SHIFT STRATEGY AND OPERATIONS TO ADDRESS POPULATION HEALTH?

Leaders in the field shared their thoughts on why they shifted their organization's strategy and operations to focus on the health of their community, rather than just the health of their patients or clients. Many hospitals have "improving health in the community" as part of their mission. In recent years, as demonstrated at the Forum, more and more hospitals, health plans, and public health departments have partnered and deepened their engagement in the community to address other factors that affect health.

Remarks from Hospital Executives:

John Bluford III, MBA, FACHE, former president and CEO of Truman Medical Center in Kansas City, shared the journey of his organization and said, although their mission included "improving health in the community," Truman initially focused on the health of its employees and then began to think about employees in the community setting. As a major local employer, Truman recognized it could not have a healthy workforce without a healthy community. As they began to work outside their walls to improve the health of their community, Truman's leadership team recognized that access to care alone would not be enough; success would require attention to the social determinants of health. Truman established a corporate academy and offered scholarships to further the education of their employees and partnered with a bank to establish a branch in the hospital, making banking accessible for employees and community members. Truman is now working to locate a full service grocery store in an area that does not have access to healthy food, also known as a food desert.

Thomas F. Zenty III, MHA, MPA, CEO of University Hospitals in Cleveland, shared their "Anchor Institution" strategy, whereby they work to create jobs, train underemployed adults, raise the bar for minority inclusion in

Our guiding philosophy is that the health of individuals and populations is inextricably linked to prosperity. Major civic organizations can collaborate to remove barriers to socioeconomic opportunity and better health

Thomas F. Zenty III, MHA, MPA, CEO of University Hospitals in Cleveland

development projects, and stimulate the local economy by encouraging suppliers to locate in the city.

Gary Gunderson, MDiv, DMin, DDiv, vice president of Faith and Health Ministries at Wake Forest Baptist Medical Center, shared the concept of "proactive mercy versus reactive charity," a strategy for reducing charity care costs by reducing the demand for charity care. At Wake Forest Baptist Medical Center, former hospital environmental service workers were employed as "supporters of health" — working in low-income neighborhoods to connect charity care patients to needed social services, a new vision for community health workers. As a result, the re-admission rate for their charity care patients lowered significantly—from 15 to 2.6 percent.

Gunderson observed that they also experienced a decline in the charity costs per census tract.

Shelly Schlenker, MPA, vice president of Public Policy, Advocacy and Government Relations at Dignity Health, shared a similar story about moving from "random acts of kindness" to a more strategic approach to their community health improvement work. For example, Dignity Health has a community investment program to provide low-interest loans to build and sustain 204 community-based organizations that address unmet patient needs.

Sister Carol Keehan, DC, RN, MS, president and CEO of the Catholic Health Association of the United States, discussed how not-for-profit hospitals are building a Culture of Health through fulfillment of their community benefit responsibilities. "Healthy communities are the backbone of population health," she said, recognizing that this trend represents a major shift away from just fixing people when they get sick to focusing on engaging the entire community to improve health for all.

Randy Oostra, DM, FACHE, president and CEO of ProMedica Health System in Toledo, explained how their system conducted the community health needs assessment and found both obesity and hunger to be major issues. In response,

ProMedica established the “Come to the Table” initiative in 2009 and continues to work at the local, regional, and national levels to ensure that basic nutritional needs of community members are met.

Remarks from Health Plan Executives:

For health plans, the incentives to engage in population health can be as simple as better care management to reduce costs and improve outcomes. Health plans and hospitals or systems that have risk-based insurance contracts (wherein they accept the risk of higher utilization), are increasingly developing programs to help manage the needs and reduce the costs of high-risk patients, or “super-utilizers.” In the process of running these programs, they have learned that patients are non-adherent or seek additional care because they don’t have access to the social services they need. Providers broadly recognize patients have unmet social needs, but they don’t always know where or how to refer them. As health plans or hospitals develop systems to fill this gap, they identify demand for social services that may not exist in the community. This often leads them to work with partners in the community to meet the unmet needs. For example, a UnitedHealthcare plan is developing a robust partnership with a local homeless coalition. The goal of this partnership is to locate homeless members, facilitate rapid supportive housing placement, and engage the managed care coordination team to provide wrap around Medicaid community-based support services.

Remarks from State and Local Health Officials:

Local and state health departments are also leading the way on population health, both to improve the health of their residents and to address health disparities. The role of public health, as explained by Minnesota’s Assistant Commissioner

of Health Jeanne Ayers, MPH, is to create the conditions in which all people can be healthy. In Minnesota, they are focusing on changing the narrative to help residents understand that health is created mostly outside of the health care system, and to impact health, you must address the social determinants. They found that this new narrative engages many more community groups and agencies in the work and supports their “Health in All Policies” strategy. She explained they took a new approach to their community health needs assessment, measuring not only the prevalence of disease but also the opportunities and risk factors related to health, from education to incarceration rates to air quality. This new narrative has helped them achieve state-level policy changes that might not at first appear to be health related (such as same sex marriage law, minimum wage increase, and women’s economic development law), yet are directly related to social determinants of health.

In Philadelphia, the Department of Public Health launched the “Get Healthy Philly” campaign, partnering with other government agencies, community-based organizations, health systems, business, and academia. Giridhar Mallya, MD, MHSP, former director of policy and planning, explained how the department has shifted its prevention strategies to focus on policy change, because they want to have the biggest effect on the largest number of people. For example, they were active in the city planning commission’s rewrite of the zoning laws and were able to encourage not only active living, but also healthy eating. Philadelphia now gives businesses “density bonuses” which allow developers to build taller buildings or buildings with additional floor area than would be allowed for including fresh food markets in mixed-use developments.

Hearing from Early Adopters in the Field: Lessons Learned

Partnerships are the Cornerstone

Leaders of organizations that have adopted population health strategies reflected on the lessons they have learned. The most commonly shared lesson was the importance of partnership. Population health work cannot be done solely by one organization or sector, yet partnership is not always easy. David Bailey, MD, MBA, president and CEO of The Nemours Foundation shared the journey that Nemours has undergone in its prevention and population health work. Like many health systems, Nemours was inwardly focused for years. As they engaged in efforts to improve the health of all children, Nemours learned how to partner effectively.

Engaging other sectors is an important first step in population health partnerships. When working with schools to address childhood obesity, Nemours provided data to engage the education sector by showing how healthy eating and physical activity impact academic achievement. In Minnesota, the state health department viewed population health as a new way of doing business and developed a cabinet-level committee to advance health in all policies, explained by Ayers. Recognizing that partnership begins with engagement, they launched “Healthy Minnesota,” a coalition that includes 32 different groups and sectors.

Population health work involves risk. Engaging partners helps to mitigate the risk, since an initiative that might involve moderate risk for a single organization may become a lower risk when groups of organizations are involved.

Executive Leadership Support is Key to Culture Change

Support from executive leadership is critical. At Nemours, prevention and population health measures are included on the organization’s “Balanced Score Card” executive compensation plan to ensure executive leadership attention to the integration and success of this work throughout their health system.

Success in population health takes time and requires the hard work inherent in culture change. The business case can be more difficult in an environment where short-term results and volume-based payment have been the norm. A cultural shift is required to embrace the importance of both short- and long-term results in most cases. Culture change in large organizations is time and resource intensive, yet necessary to gain employee engagement and fully integrate population health into organization strategic plans and operations. Bailey recounted the experience of Nemours when it established its population health division 10 years ago, and physicians did not understand why the hospital was making that investment. Now they acknowledge that you cannot have a healthy community by just treating patients one-on-one; you have to work with many partners in the community that share your vision of wellness. This cultural change required effort, including defining what is meant by population health and creating outcome measures.

Evaluate Right from the Start

Good evaluation plans are also critical to documenting the progress, value and social impact of population health investments. Evaluations should include metrics that make sense to those not in the field, including physicians. Results should be broadly shared, including both what worked and what did not. The narrative is equally important, and stories of small successes along the way need to be shared to garner commitment over the long term, particularly if there are changes in leadership.

Align Financial Incentives to Accelerate Change

Numerous leaders identified the lag in value-based payment models as the biggest challenge and the biggest risk for hospitals and health systems investing in population health. Health care providers that engage in efforts to prevent disease risk reduce demand for services, and thus may incur a loss in fee-for-service revenue. Hospital leaders emphasized the need to move to payments for creating health rather than reimbursement for treatment of illness. Hospital and health plan executives called on the federal government to use its authority to accelerate the adoption of risk-based payment.

Joshua M. Sharfstein, MD the former secretary of the Maryland Department of Health and Mental Hygiene, described the statewide alignment of economic incentives, including a shift of 95 percent of Medicare business away

from fee-for-service and into a global budget. He said, “This shift is creating a transformation of culture; hospitals have the incentive to keep patients well and reduce the demand for services. For example, hospitals are beginning to work with school systems to reduce pediatric asthma visits.”

The federal government is also moving toward value-based payment systems in its payer role, and is incentivizing Accountable Care Organizations (ACOs) to invest in prevention by establishing population-based payment. Mark B. McClellan, MD, PhD, senior fellow and director of Health Care Innovation and Value Initiative at the Brookings Institution, shared international data that shows that the United States is an outlier among the industrialized nations in spending less on social services and more on health care. In his work with ACOs, he has noticed new trends in population health strategies. For example, more ACOs are supporting social and community-based organizations, such as housing, particularly in the Medicaid market. More ACOs are measuring outcomes, such as smoking status, body mass index, and physical activity at the geographic level. McClellan noted future opportunities for expanding measurement to include nonmedical predictors of health, such as school attendance, school completion, and kindergarten readiness and described a new trend to create “community-based accountable care,” such as the Coordinated Care Organizations in

Oregon. McClellan observed that sustaining these new organizations is a challenge that needs to be addressed.

“Discretionary grants that fund state and local activities are often categorical,” noted Auerbach, “and thus limit the ability to work across sectors.” The federal government is working to promote the pooling of federal funds at the state and local levels. At a minimum, they are encouraging local and state coordination, or braiding, of various federal funding streams. One example is the State Innovation Models (SIMs). In its SIM, Oregon established Coordinated Care Organizations that link social services and the health care delivery system.

Tap Assets and New Workforce Solutions to Link Health with Social Services and Other Sectors

Hospitals and health plans are increasingly utilizing non-traditional workers to engage patients, coordinate care, educate, and connect patients to the services they need in the community. Lay providers such as community health workers and patient navigators are being integrated into or augmenting patient care teams. A key qualification for many of these positions is cultural competence with the patients they assist, since one important role is to establish trust and rapport. Once trust is established, non-traditional workers are better able to effectively build bridges between the health care system and the patients and communities they serve. Since these

workforce models are relatively new, the training, reimbursement and other policies to support employment are under development.

Hospitals are expanding their assessments of community needs to also identify assets—people, organizations, places, and other opportunities they can leverage to meet the needs of their patients and to create healthier communities. This process of “asset mapping” can also promote community engagement and empowerment.

Hospitals and health plans are tapping into community assets, including community health workers, to connect patients to the social and community-based resources they need which are outside the walls of the hospital or clinic. Raymond J. Baxter, PhD, senior vice president, Community Benefit, Research and Health Policy, Kaiser Permanente, said, “Kaiser Permanente has 12 pilot projects under way to test how they can best link patients to the social services they need in order to explore whether Kaiser should provide those services directly or link patients to existing community resources.” Data sharing between health care providers, social services, and community organizations is critical to support these linkages. There are opportunities to build information about community resources into the electronic health record.

Key Take-Aways from the Breakout Sessions

Data and Information Tools to Tackle Population Health Challenges

CommunityRX: Connecting Health Care to Self-Care

Dallas Information Exchange Portal

HelpSteps

New York City MacroScope

- Technology is being used in traditional and new ways to address population health challenges. For example, traditional public health surveillance methods which aggregate data at the community level can help set goals for health improvement and track results over time. Recent efforts to aggregate data from electronic health records can facilitate “real-time” surveillance.
- Technology is increasingly being used to link patients to the resources they need outside of the clinical system, such as community-based and social services. These linkages will be most helpful if they are bi-directional, so

that information flows to and from the community-based organizations to support coordination of care. While technology is a tool, partnerships and trust are key to making these linkages.

- Sustainability of technology solutions can be addressed by demonstrating value, bringing the right partners to the table, spreading the costs among those who benefit from having the data and, when feasible, scaling up.
- Analytical tools are being employed to identify patients and populations most at risk so they can be connected to supports and services in the community.
- Initiatives that employ technology to develop large data sets must grapple with issues of data governance such as who owns, maintains, and disseminates the data.



Hospitals Joining Forces on Community Health Needs Assessment and Implementation

Community Assessment Project
 Community Benefit Web Tool Prototype
 District of Columbia Healthy
 Communities Collaborative
 New York State Prevention Agenda
 2013–2017

- The Affordable Care Act’s requirement that nonprofit hospitals conduct a community health needs assessment every three years as part of their community benefit requirements represents a new opportunity to promote cross-sector collaboration.
- Hospitals are beginning to collaborate on these needs assessments with other hospitals (even competing hospitals) and public health and other agencies that conduct community needs assessments. Collaboration can reduce

costs and produce a more robust and complete assessment. Some collaborations even continue through the next stage of setting priorities for implementation.

- Neutral conveners, such as the public health department or the local United Way, can facilitate such collaborations and also engage additional stakeholders such as education, law enforcement, or the business community.
- Transparency and accessibility of data can help to build the trust that is necessary for collaborative community health needs assessments. Trust can also be built through clarity on roles and responsibilities (which can be documented in a memorandum of

understanding); sharing costs (even if they are not necessarily equally shared); co-branding; and sharing credit and acknowledgement.

- State policy can require hospitals and health departments to collaborate in the needs assessment process and further require that the needs assessments tie to the top priorities of the state prevention plan.
- Geo-mapping is a useful tool for clearly communicating community needs. Assets should also be mapped.
- Various methods of engaging the community in needs assessments can be used including focus groups, community forums, and reaching out to neighborhood coalitions.

“The Integrator:” Who Convenes the Stakeholders to Improve Health?

Campaign to Make Delaware’s
Children the Healthiest in the Nation

Live Well San Diego

Optimizing Health Outcomes for
Children with Asthma in Delaware

- “Integrators” are trusted leaders in the community who convene stakeholders across sectors to address the health of a community or population. Integrators are typically viewed as neutral, thus providing a table where everyone can come together and participate with an equal voice and vote.
- Integrators serve key functions in addition to convening, including gathering and aggregating data, identifying joint goals and creating shared accountability, identifying needed policy- and systems-level changes, tapping community assets, and focusing on financial sustainability.
- While integrators are often initially funded with grants, identifying other sustainable financing streams is key so that the integrators can focus on the supports and systems changes needed to continuously innovate and address community needs.

The Community Health Workforce: Taking Health to the People

Health Resilience Program™ of
CareOregon

Health Leads

St. John’s Wellchild and Family Center

- Hospitals, health systems, and health plans are increasingly employing nontraditional workers to educate patients, coordinate care and, by bridging different sectors, connect patients to the resources they need in the community.
- Information sharing is central to the success of this workforce. For example, community health workers and other nontraditional providers who work with patients with complex needs must be able to communicate their findings with the referring providers and/or care coordination teams and vice versa.
- Trust must be developed between the nontraditional caregiver and the primary care providers/care coordination team.
- Nontraditional providers should be integrated into the care team.
- Documenting the training requirements for nontraditional workers can facilitate their acceptance by other providers.

Schools, Jobs, Housing and More: Tackling the Social Determinants

Cincinnati Children's Hospital Medical Center Community and Population Health Initiative

Partnership for a Healthy Durham

Priority Spokane: Educational Attainment

- Social determinants can best be addressed by working in partnership with community-based and social services organizations. The identification of experts in the various social determinants (non-health agencies and programs) is not unlike the identification of specialists in medicine.
- Health care organizations can identify needs related to the social determinants in a number of ways such as community health needs assessments, "hot spotting," and through conversations with their communities.
- Partnerships may start out informally but should become more formal over time, e.g., with letters of commitment, memorandums of understanding,

and/or bylaws to clearly articulate roles and responsibilities.

- Partnerships can be supported in a variety of ways, including in-kind contributions, grants, membership fees, or a combination thereof.
- Community engagement is key to addressing social determinants of health. Community priorities may sometimes differ from data-identified priorities and should be given due consideration.
- Data sharing can be challenging when working across sectors such as housing, education, and law enforcement, making documenting outcomes difficult. Process measures are often a first step. Qualitative information is also important to tell the story and build support.
- Mutual consent forms can ease data-sharing challenges.
- Health care providers are incorporating prompts and referral mechanisms into the electronic medical record to support partnerships and facilitate referrals.

Collective Impact: Engaging Actors across Different Sectors

Communities That Care Coalition

Common Table Health Alliance: Backbone for the Healthy Shelby Partnership

Western North Carolina (WNC) Healthy Impact

Live Well Omaha

- Collective impact is a strategy that is gaining traction in population health efforts, particularly since it is being used to address complex problems requiring cross-sector partnerships.
- Collective impact can be a successful structure when competitors come together to collaborate on a mutual goal.
- Collective impact relies upon a "backbone" organization (or integrator,

see above) that is a neutral convener and creates shared goals, clear expectations, and a safe space for each partner organization to be transparent about their interests and agenda.

- Collaborations with clear governance and bylaws are more likely to be successful, particularly during leadership changes. At the same time, the structure of the backbone must be elastic enough to evolve as the goals of the coalition change over time.
- Effective internal and external communications, while challenging, are key to success.

Capturing Health Care Savings through Population Health

Boston Children's Hospital Community Asthma Initiative

Cultivating Health for Success

- Population health initiatives generally require relatively long timeframes — three to five years — to document success. Process indicators, or proxies, can be incorporated in the interim to ensure the project is moving in the right direction.
- Making the business case or documenting return-on-investment (ROI) for the health care sector for population health is complicated; moreover, the business case has not yet been developed for impacts in non-health sectors. The ROI argument for population health would be much stronger if other impacts were taken into account.
- Social return-on-investment (SROI) is a new tool that is being utilized in population health to document the return to society beyond an economic return. SROI helps to move the conversation beyond the total cost of care to the total cost of community care.
- A business case involves several levels of analysis. After determining that the program makes clinical sense and is reaching its goals, the next step is to determine how to scale it to reach more people, calculate the cost and program uptake. Do the health and cost outcomes outweigh the program expenses? If so, the final aspect of the business case is determining whether the community will accept and prioritize the program.
- Some health plans reimburse for nontraditional services—either provided by a nontraditional worker, in a new setting (outside the hospital's walls, such as a home visit) or providing a new benefit (e.g., vacuum, pest control, smoking cessation), particularly when they can document health care savings as a result of these innovations.
- Data collection and analysis can be a significant barrier for ROI studies. For example, hospitals don't always have access to pharmacy or behavioral health data.
- Economists may need to be involved up-front in ROI analysis.
- The transition from volume- to value-based payment will make it easier to demonstrate value. For example, re-admission penalties have created new incentives for improved care. Value-based payments such as bundled payments, shared savings, and accountable care organizations are under development to support population health.
- One of the ultimate goals of calculating ROI and capturing savings is to identify resources to re-invest for upstream prevention activities.

Conclusion

Conversations about population health are happening in board rooms, state houses, and the halls of public agencies, Federal policy is shifting to support population health, including necessary delivery and financing reforms. The challenge now is to accelerate the movement for population health by firmly embedding supportive goals and strategies within health systems, cultivating spread and scale of what works, and continuing to build a constituency for a Culture of Health across multiple sectors.



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Descriptions of Initiatives Presented at the Forum

Boston Children's Hospital Community Asthma Initiative

The Community Asthma Initiative (CAI), an initiative of Boston Children's Hospital, began addressing health disparities in Boston neighborhoods impacted by asthma in 2005. CAI provides an enhanced model of care which includes asthma education and home visits for families with children ages 2–18 living in the Greater Boston area who were previously treated in the Emergency Department (ED) or hospitalized as a result of asthma. CAI works with partners and coalitions to address asthma health disparities by implementing changes in policies at the local and state levels. As of June 2014, case management had been provided to 1,329 patients with

significant outcomes including: a 57 percent reduction in the number of children with ED visits; a 79 percent reduction in hospitalizations; a 43 percent reduction in missed school days; and 43 percent reduction in missed work days for parents. CAI is supported in part by grants, several foundations, philanthropy, Centers for Disease Control REACH US Program, American Academy of Pediatrics, the Office of Community Health at Boston's Children's Hospital and others. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Nethersole.pdf>.

Campaign to Make Delaware's Children the Healthiest in the Nation

Since 2006, Nemours, an integrated pediatric health system, has worked to address childhood (ages 2 to 17) overweight and obesity in Delaware with multisector partners including: the Governor's Office; Cabinet secretaries and other government officials; pediatric providers; child care centers; schools; principals and superintendents; and other community-based organizations. Activities include systems-level and practice interventions, such as working with state-level partners to promote healthy eating and physical activity through child care licensing, as well as creating a learning collaborative to facilitate policy and

practice change. Preliminary results show a flattening of the overweight and obesity curve for Delaware children between 2006 and 2008. This successful initiative is funded by a number of sources including: Nemours Health and Preventive Services; the Robert Wood Johnson Foundation; U.S. Department of Education; U.S. Department of Agriculture; Centers for Disease Control and Prevention; General Mills Foundation; and American Heart Association. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Chang-1-of-2.pdf>.

Changing the Narrative About What Creates Health—Essential Steps in Improving Population Health in Minnesota

The goal of Changing the Narrative about What Creates Health— Essential Steps in Improving Population Health is to bring about critical change to effectively address the social determinants of health and achieve health equity. Launched in 2011 by the Minnesota Health Department, this initiative shifts the responsibility for health to a community level to address the conditions in which all people can be healthy through policy, systems, and environmental changes. Key strategies include: the creation of a Healthy Minnesota 2020 framework that engages partners in all sectors; community engagement via the Healthy Minnesota Partnership, establishment of cabinet-level committee on Health in All Policies; a State Health Improvement Program that outlines policy, systems, and

environmental changes; and creation of Accountable Communities for Health. By focusing the narrative on what creates health (beyond the health system), community agencies and groups have become involved in health policies contributing to policy changes including: anti-bullying law; minimum wage increase; smoke-free campuses and apartments; and complete street ordinances. Minnesota has also shown decreasing rates of childhood obesity and youth tobacco use, and increasing rates of breastfeeding. This initiative is funded by State Health Department grants. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/10.23-1400-Ehlinger-Plenary-HPH14.pdf>.

Cincinnati Children’s Hospital Medical Center Community and Population Health Initiative

In 2010, Cincinnati Children’s Hospital Medical Center (CCHMC) started the Community and Population Health Initiative to tackle the most prevalent, challenging, and burdensome health issues facing children and families in southern Ohio. By creating partnerships within the community and focusing on the pillars of the Institute for Health Care Improvement’s Triple Aim framework, the Community and Population Health Initiative has reduced the negative impact of social determinants like education, housing, and the environment on

health outcomes. To date, CCHMC has seen a reduction in asthma admissions, improved social and environmental risk screening during both inpatient and outpatient care, and substantial increases in connections between families and key resources in the community. The initiative began with funding from CCHMC, as well as funding from federal agencies and foundations. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Beck.pdf>.

Come to the Table

Since 2009, ProMedica's, "Come to the Table" program has been working to ensure the well-being of communities in northwest Ohio and southeast Michigan by creating services and programs addressing basic nutritional needs. The link between hunger and poor health is clear—adults living in food insecure homes have chronic diseases and behavioral health conditions. Food-insecure children suffer an even greater impact with delayed development and poorer quality of life. Health threats resulting from hunger are preventable and ProMedica continues to develop and implement strategies to feed communities including: operating a food reclamation program to repackage un-served food and

distribute to homeless shelters; developing a food security screening program to identify hospital patients who are food insecure to ensure they have food and access to resources upon being discharged from the hospital; and the future opening of the Ebeid Institute for Population Health in Toledo, Ohio, which will have a fresh food market and offer job training and health services. ProMedica's strong community partnerships at the local, state, and federal levels are central to developing these collaborative opportunities. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Oostra.pdf>.

Common Table Health Alliance: Backbone for the Healthy Shelby Partnership

The Common Table Health Alliance is a regional health improvement collaborative and an Aligning Forces for Quality Community. In 2011, the Shelby County Mayor, Memphis City Mayor, and the four major health systems engaged the Common Table Health Alliance as the backbone organization for the Healthy Shelby Partnership, which is one of the key pillars of Memphis Fast Forward, a broad-based collective impact initiative. Healthy Shelby connects social service agencies with the health care system to jointly address the social determinants of health. Common Table Health Alliance has implemented evidence-based and best practices, used social media, employed education pro-

grams, coordinated partner engagement, and is tracking 12 measures. Successful programs include a safe sleep campaign and a community hypertension registry. The goal is to improve the health rankings of Memphis and Shelby County. Healthy Shelby has received core funding from the Baptist Memorial Health Care, Methodist LeBonheur Healthcare, Region One Health and Saint Francis Hospital, city and county governments, and grants from the United Way and Medtronic. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Frazier.pdf>.

Community Assessment Project

The Community Assessment Project (CAP) is a broad-based collaborative of the United Way of Santa Cruz County, California that jointly conducts community health needs assessments and publishes an annual countywide community indicators report. The report, first introduced 20 years ago, serves as the community health needs assessment for local nonprofit hospitals and includes indicators in six domains: economy, education, health, public safety, natural environment, and social environment. The CAP also conducts a bi-annual quality-of-life survey of the County's households. A sampling of the goals in 2015

include: improvement in access to primary care; comprehensive health care coverage for children; and a decrease in the prevalence of childhood obesity. Annually, CAP measures and reports progress toward its goals. For example, in 2007, the Healthy Kids Insurance Program achieved 98 percent insurance coverage for children in Santa Cruz County. CAP is funded by local hospitals, city and county governments, utility companies, colleges, and non-profit organizations. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Goeke.pdf>.

Community Benefit Web Tool Prototype

The Department of Health Policy in the Milken Institute School of Public Health at The George Washington University was awarded a contract by the Robert Wood Johnson Foundation to develop a prototype Web Tool that provides easy access to the community benefit investment information that all nonprofit hospitals must submit annually to the Internal Revenue Service (IRS). The Web Tool will make hospital community benefit investment information easily available to public health

experts, community stakeholders, hospital, and policymakers, among others. The Web Tool (to be completed in 2015) will enable users to compare hospital investments in their communities on the basis of factors such as geographic location, community economic status, and hospital characteristics such as size. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Byrnes.pdf>.

CommunityRX: Connecting Health Care to Self-Care

CommunityRX is a new, patient-centered health information technology system that transforms the quality of information about and access to self-care resources, especially in lower-income communities. Through this technology, patients are provided with a personalized HealtheRX referral list for self-care resources to access once they leave the clinical setting. To date, more than 950+ health care professionals have been trained to deliver HealtheRx to over 45,000 patients; 20

clinical sites have implemented this technology; and more than 250 Chicago Public School students and 100 science-oriented college students are employed by CommunityRX to map the health assets in the community. CommunityRX was developed in 2012 and is funded by a Centers for Medicare & Medicaid Services Innovation Award. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Lindau.pdf>.

Communities That Care Coalition

The Communities That Care Coalition began in 2000 in Western Massachusetts to reduce youth substance abuse and improve youth health. The program brought together and coordinated the efforts of various local stakeholders including schools, youth and parent groups, law enforcement, health care providers, and the local hospitals. By implementing its Community Action Plan—which includes an annual Teen Health Survey, anti-substance curricula in local schools, social marketing, and forming strategic partnerships within the community—the Coalition

has been successful in identifying several underlying risk factors of youth substance use in the area and priorities for improvement. During the 12 years of its work, the Coalition has measured substantial improvements in youth substance abuse, as well as a reduction in the underlying factors causing it. The Coalition is supported by state and federal grants. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Allen.pdf>.

Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) provides capital, expertise, information, and innovation to transform how communities use housing solutions to improve lives of vulnerable populations. Founded in 1991 and headquartered in New York City with staff stationed in more than 20 locations throughout the country, CSH's work focuses on capacity-building, policy and advocacy, supportive housing technical assistance and housing development, and demonstrating pilot initiatives to build evidence. One of CSH's most effective pilots is the Frequent Users of Health Services Initiative, a six-year, \$10 million pilot that sought to deliver innovative, integrated approaches to meet the health, housing, and social service needs of frequent users of emergency departments and inpatient hospitalization. Program results included a 27 percent drop in inpatient hospital-

ization versus a 26 percent increase for those not connected to housing. In addition, those in supportive housing experienced a 34 percent drop in emergency room visits compared to only a 12 percent drop among those not in supportive housing. In 2011, CSH was awarded \$2.3 million over two years by the federal Corporation for National and Community Service and is using these funds to invest in supportive housing models that provide cost-effective solutions for people with complex health needs and facing housing crises. CSH funding comes from a mix of roughly 150 foundations, corporations, public agencies, investment income, and gifts from individual donors. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Desantis.pdf>.

Cultivating Health for Success

Cultivating Health for Success (CHS) established in 2010, focuses on the inclusion of safe, affordable, and supportive housing to reduce unplanned care, improve adherence to recommended treatment, and improve health care cost and outcomes as well as quality of life for participants in greater Pittsburgh. CHS serves adults with one or more chronic illnesses and those with a history of at least one year of above average use of unplanned care, such as crisis services, Emergency Department visits, and the homeless. To deliver services, CHS partners with the Allegheny County Department of Human Services, Metro Fam-

ily Practice, Community Human Services, UPMC for You, and the Community Care Behavioral Health Organization. Since CHS's inception, per-member per-month (PMPM) medical costs have decreased 11.5 percent, the average PMPM for unplanned care has decreased by 19.2 percent, and the average prescription PMPM increased by 5.2 percent for participants with a meaningful tenure in the program. CHS is funded by UPMC for You contributions. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Lovelace.pdf>.

Dallas Information Exchange Portal

The Dallas Information Exchange Portal (IEP) is an electronic platform which enables health care providers, community based organizations, and social service agencies to share medical and social information via a secure network. Through patient-authorized, secure two-way exchange of information, IEP is improving care transitions and increasing coordination of care around both clinical and social issues like homelessness, hunger, and substance

abuse. The ultimate goal of the program is not only to improve clinical outcomes and measures, but also generate significant cost savings to health systems. The initiative began in 2014 with a \$12 million grant from the W.W. Caruth, Jr. Foundation at Communities Foundation of Texas. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Shah.pdf>.

Dignity Health's Community Health Investments

For more than 20 years, Dignity Health, a health care provider in multiple states, has been investing in the health of the communities it serves through community benefit programs and community economic initiatives, including grants and low-interest loans to nonprofits addressing community needs. Investments are targeted to populations with disproportionate unmet health needs as identified through the community health needs assessment and a Community Need Index developed by Dignity Health. Since 1990, Dignity Health has awarded more than \$51 million in areas such as prevention,

HIV/AIDS services, behavioral health services, and improving access to care. The Dignity Health Community Investment Program has had a total loan volume of \$143 million, benefiting the community-based health programs of California, Nevada, and Arizona including: providing affordable housing for seniors; access to shelters for the homeless discharged from community hospitals; and healthy food projects. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Dean-One-Pager-FOR-PRINTING.pdf>.

District of Columbia Healthy Communities Collaborative

DC Healthy Communities Collaborative—a collaborative of community health leaders and organizations—formed in 2012 to assess and address the community health needs in the Washington, D.C. area. The Collaborative works in four key areas identified as community health needs in the D.C. area: asthma, obesity, sexual health, and substance abuse/mental health. To date, the Collaborative has conducted a commu-

nity health assessment identifying health needs within the D.C. area and produced a community health improvement plan with strategies to address the aforementioned health needs. D.C. Healthy Communities Collaborative is funded by member contributions. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Merrill.pdf>.

Get Healthy Philly

“Get Healthy Philly” is an initiative of the Philadelphia Department of Public Health that brings together government agencies, community-based organizations, academia, and the private sector to address obesity and smoking in Philadelphia. The organization is making great strides toward a healthy Philly through actions including: designating nearly 12,000 acres of new smoke-free spaces; passing a \$2 per pack tax increase on cigarettes; establishing school nutrition standards; menu labeling; and working with food retailers to promote healthy food sales. Accomplishments over

the past four years include a 15 percent reduction in smoking among adults, a 30 percent reduction in smoking among youth, and a 5 percent reduction in childhood obesity. The initiative is supported by local, state, and federal funding, including the Centers for Disease Control and Prevention through the Prevention and Public Health Fund and the Pennsylvania Department of Health. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Mallya.pdf>.

Health Leads

Health Leads, operated by lay resource specialists and college student volunteers, is a collaborative comprised of partner hospitals, health systems, community health centers, and Federally Qualified Health Centers (FQHCs) working together to integrate basic resources such as access to food, heat, and other necessities into health care delivery. Operating via clinical settings since 1996, this initiative enables providers to prescribe solutions to patients helping them manage their disease and lives. The impact of Health Leads is two-fold. The program expands clinics’ capacity to secure nonmedical resources for patients— in 2013, 92 percent

of patients identified that Health Leads helped them secure at least one resource they needed to be healthy. Additionally, Health Leads is producing a pipeline of new leaders—in 2013, nearly 70 percent of Health Leads graduates entered jobs or graduate study in the fields of health or poverty. Health Leads sustainability model utilizes earned revenue, national and local philanthropy, and in-kind contributions from volunteers and health care partners to fund its operation. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Dalelio.pdf>.

Health Resilience Program™ of CareOregon

CareOregon has developed a new model of Community-Oriented Primary Care that travels beyond the four walls of the medical office practice. The initiative “takes health to the people” reaching into the community where the city’s most vulnerable residents live. Care is provided by Health Resilience Specialists (HRS) who are master’s level ‘engagement specialists’ tasked with developing meaningful partnerships with a panel of high-acuity/high-cost patients to enable wellness and stability in their lives. This approach not only reduces the total cost of care but enhances patient experience and outcomes.

CareOregon’s six programmatic principles of trauma-informed care include: reducing barriers; providing client-centered care; increasing transparency; taking time and building trust; avoiding judgement and labels; and providing care in a community-based setting. CareOregon receives its funding from public programs such as Medicaid, Medicare, and the State Children’s Health Insurance Program. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Lockert.pdf>.

HelpSteps

HelpSteps is an online assessment and referral system for families’ and individuals’ social determinants of health. It began as a research project in 2003 and became a fully implemented referral system in 2007. The online system assesses needs in 13 broad social domains and provides access to resources related to over 100 social problems that affect lower socioeconomic families, including services related to food insecurity, housing, and income resources. The system is used by a variety of social services in the Boston area, including the Boston Public Health Commission, The Mayor’s Health Line, and medical and free clinics throughout the area. HelpSteps findings include:

82 percent of families in urban clinics experience at least one type of social problem in a given year; families are interested in assessment referrals; 40 percent of individuals who selected referrals followed up with one of their selections; 52 percent said their problem had either completely or mostly resolved; and 80 percent stated they would like to use the online tool as part of an annual assessment. HelpSteps receives funding from the Boston Children’s Hospital, the Boston Public Health Commission, and small grants. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Fleegler.pdf>.

Live Well Omaha

Initiated in 1995, Live Well Omaha (LWO) is a community-led collaborative created out of a shared concern that no one organization in the community has the capacity to solve health disparity issues alone. With a focus on healthy eating and active living, and an interest in obesity prevention, LWO has more than 40 active partners from a variety of sectors—public/private organizations, nonprofit, businesses, educators, health systems, and insurance companies. As a result of LWO's work, childhood obesity rates have been held constant in the Omaha community (from

2008 to 2012); 30 municipal bike-sharing stations have been created; the employer community has embraced healthy vending; and more than \$7 million of investment funding has been brought into the Omaha metro area. LWO is funded by the Robert Wood Johnson Foundation and the Centers for Disease Control and Prevention Communities Putting Prevention to Work and Community Transformation Grants. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Sjolie.pdf>.

Live Well San Diego

In 2010, the San Diego County Board of Supervisors adopted Live Well San Diego, a 10-year plan to advance health, safety, and well-being of the region's more than three million residents. The County's partners include cities and tribal governments; diverse businesses, including health care and technology; military and veterans organizations; schools; and community and faith-based organizations. The initiative has four strategic approaches: building a better service delivery system; supporting positive choices; pursuing policy and environmental changes; and improving the culture. Ten indicators have been identified to capture the

overall well-being of residents. The initiative now has three components: Building Better Health, Living Safely, and Thriving. Funding began in 2010 with a \$16 million Communities Putting Prevention to Work (CPPW) Federal Grant Award. In 2010, Live Well San Diego also received a five-year grant from the Centers for Disease Control and Prevention National Public Health Improvement Initiative. In 2011, they received a five-year, \$15 million Community Transformation Grant. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Macchione.pdf>.

Maryland Model for Hospital Payment

In 2014, Maryland and the Center for Medicare & Medicare Innovation negotiated a waiver that established a per capita expenditure rate for Medicare hospital services and a limit on the growth of inpatient and outpatient hospital costs for all payers to 3.58 percent. The waiver projects Medicare savings over five years to be \$330 million. To implement the model, the state rate-setting commission will replace fee-for-service models with population-based payment models that reward providers for improving health outcomes, enhancing

quality, and controlling costs. Although the new model has just been introduced, several early adoptees of the new payment models have observed significant reductions in preventable hospitalizations. With these new incentives, hospitals are expected to form more creative partnerships with public health agencies, community health organizations, and long-term care providers. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Sharfstein.pdf>.

Molina Healthcare Community Connectors

Molina Healthcare serves Medicaid, Medicare, CHIP, Marketplace, and dual-eligible plans in multiple states. In 2004, Molina Healthcare began leveraging community health care workers known as Community Connectors to engage and empower Molina members to achieve better health outcomes. By partnering with state Medicaid organizations and other community partners, Community Connectors serve as liaisons between patients and clinicians, assessing needs and assisting the treatment team with coordinating members' care. They coach members to self-manage their chronic conditions, connect them to basic community resources

(e.g., food, shelter and safety) and more traditional health-related social services, and advocate on their behalf. Community Connectors are familiar with the community and the available resources that can help members improve their health. In New Mexico, the program has demonstrated a savings of \$4,564 per enrollee through reduced emergency department use, days of inpatient care, and substance abuse. The program is funded by Molina Healthcare. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Krokos.pdf>.

Nemours Children's Health System

Nemours is an integrated pediatric health system committed to improving the health of children. Established in Delaware in 2004, Nemours Health & Prevention Services were first created to help children grow up healthy by integrating treatment and prevention of illness. They work with community partners to influence policies and practices to improve children's health. Through family-centered care in children's hospitals and clinics in Delaware, New Jersey, Pennsylvania, and

Florida, as well as world-changing research, education, population health, and advocacy, Nemours fulfills the promise of a healthier tomorrow for all children — even those who may never enter the doors. The work is financed by Nemours operating budget and with limited external grants. To read more about this innovative program, see this brief two-page summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Bailey.pdf>.

New York City Macroscopic

In 2013, the New York City Department of Health and Mental Hygiene launched NYC Macroscopic, a program that uses aggregate data from primary care providers to estimate the prevalence of selected health conditions in New York City. Using data from electronic health records, the goal is for estimates to efficiently and cost-effectively characterize the burden of disease in New York City and changes in that burden over time. The Department of Health and Mental Hygiene, in partnership with the City University of New

York School of Public Health is gathering the data from over 700 ambulatory care practices across the city. This program is funded by the deBeaumont Foundation; the Robert Wood Johnson Foundation; the Robin Hood Foundation; the Doris Duke Foundation; the New York State Health Foundation; and the Centers for Disease Control and Prevention. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/McVeigh.pdf>.

New York State Prevention Agenda 2013–2017

The New York State Public Health and Health Planning Council—a group made up of more than 140 organizations across New York—developed the New York State Prevention Agenda 2013–2017 at the request of the Department of Health. The Council, a collaboration of health departments, state agencies, providers, health plans, community-based organizations, academia, advocacy groups, schools, and employers, developed this plan to demonstrate how communities across the state can work together to improve health and quality of life. The Prevention Agenda serves as a guide to local health departments and hospitals

as they develop their community health assessments. Statewide and local planning organizations provide technical support to local communities that are collaborating to assess needs and develop local implementation plans, with support from the Robert Wood Johnson Foundation. The New York State Health Foundation provides grants to organizations that help local health departments and their partners advance the goals of the Prevention Agenda. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Wagner.pdf>.

Ohio Correctional Health Project

The Ohio Correctional Health Program (Ohio Offender Project) helps offenders who are preparing to be released from prison develop a transition of care plan to ensure their health needs are met as they re-enter society. The Ohio Department of Medicaid and Department of Rehabilitation and Corrections partnered with all participating Medicaid managed care organizations, the Ohio Department of Health, and the Department of Mental Health and Addiction to begin this program in 2014. Offenders who have two or more infectious or chronic health conditions are eligible to be matched with a peer mentor (peer mentors are offenders who have long-term sentences) who assists them with a Medicaid application and selection of a

health plan. The chosen health plan works with the offender to develop a transition of care plan to ensure access to needed care, medication, and assistance with food, shelter, or safety issues, and access to community-based transition services. One goal of this program is to reduce Ohio's 26 percent recidivism rate by helping released offenders manage chronic health or mental health conditions. The expenses for this program are financed as part of the health plan's Medicaid capitation rate (administrative dollars). To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Davidson-3-of-3.pdf>.

Optimizing Health Outcomes for Children with Asthma in Delaware

In 2012, Nemours, an integrated pediatric health system, implemented a dynamic approach to managing pediatric asthma in children throughout Delaware's major cities and on behalf of the 42,000 children in surrounding zip codes. The model of care addresses broader system issues by using an integrator function—convening multisector partners in support of a shared goal, led by community health worker leadership, a patient-centered medical home, and optimal technology to treat pediatric asthma in the state. Key partners include: state-based chapters of the American Lung Association; state/local housing and public health departments and stakeholders;

the U.S. Department of Housing and Urban Development; leadership councils; as well as other coalitions and community-based partners. Between 2012 and 2013, early findings from the Nemours' self-monitoring plan indicate that emergency department visits to the Nemours Alfred I. DuPont Hospital for Children for asthma registry patients decreased by more than 40 percent. Nemours is funded by a Center for Medicare & Medicaid Innovation's Health Care Innovation Award. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Chang-2-of-2.pdf>.

Partnership for a Healthy Durham

Partnership for a Healthy Durham is a collaboration on health initiatives that began in 2004. The Partnership, comprised of 475 coalition members, includes government agency and organizational leaders as well as community members. Every three years the Partnership conducts community health assessments to determine and set health priorities for the city. The 2011 assessment identified the following three social determinants as critical to improving health outcomes for residents of Durham: poverty, homelessness, and education/workforce development. As a result of the assessment, social

determinants have been integrated into community policies, projects, and plans. Additionally, a pilot medical respite for the homeless has been established and a task force has been developed to create a pipeline of education and training opportunities for local high school students to gain employment. Support for the Partnership comes from local county government with additional funding from grants that support projects. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Monroe.pdf>.

Priority Spokane: Educational Attainment

Priority Spokane: Educational Attainment is a collaboration of community leaders serving as a catalyst and convener for data-driven improvements within Spokane Public Schools (SPS) in Washington. In the 2005–2006 academic year, SPS had a graduation rate of 57.7 percent (the county rate was 69.2 percent). Following the release of a community assessment in 2009 revealing educational attainment as a top priority of the community, Priority Spokane conducted a series of studies identifying model practices to improve education along with student risk factors for dropping out. Working with resources committed by school superintendents, business leaders, college and university presidents, elected officials, and others in the community,

many of those model practices have been put into practice. These practices include: professional training on childhood trauma; a school Early Warning System weighted by student risk factors and aligned with community services; and a STEM Education network providing hands-on learning. In the 2012–2013 academic year, the SPS graduation rate improved to 79.5 percent, almost even with the county rate of 80.8 percent. Priority Spokane has had over \$800,000 of funding provided by local and state foundations during a five-year period with partners providing extensive support to the projects. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/WilsonI.pdf>.

St. John's Wellchild and Family Center

Since 1996, St. John's Wellchild and Family Center (SJWCFC), a FQHC network in California, has been working to reduce the negative impacts of substandard housing on health. When first launched, SJWCFC and Esperanza Community Housing Corporation worked together on lead poisoning prevention. From 1996 through 2003, Strategic Actions for a Just Society joined the collaborative to collect data about the health impact of substandard housing to influence state and local policy. In 2009, Healthy Homes Healthy Kids joined with a comprehensive approach around home visits, health program enrollment, medical homes, advocacy, and policy development. Highlights of collaborative outcomes include:

100 percent decrease in asthma hospitalizations; 100 percent decrease in missed work days by parents; 80 percent reduction in percent of clients with asthma ER visits; 69 percent reduction in the percentage of children missing one or more days of school due to asthma; and 69 percent reduction in clinic/doctor visits due to acute asthma attacks. SJWCFC is funded by British Petroleum Settlement/Air Quality Management District Funds, First 5 Los Angeles, Every-Child Foundation, Housing and Urban Development Agency, and Kresge Foundation. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Duplessis.pdf>.

Total Health at Kaiser Permanente

Total Health is a state of complete physical, mental, and social well-being. In 2013, Kaiser Permanente launched Total Health to help Kaiser Permanent members and workforce, their families, and communities achieve this vision of health. By focusing on chronic conditions driven by modifiable social and environmental determinants of health, Kaiser Permanente Total Health works to benefit communities through a variety of programs including: Thriving Schools initiative (300 schools participate) which aims to create a culture of wellness in schools including healthy meals; Every Body Walk! which raises

awareness about the benefits of walking; and an incentive plan for the Kaiser Permanente workforce to improve health metrics. Partners include safety-net providers, fresh food providers, theatres, and grassroots organizations, in addition to schools and school-related organizations. Kaiser Permanente funds \$2 billion that is needed annually for this population health work and supplemental funding is provided by partner organizations. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Baxter.pdf>.

Truman Medical Center Corporate Academy and Financial Literacy Program

In 2001, Truman Medical Center in Kansas City, MO, started a corporate academy. This academy has helped students register for over 8,000 courses, from GED preparation classes to MBA degree courses. Many of their employees and their families have graduated from high schools, from colleges and with masters' degrees. In 2009 Truman Medical Center began a Financial Literacy program to focus on the economic determinants of health. They partnered with U.S. Bank to locate a branch on-site at

the hospital and thus provided access to banking and banking literacy to their patient population and employees. The U.S. Bank invested \$400,000 into the program. As a result of the program, hundreds of employees and community members come into the hospital to use the bank, rather than using cash stores, and numerous loans have been made. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Bluford.pdf>.

UnitedHealthcare Health Teams With Community Health Workers

UnitedHealthcare Community & State is a Medicaid managed care organization operating in 26 states. It has incorporated community health workers into its health team to help members with complex needs who also experience barriers with access to care—to connect them to behavioral, medical, and social supports. Community health workers build rapport and trust with patients, teach them how to utilize the health care system (e.g., the importance of the primary care provider relationship and appropriate use of the emergency department), and connect patients to nonclinical community-based resources to address the social determi-

nants of health. For example, the community health worker may accompany the patient to a primary care visit and help them find resources in the community to better manage their chronic conditions. The community health worker role contributes to improved health outcomes, member experience, and improved efficiencies. Augmenting the traditional health care workforce with community health workers also allows licensed staff to work at the top of their licensure. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Davidson-1-of-3.pdf>.

UnitedHealthcare Housing Initiatives

UnitedHealthcare Community & State has also developed a partnership to improve housing stability and conditions for beneficiaries. By partnering with a local homeless coalition in Ohio, they are better able to locate members who are homeless or precariously housed, facilitate supportive housing placement, and engage the care coordination team to connect members to community-based support services. In addition, the Ohio plan is partnering with a supportive housing development with a significant concentration of Unit-

edHealthcare members to better connect housing managers and social workers with the managed care coordination team. The goal of these partnerships is to provide stable and healthy housing since evidence demonstrates a clear linkage between housing stabilization and reduction in emergency rooms visits, inpatient admissions, and crisis services. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Davidson-2-of-3.pdf>.

University Hospitals as an Anchor Institution

Teaming with community partners over the past decade, University Hospitals of Cleveland (UH) created its “Anchor Institution” strategy aimed at addressing core city needs by creating jobs, stimulating the economy, and empowering urban residents to take ownership of their communities and futures. UH has committed to historically excluded minorities and diverse contractors in construction opportunities; to buy local and support diverse suppliers; and create and nurture innovative nonprofits to boost educational and economic activity. For example, through this effort, the Evergreen Cooperatives established four worker-owned companies, resulting

in nearly 100 living-wage jobs with full benefits for inner-city residents; UH’s Buy Local vendor preference encouraged their largest supplier to open a distribution center in Cleveland; and NewBridge Cleveland, a dual-mission nonprofit, trains underemployed adults for high-demand health care jobs and engages at-risk youth in after-school arts curricula to kindle a love for learning and education. UH partners include Living Cities and The Cleveland Foundation for support. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Zenty.pdf>.

Visiting Nurse Service of New York Population Health Management

The Visiting Nurse Service of New York (VNSNY) is the largest free-standing home and community-based nonprofit health system in the country. VNSNY has established a population health division to provide care coordination to at-risk populations, employing strategies such as transitions of care, health coaching, caregiver support, community-based peer workers, hot-spotting, motivational interviewing, and behavior activation. The Institute for

Healthcare Improvement (IHI)/Rockaways Wellness Partnership with VNSNY is an innovative, community-based intervention for improving the health of “at-risk” populations through proactive client engagement and self-empowerment. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Christopher.pdf>.

Wake Forest Baptist Health’s Supporters of Health

Wake Forest Baptist Health is working in Forsyth County, N.C. to improve health and reduce re-admissions and charity care costs for the hospital. In 2014, the hospital trained former environmental service workers as community health workers. The community health workers receive referrals from hospital staff when patients are discharged and from agencies outside the hospital, and then work with the referred patients, connecting them to community

resources. Partners include faith communities, social services agencies, safety-net clinics, and the hospital’s care transitions and pastoral care staff. The program has reduced hospital re-admissions. Wake Forest is funding this work through its foundation. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Gunderson-2-of-2.pdf>.

West Baltimore Primary Care Access Collaboration

The West Baltimore Primary Care Access Collaboration (WBPCAC) is a group of 16 organizations that aim to improve the overall health of the residents of west Baltimore. The mission of the Collaborative is to create a sustainable, replicable system of care, reduce costs and expand the primary care and community health workforce. In January 2013, the WBPCAC was awarded a five million dollar grant from the Maryland Community Health Resources Commission to reduce cardiovascular disease in west Baltimore in the four zip codes with the highest disease burden and

most intense social needs of any other community in Maryland. To date, this is being accomplished by improving access to and the quality of healthcare by hiring 23 health care providers and providing training to many others. The WBPCAC has also deployed 11 Community Health Workers into these neighborhoods to partner with 172 community members to maximize their utilization of health and social services. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Ross.pdf>

Western North Carolina Healthy Impact

WNC Healthy Impact is a partnership between hospitals, health departments, and key regional partners working together to improve community health in western North Carolina. The initiative began with investments by hospitals and health departments in 16 western North Carolina counties. It brings together local health care partners in the health improvement process to jointly assess health needs, develop collaborative Community Health Improvement plans, take

coordinated action, and evaluate progress and impact. Since 2012, WNC Health Impact has led efforts to standardize and collect data, create reporting and communication templates and tools, encourage collaboration, and provide training and technical assistance across the western North Carolina community. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Gates.pdf>.

Women-Inspired Neighborhood Network (WIN Network): Detroit

In 2008, the CEOs of Detroit Medical Center, Henry Ford Health System, Oakwood Healthcare System, and St. John Providence Health System commissioned the Detroit Regional Infant Mortality Reduction Task Force to develop a plan of action to help more babies reach their first birthdays. The Task Force addresses Detroit's infant mortality rate, which is nearly 15/1,000 live births, among the highest in the nation. Working through a public-private partnership of Detroit's major health systems, public health, academic, and community partners, the Task Force

seeks to tighten the disconnected medical and social services for women. The Task Force and its WIN Network have realized a number of accomplishments as of August 2014 including zero infant deaths among more than 200 babies born to date and the enrollment of 364 pregnant women in the program. Funding for this project comes from a variety of foundations, organizations, and institutions. To read more about this innovative program, see this brief summary <http://healthyamericans.org/health-issues/wp-content/uploads/2015/09/Wisdom.pdf>.



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