Shifting Hospitals From Health Care Spending to Disease Prevention

Improving health outcomes through community partnerships

**SUMMARY**

In 2012–13, Stakeholder Health, a newly formed learning collaborative of health systems, explored ways to shift hospitals’ spending on charity to care into neighborhood- and community-wide disease-prevention efforts.

Traditionally, hospitals have served their communities by providing free “charity care” to indigent patients. However, there has been a growing interest in urging hospitals and health systems to make pro-active investments in community health, rather than waiting for sick patients to come to them. The federal Affordable Care Act of 2010 requires that hospitals perform community needs assessments and adopt an implementation strategy in response to identified needs.

Stakeholder Health (called Health Systems Learning Group until July 2013) is a collaborative originally administered by the Center of Excellence in Faith and Health at Methodist Le Bonheur Health Care in Memphis, Tenn. It grew out of a series of stakeholder meetings at the federal Center for Faith-Based and Neighborhood Partnerships. The learning group was formed to identify and implement strategies to strengthen hospitals’ pro-active investments in community health, called the community benefit. (See the Appendix for a list of participating health centers.)

A key aim of the project was to work toward reducing the profound health disparities in urban and rural communities. The project also examined ways to measure the return on investment of community health initiatives.

Many of the participating health systems were faith-based, but all were “values based.” “Our theology is social justice,” said Project Director Teresa Cutts, PhD. “The intersection of faith and health is where you can really improve community health.”

The Public Health Institute served as a subcontractor on the project, providing consulting services, including help in designing meetings, writing briefs on the return on investment, surveying health system staff, and being part of the monograph writing team. A senior
investigator there, Kevin Barnett, DrPH, MCP, served as a content consultant on the project.

Gary Gunderson, MD, vice president of FaithHealth at Wake Forest Baptist Medical Center, served as co-principal investigator and, according to Cutts, “is the intellectual and visionary leader of the ‘movement’ undergirding this work.”

Key Results

Project Director Cutts reported that during the grant period, the learning group:

- Held three “field site learnings”:
  - At Loma Linda University, Loma Linda, Calif., June 28–29, 2012. About 45 people attended, largely from the operations and finance areas.
  - At Henry Ford Health Systems, Detroit, October 10–11, 2012. About 75 people attended, many from operations and finance. The focus was on return on investment (ROI).
  - A CEO summit at the offices of the federal Department of Health and Human Services, Washington, April 4, 2013. Some 51 attendees represented 21 health systems. The meeting was co-hosted by the federal Center for Faith-Based and Neighborhood Partnerships. Howard Koh, MD, MPH, Assistant Secretary for Health, gave the keynote address.
    Agendas and further details of the meetings are available online.

- Started a webinar series and a blog and developed a website (StakeholderHealth.org) with resources in areas such as:
  - Financial best practices in terms of improving and monitoring ROI from population health management initiatives
  - Community health needs assessments with participatory mapping integration
  - Specific health issues such as obesity and HIV/AIDS, as well as broader foci on food security, housing, and more traditional community development arenas

All told, 235 individuals from 65 health care systems, eight foundations, and 18 advocacy groups participated in webinars or attended meetings, according to the project director. These included 28 CEOs of organizations.
Produced a *Health Systems Learning Group Monograph* describing project goals, philosophy and case studies. It was the result of a collaborative writing effort that reflected the work of more than 35 volunteer health system participants/writers. Examples of successful “transformative community partnerships” developed by participating health care systems included:

- Reaching out to more than 500 faith communities, Methodist Le Bonheur Healthcare in Memphis, Tenn., developed a “person-centered approach” that reduced hospital readmissions by 20 percent. The Congregational Health Network, a partnership of the hospital, mid-South congregations, and community health organizations hired 10 “congregational navigators” to provide health education and prevention training to more than 2,000 people.

- In Alaska, Southcentral Foundation’s model of integrated health care delivery system, which replaced the Indian Health Service’s Native system, resulted in a 50 percent drop in urgent care and emergency room utilization and a 53 percent drop in hospital admissions. The new system, called the Nuka System of Care, includes behavioral, dental, medical, and traditional services—and all the systems, processes, and departments supporting the service delivery. The foundation staff describes this as a health care system “managed and owned by Alaska Native people to achieve physical, mental, emotional, and spiritual wellness.” It is based on a set of core principles, including: 1) the customer drives everything; 2) all customers deserve to have a health care team they know and trust; 3) customers should not face any barriers to care; and 4) staff and supporting infrastructure are vital to successful outcomes. RWJF has been supporting the development of infrastructure, a business plan, and learning materials for the Nuka Institute.¹

- Camden Coalition of Health Care Providers in New Jersey created a “hotspotting model” to track high utilizers of medical care and meet their needs by “pulling together local hospitals, social service agencies, and other stakeholders to provide comprehensive care and decrease avoidable emergency room visits.” See the Program Results Report and the Grantee Story on Jeffrey C. Brenner, MD, who founded the project. RWJF has built on this work by starting a $2.5 program, *Improving Management of Health Care Super Utilizers*, to develop locally adapted models to address the needs of high users of the health care system; evaluate those models; and develop a program guide for other communities to create and manage similar programs. It started in October 2011 and runs through October 2014.

- Between 2008 and 2010, Dignity Health hospitals in California, Arizona, and Nevada invested $5.7 million in prevention and disease management programs for

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¹ Grant ID# 71299 ($750,000, November 1, 2013 to October 31, 2015)
patients at risk for hospitalization for asthma, diabetes, or congestive heart failure. Almost 9,000 people participated in disease self-management programs.

Christ Medical Center, a level 1 trauma center that is a division of Advocate Health Care in Chicago, partnered with the CeaseFire Illinois program to develop the region’s first hospital-based gun violence-prevention project. CeaseFire Illinois is part of this program.

**Recommendations**

To promote more such initiatives, the report recommended the following steps for health systems:

- Designate a senior executive leader for community health who reports directly to the CEO
- Develop, monitor, and report community health metrics that support the health system’s strategic goals
- Use automated software to collect, track, and report community benefit information
- Set a system-wide community benefit goal that exceeds federal requirements to serve the community

**Lessons Learned**

1. **Start with funds from private and nonprofit organizations that will participate in a project.** Government and foundations can provide added resources, but starting with those involved helps attract those who “value it enough to invest in the process.” This also supports sustainability without continued grants funds. (Project Director/Cutts)

2. **Involve CEO’s of participating agencies.** “We dropped the ball by not bringing CEOs together at their own table earlier in the process,” Cutts said. “They speak their own language and value more private conversations for collaborative learning.”

3. **In creating a collaboration, fully involve all participants to get buy in from their institutions.** The collaborative nature of the learning and writing increased the credibility of the findings. The more than 35 experts within the health systems who were engaged in creating the monograph “were treated appropriately, as authors and intellectual contributors—not just as consumers of answers developed by external consultants or academics,” said Cutts. “This increased the credibility of the findings among the health systems and led to a higher likelihood that the findings will be implemented.”

4. **By focusing on learning that informs the missions of the health systems, and the extent to which the missions could be realized, the subject shifted away from what they were required to do to what they deeply wanted to do.** “This changed
the whole subject—and character—of the learning process and led to much more aspirational learning that was more tuned to the moral possibilities,” noted Cutts.

5. “The collaborative strategy of working with the government as a learning partner—not as a funder or target of advocacy—increased the credibility and intelligence of the whole process,” said Cutts. “Governmental staff was able to be generous with their learning because they were not expecting to be asked for funding. This demonstrated respect for the boundaries appropriate to governmental agencies, but also respect for their contribution to the intellectual process. It also helped the healthcare organizations model the Stakeholder Health findings and the findings gain traction among the press—as well as attract new partnerships with groups like Trust for America’s Health and the IOM.”

Funding

RWJF supported this project from August 2012 through October 2013 with a grant of $220,335 to the Methodist Healthcare Foundation, Memphis, Tenn., which served as fiscal agent.

Afterward

The management of Stakeholder Health has transferred to Wake Forest University Baptist Medical Center in Winston-Salem, N.C. Post-grant activities include:

- Project staff appeared on a special plenary forum at the summer leadership summit of the American Hospital Association in San Diego on July 27, 2013.

- Staff also appeared with Kevin Barnett of the Public Health Institute at an Institute of Medicine roundtable on population health improvement on Feb. 6, 2014, in Washington.

- Stakeholder Health held a “Consultation on Mission, Purpose, Power” at Loma Linda University on Feb. 17–18, 2014. There were 26 attendees from 15 health systems.

- Stakeholder Health continued the monthly webinar series that began as the grant period was ending, under the leadership of Heidi Christensen, associate director for Community Engagement of the U.S. Dept. of Health and Human Service, Center for Faith-Based and Neighborhood Partnerships. By July 2014, nine had been produced.

- An Information Technology Working Group (co-chaired by Dora Barilla of Loma Linda University Health and Eileen Barsi of Dignity Health), representing more than 45 health care systems with more than 400 hospitals, met initially at the American Hospital Association conference in San Diego in July 2013. A follow-up meeting was held on July 25, 2014 in Winston Salem, N.C.

From this session, the working group plans to produce a white paper that will be presented at a joint meeting of health systems, government, and information
technology (IT) vendors at a meeting in September 2014 in Washington. The aim is to develop specifications for IT systems that blend the hospitals’ community health assets with the work being done inside the walls of hospitals to improve place-based population health.
## APPENDIX

### Health Systems in the Stakeholder Health Collaborative

<table>
<thead>
<tr>
<th>System Name</th>
<th>Location</th>
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<tbody>
<tr>
<td>Adventist Health Central Valley Network</td>
<td>Fresno, Calif.</td>
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<tr>
<td>Adventist HealthCare</td>
<td>Gaithersburg, Md.</td>
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<tr>
<td>Adventist Health Ministries</td>
<td>Orlando, Fla.</td>
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<tr>
<td>Adventist Health System</td>
<td>Orlando, Fla.</td>
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<tr>
<td>Advocate HealthCare</td>
<td>Chicago, Ill.</td>
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<td>Aurora Health System</td>
<td>Milwaukee, Wis.</td>
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<tr>
<td>Baptist Health</td>
<td>Northeast Florida and Southeast Georgia</td>
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<tr>
<td>Bon Secours Health System</td>
<td>Marriottsville, Md., operating in six states</td>
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<tr>
<td>Centura Health</td>
<td>Englewood, Colo.</td>
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<tr>
<td>CHRISTUS Health</td>
<td>Irving, Texas</td>
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<tr>
<td>Dignity Health</td>
<td>San Francisco, Calif.</td>
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<tr>
<td>Fairview Health Services</td>
<td>Minneapolis, Minn.</td>
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<tr>
<td>Henry Ford Health System</td>
<td>Detroit, Mich.</td>
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<tr>
<td>Howard University Hospital</td>
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<tr>
<td>Indiana University Health</td>
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<tr>
<td>Inova Health System</td>
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<td>Johns Hopkins University School of Medicine</td>
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<td>Kettering Health Network</td>
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<tr>
<td>Loma Linda University Health</td>
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<td>Lutheran Healthcare</td>
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<td>Methodist Le Bonheur Healthcare</td>
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<td>Nemours</td>
<td>Delaware, Fla.</td>
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<tr>
<td>OhioHealth</td>
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<td>Penrose-St. Francis Health Services</td>
<td>Colorado Springs, Colo.</td>
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<tr>
<td>Pinnacle Health Systems</td>
<td>Harrisburg, Pa.</td>
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<tr>
<td>ProMedica Health</td>
<td>Toledo, Ohio</td>
</tr>
<tr>
<td>Providence Hospital</td>
<td>Washington, D.C.</td>
</tr>
<tr>
<td>Shawnee Mission Medical Center</td>
<td>Shawnee Mission, Kan.</td>
</tr>
</tbody>
</table>
Sibley Hospital
Washington, D.C.

St. Joseph Health System
Akron, Ohio

Southcentral Foundation
Anchorage, Alaska

Summa Health System
Akron, Ohio

Texas Health Resources
Dallas/Ft. Worth, Texas

Trinity Health System
Livonia, Mich.

UMASS Memorial Health System

University of Illinois Health and Hospital System
Chicago, Ill.

Wake Forest Baptist Health
Winston-Salem, N.C.
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Reports


Grantee Website

http://stakeholderhealth.org. Website containing information and resources about Stakeholder Health, including reports, presentations, meeting agendas and blog posts. Winston-Salem, NC.