Health Reform as an Opportunity

Access Health SC Partnership Meeting

November 2011
JoAnn Webster – Vice President, Community Health
Our time together today....

1. Overview of Ascension Health’s work – past and future
2. Discussion of opportunities inherent in the Affordable Care Act for community coalitions
3. Discussion of best practices in Sustainability
4. Identification of two ideas you can start on next week
We are the largest Catholic health system, the largest private nonprofit system and the third largest system (based on revenues) in the United States, operating in 20 states and the District of Columbia.

**Facilities and Staff**
- Locations: 500+
- Acute Care Hospitals: 70
- Long-term Acute Care Hospitals: 2
- Rehabilitation Hospitals: 3
- Psychiatric Hospitals: 4
- Available Beds: 17,836
- Associates: 112,500
- Physicians: 30,000

**Financial Information (FY10)**
- Total Assets: $18 Billion
- Operating Revenue: $14.8 Billion
- Operating Income: $569 Million
- Net Income: $1.2 Billion
- Investment: $723 Million

Care of Persons Who Are Poor and Community Benefit $1 Billion
Ascension Health has a significant presence along the Continuum of Care

<table>
<thead>
<tr>
<th>Hospitals</th>
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<tbody>
<tr>
<td>General acute care hospitals</td>
<td>70</td>
</tr>
<tr>
<td>Long-term acute care hospitals</td>
<td>2</td>
</tr>
<tr>
<td>Rehabilitation hospitals</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatric hospitals</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
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<table>
<thead>
<tr>
<th>Ambulatory Care &amp; Diagnostics</th>
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</thead>
<tbody>
<tr>
<td>Ambulatory Megaplex</td>
<td>21</td>
</tr>
<tr>
<td>Dental Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Employer/Occupational Health</td>
<td>12</td>
</tr>
<tr>
<td>Free Standing Imaging Sites</td>
<td>37</td>
</tr>
<tr>
<td>Lab</td>
<td>4</td>
</tr>
<tr>
<td>Primary Care Clinics</td>
<td>60</td>
</tr>
<tr>
<td>Retail Pharmacy</td>
<td>8</td>
</tr>
<tr>
<td>Sleep Center</td>
<td>15</td>
</tr>
<tr>
<td>Specialty Clinics</td>
<td>60</td>
</tr>
<tr>
<td>Ambulatory Surgery Centers</td>
<td>48</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>4</td>
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<thead>
<tr>
<th>Extended Care</th>
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<tbody>
<tr>
<td>Adult Day Care</td>
<td>4</td>
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<tr>
<td>Assisted Living</td>
<td>6</td>
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<tr>
<td>Dialysis</td>
<td>5</td>
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<tr>
<td>Independent Living</td>
<td>3</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>17</td>
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</table>

<table>
<thead>
<tr>
<th>Prevention &amp; Wellness</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Alternative Care</td>
<td>13</td>
</tr>
<tr>
<td>Community/Social Services</td>
<td>24</td>
</tr>
<tr>
<td>Wellness /Fitness</td>
<td>8</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Post Acute</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health – Outpatient</td>
<td>39</td>
</tr>
<tr>
<td>Cancer Center</td>
<td>22</td>
</tr>
<tr>
<td>DME</td>
<td>10</td>
</tr>
<tr>
<td>Home Health</td>
<td>21</td>
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<tr>
<td>Hospice/Palliative</td>
<td>24</td>
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<tr>
<td>Infusion Therapy</td>
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<tr>
<td>Infusion Therapy Center</td>
<td>7</td>
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<tr>
<td>Private Duty Services</td>
<td>6</td>
</tr>
<tr>
<td>Rehabilitation – Outpatient</td>
<td>55</td>
</tr>
</tbody>
</table>

Note: Excludes unconsolidated joint ventures (Via Christi, etc.)
<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>678,203</td>
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<tr>
<td>Available beds</td>
<td>17,836</td>
</tr>
<tr>
<td>Number of births</td>
<td>71,539</td>
</tr>
<tr>
<td>Total surgical visits</td>
<td>349,321</td>
</tr>
<tr>
<td>Home health visits</td>
<td>560,124</td>
</tr>
<tr>
<td>Clinic visits</td>
<td>1,791,133</td>
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<tr>
<td>Emergency visits</td>
<td>2,339,373</td>
</tr>
<tr>
<td>Physician office visits</td>
<td>5,530,285</td>
</tr>
<tr>
<td>Total outpatient visits</td>
<td>18,609,900</td>
</tr>
<tr>
<td>Associates</td>
<td>112,500</td>
</tr>
</tbody>
</table>
Rooted in the loving memory of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.
1999 Criteria for System Advocacy Priorities

- Address a Real Healthcare Need of the Poor;
- Showcase Our Health Ministries; AND
- Impact Federal Legislation

Approved November 16, 1999 by Ascension Health Board of Trustees
What, and For Whom, is 100% Access and 100% Coverage?

100% access and 100% coverage means that all persons, particularly those persons who are uninsured or underinsured, receive healthcare services and health insurance that:

1. Creates and supports the best journey to improved health outcomes for each individual, and

2. Is financed in an adequate and sustainable fashion.

Approved by the Board of Trustees in 2002

Strategies

- National Legislative Leader
- National Public Policy Partner
- Access Model Catalyst
- Voice of the Voiceless
Access Model Catalyst

• Access Leadership work done by local Health Ministries and community coalitions to improve Access to Care for the Uninsured in their communities.
Pre-Healthcare Reform: Ascension Health’s 5-Step Model to 100% Access and 100% Coverage

1. Develop Community-wide Formal Infrastructure
   - Leadership Coalitions
   - Shared Information Systems
   - Catalyst Funding

2. Community Service Gaps Filled (Dental/Pharmaceutical/Mental Health)

3. Care Models Achieve Improved Health Outcomes

4. Private Physicians Volunteer as Medical Homes/Specialists for the Uninsured and Underinsured

5. Sustainable Funding is Achieved for Care (State/local government; business; community partnerships)

SYSTEMIC CHANGE = 100% ACCESS and 100% Coverage
Community Needs Assessment focused on Access to Care for the Uninsured.
Access Leadership Plan to identify specific tactics to implement the 5 step model in the local community working with community coalitions
Identifying necessary resources (tools, education, coaching, consulting, facilitation support, etc.) for successful implementation of the plan.
Providing support to CEO’s through individual consulting, provision of relevant information, opportunities to network with other executives working on Access to Healthcare issues, assistance with valid measurement of outcomes and documentation of accomplishments, etc.
Linking this work to the executive incentive compensation plan.
# Outcome Measures - Definitions

<table>
<thead>
<tr>
<th>Measure No.</th>
<th>Outcome Measures</th>
</tr>
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<tbody>
<tr>
<td><strong>Access</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Demonstrate an increase in the number of individuals in the targeted population with funded healthcare by increasing enrollment in <strong>public</strong> funded healthcare programs such as Medicaid, SCHIP, existing State and Local coverage initiatives.</td>
</tr>
<tr>
<td>2</td>
<td>Demonstrate an increase in the number of individuals in the targeted population with funded healthcare by increasing enrollment in <strong>private</strong> funded healthcare programs such as New Plan for the uninsured.</td>
</tr>
<tr>
<td>3</td>
<td>Demonstrate access and assignment to a Medical Home as evidenced by a documented visit to a Primary Care Physician.</td>
</tr>
<tr>
<td>4</td>
<td>Demonstrate the impact of Pharmaceutical Assistance Programs by the percentage of unduplicated people who receive pharmaceutical assistance.</td>
</tr>
<tr>
<td>5</td>
<td>Demonstrate the impact of Pharmaceutical Assistance Programs by the retail cost of drugs obtained.</td>
</tr>
<tr>
<td>6</td>
<td>Demonstrate a reduction in unnecessary emergency room visits in the targeted population as measured by <strong>Method 1</strong>: Discharge diagnosis by CPT codes 99281 and 99282 OR <strong>Method 2</strong>: Discharge diagnosis by Ambulatory Care Sensitive Conditions as follows: Asthma: 493, Diabetes: 250-251, Hypertension 401.1, 401.9, 402.00, 402.10, 402.90, CHF: 428, 402.01, 402.11, 402.91, 518.4, COPD: 491, 493, 496, 466.0, Chronic Bronchitis: 491.</td>
</tr>
<tr>
<td>7</td>
<td>Demonstrate a reduction in unnecessary hospitalizations in the targeted population as measured by discharge diagnosis Ambulatory Care Sensitive Conditions as follows: Asthma: 493, Diabetes: 250-251, Hypertension: 401.1, 401.9, 402.00, 402.10, and 402.90, CHF: 428, 402.01, 402.11, 402.91, and 518.4, COPD: 491, 492, 494, 496, and 466.0, Chronic Bronchitis: 491.</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Diabetes: Demonstrate improved health status of diabetic clients who are enrolled in care management programs.</td>
</tr>
<tr>
<td>2</td>
<td>Asthma</td>
</tr>
<tr>
<td>3</td>
<td>Hypertension</td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Demonstrate a reduction in cost of unnecessary emergency room visits</td>
</tr>
<tr>
<td>2</td>
<td>Demonstrate a reduction in cost of unnecessary hospitalizations</td>
</tr>
</tbody>
</table>
### Threshold

28* Health Ministries initiate the development of a qualified Access Leadership Plan that will be incorporated and approved in the board-approved ISFP

Health Ministries meeting Threshold:

**ALL Health Ministries have a Board approved Access Leadership Plan in place which has been incorporated into the Health Ministry ISOFP.**

### Target

10 Health Ministries report 3 outcome measures from the National Access Outcome Measure Initiative (NAOMI) list

**12 Health Ministries meeting Target:**
- Carondelet Health – Tucson
- Lourdes - Binghamton
- Lourdes – Pasco
- Providence – Waco
- Saint Thomas Health
- Seton – Troy
- Seton Family of Hospitals
- St. John Health
- St. Joseph – Tawas City
- St. Mary’s - Amsterdam
- St. Mary’s of Michigan
- St. Vincent-Jacksonville

### Exceeds

12 Health Ministries report 4 outcome measures from NAOMI including at least one NAOMI measure of a health outcome;

**7 Health Ministries reporting 4 measures including 1 health outcome measure:**
- Lourdes – Pasco
- Providence – Waco
- Saint Thomas Health
- Seton – Troy
- St. John Health
- St. Joseph – Tawas City
- St. Mary’s of Michigan

AND

50% of those reporting a health outcome measure demonstrate an improved health outcome

Health Ministries meeting Exceeds:
- Improvement in health outcome not demonstrated at this time.

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*Actual number is 26 due to divestment of Good Samaritan Health System, Pottsville, PA in FY’08 and senior leadership decision to exclude St. Anthony’s, Chicago, IL*
Collective Accomplishments Contribute to System Expertise

- Access Models Community on [communities.myascensionhealth.org](http://www.communities.myascensionhealth.org) contains over 600 resources organized into searchable libraries with most resources coming from our Health Ministries.
- Eight “toolkits” developed to support spread of best practices developed in our Health Ministries:
  - Care Management
  - Fund Development
  - Pharmaceutical Access
  - Outcome Measurement
  - Return on Community Investment (ROCI)
  - School Based Clinics
  - Transportation Assistance
  - Medical Homes
- Eight ROCI tools developed to calculate financial return on investment in improving access.
Other Impacts – System Wide

- Seventeen community coalitions recognized the value of measuring the impact of their work and participated in collecting and submitting measurements to our NAOMI initiative.
- As a result of collecting the NAOMI measures we are able to document cumulative impacts like the provision of $38,725,669 of needed pharmaceuticals to 151,524 uninsured people.
- For the past seven years, Ascension Health Ministries and their community partners have participated in Cover The Uninsured Week, sponsoring up to 192 activities a year touching as many as 49,678 people per year.
- Other system wide efforts have including advocating for reauthorization and expansion of the Children’s Health Insurance Program and the My Voice, My Vote effort to encourage registration and voting.
Where are we today?

• Building on 10 years of work toward 100% Access and 100% coverage
• Building on a foundation at each Health Ministry of an Access Leadership Plan that addresses community collaboration to improve access to care for the uninsured.
• Working in an internal environment that requires us to redirect our resources to the most effective strategies and tactics and to integrate our work with others in the organization (both local and national)
• Experiencing an internal shift from a focus on “patient-centered” to “person-centered” care
• Facing an external environment that calls for changes in our business and care models to manage the health of defined populations for bundled reimbursement.
• Experiencing a national groundswell of interest in improving the health of individuals and communities driven by an increasing awareness of the implications of issues like childhood obesity, aging population struggling with chronic diseases, and increasing health disparities.
Revised 2020 Goal and Associated Strategies of Healthcare That Leaves No One Behind

Revised 2020 Goal

**What, and For Whom, is 100% Access and 100% Coverage?**

100% access and 100% coverage means that all persons, particularly those persons who are poor and vulnerable, can access environments and healthcare that:

1. Create and support the best journey to improved health status for individuals and communities, and
2. Are financed in an adequate and sustainable fashion.

**Strategies**

Approved by AH Board of Trustees March 2011

- National Legislative Leader
- National Public Policy Partner
- Pacesetter for Improved Community Health
- Voice of the Voiceless
Improved Community Health

- Evaluate impact and report results
- Implement plans, pilot innovations and leverage collaboration
- Develop Community Benefit Plans
  - Incorporation of Access Leadership Plans as appropriate
  - Highest priority community health needs
  - At least one social determinant of health
  - Cultural Competency and Health Literacy
  - Policy, systems, and environments (PSE) change methods
  - Measurement strategies
- Complete Community Health Needs Assessments
- Adopt “Pacesetter” role
Opportunities for all of us in the post healthcare reform world

• 20+ million remain uninsured
• 30+ million newly insured
• New focus on prevention
• New grant opportunities
• New potential partners
• What core competencies can you leverage to serve?
  - Undocumented immigrants
  - Highly vulnerable populations – homeless, serious chronic mental illness or substance abuse, serious physical disabilities
The Newly Insured

• How can you serve the unique needs of this population and who will see the value-proposition of your services?
  – Facilitated enrollment into multiple complex coverage options
  – Orientation to use of primary care or medical home
  – Navigation of healthcare system
  – Case or Disease Management
## School-based Health Centers (Section 4101)

The Secretary of HHS will establish a grant program “to support the operation of school-based Health Centers”

- grants for schools, preference to those with large number of children eligible for Medicaid
- funds to support facilities and equipment, not to support personnel or pay for health services
- Secretary is to develop evaluation plan and monitor quality performance of grants
- appropriates $50 million per year for FY2010 to FY2013

## Incentives for Prevention of Chronic Disease in Medicaid (Section 4108)

The Secretary of the Department of Health and Human Services (HHS) will award grants to states to carry out comprehensive, evidence-based, accessible programs to lower health risks of Medicaid beneficiaries

- funds can be used, for example, for programs to cease use of tobacco products, control or reduce weight, lower cholesterol, lower blood pressure, avoid onset of diabetes
- requires various reports from states receiving grants, independent evaluation of initiatives, reports from Secretary to Congress
- appropriates $100,000,000 for the five-year period beginning January 1, 2011

## Community Transformation Grants (Section 4201)*

The Secretary of HHS, through the Director of the Centers for Disease Control and Prevention (CDC), to award grants “for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming”

- competitive grants to state and local governmental agencies, community-based organizations, non-profit organizations, and Indian tribes for implementation, evaluation and dissemination of evidence-based community preventive health care activities
- grant recipients to provide detailed plan for the policy, environmental, programmatic and (as appropriate) infrastructure changes needed to promote healthy living and reduce disparities
- activities could include: creating healthier school environments, creating infrastructure to support active living, access to nutritious food, and tobacco cessation
- grant recipients are to evaluate impact by measuring the changes in prevalence of chronic disease risk factors of community members participating in preventive health activities
- grantees will meet at least annually to discuss challenges, best practices, and lessons learned
- does not specify an amount to be appropriated (authorizes “sums as may be necessary”)
## Grant Programs to Promote Prevention

### Health Aging, Living Well (Section 4202)*

The Secretary of HHS (through the Director of the CDC) will award grants to states, local health departments and Indian tribes:

- to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary clinical referrals for individuals who are between 55 and 64;
- interventions include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyle;
- grant applicants to design a strategy to improve the health of individuals between ages 55 and 64 through community-based public health interventions;
- does not specify an amount to be appropriated (authorizes “sums as may be necessary”)

### Epidemiology and Laboratory Capacity Grant Program (Section 4304)*

The Secretary of HHS (through the CDC Director) to establish a grant program to provide:

- grants to state health departments, local health departments, tribal jurisdictions, and academic centers;
- funding for assisting public health agencies in improving surveillance for, and response to, infectious diseases and other important public health conditions;
- authorizes $190,000,000 for each year between FY2010 and FY2013.

### Maternal, Infant and Early Childhood Home Visiting Programs (Section 2951)

The Secretary of HHS will award grants to states, Indian tribes, and (in certain circumstances) non-profit organizations:

- to fund early childhood home visitation programs;
- each grantee is to measure benchmarks including maternal and newborn health, prevention of child injuries, improvement in school readiness, reduction in crime or domestic violence;
- Appropriates $100 million in FY2010, increasing steadily until FY2014 when appropriations are $400,000.
Patient Protection and Affordable Care Act

Selected Prevention and Wellness Provisions

- Group health plans: ensures first dollar co-pay, no deductible, for coverage of clinical preventive services
- Prevention and Public Health Fund ($15B over 10 years)
- National Prevention Strategy & Council to coordinate prevention
- Multiple Research and Community Transformation Grant programs (including Childhood Obesity Demonstration)
- Prevention & Wellness for Small Businesses / Healthy Lifestyles
- Healthy Aging / Living Well
- National Menu Labeling for chains & vending machines
- Address health disparities in context of social / economic /physical environment
New Partnership Opportunities

- PPACA Prevention Funds ($500M-$2T/yr)
- Healthy Food Financing Initiative ($345M)
- Promise Communities ($210M)
- Choice Neighborhoods ($250M)
- Sustainable Communities ($688M)
- Social Innovations Fund ($60M)
New Partnership Opportunities

- New Housing Trust Fund ($1B)
- Rental Housing Initiative ($350M)
- CDBG ($4B)
- Transit / TIGER (high speed rail, local projects)
- Partnership for Healthy Communities (HUD/DOT/EPA/AG/DOE, links to HHS & DOI)
- CDC “Big Cities” Initiative
New Partnership Opportunities

- Hospitals, Federally Qualified Health Centers and Public Health Departments
  - All have new requirements around Community Health Needs Assessment and Implementation Planning
New Reimbursement Models for Hospitals and Physicians

• Multiple provisions are driving toward paying providers to keep people healthy or get them well faster and cheaper (ACO’s, VBP, Bundled Payments, no pay for readmissions, etc.)
  – Wellness and Prevention
  – Care Navigation
  – Case/Disease Management
Best Practices in Sustainability

1. Identify your current core competencies
2. Identify logical extensions of your competencies to meet the changing needs in your environment
3. Identify who benefits from your results – the stakeholders
4. Identify the Return on Investment or the Value Proposition – “Monetize” your results
5. Prepare a business case and proposal for them
6. Be prepared to document and report results

**Note – Grants are important but not sustainable revenue sources**
Core Competencies

• Facilitated Enrollment
• Care Navigation
• Provider Network Management
• Data Collection and Analysis
• Health Coaching or Patient Education
• Cultural Competence/Health Literacy
• Clinical Case or Disease Management
• Social Services, Medical Transportation, Housing, etc.
• Coalition Formation and Management
• Community Organizing
• Prescription Assistance
Return on Investment or Value Proposition

• Can be simple or sophisticated
• Need to identify what your stakeholders perceive to be valuable; include value to community (ROCI)
• Use credible data sources
• Allow discussion and disagreement – the exchange of ideas is valuable in and of itself
• Value is usually so high, that even if some data is not accepted you can usually still prove value
ROCI Model Example

**Stakeholders**
- Community
  - Increase taxable income
- Employers
  - Increase employee productivity
- Hospitals
  - Decrease unnecessary ED usage
- Patients
  - Decrease cost
  - Decrease unnecessary hospitalizations
  - Increase earnings

**Benefits**
- Decrease unnecessary hospitalizations
- Increase earnings

Calculations combine program input with research.
Developed from a community-wide perspective.
Testing occurred with numerous internal and external audiences.
Sources that support ROCI model calculations

<table>
<thead>
<tr>
<th>Stakeholder Benefit</th>
<th>Calculation Support Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase taxable Income</td>
<td>Tax Foundation – Michigan state and local tax burden</td>
</tr>
<tr>
<td>Decrease unnecessary ED visits</td>
<td>St. John Health – cost of an ED visit, Centers for Disease Control and Prevention (CDC), Medical Care</td>
</tr>
<tr>
<td>Decrease unnecessary hospitalizations</td>
<td>St. John Health – cost of a hospitalization, Centers for Medicare and Medicaid Services (CMS), Health Affairs</td>
</tr>
<tr>
<td>Decrease patient costs</td>
<td>St. John Health – cost of an ED visit, National Association of Community Health Centers – cost of Michigan CHC visit, CDC, New England Journal of Medicine (NEJM), Families USA</td>
</tr>
<tr>
<td>Increase patient earnings</td>
<td>US Department of Labor – average weekly earnings state of Michigan, Kaiser Family Foundation, Department of Health and Human Services</td>
</tr>
</tbody>
</table>
The Community Health Investment Corporation (CHIC) - St. John Health in Detroit enrolls eligible, uninsured patients into primary care medical homes and is interested in understanding the financial benefits of the initiative.

CHIC wanted to calculate and analyze the community-wide financial benefits of primary care medical home enrollment on its eligible patient population.

A Return on Community Investment (ROCI) analysis was completed with a focus on:

- Determination of specific, quantifiable benefits
- Identification of stakeholders
- Comparison of operating expenses to financial benefits
Model Inputs

• FY2008 operating costs of enrolling eligible, uninsured patients into primary care medical homes – $188,273
  – enrollment workers,
  – office space,
  – equipment and supplies, and
  – technology

• FY2008 number of eligible, uninsured patients who are enrolled into primary care medical homes – 4,783
  – low income (<200% FPL),
  – 19-64 years old,
  – ineligible for any other public programs such as Medicaid, and
  – are most often referred from a St. John Health hospital ED
Benefits to the St. John Health service area:

- Benefit to the local community - $113,839
- Benefit to the employers of enrolled patients - $210,137
- Benefit to the hospitals - $204,459
- Benefit to the enrolled patients - $1,214,702
- Total financial benefit based on ROCI Model - $1,743,137
Comparison of the total financial benefit of the CHIC primary care medical home enrollment program to the operational costs of maintaining the program = $1,743,137 / $188,273 = 926%

$1.00 spent to enroll patients into medical homes = $9.26 in community benefit or Return on Community Investment
Prepare the proposal

• Keep it simple
  – Here’s what we want to do
  – Here’s why it is of value
  – Here is our ask
  – Next steps

• Make it look professional

• What’s the worst that can happen?
Deliver the results

- Have a measurement and evaluation plan before you start
- Measure outcome and process
- Monetize everything you can
- Keep reports simple and understandable (graphs, charts, color, labels, keys, titles that tell the story)
Examples/Ideas from Ascension Health

- Mobile clinic for the homeless created with a private grant then licensed to an FQHC to provide billable services to the homeless.
- Diabetes case management, telemedicine, and CDE training developed to serve “billable” populations and to subsidize services for the uninsured.
- Care coordination services developed under an HCAP grant “sold” to county health plans for the indigent and to churches who had funds to invest in a health care ministry.
- Advanced Telemedicine (tele-presence) program developed with an equipment vendor for billable specialist physician services included a component to subsidize primary care telemedicine services for the uninsured.
- Coalition that developed a discounted network of providers for the uninsured (HMO type model) under an HCAP grant then provided development and administration services to new coalitions in other counties that received grants.
- Facilitated enrollment services developed under HCAP grants then “sold” to state Medicaid programs and hospitals to enroll most difficult populations.
- Medical interpretation training program developed with grant funds then “sold” to hospitals and other providers.
- Central Data Repository developed with grant funds for all safety net providers in a county, then sustained with annual fees from providers to use the data and analysis generated from the system.
- Pharmaceutical Assistance programs developed under grant programs then “sold” to provider and social services organizations or directly to clients.
• What two steps will you take toward sustainability next week?