Arizona’s Statewide Conference: Social Determinants of Health

Tuesday, March 27, 2018
Current State of the State Readmission Data

Barb Averyt, Health Services Advisory Group
Arizona Social Determinants of Health Conference

Barb Averyt, Executive Director
Health Services Advisory Group (HSAG)
March 27, 2017
Social Determinants of Health and Readmissions. What Is the Connection?

• Research shows that, of an individual’s health:
  – 20% is attributed to healthcare
  – 30% linked to health behaviors
  – 50% related to socioeconomic or environmental factors.

• Concurrently, hospitals are receiving financial penalties for patients who readmit within 30 days of a hospital discharge.

• Readmissions do occur when social determinants are not addressed.

Arizona By Regions

- 6.8 million residents
- 659,042 Medicare Fee-for-Service (FFS) beneficiaries
- Approximately 60% of the FFS beneficiaries live in the metro Phoenix area
- HSAG facilitates 3 community coalitions to reduce avoidable readmissions in the West, Central, and East Valleys of the metro Phoenix area (43% of the state’s beneficiaries)
A Linear View of The CMS\(^1\) Hospital Readmissions Reduction Program (HRRP)

Requires CMS to reduce payments to IPPS\(^2\) hospitals with excess 30-day readmissions, effective for discharges beginning on October 1, 2012.

Penalty is up to 1% and applied to all DRG\(^3\) payments. Adopted readmission measures for the applicable conditions of AMI,\(^4\) HF,\(^5\) and PNE.\(^6\)

Penalty increased to up to 2% for all DRGs. CMS allows for planned readmissions (such as chemotherapy) to be excluded.

Penalty increased to up to 3% for all DRGs. Expanded the applicable conditions to include: (1) COPD,\(^7\) and (2) elective THA\(^8\) and TKA.\(^9\)

Penalty remains up to 3% for all DRGs. CMS expanded the PNE measure to include additional diagnoses: (1) patients with aspiration PNE; and (2) sepsis patients coded with PNE present on admission (but not including severe sepsis).

Expanded the applicable conditions to include CABG\(^10\) surgery.

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1. Centers for Medicare and Medicaid Services=CMS
2. Inpatient Prospective Payment System=IPPS
3. Diagnosis Related Group=DRG
4. Acute Myocardial Infarction=AMI
5. Heart Failure=HF
6. Pneumonia=PNE
7. Chronic Obstructive Pulmonary Disease=COPD
8. Total Hip Arthroplasty=THA
9. Total Knee Arthroplasty=TKA
10. Coronary Artery Bypass Graft=CABG
11. Fiscal Year=FY
### National and Arizona Picture: CMS Penalties and Reduction in Payments on the Rise

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>National Hospitals Receiving Penalty (%)</th>
<th>National Average Penalty (%)</th>
<th>Estimated National Reduction in Payments</th>
<th>Arizona Average Penalty (%)</th>
<th>Estimated Arizona Reduction in Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>80%</td>
<td>0.61%</td>
<td>$420 million¹</td>
<td>0.48%</td>
<td>$4.5 million¹</td>
</tr>
<tr>
<td>2017</td>
<td>80%</td>
<td>0.73%</td>
<td>$528 million¹</td>
<td>0.57%</td>
<td>$5.6 million²</td>
</tr>
<tr>
<td>2018</td>
<td>80%</td>
<td>0.73%</td>
<td>$564 million¹ projected¹</td>
<td>0.58%</td>
<td>$6.0 million</td>
</tr>
</tbody>
</table>

2. Calculated using the estimated percentage of increase in the National Reduction in Payments for FY17 and FY18 to Arizona’s FY17 and FY18 Reduction in Payment.
National and Arizona Picture: CMS Penalties and Reduction in Payments on the Rise (cont.)

<table>
<thead>
<tr>
<th>FY</th>
<th>Arizona Average Penalty (%)</th>
<th>Estimated Arizona Reduction in Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0.48%</td>
<td>$4.5 million¹</td>
</tr>
<tr>
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<td>0.58%</td>
<td>$6.0 million</td>
</tr>
</tbody>
</table>

Imagine what we could accomplish if we used part of the $16,100,000 from Arizona hospital readmission penalties to develop resources that addressed social determinants of health (SDoH)?

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2. Calculated using the estimated percentage of increase in the National Reduction in Payments for FY17 and FY18 to Arizona’s FY17 and FY18 Reduction in Payment.
<table>
<thead>
<tr>
<th>Region</th>
<th>Region</th>
<th>Readmission Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1</td>
<td>NAZ</td>
<td>0.62%</td>
</tr>
<tr>
<td>Region 2</td>
<td>SAZ</td>
<td>0.65%</td>
</tr>
<tr>
<td>Region 3</td>
<td>WAZ</td>
<td>1.02%</td>
</tr>
<tr>
<td>Region 4</td>
<td>WV</td>
<td>0.29%</td>
</tr>
<tr>
<td>Region 5</td>
<td>CV</td>
<td>0.43%</td>
</tr>
<tr>
<td>Region 6</td>
<td>EV</td>
<td>0.61%</td>
</tr>
</tbody>
</table>

NAZ—Northern AZ
SAZ—Southern Arizona
WAZ—Western Arizona
WV—West Valley of Phoenix
CV—Central Valley of Phoenix
EV—East Valley of Phoenix

So, Let’s Talk About 30-Day Readmission Rates

• Methodology:
  – Derived from FFS, Part-A hospital claims
  – Excludes all planned readmissions
  – Excludes any beneficiary who dies in the hospital or is transferred to another hospital on the same day
  – Inclusive of all Medicare beneficiaries, regardless of age
**Regional Readmission Rates**

<table>
<thead>
<tr>
<th>Region</th>
<th>Region Abbreviation</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NAZ</td>
<td>12.7</td>
</tr>
<tr>
<td>2</td>
<td>SAZ</td>
<td>14.8</td>
</tr>
<tr>
<td>3</td>
<td>WAZ</td>
<td>14.1</td>
</tr>
<tr>
<td>4</td>
<td>WV</td>
<td>15.1</td>
</tr>
<tr>
<td>5</td>
<td>CV</td>
<td>14.7</td>
</tr>
<tr>
<td>6</td>
<td>EV</td>
<td>15.5</td>
</tr>
<tr>
<td>Arizona</td>
<td></td>
<td>14.7</td>
</tr>
</tbody>
</table>

NAZ—Northern AZ  
SAZ—Southern Arizona  
WAZ—Western Arizona  
WV—West Valley of Phoenix  
CV—Central Valley of Phoenix  
EV—East Valley of Phoenix

Under Trump, Hospitals Face Same Penalties Embraced By Obama, Jordan Rau, 8/3/17.  
## Arizona All-Cause Readmission Rates by Quarter

<table>
<thead>
<tr>
<th>Calendar Quarter</th>
<th>30-Day Readmission Rate</th>
<th>30-Day Readmission Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 4, 2016</td>
<td>14.8%</td>
<td>5,663</td>
</tr>
<tr>
<td>Quarter 1, 2017</td>
<td>14.5%</td>
<td>6,528</td>
</tr>
<tr>
<td>Quarter 2, 2017</td>
<td>14.8%</td>
<td>5,934</td>
</tr>
<tr>
<td>Quarter 3, 2017</td>
<td>14.8%</td>
<td>5,199</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14.7%</strong></td>
<td><strong>23,324</strong></td>
</tr>
</tbody>
</table>

Data files provided to HSAG by the Centers for Medicare & Medicaid Services (CMS) were used for analysis in this report. The data files include Part A claims for Medicare FFS beneficiaries.
All-Cause Readmission Rates

64 readmissions every day, 365 days of the year
## Arizona All-Cause Readmission Rates by Discharge Setting

<table>
<thead>
<tr>
<th>Setting Discharged To</th>
<th>30-Day Readmission Rate</th>
<th>30-Day Readmission Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Home</td>
<td>13.0%</td>
<td>12,055</td>
</tr>
<tr>
<td>Arizona Skilled Nursing Facility (SNF)</td>
<td>19.1%</td>
<td>4,789</td>
</tr>
<tr>
<td>Arizona Home Health Agency (HHA)</td>
<td>18.2%</td>
<td>4,033</td>
</tr>
<tr>
<td>Arizona Hospice</td>
<td>1.8%</td>
<td>109</td>
</tr>
<tr>
<td>Arizona Other</td>
<td>19.2%</td>
<td>2,338</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14.7%</strong></td>
<td><strong>23,324</strong></td>
</tr>
</tbody>
</table>

*Other: psychiatric hospital, long-term care hospital, acute rehab, intermediate-care, left against medical advise, based on hospital discharge disposition codes.

Data files provided to HSAG by the Centers for Medicare & Medicaid Services (CMS) were used for analysis in this report. The data files include Part A claims for Medicare FFS beneficiaries.
### Arizona All-Cause Readmission Rates by Discharge Setting

<table>
<thead>
<tr>
<th>Setting Discharged To</th>
<th>30-Day Readmission Rate/Volume</th>
<th>Percent of Those That Readmitted in 30 days, Who Returned in 1 Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>13.0% 12,055</td>
<td>37.2%</td>
</tr>
<tr>
<td>SNF</td>
<td>19.1% 4,789</td>
<td>32.1%</td>
</tr>
<tr>
<td>HHA</td>
<td>18.2% 4,033</td>
<td>37.8%</td>
</tr>
<tr>
<td>Hospice</td>
<td>1.8% 109</td>
<td>47.7%</td>
</tr>
<tr>
<td>Other</td>
<td>19.2% 2,338</td>
<td>39.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14.7%</td>
<td><strong>36.6%</strong></td>
</tr>
</tbody>
</table>

*Other: psychiatric hospital, long-term care hospital, acute rehab, intermediate-care, left against medical advise, based on hospital discharge disposition codes.

Data files provided to HSAG by the Centers for Medicare & Medicaid Services (CMS) were used for analysis in this report. The data files include Part-A claims for Medicare FFS beneficiaries.
Arizona Readmission Rates by Condition: Which Conditions are the Priority?

<table>
<thead>
<tr>
<th>Condition</th>
<th>30-Day Readmission Rate</th>
<th>Percent of Those That Readmitted in 30 days, Who Returned in 1 Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>14.0%</td>
<td>44.4%</td>
</tr>
<tr>
<td>HF</td>
<td>20.0%</td>
<td>34.5%</td>
</tr>
<tr>
<td>PNE</td>
<td>15.5%</td>
<td>36.8%</td>
</tr>
<tr>
<td>COPD</td>
<td>18.6%</td>
<td>30.7%</td>
</tr>
<tr>
<td>CABG</td>
<td>12.6%</td>
<td>45.3%</td>
</tr>
<tr>
<td>THA/TKA</td>
<td>3.6%</td>
<td>44.1%</td>
</tr>
</tbody>
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Data files provided to HSAG by the CMS were used for analysis in this report. The data files include Part-A claims for Medicare FFS beneficiaries.
## Arizona Readmission Rates and Volume by Condition: Changes the Priority

<table>
<thead>
<tr>
<th>Condition</th>
<th>30-Day Readmission Rate</th>
<th>Percent of Those That Readmitted in 30 days, Who Returned in 1 Week</th>
<th>Volume of Those That Readmitted in 30 days, Who Returned in 1 Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI</td>
<td>14.0%</td>
<td>44.4%</td>
<td>261</td>
</tr>
<tr>
<td>HF</td>
<td>20.0%</td>
<td>34.5%</td>
<td>481</td>
</tr>
<tr>
<td>PNE</td>
<td>15.5%</td>
<td>36.8%</td>
<td>534</td>
</tr>
<tr>
<td>COPD</td>
<td>18.6%</td>
<td>30.7%</td>
<td>378</td>
</tr>
<tr>
<td>CABG</td>
<td>12.6%</td>
<td>45.3%</td>
<td>59</td>
</tr>
<tr>
<td>THA/TKA</td>
<td>3.6%</td>
<td>44.1%</td>
<td>167</td>
</tr>
</tbody>
</table>

Data files provided to HSAG by the CMS were used for analysis in this report. The data files include Part-A claims for Medicare FFS beneficiaries.
HRM$^1$ and the Impact on Readmissions Compared to the All-Cause Rate of 14.7%

**Anticoagulants**
The readmission rate in Arizona for patients on **Anticoagulants** is 18.4%

**Diabetic Agents**
The readmission rate in Arizona for patients on **Diabetic agents** is 19.5%

**Opioid**
The readmission rate in Arizona for patients on an **Opioid** is 19.1%

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1. High-Risk Medication=HRM
   Data files provided to HSAG by the CMS were used for analysis in this report. The data files include Part-A and Part-D claims for Medicare FFS beneficiaries.
Even if you are on the right track, you will get run over if you just sit there.

—Will Rogers
How Do We Define a Determinant of Health?

According to Healthy People, 2020:

“The range of personal, social, economic, and environmental factors that influence health status are known as determinants of health.”

Social determinants of health reflect the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age. Also known as social and physical determinants of health, they impact a wide range of health, functioning, and quality-of-life outcomes.

Source: https://www.healthypeople.gov/2020/about/foundation-health-measures/determinants-of-health
How Do We Define a Determinant of Health?

**Social Factors**

- Availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods
- Social norms and attitudes, such as discrimination
- Exposure to crime, violence, and social disorder, such as the presence of trash
- Social support and social interactions
- Exposure to mass media and emerging technologies, such as the Internet or cell phones
- Socioeconomic conditions, such as concentrated poverty.
- Transportation options
- Public safety

Source: https://www.healthypeople.gov/2020/about/foundation-health-measures/determinants-of-health
How Do We Define a Determinant of Health? *Physical Determinants*

- Natural environment, such as plants, weather, or climate change
- Built environment, such as buildings or transportation
- Worksites, schools, and recreational settings
- Housing, homes, and neighborhoods
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements, such as good lighting, trees, or benches
- Poor health outcomes are often made worse by the interaction between individuals and their social and physical environment

Source: https://www.healthypeople.gov/2020/about/foundation-health-measures/determinants-of-health
Loneliness

• The social determinants of loneliness and social isolation pose as great a threat to longevity as obesity.¹

Poverty

• Patients living in high-poverty neighborhoods were 24% more likely than others to be readmitted, after demographic characteristics and clinical conditions were adjusted.²

Single vs. Married

• Married patients were at significantly reduced risk of readmission, which suggests that they had more social support than unmarried patients.²

2. Socioeconomic Status And Readmissions: Evidence From An Urban Teaching Hospital, May 2014. http://content.healthaffairs.org/content/33/5/778.full
Education and Income

- Low education and low income were often associated with an increased risk for readmission among patients with heart failure or community-acquired pneumonia (use teach-back).²

- Limited education was associated with 60-day readmission rates.²

Stress and Depression

- Specific to heart failure, the interaction of caregiver stress and depression were significant predictors of readmissions.³

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² Socioeconomic Status And Readmissions: Evidence From An Urban Teaching Hospital, May 2014. [http://content.healthaffairs.org/content/33/5/778.full](http://content.healthaffairs.org/content/33/5/778.full)

Uncovering SDoH: Asking Questions Correctly Is Key

**Housing**

“Are you worried about losing your housing or not having money to pay the rent?”

“In the past year, have you had difficulty paying your utility bills?”

“In the past year, have you (or your landlord) repaired everything that needed to be fixed?”
Uncovering SDoH: Asking Questions Correctly Is Key (cont.)

Transportation
“In the past year, have you had trouble getting to medical appointments, or the pharmacy, or to run errands?”

Food
“In the past year, have you ever worried about whether your food would run out before you had the money to buy more?”
Today’s Goal

• Learn about local SDoH efforts.
• Discover national models and case studies.
• Familiarize yourself with the community organizations and healthcare providers here today who are interested in SDoH solutions.
• Introduce yourself to these opportunities/ potential partners.
• Find your role in the “solutions” work.


E. Socioeconomic Status And Readmissions: Evidence From An Urban Teaching Hospital. *Health Affairs Journal*. May 2014. [http://content.healthaffairs.org/content/33/5/778.full](http://content.healthaffairs.org/content/33/5/778.full)


Thank You!

Barb Averyt
baveryt@hsag.com
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Panel: Active Projects

Joe Gaudio, *United Health Care*
Anna Maria Maldonado, *Care 1st Health Plan*
Sue Sadecki, *HonorHealth Desert Mission*
Dr. Charlton Wilson, *Mercy Care Plan*
Moderated by: Jon Ford, *Vitalyst Health Foundation*
Join the Conversation
Online: #SDOH
SDOH in the Big Picture

David Erikson, Federal Reserve Bank of San Francisco
Doug Jutte, Build Healthy Places Network
THE BUILD HEALTHY PLACES NETWORK

Connect partners across health & community development

Provide access to research, best practices, innovations, and models that demonstrate what works

Highlight the health-related value of community development investments

Encourage and enable measurement of health-related impact
Achieving Better Health through Better Partnerships

Equitable and healthy communities

DRIVE NEW CROSS-SECTOR INVESTMENTS

Build Healthy Places Network

Speed and spread innovative solutions
Accelerate the flow of healthcare dollars
CONTRIBUTIONS TO PREMATURE DEATH

- Behavioral Patterns: 40%
- Genetic Predisposition: 30%
- Social Circumstances: 15%
- Health Care: 10%
- Environmental Exposure: 5%

Life expectancy of men at age 25

By educational attainment
Percent of children with less than very good health

By income (% of Federal poverty line)
ACROSS ALL RACIAL AND ETHNIC GROUPS

Percent of adults with poor health

By income (% of Federal poverty line)
BUT POVERTY IS CONCENTRATED

Percent of people in poverty

By racial or ethnic group
SOCIAL DETERMINANTS OF HEALTH

- Poor nutrition
- Limited transportation
- Challenged mental health
- Teenage pregnancy
- Inadequate social network
- Single parent home
- Poverty
- No recreation
- Educational deficit
- Homelessness
- Underemployment
- Discrimination
- Death of a loved one
- Poor parenting
- Family violence
- Lack of health care

Source: www.smartcitymemphis.com/cartoon/toxic-stress/
Lack of control

Toxic stress

Compromised immune system

Inflammation

Altered fight or flight response

Disrupted brain development

Social Determinants of Health

Source: www.smartcitymemphis.com/cartoon/toxic-stress/
Elements of a Healthy Community

- Health Equity Resiliency
- Social Justice
- Transportation Options
- Access to Care
- Affordable Quality Housing
- Community Safety
- Economic Opportunity
- Educational Opportunity
- Environmental Quality
- Quality Affordable Food
- Community Design
- Parks and Recreation
- Social/Cultural Cohesion
HEALTH DISPARITIES

Short distances, large differences

Miami, FL
HEALTH DISPARITIES

Short distances, large differences

Phoenix, AZ
IN DETERMINING YOUR HEALTH...

85040 >
COMMUNITY DEVELOPMENT & HEALTH WORK SIDE-BY-SIDE

Economic hardship by city

Childhood obesity by city

Los Angeles County
“We are likely to look back at this time and wonder why community development and health were ever separate sectors.”

– Risa Lavizzo-Mourey, MD, Former President and CEO, Robert Wood Johnson Foundation, Speaking at the 2016 National Interagency Community Reinvestment Conference
What is Community Development?
COMMUNITY DEVELOPMENT: PAST

Pruitt-Igoe, St. Louis, MO

1956 to 1972

Architect: Minoru Yamasaki
ZIP CODE IMPROVEMENT...
HOUSING COORDINATED WITH SERVICES

Solara, San Diego
Zero Energy Affordable Housing

Plaza Apartments, San Francisco
Supportive Housing
ZIP CODE IMPROVEMENT...
COMPREHENSIVE YOUTH DEVELOPMENT

KIPP Academy, Washington D.C.
Neighborhood Centers Inc, Houston
ZIP CODE IMPROVEMENT...
RESIDENT-FOCUSED ECONOMIC DEVELOPMENT

Baker-Ripley Center, Houston
Market Creek Plaza, San Diego
REDLINING

Community Reinvestment Act of 1977 (CRA)

Philadelphia, 1949
Community Revitalization since the 1960s
Mature Sector with Large Scale Investments

OVER $150 BILLION DOLLARS ANNUALLY
DIRECTED INTO LOW-INCOME NEIGHBORHOODS

- Network of organizations
  - Community Development Corporations (CDCs)
  - Community Development Financial Institutions (CDFIs)
  - For-profit & non-profit affordable housing developers

- Federal/state tax credits & grants
  - Low Income Housing Tax Credit (LIHTC);
  - New Markets Tax Credit (NMTC);
  - Community Development Block Grants (CDBG);
  - Healthy Food Financing Initiative (HFFI)

- Community Reinvestment Act dollars
  - CRA-motivated loans and investments from private, for-profit banks
Please get your lunch from the cafeteria and return to the Cottonwood Ballroom.
Join the Conversation
Online: #SDOH
SDOH on the Ground

David Erikson, Federal Reserve Bank of San Francisco
Doug Jutte, Build Healthy Places Network
Health Happens in Neighborhoods: What We Can Do About It!

Part 2: Promising Innovations

Douglas Jutte, MD, MPH
David Erickson, PhD

Arizona Social Determinants
March 27, 2018
OUTLINE

Where are we now?:
High costs and downstream interventions

Upstream Interventions:
Innovative Financing & New Partnerships

Coordinated Upstream Interventions:
The Market that Values Health
WHERE ARE WE NOW?: High costs

$3.5 trillion per year

- >80% of costs are due to chronic disease
- Most chronic disease is preventable
- Most chronic disease happens to low-income people in low-income places
WHERE ARE WE NOW?: Inefficient investments

>$1 trillion per year

Spent on avoidable chronic disease occurring in low-income neighborhoods
WHERE ARE WE NOW?: Downstream interventions

Improved Screening & Referrals: e.g. Health Leads

Strengthened Social Service Sector:
e.g. Kaiser Permanente & Nonprofit Finance Fund
Moving Upstream: Innovative Financing & New Partnerships
New Healthcare Financing & Partnerships

Direct Healthcare Investments in SDOH:
• Community benefit and treasury dollars

Community Development & SDOH Investment Funds:
• Hospital loan funds
• CDFI loan funds
• Equity fund
Direct Healthcare Investments in SDOH
Innovative SDOH Financing Tools and Partnerships
Build Healthy Places Network

Dignity Health

$120 million loan fund
3.13.2018
ProMedica, LISC launch $45M partnership
BOSTON: Neighborhoods of gentrification
RESOURCES:
Diving deeper and taking next steps
By joining forces, community developers and health professionals can have a more powerful impact.

Learn More About the Network

The Pulse
A monthly newsletter featuring stories at the intersection of community development and health.

Crosswalk Magazine
A gathering place for stories illustrating community investments—creating neighborhoods that promote health and well-being for all. Produced by the Build Healthy Places Network.

Partner Finder
Looking for partners in your local area? Check out our Partner Finder.

Healthy Communities Initiative

www.BuildHealthyPlaces.org  @BHPNetwork
Jargon Buster

Working across sectors begins with speaking the same language. If you're lost in a sea of acronyms, this tool can help. Below we aim to demystify common industry jargon.

- CDC (Centers for Disease Control and Prevention)
- CDC (Community Development Corporation)
- Community Benefits (Agreements)
- Community Benefits (Hospital)
- Community Development
- Community Development Financial Institutions (CDFIs)
- Community Reinvestment Act
- Equitable Development
- Community Health Assessment (CHA)

Related Terms: CDC (Community Development Corporation), Community Development Financial Institutions (CDFIs), Social Determinants of Health, Health Equity

Community development is a multi-billion-dollar sector of the American economy that invests in low- and moderate-income communities through the development and financing of affordable housing, businesses, community centers, health clinics, job training programs, and services to support children, youth, and families. The sector has its roots in the urban revitalization efforts of the late 19th century but expanded as a result of the War on Poverty programs of the 1960s. Today, the community development sector invests more than $200 billion annually in low-income communities.
Crosswalk

Whose City Is it? The Promise and Peril of Gentrification

What to Make of Social Impact Bonds

Investing With Health in Mind

From Treating the Ill to Preventing the Illness
Welcome to Partner Finder

Welcome to Partner Finder, a collection of directories to help you find the community development and health organizations nearest to you. Partner Finder helps you take the first steps to identify potential cross-sector partners in improving the health and well-being of your community.

» NACCHO
  National Association of County & City Health Officials

» naceda
  building prosperous communities together

» National Network of Public Health Institutes

» NeighborWorks®
  AMERICA

» OPPORTUNITYFINANCE NETWORK

» UNITED STATES FEDERAL RESERVE SYSTEM
COORDINATING UPSTREAM: A Market that Values Health
STATE OF THE ART

- Trust and buy-in
- Cross-sectoral
- Place-based
- Data-driven
- Community Quarterback
BUYERS:
All who are willing to pay for better health
SELLERS: Any entity that can improve the upstream social determinants of health
TOOL MAKERS:
Those who can create the tools to connect the buyers to the sellers
WHAT MATTERS INVESTING IN RESULTS TO BUILD STRONG, VIBRANT COMMUNITIES

Federal Reserve Bank of San Francisco & Nonprofit Finance Fund
Moving Forward with Action

Jon Ford, Vitalyst Health Foundation
What Will it Take?

March 27, 2018
Q. What Will it Take?
Q. What Will It Take?

A. Everything we’ve got

Including...
things we know and things we haven’t even thought of yet
There is a gap out there...

What is

What should be
There is a gap out there...

What is

Ways of thinking

Ways of being

What should be
There is a gap out there...

What is

Policies
Institutions
Ways of being
Ways of thinking
Systems
Environments

What should be
There is a gap out there...

What is

Policies
Institutions
Ways of being
Ways of thinking
Systems
Environments

What should be

Join the Conversation: #SDOH
There is a gap out there…

*Policies – Institutions – Ways of being*

**Ways of thinking – Systems - Environments**

What is | What should be
---|---
Transportation → Food → Healthcare → Housing → Education
There is a gap out there...

Policies – Institutions – Ways of being

Transportation
Food
Healthcare
Housing
Education

Ways of thinking – Systems - Environments

What is

Technical

What should be

Join the Conversation: #SDOH
The Map for Adapting Through the Gap

New ways of thinking

What is

New ways of being

Adapting Institutions

Policy change

Systems change

Environmental change

What should be

Join the Conversation: #SDOH
Shifting the health paradigm as we celebrate and connect efforts to help communities be healthier and live well.

Learn More About Our Approach
GOAL #1 IDENTIFY
Identify, lift up and celebrate efforts to help Arizonans be healthier and live well.

GOAL #2 CONNECT
Facilitate connections between groups and sectors.

GOAL #3 SHIFT
Shift the health paradigm - health is more than health care.

GOAL #4 INFLUENCE
Influence policies and systems for change.
The Map for Adapting Through the Gap

New ways of thinking

What is

New ways of being

Adapting Institutions

Policy change

Systems change

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What should be

Join the Conversation: #SDOH
How Do We Get There?

1. Get place-based
2. Build cross-sector collaborative muscle and influence
3. Be clear – and stay focused on – the adaptive challenges we face that limit health and well-being
## Technical vs. Adaptive

<table>
<thead>
<tr>
<th>Technical</th>
<th>Adaptive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to identify</td>
<td>Difficult to identify (easy to deny)</td>
</tr>
<tr>
<td>Often lend themselves to “cut-and-dried” solutions</td>
<td>Require changes in values, beliefs, roles, relationships and approaches to work</td>
</tr>
<tr>
<td>Often can be solved by an authority or expert</td>
<td>People with the problem do the work of solving it</td>
</tr>
<tr>
<td>Require change in one or a few places; often contained within organizational boundaries</td>
<td>Require change in numerous places; usually across organizational boundaries</td>
</tr>
<tr>
<td>People are generally receptive to technical solutions</td>
<td>People often resist even acknowledging adaptive challenges</td>
</tr>
<tr>
<td>Solutions can often be implemented quickly – just add money or capacity</td>
<td>“Solutions” require experiments and new discoveries – being iterative</td>
</tr>
</tbody>
</table>
How Do We Know?

• When the goal (“what should be”) represents a value in practice
  • If that value challenges/transforms someone, something or some system, then you’re on to something

• Partners should feel stretched
  • Creativity – new ways of being and doing in the space
  • When values, loyalties, losses of partners are part of the change equation
Think About*

1. Place
  ✓ Where “un-well” and “unhealthy” reveal themselves
  ✓ Where hope, leadership and innovation do too
  ✓ America’s most accurate predictor of life expectancy is... zip code

2. Narrative Change
  ✓ Community voice is the game-changer for local public and political attitudes
  ✓ Once you see it, you can’t unsee it

3. Power
  ✓ Organize to build power and voice
  ✓ Compellingly express what research and experiences tell us about health

*California Endowment: BHC 5-Year Report
The Vitalyst Spark Podcast

The Vitalyst Spark podcast will explore what it means to create a healthy community. Listen to the podcast below.

- Launched 10/24/17
- Over 16,000 hits
- Nearly 350 episode downloads
- Strong feedback

Join the Conversation: #SDOH
Be Mindful of The Community Continuum

Feedback
- Come to the open house
- See what what’s already done

Engagement
- Help experts see your concerns

Power/Effectiveness

Influence

We’ll All Own It

Join the Conversation: #SDOH
Be Iterative

- Identify the need -> experiment with temporary improvements -> evaluate -> iterate again
- Discover the "desire lines"
Remember

• Don’t confuse the smoke for the fire

• It’s not community engagement, it’s community influence

• A good solution solves many problems
Shifting the health paradigm as we celebrate and connect efforts to help communities be healthier and live well.

Learn More About Our Approach
Live Well Arizona Mini-Grants

- Rolling submission review: 30-60 days
- $100,000 in funding available.
- Award range of $1,000-$15,000 per mini-grant
- Work completed within six months of award.
- Application online at livewellaz.org
- Reporting: as short and sweet as the application
  - Did you hit your objective?
  - What have you learned?
  - Barriers (to) overcome?
  - Who (still) needs to be at the table?
  - What more would you need to go to the next level?
What’s Next?

• Identify and Connect via livewellaz.org

• Request a Live Well Arizona workshop: jford@vitalysthealth.org

• Subscribe to the Vitalyst Spark podcast
Dream Big and Live Well

Brandon Clark, *Circle the City*
Medical Respite & Supportive Housing | April 2017

Partners

Medical respite programs vary in the types of partners they engage. In most cases one or more hospital partners are involved, as well as primary care providers to ensure a smooth transition to care.

Hospitals:
Hospital partners sometimes refer consumers for medical respite, provide medical services in respite, and are a payer for services (i.e. pay for bed nights). Circle the City has a staff member based in one partner hospital to help navigate the system.

Other Health Care:
YNHS partners with nursing homes, home health, & same day surgery centers as needed.

Continuum of Care:
YNHS is part of the local CoC and receives HUD funding to operate housing units. CoC funding also supports room and board for medical respite. Circle the City is not formally part of the CoC but they are engaged and working to align priorities.

Primary Care:
YNHS and Circle the City are both Health Center Program Grantees and providing primary care. They also link to local services as needed.

Housing Providers:
YNHS partners with the local housing authority and landlords to lease a pool of units for their consumers. Circle the City works with providers to prioritize consumers in medical respite care for housing placements.

Behavioral Health:
YNHS and Circle the City both provide connections to behavioral health services internally and refer to external partners as appropriate.

Academic Institutions:
Circle the City partners with local residency programs and nursing schools to fill gaps in care and receive additional clinical support. YNHS offers rotations for medical and nursing students.

Medicaid Health Plans/MCOs:
Health insurance plans pay for services at YNHS and Circle the City. At Circle the City, health plans also refer vulnerable consumers directly to medical respite care in hopes of avoiding unnecessary hospitalizations.
Circle The City Medical Respite Housed 92% of Participants

% of Discharged Clients

- Housed 92%
- Goal 50%

*Institutional housing includes hospice, inpatient treatment facilities, and residential chemical treatment programs. Patients exiting to a hospital and those without a known exit destination have been excluded.
Medicare study shows Circle the City medical respite care for the homeless saves money

A new study released by the U.S. Centers for Medicare and Medicaid shows medical respite care for the homeless not only saves money but helps to keep this fragile population off the street.

Circle the City, a Phoenix nonprofit that provides medical respite care for the homeless, was one of five demonstration sites nationwide selected for the study by the National Healthcare for the Homeless Council and research partner Brandeis University.

According to the council, medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but are not ill enough to be in a hospital.

In Arizona, the per-patient cost to CMS when comparing the 12 months before and after receiving medical respite care at Circle the City was reduced by an average of 58 percent. Going from $2,220 monthly down to a $900 monthly average, that’s a potential savings of more than $4.7 million attributed to the 309 patients who participated in the study.

The CMS study also found patients receiving medical respite care are less likely to return to homelessness. In Arizona, 92 percent of study participants were discharged from Circle the City’s medical respite program into a housing situation other than the street or emergency shelter system.

Brandon Clark, CEO for Circle the City, said he’s known the program changes lives for the better but was glad to see how much money is saved in the process. “It’s a remarkable amount of money,” he said. “To reduce the cost of care to this degree is almost unheard of in the value-driven health care space.”

With its track record of providing medical respite care to the homeless, Circle the City won a $3 million annual contract from U.S. Department of Health Resources and Services Administration to care for 10,000 homeless people in Maricopa County.

This contract has been held by the Maricopa County Department of Public Health for many years, but had been looking for an organization to take over, said Dr. Bob England, who retired in January as director of the county health department.
Circle the City’s Continuum of Care

Homeless Primary and Preventative Care
The Parsons Family Health Center
CTC Downtown Family Health Center

Medical Respite Care
Midtown Medical Respite Center
Downtown Medical Respite Center

Homeless-Specialty Outreach
2-Exam Room Mobile Clinic
East Valley Neighborhood Partnership
UMOM Clinic
Shelter-Based Clinic Sites

Permanent Community-Based Housing
Brandon Clark, MBA, FACHE
bclark@circlethecity.org
Join the Conversation
Online: #SDOH
Now What?

Next Steps
Get a Shoe Box?

Be like

Sister Adele

Be like Mike
TO DO LIST

1. Call Joe Gaudio...
2. Ask for $20 million
3.
4.
5.
Soak All your troubles away...?
Take a page from Ben...

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Rise, wash, and address Powerful Goodness; contrive day’s business and take the resolution of the day; prosecute the present study; and breakfast.</td>
</tr>
<tr>
<td>6</td>
<td>Work.</td>
</tr>
<tr>
<td>7</td>
<td>Read or overlook my accounts, and dine.</td>
</tr>
<tr>
<td>8</td>
<td>Work.</td>
</tr>
<tr>
<td>9</td>
<td>Put things in their places, supper, music, or diversion, or conversation; examination of the day.</td>
</tr>
<tr>
<td>10</td>
<td>Sleep.</td>
</tr>
<tr>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12</td>
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<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Evening question, What good have I done today?
Revised...

March 28
Happy Wednesday

TO DO LIST

1. livewellaz.org-grants
2. hsag.com-coalitions
3. APHC – JOIN!
4. Fed:partners/capital
5. Walk dog/take out trash etc.

Join the Conversation: #SDOH
We’ve got a lot to do to go from this...

What is

Ways of being

Ways of thinking

What should be
New ways of thinking

What is

Adapting Institutions

Policy change

Systems change

Environmental change

What should be

...To This
A Collective Call to Action

1. Get comfortable with being uncomfortable.
A Collective Call to Action

1. Get comfortable with being uncomfortable.
2. Engage: make new friends and listen.
A Collective Call to Action

1. Get comfortable with being uncomfortable.
2. Engage: make new friends and listen.
3. Learn *in order to* grow.
A Collective Call to Action

1. Get comfortable with being uncomfortable.
2. Engage: make new friends and listen.
3. Learn *in order to* grow.
4. Dig into what’s happening with people from new sectors/disciplines.
5. Embrace the mess the ensues.

Help work through it – always with the outcomes of well-being at the fore
With great RESPONSIBILITY
Comes great POWER
attack each day with an **ENTHUSIASM**
unknown to mankind

Jim Harbaugh
Please complete your evaluation and return it to the table in the lobby.