Can Hospitals Heal America's Communities?

"All in for Mission" is the Emerging Model for Impact

Tyler Norris
Vice President of Total Health Partnerships, Kaiser Permanente
Ted Howard
President, The Democracy Collaborative

DEMOCRACY COLLABORATIVE

Can Hospitals Heal America's Communities?

"All in for Mission" is the Emerging Model for Impact

Tyler Norris and Ted Howard

Healthcare's role in creating healthy communities through increasing access to quality care, research, and grantmaking is being complemented by a higher impact approach; hospitals and integrated health systems are increasingly stepping outside of their walls to address the social, economic, and environmental conditions that contribute to poor health outcomes, shortened lives, and higher costs in the first place.

Hospitals and integrated health systems are increasingly stepping outside of their walls to address the social, economic, and environmental conditions that contribute to poor health outcomes, shortened lives, and higher costs in the first place.

They are doing so for several reasons: by addressing these social determinants of health through their business and non-clinical practices (for

Tyler Norris is the Vice President of Total Health Partnerships for Kaiser Permanente. Ted Howard is co-founder and President of The Democracy Collaborative. David Zuckerman, The Democracy Collaborative's Manager of Healthcare Engagement, contributed research to this paper.

example, through purchasing, hiring, and investments), hospitals and health systems can produce increased measurably beneficial impacts on population and community health. By adopting this "anchor mission," they can also prevent unnecessary demand on the healthcare system. This in turn can contribute to lower costs and make care more affordable for all, especially those truly in need. Simply put, this approach can improve a health system's quality and cost effectiveness while simultaneously significantly benefiting society.

With hospitals and health systems representing more than $780 billion in total annual expenditures, $340 billion in purchasing of goods and services, and more than $500 billion in investment portfolios, this approach expands the set of resources and tools institutions have at their disposal to carry out their mission. It shifts the discussion of community benefit from the margins of an institution's operations to overall accountability, where all resources can be leveraged to benefit the communities in which institutions are located.

Physicians, healthcare administrators, and hospital trustees face an important and historic leadership opportunity that our country and our communities desperately need.

Physicians, healthcare administrators, and hospital trustees face an important and historic leadership opportunity that our country and our communities desperately need. Hospitals and health systems throughout the country are beginning to build on their charitable efforts, beyond traditional corporate social responsibility, to adopt elements of an anchor mission in their business models and operations.

Can hospitals and health systems heal America's communities? This paper illuminates the possibilities and explores how "all in for mission" is the emerging healthcare model.

Introduction

For most Americans, the term "healthcare" connotes accessing good quality doctors and getting treatment once ill, with a smattering of lifestyle actions that can be taken to try to prevent illness, such as exercise, diet, and supplements. Hospitals, many believe, exist to take care of sick people.

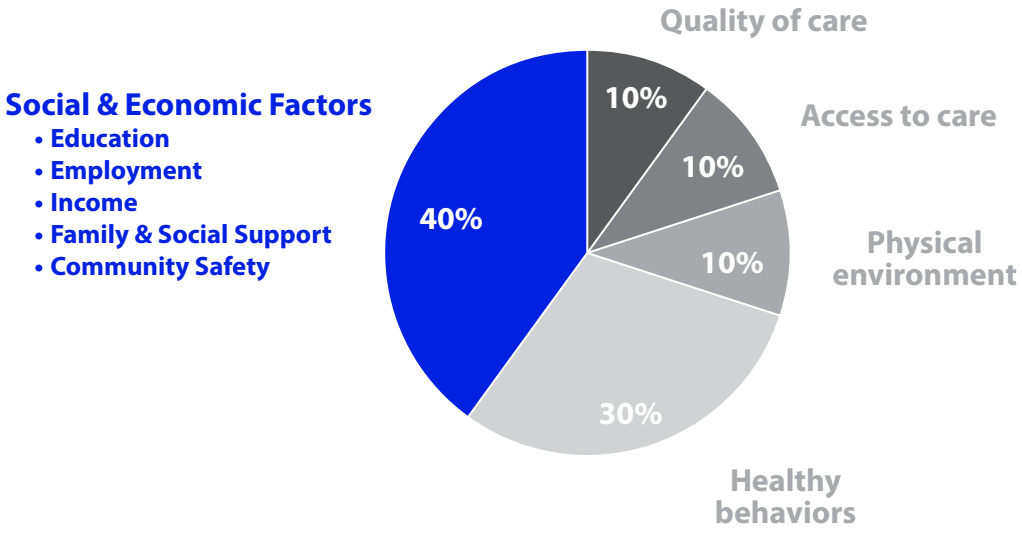
But in recent years, the healthcare sector has expanded its focus beyond illness treatment alone to what creates health in the first place, tackling the challenging social, economic, and environmental issues that, to a large extent, determine our health status, our outlook, and our life expectancy. These are the "social determinants of health," a complex of factors related to where people are born, grow, work, live, and age. They represent the wider set of forces and systems shaping the conditions of daily life that drive health outcomes, such as inequality, social mobility, community stability, and the quality of civic life.[1]

Just 10 to 20 percent of what creates health is related to access to care and the quality of the services received.

For over two decades, overwhelming evidence from the U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, and other sources suggests that social, economic, and environmental factors are more significant predictors of health than access to care. The University of Wisconsin Population Health Institute found that over 40 percent of the factors that contribute to the length and quality of life are social and economic; another 30 percent are health behaviors, directly shaped by socio-economic factors; and another 10 percent are related to the physical environment where we live and make day to day choices—again inextricably linked to social and economic realities. Just 10 to 20 percent of what creates health is related to access to care, and the quality of the services received.[2]

The Social Determinants of Health

To address health inequalities, you must address social and economic inequities.



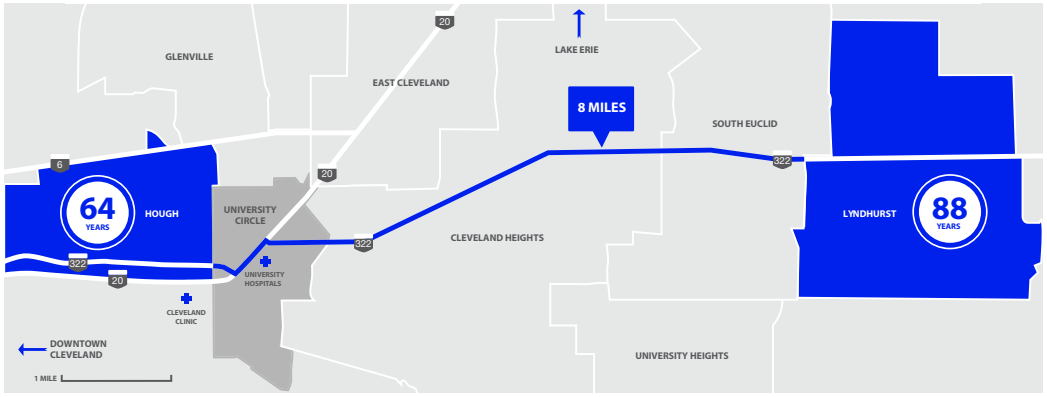
Data from "County Health Rankings & Roadmaps," University of Wisconsin Population Health Institute.

An oft-cited observation these days is "Your zip code is more predictive of your health than your genetic code." Take Cleveland, for example. The median household income in the inner-city neighborhood of Hough is $18,500; eight miles due east in the suburb of Lyndhurst, the median is $63,000. How does this translate in terms of health? In Hough (98 percent African American) the average life expectancy for a male is 64 years. In Lyndhurst (86 percent white) the average life expectancy for a male is 88 years. A difference of 24 years, in just 8 miles.[3]

Given the fact that 80 percent of an individual's and a community's health is related to the social determinants, health sector professionals are increasingly asking themselves, "How do we more effectively intervene 'upstream' to impact the forces that contribute to high rates of chronic and other diseases?" Yes, timely access to good quality care is incredibly important, especially when one is sick or injured. But more relevant to improving the population health status of the nation, and making care more affordable over time, is

Place Matters

Male life expectancy in Hough and Lyndhurst, OH

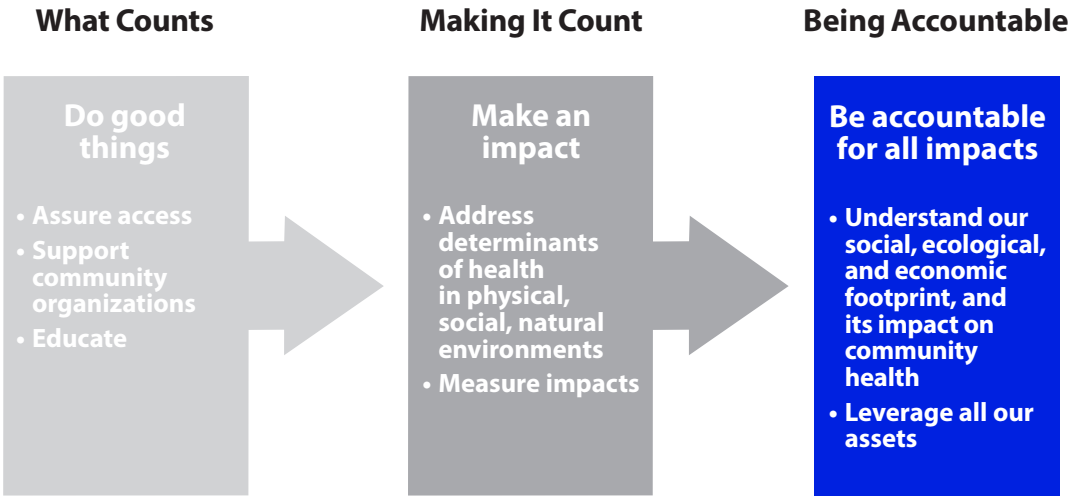


Data from Justin Glanville, *Cleveland's Greater University Circle Initiative: A Partnership Between Philanthropy, Anchor Institutions and the Public Sector* (Cleveland: The Cleveland Foundation, 2014), 89.

improving the conditions—employment, income, transportation, education and housing—in which people live. These are the forces that are driving much human suffering and corresponding healthcare costs. And just as human action—and inaction—have created these conditions, we now have the opportunity to engage our society to transform them.

As this recognition has taken hold, health systems around the country are beginning to strengthen and go beyond their "community benefit" strategies, to reorient many of their non-clinical practices and assets—supply chain procurement policies, hiring and workforce development practices, investment portfolio, and more—to impact community conditions. In effect, the leading health organizations are moving along a progression from: 1) doing good things for the community; to 2) intentionally addressing social determinants of health and measuring and reporting on the impact they are having in addressing community challenges; to 3) recognizing that their institutions must be accountable for ***all*** of their impacts on community health, and leveraging ***all*** of their assets to ensure the well-being of the community in which they are based.

Moving From Contribution To Accountability



Developed by Raymond J Baxter, Senior Vice President, Community Benefit, Research and Health Policy, Kaiser Permanente.

By way of example:

- **Kaiser Permanente,** the nation's largest nonprofit integrated health system, is advancing the concept of "total health," an innovative framework focused on using all its assets to maximize physical, mental, and social well-being for its members and the communities it serves. To deliver on its total health ethos, Kaiser Permanente emphasizes high-impact approaches such as workforce wellness initiatives for its employees and customers, increasing access to healthy foods and physical activity in thousands of schools, and reducing the organization's institutional carbon footprint by purchasing green energy. To help drive local economic development in communities of color across the country, Kaiser Permanente prioritizes supplier diversity, purchasing more than $1.5 billion from women and minority-owned firms in 2014 alone.[4]

- **University Hospitals,** a regional health system based in Cleveland, Ohio has begun targeted

procurement strategies aimed at creating local jobs and community wealth. In one recent 5-year period, University Hospitals drove 92 percent of a $1.2 billion construction and expansion budget into the regional economy, including purchasing from more than 100 minority-owned local businesses based in the area.[5]

- **Dignity Health,** the fifth largest health system in the nation (serving California, Arizona and Nevada), has created a $100 million loan fund to develop affordable housing, provide job training, assist neighborhood revitalization, offer needed medical services, and build wealth in underserved communities.[6]

- **The Mayo Clinic** in Rochester, Minnesota has helped finance the state's largest community-based assisted-housing program, including the construction of more than 875 units of housing.[7]

- In Richmond, Virginia, **Bon Secours** CEO Peter Bernard says that his hospital "is critically important to the economic success and social development of the East End [a low-income area of the city]... More than a hospital, it is a fully engaged partner, an advocate for justice, and a voice for social transformation."[8]

The Anchor Mission

A commitment to consciously apply the long-term, place-based economic power of the institution, in combination with its human and intellectual resources, to better the long-term welfare of the community in which the institution is anchored.

Some call this new approach to health "the anchor mission," meaning that a hospital not only provides charitable and philanthropic support for the community, but begins to re-orient its institutional business practices to benefit the place in which it is based.

Tom Zenty, CEO of University Hospitals in Cleveland expresses healthcare's anchor mission this way: "Community and healthcare leaders are discovering that hospitals can help heal entire cities through economic development … healthcare systems can create jobs and wealth … and we can earn the trust and goodwill of our neighbors."[9]

Bernard Tyson, CEO of Kaiser Permanente adds "As a trusted partner in total health, we need to collaborate with local business and community leaders, and even our competitors, to create communities that are among the healthiest in the nation. This is critical to fulfill our mission and to make healthcare more affordable for all."[10]

"We need to collaborate with local business and community leaders, and even our competitors, to create communities that are among the healthiest in the nation."
—Bernard Tyson
CEO, Kaiser Permanente

The idea of an anchor mission is linked to the very nature of large hospitals, universities, local governments, utilities, and other place-based institutions that are firmly rooted in their locales. Typically they are nonprofit or public (and thus have a social or charitable purpose). Economists call them "sticky capital"—unlike for-profit corporations that come and go from our communities, and which tend to export wealth to capital centers, anchor institutions are rooted in place. As such, they have a vested self-interest in helping to ensure that the communities in which they are based are safe, vibrant, healthy, and stable.

For integrated health systems such as Kaiser Permanente, that means intentionally aligning and activating all of the resources of the institution—including sourcing and procurement, workforce pipeline development, training, investment capital, education programs, research, community health initiatives, environmental stewardship, and clinical prevention—to produce total health: a state of complete physical, mental, and social well-being for all people.

By adopting an anchor mission, healthcare institutions and systems can produce measurably beneficial impacts on individual and community health, and by so doing, lower preventable demand on the healthcare system. The result is a win-win: refocused hospital business practices and operations produce conditions in which citizens and communities become healthier. This prevents avoidable demand on the health system, which in turns lowers costs and makes care more affordable for those truly in need. Healthcare professionals call this "moving from volume to value," a process in which hospitals are rewarded for improving health, rather than delivering more care.

U.S. healthcare spending is now nearly 18 percent of the U.S. economy and could possibly move to 20 percent or beyond in the next decade.[11] For twenty cents on every dollar, it is essential that the nation gets a better "triple aim" return on that investment—in terms of improved health outcomes and care experience, at lower cost, while improving overall population health. Going "all in for mission" is a breakthrough strategy for hospitals and health system to realize those goals.

The Economic Power of America's Hospitals

The nation's hospitals (non-profit, public and for-profit) are a tremendous economic force.

- **Procurement: $340 billion in goods and services**
- **Total expenditures: $782 billion**
- **Investment portfolios conservatively estimated: $500 billion**
- **Employees: 5.5 million full and part-time (4% of total national employment)**
- **Total community benefit estimated: $62 billion[12]**

Given the reality many of our communities are facing in 2015 and for the foreseeable future, nothing is more urgently needed.

America's Communities Are Ailing

A recent report by the Century Foundation examined "trends in the population and characteristics of neighborhoods of ex-

treme deprivation" across the country. Some of the key findings include:

- a dramatic increase in the number of high poverty neighborhoods
- the number of people living in high-poverty ghettos, barrios, and slums has nearly doubled since 2000, rising from 7.2 million to 13.8 million
- poverty became more concentrated—more than one in four of the African American poor and nearly one in six of the Hispanic poor lives in a neighborhood of extreme poverty, compared to one in thirteen of the White poor.[13]

In America's inner cities, economies have been getting markedly worse. Harvard's Michael Porter reported that the Institute for a Competitive Inner City looked at the inner cities of 339 cities nationwide with populations over 75,000. Between 2000 and 2011, 90 percent of these inner cities saw increases in their rates of poverty and unemployment.[14]

Despite long years of efforts to end poverty, a greater proportion of Americans live in poverty today—a staggering 45 million—than in the late 1960s.

Children fare worst of all, with close to half of all children up to the age of five living in low-income families.

Even with the end of the Great Recession and the recovery long declared, many Americans see little evidence of recovery in their own economic fate. A troubling one in four U.S. jobs pay less than poverty-level wages. Despite long years of efforts to end poverty, a greater proportion of Americans live in poverty today—a staggering 45 million—than in the late 1960s. Children fare worst of all, with close to half of all children up to the age of five living in low-income families.[15]

Social Determinants and Health Equity

While these types of social determinants impact everyone's health, differences in health status by racial and ethnic group, also known as "health disparities" or "health inequities," remain disturbingly widespread in the United States. The burden of illness, premature death, and disability disproportionately affects racial and ethnic minority population groups and other underserved populations.[16]

The United States spends significantly more money on healthcare than any other nation. Despite this fact and despite significant improvements in the quality of healthcare over the last century, the nation's relative standing in health outcomes and life expectancy continues to erode. "Americans die sooner and experience more illness than residents in many other countries," a 2013 report from the National Research Council and Institute of Medicine bluntly noted.[17]

Differences in health status by racial and ethnic group, also known as "health disparities" or "health inequities," remain disturbingly widespread in the United States.

In a 2009 analysis, an estimated 30 percent of direct medical costs for African Americans, Hispanics, and Asian Americans were excess expenditures due to health disparities. The analysis further estimated that the U.S. economy loses an estimated $309 billion annually due to both the direct and indirect costs of these disparities. By 2045, the United States is projected to become a nation in which the majority of its residents are people of color; the cost in both dollars and quality of life creates a compelling economic and moral imperative to address the causes of these inequities.[18]

The health-equity lens is being increasingly adopted by health, economic development, and civic organizations as a means to

address systemic health challenges and promote community well-being. For these groups, the health equity lens provides a meaningful way to define the conditions that create success. By using the lens, these organizations are able to shift their inquiry from the question, "*Who* is at greater risk for disease?" to the question "*Why* are some populations at greater risk of preventable illness, injury and death than others?" This perspective obliges communities to analyze how current policies and programs perpetuate social, economic, and environmental disadvantages. By way of example, healthcare, business, and civic leaders need to ask a profound question: what is the implication for the vitality of our nation if one out of every two African American and Hispanic children born today, based on current trends, is likely to become diabetic?[19]

Leveraging Anchor Institutions to Benefit Community

Anchor institutions are enterprises such as hospitals and universities that are rooted in their local communities by mission, invested capital or relationships to customers, employees, and vendors. Anchor institutions possess considerable human and economic resources that can be leveraged for local development, particularly to improve the well-being of low-income children, families, and neighborhoods that are often proximate to their campuses. U.S. universities, for instance, educate 21 million students annually and employ 3.8 million people. The annual purchases of universities represent roughly 3 percent of U.S. gross domestic product, and they have endowments in excess of $516 billion. The hospital industry is even larger: more than 5.5 million Americans work for hospitals and health systems. Hospital sector economic activity exceeds $780 billion annually, and the sector's investment portfolios total an estimated $500 billion. All told, hospitals and universities collectively employ 6 percent of the U.S. labor force, with concomitant shares of investment and purchasing power. Together, "eds and meds"—universities and hospitals—represent more than 7 percent of U.S. GDP. [20]

Over the past few decades, many anchor institutions have come to realize that it is in their self-interest to invest in their local communities, and some have directed substantial amounts of dollars and personnel toward discrete community programs. However, an anchor mission approach to community development is qualitatively more comprehensive, integrated and embedded within an institution. Pursuing what we call an anchor mission means that a place-based institution consciously applies its considerable resources toward improving the long-term well being of its community. An anchor strategy is more than the sum of individual community engagement programs or philanthropic initiatives; it is a mission developed to address persistent community challenges, and implemented to permeate an institution's culture and change the way it does business.

New Opportunities Related to the Affordable Care Act

Amidst the hue and cry surrounding the implementation of the Affordable Care Act (ACA or "Obamacare"), many Americans have missed some of the most important and far-reaching aspects of the law that will have the greatest impact on population community health status and affordability. But healthcare professionals are

keenly aware of the implications. One of these is the requirement that non-profit hospitals regularly assess the social, economic, environmental, and health challenges facing their community and commit themselves to address them in order to help produce a healthier population. The law's broader focus on prevention and moving healthcare provision from "volume to value" has helped initiate new conversations and incentives stemming from the recognition that healthcare interventions themselves only play a small part in creating healthy people and communities.

Beginning with tax year 2013, tax-exempt hospitals across the country (nationally, about 60 percent of all hospitals are non-profit, another 20 percent are owned by local and state government, and 20 percent are for-profit) are required to file a "community health needs assessment" with the IRS. ACA regulations include additional requirements to prioritize community health needs through a comprehensive review of local health data and the gathering of local community input. Following this initial assessment, each nonprofit hospital is required to prepare an "implementation strategy" that shows how the hospital will use its community benefit or charitable resources and the assets of the local communities to address the prioritized health needs.[21]

This recent requirement and standardization of community benefit reporting has generated considerable interest and enthusiasm for fully leveraging these charitable investments for

Local Procurement

According to the American Hospital Association, hospitals spend more than $340 billion each year on goods and services. Redirecting even a small portion of that spending could have a tremendous impact on helping to restore local economic vitality, providing jobs for hard-to-employ people, and rebuilding urban fabrics and rural value chains.

In Detroit, for example, Henry Ford Health System, in partnership with Detroit Medical Center and Wayne State University, is working to localize procurement, recognizing the tremendous impact they can have on bringing vitality back to Detroit. Although this collaboration is at an early stage, the institutions have already redirected more than $18 million to support local businesses in Detroit.

Gundersen Lutheran Health System has taken a different but equally innovative approach in La Crosse, Wisconsin. Having set a target of procuring 20 percent of its food locally, it recognized that it would be unable to achieve that goal unless it helped strengthen the local food economy by creating the necessary infrastructure. Together with other local anchor institutions, Gundersen co-founded the multi-stakeholder-owned Fifth Season Co-op. Although still small, it has grown exponentially from its founding in 2010—from sales of just $40,000 to projected sales of nearly $500,000 in 2015. Current membership includes 33 independent farms, three producer groups, seven processors, one worker member, and two distributors.[22]

Community Investment

Information about university endowments is carefully tabulated and reported each year. But currently there exists no accurate survey of how many dollars health systems nationwide have in their endowments and investment portfolios. Our research leads us to estimate that conservatively, healthcare endowments amount to at least $500 billion. While fragmentary at this point, a handful of health systems have created dedicated community investment portfolios in which they leverage a portion of this money and target it directly or indirectly to support the kinds of interventions that create healthy communities. These would include affordable housing, federal qualified health centers, grocery stores, childcare centers, and local small, disadvantaged and minority- and women-owned businesses.

In March 2014, The Democracy Collaborative organized a panel on "Hospitals Building Healthier Communities: Investing Outside Institutional Walls" at the Association for Community Health Improvement's annual conference. In introducing the panel, Eileen Barsi, former Senior Director of Community Benefit for Dignity Health and a well-respected voice throughout the field, noted that she views the impact of Dignity's charitable work as only a small portion of the total impact Dignity can have on the health of communities where their facilities are based. In Barsi's view, by far the most significant impact of Dignity Health's community work to date results from the $100 million low-interest loan fund overseen by her colleague Pablo Bravo. And even at that, the fund is just one percent of Dignity's total investment portfolio.[23]

the greatest public health impact. This attention is rightly deserved and has created an important conversation about how to begin to redefine the responsibilities of health systems in and to their communities.

However, hospital charitable grants and investments alone—while vitally important—are not strong enough by themselves to fundamentally alter key determinants of health such as local income and wealth disparities, generational poverty, substandard housing, and overall disinvestment in low-income neighborhoods and communities. Community benefits will always be a small portion—at most 10 percent—of the possible total impact that any hospital or health system can have on its community.

The much larger and ultimately more sustainable opportunity is to transform the hospital business model, integrating community benefit into the fabric of the institution and bringing to bear the full potential of hospitals and health systems as economic drivers of community transformation and health promotion. This is what we mean by "all in for mission"—and this is where the true breakthrough for our nation's communities resides.

Strategies to create healthier people and places are precisely the same as those needed to reduce preventable demand on the healthcare delivery system. Leveraging non-clinical health assets to prevent avoidable demand primarily driven by chronic disease rates not only benefits the community, but

also can become an essential cost-saving strategy for the institution and society as these are passed on to patients and members. To say it plainly, "all in for mission" is inherently linked to improving a hospital or health system's margin and cost effectiveness as well as benefitting society.

Kaiser Permanente and Total Health

Hospitals and health systems throughout the country are beginning to adopt elements of an anchor mission in their business models and operations. While no institution or system yet is fully "all in" on its anchor mission, Kaiser Permanente, based in Oakland, California, is measuring all its impacts and is articulating a clear approach with operational levers and incentives. In many ways, it is setting the benchmark for how healthcare systems and hospitals can most significantly impact America's greatest social, economic, and environmental challenges. In the words of Kaiser Permanente's chairman and CEO, Bernard Tyson, "We are trusted partners in total health, collaborating with people to help them thrive and creating communities that are among the healthiest in the nation."

Founded in 1945, Kaiser Permanente is one of the nation's largest not-for-profit health systems, serving over 10 million members. Kaiser Permanente operates 38 hospitals and manages more than 600 medical offices and outpatient facilities. It employs nearly 200,000 people, of whom about 18,000 are

Workforce Development and Local Hiring

There are, of course, many studies of workforce development interventions within healthcare, and more broadly in American industry, but very few have focused explicitly on the challenges of local hiring from targeted communities. Yet this conscious placed-based intention to hire from designated areas—even specific low-income census tracks—is critically important if hospitals intend to orient their workforce efforts to produce upstream impacts and benefits for those most in distress. Without an intentional strategy, institutions are unlikely to reach individuals with barriers to employment in their surrounding community. For example, University Hospitals in Cleveland reports that it receives more than 10,000 job applications monthly. Historically, a hard-to-employ local resident had very little chance getting to the interview stage, let alone securing a job within a healthcare institution in Cleveland.

As a result, University Hospitals has launched "Step Up To UH," a targeted employment strategy for frontline positions that links a community-based organization, a local workforce intermediary, and the hospital's human resources department to provide a pipeline from the local community. In its initial phase, this pilot has helped hire more than 60 local residents and has a 90 percent retention rate. Now University Hospitals is looking to scale this initiative and share the lessons they are learning throughout healthcare nationally.[24]

physicians and 50,000 are nurses. In 2014, the organization's operating revenues exceeded $56 billion. If Kaiser Permanente were a for-profit corporation, it would be listed near the 50th entry in the U.S. Fortune 500.

A primary objective for Kaiser Permanente is delivering high quality care that is affordable for all. To achieve that, it has committed itself to deploy all of its clinical and non-clinical assets to deliver on the mission of the organization—"to provide high quality affordable healthcare services, and to improve the health of its members and the communities it serves."

Whether by using its supply chain to buy local, fair, and sustainable products and services; or investing in the local workforce development pipeline; or purchasing green energy that can reduce the health impacts of carbon emissions while creating living wage local jobs, Kaiser Permanente is actively pursuing a values- and mission-guided corporate strategy to support the total health of the people and communities it serves.

Kaiser Permanente's anchor mission philosophy is embodied in this total health approach, defined as "a state of complete physical, mental, and social well-being for all people." Total health has three inter-related facets:

- a focus on the "whole person"—physical, mental, and spiritual well-being, including "resilience" factors not traditionally considered by medicine, such as people having a sense of purpose, belonging, and self-efficacy

- a commitment to deliver the best possible healthcare services through its delivery system, explicitly integrated with health-promoting community assets such access to affordable healthy food, safe housing, transportation

mobility, and supports from community health workers

- bringing all of the enterprise's assets to bear (purchasing, payroll, investment portfolio, facilities, etc.) in support of the health of its members and the communities in which they live.

Eating healthier, moving more, moderating use of alcohol, and eliminating tobacco consumption are the four most leveraged places to start in addressing health status and the demand-side driven, bank-breaking, epidemic of chronic disease. But Kaiser Permanente recognizes that increasing health requires far more than working on individual behavior changes alone. It requires that people have access to health-promoting environments at work, school, and in the diverse community settings where people spend the majority of their days.

Increasing health requires far more than working on individual behavior changes alone.

The total health approach motivates Kaiser Permanente to continually explore ways to bring all its assets to bear on addressing the social determinants of health. This includes, but goes well beyond charitable and community benefit investments and strategies. For Kaiser Permanente, an anchor mission systematically allows for identifying, measuring, and deploying the organization's non-clinical assets as a powerful complement to clinical and community assets.

Leveraging Non-Clinical Assets to Create Total Health

In recent years, Kaiser Permanente has launched numerous community-based anchor initiatives designed to address the

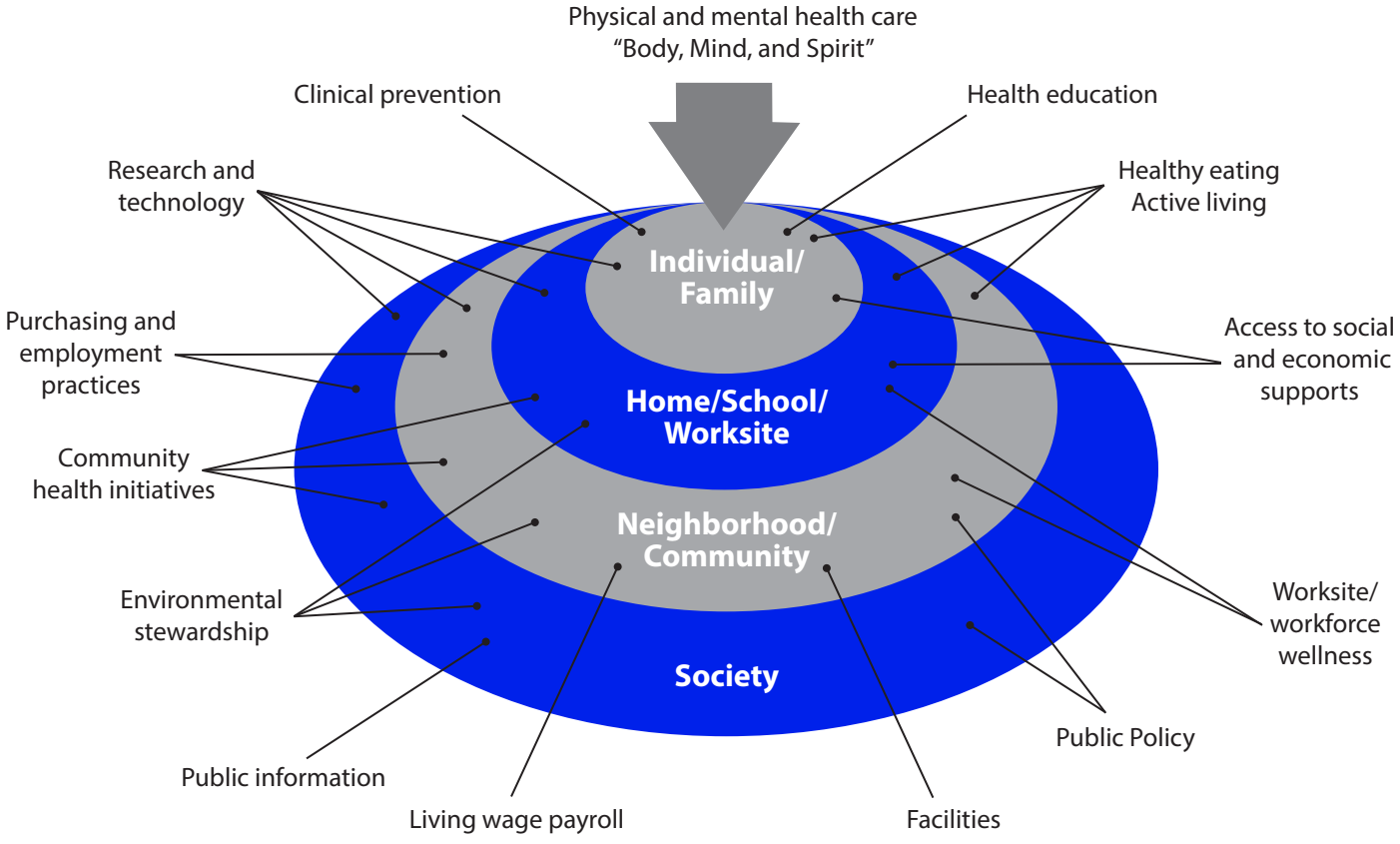
social determinants of health that impact the wellness of its members and geographies.

Addressing Climate Change

Like all hospital systems, Kaiser Permanente facilities are huge consumers of energy. In early 2015, Kaiser Permanente concluded two major renewable energy deals in its home state of California. Together, these two clean energy projects will produce 50 percent of all the electricity the organization uses in California (roughly enough clean energy to power 82,000 homes) and reduce its greenhouse gas emissions by at least 30 percent, allowing it to achieve its GHG-reduction goal three

Deploying All Kaiser Permanente Assets for Total Health

Bringing together mission, brand, knowledge, and capabilities



Kaiser Permanente, 2015.

years ahead of schedule. Kaiser Permanente's renewable energy model avoids emitting 215,000 metric tons of greenhouse gases annually.

The deal makes Kaiser Permanente one of the top users of renewable energy in the country and the largest solar energy user among healthcare providers nationwide. How does this improve health? Renewable energy reduces air pollution that contributes to asthma and chronic lung disease, while reducing the potential impacts of climate change that can spread infectious disease.[25]

Promoting Healthy Local Food

Kaiser Permanente is committed to improving community food environments by modeling good nutrition in their facilities guided by a strong internal policy and by collaborating with community-based programs to support a healthy, regional food system and increased access to healthy food. To encourage healthy choices, Kaiser Permanente supports innovative efforts to bring nutritious foods and safe physical activity to local schools, workplaces, and neighborhoods.

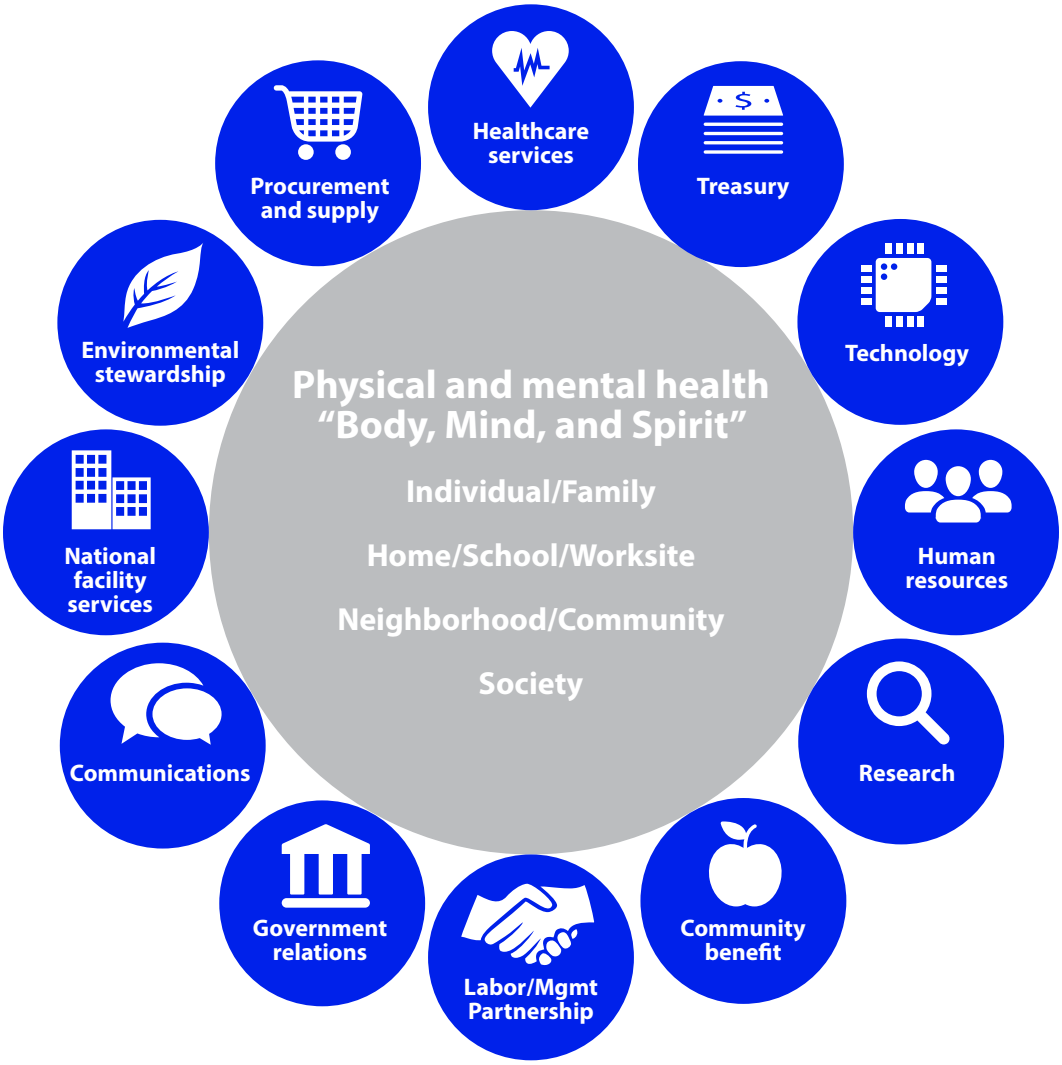
- Kaiser Permanente founded one of the first hospital-based farmers markets in 2003 and now hosts more than 50 farmers markets nationwide.

- 590 tons of the fruits and vegetables served on patient menus are sustainably produced and/or locally grown. In addition to supporting its members with healthier food, Kaiser Permanente's purchasing of sustainably-grown produce decreases water pollution, soil contamination, and farmworkers' exposure to harmful pesticides.

- Kaiser Permanente is a founding member of the California FreshWorks Fund, a unique public-private partnership loan fund created to bring greater access to healthy foods in underserved communities, spur economic development that supports healthy communities, and inspire innovation in healthy food retailing.[26]

Creating Total Health Impact By Addressing Health With All Resources

Leveraging Kaiser Permanente's multiple assets as a total health organization



Tyler Norris, Total Health Partnerships, Kaiser Permanente, 2015.

Making a Difference with the Supply Chain

Kaiser Permanente is a national leader within healthcare in setting procurement goals designed to help impact social, economic, and environmental issues. Similar to how it has used its purchasing practices to advance renewable energy and local food, the organization has a significant commitment to supplier diversity—purchasing from minority- and women-owned businesses. While the physical location of these firms had not inititally been a determining factor in whether they receive contracts, in fact an increasing number of these diverse suppliers are based in the communities in which Kaiser Permanente operates hospitals and other facilities and where its members live.

Through its supplier diversity program, Kaiser Permanente intends to leverage its economic power to help drive local economic development, job creation, and wealth building in its communities.

Today, Kaiser Permanente is the only healthcare provider member of the "Billion Dollar Roundtable," a consortium of large corporations that each commit to spending a minimum of $1 billion annually with minority- and women-owned firms. In 2014, Kaiser Permanente spent $1.5 billion with such firms, an initiative that is fully endorsed by the board of directors and the organization's leadership nationally. To support its ongoing expansion of its supplier diversity program, Kaiser Permanente also works with majority-owned companies to ensure minority-owned businesses are brought in as sub-contractors.

Kaiser Permanente also has a mentoring program involving its executives and other key personnel to show diverse suppliers how to work effectively with a large, complex organization like Kaiser Permanente. Through its supplier diversity program, the organization intends to leverage its economic power to help drive local economic development, job creation, and wealth building in its communities.

What Does it Take to Go "All in for Mission"?

While many hospitals and health systems across the country are making important strides in expressing their anchor mission, no institution has yet fully realized its full anchor potential.

Experience gained to date from the institutions and systems cited in this paper suggest a number of important lessons for healthcare professionals who seek to advance the anchor mission within their organization.

Leadership Matters

Fully expressing an anchor mission requires substantial culture change in corporate practices within healthcare institutions. Leadership at the board and C-suite levels is essential, but insufficient. An appreciation for the anchor mission as core to the very DNA of the institution needs to be fostered and promoted at all levels—from front-line procurement officers and HR personnel to care delivery, finance, marketing, and facilities administration. People throughout the system need to embrace, take pride, and buy into the transformative potential of the anchor mission.

Fully expressing an anchor mission requires substantial culture change in corporate practices within healthcare institutions.

Metrics Matter

As hospitals and health systems begin to move forward with their anchor mission, they need a baseline of their various community benefit and non-clinical activities to understand the current reality (good and bad, intended and unintended) and where they want to improve. How much procurement is currently going to locally-owned and based firms? What is the

level and impact of supplier diversity? What percentage of the workforce comes from adjacent low-income census tracks? How much energy flowing through the institution's buildings is generated by renewable sources?

Using this baseline, an institution can then set goals for improving its performance in order to enhance local community impact, produce good quality employment, achieve a multiplier effect by keeping contracts local, or help to shape the market for renewable energy and local food. Tracking movement on these goals over time informs the institution of the level of effort it is making. Mapping that effort to changes in key external indicators of community well-being—poverty levels, employment, safety, housing, and more—enables an institution to more fully express its anchor mission and deliver impact.

Incentives Matter

Institutions that have experienced the most success in advancing their anchor mission have done so by creatively using incentives within their bureaucracy. Supply chain officers, for example, are typically incentivized to hit various targets related to cost, supplier diversity, and other factors as part of their performance evaluation. New incentives, including for local purchasing, hiring, and investment, may be needed in order to drive change internally. New metrics for equity and inclusion may need to be developed.

Learning Matters

Implementing an anchor mission requires learning new skills and approaches to one's job. In order to bring about this new direction, healthcare leaders and hospital administrators need tools that demonstrate the viability of new business approaches. Many will support the new direction but wonder how to get started. Tools are needed to provide concrete steps for ex-

panding local purchasing, local hiring, local investing, and so forth. Institutions that have made significant strides in particular business areas have an important leadership role to play in promoting cross-institutional learning. Documenting existing practices for achieving this critical work and translating them into roadmaps applicable in different settings is key.

The anchor mission offers a new vision for what healthcare can be and how it can operate, and how America's communities, including our most disadvantaged neighborhoods, can become healthier, wealthier, and more resilient.

Vision Matters

At the end of the day, the anchor mission offers a new vision for what healthcare can be and how it can operate so that America's communities, including our most disadvantaged neighborhoods, can become healthier, wealthier, and more resilient. This is not simply a matter of new practices and procedures. It goes to the very heart of who we see ourselves to be—as individuals, as institutions, as communities.

Conclusion

During these hyper-partisan and divisive times, anchor institution collaborations and partnerships with their communities are creating local investment strategies that are truly win-win for population health and equitable prosperity. Imagine how the community can benefit as hundreds, then thousands, of multi-billion dollar institutions evolve their business models to maximize equitable and inclusive development for the whole community, with special focus on those neighborhoods and residents who are most disadvantaged. And, at the same time, those institutions benefit from stabilizing and invigorating the places in which they live.

It is worth reflecting on the fact that it was not very long ago—perhaps 30 years at most—that most of America's largest institutions did not incorporate a concern for environmental sustainability into their daily practices and strategic plans. Today, it is a rare institution indeed—be it government, healthcare, university, for-profit business—that is not actively trying to improve its environmental record and reputation. What was once at the margins—a concern for pollution, the energy used by buildings, the threat of climate change, society's responsibility for protecting our fragile planet—is now at the heart of the matter morally and economically.

What was once at the margins—a concern for pollution, the energy used by our buildings, the threat of climate change, our own responsibility for protecting our fragile planet—is now at the heart of the matter morally and economically.

Physicians, healthcare administrators, and hospital trustees face an important and historic leadership opportunity that our country and our communities desperately need. For healthcare to both improve health and be more affordable, it must embrace a deep-seated concern for community, inclusion, and equity as core to the business model, driving 100% of institutional activity toward these aims, rather than being satisfied with corporate social responsibility at the margin. This can set the pace for large economic actors in other sectors to consider their total impact on the communities in which they operate and serve.

When that happens, we will see the fulfillment of the promise of the anchor mission to help shape the future of corporate enterprise in service to people and place in America's third century.

About the Authors

Tyler Norris

Tyler Norris, MDiv, is an entrepreneur and founder of over a dozen businesses and social ventures. His three decades of service in the public, private, and non-profit sectors have focused on population health, community vitality, and equitable prosperity. Currently, he serves as Vice President, Total Health Partnerships at Kaiser Permanente, where he helps lead the implementation of anchor institution work, applying all of the health system's assets to measurably improve population health and community well-being. He is an avid mountain biker, backcountry skier, and pilot, and now resides in Oakland, CA.

Ted Howard

Ted Howard is the co-founder and President of The Democracy Collaborative. In July 2010, Mr. Howard was appointed the Steven Minter Senior Fellow for Social Justice at The Cleveland Foundation, a position he held for four years. Working with the Foundation, he was a member of a team that developed the comprehensive job creation and economic inclusion strategy that resulted in the widely reported Evergreen Cooperative Initiative. In recent years, he has headed up consulting teams at the Democracy Collaborative to help U.S. Mayors and other civic leaders develop comprehensive wealth building initiatives drawing on the economic power of anchor institutions in New Orleans, Rochester (NY), Jacksonville (FL), Richmond (VA), and many other cities.

The Democracy Collaborative

The Democracy Collaborative, a nonprofit founded in 2000, is a national leader in equitable, inclusive, and sustainable development. Our work in community wealth building encompasses a range of advisory, research, policy development, and field-building activities aiding on-the-ground practitioners. Our mission is to help shift the prevailing paradigm of economic development, and of the economy as a whole, toward a new system that is place-based, inclusive, collaborative, and ecologically sustainable. A particular focus of our program is assisting universities, hospitals, and other community-rooted institutions to design and implement an anchor mission in which all of the institution's diverse assets are harmonized and leveraged for community impact.

Learn more:

http://democracycollaborative.org

http://community-wealth.org

Endnotes

1 "Social Determinants of Health," World Health Organization, accessed April 2015, http://www.who.int/social_determinants/en/.

2 "Social Determinants of Health," Centers for Disease Control and Prevention, accessed October 2015, http://www.cdc.gov/nchhstp/socialdeterminants/faq.html; M. Hillemeier, J. Lynch, S. Harper, and M. Casper, *Data Set Directory of Social Determinants of Health at the Local Level* (Atlanta: Centers for Disease Control and Prevention, 2015), http://www.cdc.gov/dhdsp/docs/data_set_directory.pdf; J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, "The Case For More Active Policy Attention to Health Promotion," *Health Affairs*, 21:2 (March 2002): 98-93; "County Health Rankings & Roadmaps," University of Wisconsin Population Health Institute, accessed September 2015, http://www.countyhealthrankings.org/Our-Approach.

3 "Zip code better predictor of health than genetic code," *Harvard Gazette*, August 13, 2014, accessed September 2015, http://news.harvard.edu/gazette/story/newsplus/zip-code-better-predictor-of-health-than-genetic-code/; James Marks, "Why Your ZIP Code May Be More Important to Your Health Than Your Genetic Code," *The Huffington Post*, May 25, 2011, accessed September, 2015, http://www.huffingtonpost.com/james-s-marks/why-your-zip-code-may-be_b_190650.html; Justin Glanville, *Cleveland's Greater University Circle Initiative: A Partnership Between Philanthropy, Anchor Institutions and the Public Sector* (Cleveland: The Cleveland Foundation, 2014), 89.

4 Christina Dong, "Tyler Norris on Mission-Driven Alignment: Q & A," *Stakeholder Health*, June 1, 2015, http://stakeholderhealth.org/tyler-norris/.

5 David Zuckerman, *Hospitals Building Healthier Communities: Embracing the anchor mission* (Takoma Park, MD: The Democracy Collaborative, March 2013), 96-104.

6 "Mission Integration Annual Report 2013," Dignity Health, https://www.dignityhealth.org/cm/media/documents/Mission-Integration-Annual-Report.pdf, 39.

7 Zuckerman, *Hospitals Building Healthier Communities*, 59-67.

8 Peter Bernard, "Bringing Church Hill to health, wholeness," *Richmond Times-Dispatch*, May 13, 2014, http://m.richmond.com/article_2c4cb0e4-0e2e-5f44-8759-c27b1c68afcb.html?mode=jqm.

9 Tom Zenty (panel remarks at Leveraging The Power of Anchor Institutions to Build Community Wealth: A Community Forum, Cambridge, MA, May 8, 2013).

10 Bernard Tyson, Kaiser Permanente, 2015.

11 "Health Care Spending in the United States and Selected OECD Countries," Kaiser Family Foundation Health Care Marketplace Project, accessed October 18, 2012, http://www.kff.org/insurance/snapshot/oecd042111.cfm; Charles Roehrig, et al., *Health Sector Economic Indicators: Spending Brief #11–07* (Atlanta: Altarum Institute, July 2011), 1–2.

12 American Hospital Association, *Economic Contribution of Hospitals Often Over Overlooked*, Chicago, IL: AHA, June 2011, 1–2; "Fast Facts on US Hospitals," American Hospital Association, accessed September 2015, http://www.aha.org/research/rc/stat-studies/

fast-facts.shtml; Endowment estimate calculated from Hazel Bradford, "Non-profits put investible assets under microscope," *Pensions & Investments*, March 19, 2012, http://www.pionline.com/article/20120319/PRINT/303199977/non-profits-put-investible-assets-under-microscope; Employment data from chart 6.2 in Avalere Health, *Trendwatch Chartbook 2014: Trends Affecting Hospitals and Health Systems* (Washington, DC: Avalere Health, 2014), 53; Community benefit estimate calculated based on best available research regarding community benefit as percent of total expenditures and total hospital expenditures as reported by AHA; Gary J. Young et al. "Provision of community benefits by tax-exempt US hospitals" *New England Journal of Medicine*, 368.16 (2013), http://www.nejm.org/doi/full/10.1056/NEJMsa1210239, 1519-1527; Sara Rosenbaum, "Hospital Community Benefit and Community Health Needs Assessment" (presentation slides, Health and economic mobility policy meeting, Brookings Institution, Washington, DC, October 14, 2015); Sara Rosenbaum et al., "The Value of the Nonprofit Hospital Tax Exemption was $24.6 Billion in 2011," *Health Affairs*, June 2015, http://content.healthaffairs.org/content/early/2015/06/12/hlthaff.2014.1424.abstract.

13 Paul A. Jargowsky, *The Architecture of Segregation: Civil Unrest, the Concentration of Poverty, and Public Policy* (New York: The Century Foundation, August 9, 2015), http://apps.tcf.org/architecture-of-segregation, 1-2.

14 Michael Porter, "Key Drivers for Inner City Growth" (presentation at the Transforming Urban Ecologies: What Works for Cities conference of Institute for Competitive Inner City, Cleveland, Ohio, October 23-24, 2013).

15 Elizabeth Lower-Basch, *Opportunity at Work: Improving Job Quality* (Washington, DC: Center for Law and Social Policy, Sept. 2007); "Basic Facts About Low-Income Children 2010," National Center for Children in Poverty, accessed January 31, 2015, http://www.nccp.org/publications/pub_1049.html; Marjorie Kelly and Sarah McKinley, *Cities Building Community Wealth* (Takoma Park, MD: The Democracy Collaborative, November 2015), 42.

16 U.S. Department of Health and Human Services, *HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care* (Washington, DC: U.S. Department of Health and Human Services, Office Of Minority Health, 2011), http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf, 2.

17 Steven H. Woolf and Laudan Aron, eds., *US Health in International Perspective: Shorter Lives, Poorer Health* (Washington, DC: National Research Council and the Institute of Medicine of the National Academies, 2013).

18 Thomas A LaVeist, D. Gaskin, and P. Richard, *The Economic Burden of Health Inequalities in the United States* (Washington, DC: Joint Center for Political and Economic Studies, September 2009), http://www.ncbi.nlm.nih.gov/pubmed/21563622.

19 National Partnership for Action to End Health Disparities, *National Stakeholder Strategy for Achieving Equity* (Rockville, MD: U.S. Department of Health & Human Services, Office of Minority Health, April 2011); Samuel Sinyangwe, Dalila Butler, and Nisha Balaram, *Achieving Health Equity in Promise Neighborhoods: A Resource and Implementation Guide* (Oakland, CA: PolicyLink, 2014), http://www.policylink.org/sites/default/files/pl-report-health-equity-102914-a.pdf, 7; Lecia Bushak, "Black and Hispanic Children Have a 50% Chance of Getting Diabetes, Comparted to 40% of Americans Overall," *Medical Daily*, August

13, 2014, accessed October 2015, http://www.medicaldaily.com/black-and-hispanic-children-have-50-chance-getting-diabetes-compared-40-americans-overall-297960.

20 Susan Aud et al., *The Condition of Education 2013* (Washington, DC: National Center for Education Statistics, 2013), http://nces.ed.gov/pubs2013/2013037.pdf, 137; "Digest of Education Statistics: Table 314.20," National Center for Education Statistics, accessed November 2015, https://nces.ed.gov/programs/digest/2014menu_tables.asp; "Digest of Education Statistics: 2013 Introduction," National Center for Education Statistics, accessed November 2015, https://nces.ed.gov/programs/digest/d13/; "Data: United States," The World Bank, accessed November, 2015, http://data.worldbank.org/country/united-states; "Building on 11.7% Gain in FY2013, Education Endowments' Investment Returns Averaged 15.5% in FY2014," National Association of College and University Business Officers, http://www.nacubo.org/About_NACUBO/Press_Room/2014_NACUBO-Commonfund_Study_of_Endowments_(Final_Data).html; Avalere Health, *Trendwatch Chartbook 2014: Trends Affecting Hospitals and Health Systems* (Washington, DC: Avalere Health, 2014), 53; "Fast Facts on US Hospitals" ; Bradford, "Non-profits put investible assets under microscope"; "United States Labor Force Statistics," RI Department of Labor and Training, accessed November 2015, http://www.dlt.ri.gov/lmi/laus/us/usadj.htm.

21 "Fast Facts on US Hospitals"; language adapted from "2013 Sonoma County Community Health Needs Assessment," Sonoma County, http://www.sonoma-county.org/health/publications/pdf/needsassessment2013.pdf, 5.

22 American Hospital Association, *Economic Contribution of Hospitals Often Over Overlooked*, 1–2; Zuckerman, *Hospitals Building Healthier Communities*, 67-76, 87-96.

23 Bradford, "Non-profits put investible assets under microscope"; Eileen Barsi, "Hospitals Building Healthier Communities: Investing Outside Institutional Walls" (panel remarks at 2014 Association for Community Health Improvement National Conference).

24 Zuckerman, *Hospitals Building Healthier Communities*, 96-104.

25 Kaiser Permanente, "Kaiser Permanente's Commitment to Renewable Energy," Infographic, 2015.

26 Kaiser Permanente, "Health Care Food Purchasing Power," Infographic, 2015.

Design by John Duda, The Democracy Collaborative

CC icons by Rediffusion, Creative Stall ,Yi Chen, Martin Chapman Fromm, Jose Vanaclocha, Lemon Liu, Anton Gajdosik, Lloyd Humphreys, Castor & Pollux

CC map imagery from Stamen & Open Street Map